# Reforming Obamacare: How Congress, and the President, Can Win after *King v. Burwell*

**by John R. Graham, senior fellow**

## Executive Summary

The U.S. Supreme Court's decision on *King v. Burwell*, the lawsuit which asserts tax credits currently being paid to health insurers in 34 to 37 states that use the federal health insurance exchange (healthcare.gov) are illegal, could require almost seven million people to pay the full premiums for their Obamacare policies. This will cause a crisis, and demand a response, giving Congress the opportunity to remove some of Affordable Care Act's most harmful features.

A congressional response to *King v. Burwell* will be successful if President Obama signs a bill making at least one permanent change to the law that removes at least one of Obamacare's harmful effects.

**Six Reform Buckets.** This proposal contains reforms in six buckets, which can be adopted independently or comprehensively:

- Reforming Obamacare tax credits for premiums to reduce disincentives for beneficiaries to work more hours and increase their incomes.

- Combine Obamacare's tax credits and cost sharing subsidies so beneficiaries can decide themselves how much to pay directly for health goods and services versus how much to pay in premium to health insurers.



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- Allow beneficiaries to buy health insurance from brokers or agents, instead of the broken exchanges, and get tax credits through the IRS directly.

- Remove federal mandates on health insurance, such as age bands and mandated benefits, which increase cost.

- Remove the mandates on individuals and employers to purchase government-compliant health insurance.

- Combine these reforms with reforms unrelated to *King v. Burwell* or even Obamacare itself, in order to increase the likelihood of wining the president's signature.

**Outcomes.** If enacted fully, these reforms will:

- Reduce Obamacare's disincentives for workers to limit their hours and earnings.
- Give beneficiaries more control of the dollars spent on their health care.
- Free beneficiaries and taxpayers from Obamacare's unnecessary and expensive exchanges.
- Reduce the cost and increase choice of health insurance.
- Free employers to add hours and hire more workers without fear of being penalized.
- Reduce the cost to taxpayers of Obamacare, Medicare, and Medicaid.

Even if the Supreme Court rules in favor of the government and Health and Human Services Secretary Sylvia Mathews Burwell, these reforms would solve some of the problems created by the Affordable Care Act while helping fulfill the goals of increasing health insurance coverage and reducing costs to consumers, employers and taxpayers.

# Introduction

The U.S. Supreme Court's decision on *King v. Burwell*, the lawsuit which asserts tax credits currently being paid to health insurers in 34 to 37 states that use the federal health insurance exchange (healthcare.gov) are illegal, could require almost seven million people to pay the full premiums for their Obamacare policies.[1] Many would choose to drop coverage if and when they have to face paying full premium for their policies. This will cause a crisis, and demand a response, giving Congress the opportunity to remove some of Affordable Care Act's most harmful features.

A congressional response to *King v. Burwell* will be successful if President Obama signs a bill making at least one permanent change to the law that removes at least one of Obamacare's harmful effects.

**Congress Must Act**. Congress must prepare an alternative because President Obama will immediately propose an amendment to change the law to accord with how he is executing it. That is: Let tax credits continue to flow through healthcare.gov and just forget the money paid since January 2014 was illegal. It would be a very simple amendment — just a sentence or two. The risk of Congress panicking and simply voting for that amendment, and finally surrendering to Obamacare, is unacceptable.

Americans have had their health coverage upended not only by the Affordable Care Act, but also by the allegedly illegal execution of the law by the administration. Congress has a duty to respond to a court decision favoring *King* with a new law. However, it has to be one the

[1] Conor Ryan, "Updated *King v. Burwell* Impact: Who Loses Subsidies?" Weekly Checkup, American Action Forum, June 4, 2015.

president will sign, but will not leave the Republican-majority Congress' fingerprints on Obamacare. This is a tricky needle to thread.

**President Obama's Advantage**. This proposal makes a few assumptions about what is possible in the case of a *King v. Burwell* victory. First, it recognizes that President Obama himself is not up for re-election, and can likely withstand a backlash in public opinion longer than Congress. A congressional bill that simply provokes the president with anti-Obamacare talking points will be self-defeating.

Second, it recognizes that even governors and state legislators in the 34 to 37 states who have pledged to oppose Obamacare — to the extent of passing statutes or constitutional amendments prevent them from establishing exchanges — will feel overwhelming pressure from beneficiaries, insurers, hospitals, doctors and others in the he health care complex to quickly restore the cash flows lost to them from a victory for *King*.

Third, it recognizes that an alternate health reform — the much discussed but never seen bill to "repeal and replace Obamacare" might be very many years down the road. Congressional response to a *King v. Burwell* victory should incorporate permanent changes to Obamacare — no matter how small they might appear — rather than simply turn on the cash spigot until after the next election (also known as "kicking the can down the road"). A short-term extension of Obamacare subsidies, even for a year or two, risks being extended again and again as the years roll by and Congress and a new president fail to coalesce around an alternative, patient-centered reform.

A congressional response to *King v. Burwell* will be successful if it achieves two things. First, it must be signed by President Obama. Second, it must make at least one permanent change to the law that removes at least one of Obamacare's harmful effects.

**Six Reform Buckets.** This proposal contains a number of reforms in six buckets:

- Reforming Obamacare tax credits for premiums to reduce disincentives for beneficiaries to work more hours and increase their incomes.
- Combine Obamacare's tax credits and cost-sharing subsidies so beneficiaries can decide themselves how much to pay directly for health goods and services versus how much to pay in premiums to health insurers.
- Allow beneficiaries to buy health insurance from brokers or agents, instead of the broken exchanges, and get tax credits through the IRS directly.
- Remove federal mandates on health insurance, such as age bands and mandated benefits, which increase cost.
- Remove the mandates on individuals and employers to purchase government-compliant health insurance.
- Combine these reforms with reforms unrelated to *King v. Burwell* or even Obamacare itself, in order to increase the likelihood of wining the president's signature.

**Small, Significant Steps to Real Reform.** Other, bigger reforms will be called for in the years to come. However, there is no point in provoking Obamacare's supporters by emphasizing such reforms in the wake of a *King v. Burwell* victory. Each of the reforms described in the six categories defined in this papers stands independently. If only one of them is legislated, it would be a small but significant step towards real reform later. However, it is also reasonable to expect

that the president and Obamacare's supporters could accept a legislative package that contains all of them as a comprehensive and responsible answer to *King v. Burwell*.

## Flat-rate, Means-tested Tax Credits

Notches and cliffs are terms used to describe the effect of large changes in tax rates over small income ranges. Obamacare's notches and cliffs are best illustrated using the Kaiser Family Foundation's Health Insurance Marketplace Calculator.[2] For a family of four, with two 35-year old (nonsmoking) parents and two children, $23,850 is their household income at 100 percent of the Federal Poverty Level (FPL), which is the lower bound of the income range to claim Obamacare tax credits that reduce premiums. Their household income at 133 percent of the FPL would be $31,720. For households within this income range, their Obamacare premiums cannot exceed 2.01 percent of their incomes (see Table I). The Kaiser Family Foundation estimates the gross premium for the second least expensive Silver plan for this family would be $9,625.

If the household income were $23,850, the family's maximum annual premium would be $479 (2.01 percent of $23,850), so it would benefit from a tax credit of $9,146 ($9,625 minus $479) paid to its health insurer. If the family's income rose to $31,720, its maximum annual premium would be $638, so its tax credit would go down to $8,987. The household income has increased $7,870, and its tax credit has dropped $159. Effectively, the household has experienced an income tax rate of 2.01 percent ($159 divided by $7,870).

[2] Kaiser Family Foundation, "Health Insurance Marketplace Calculator." Available at http://kff.org/interactive/subsidy-calculator/.

This rate is consistent along the entire range of income between 100 percent and 133 percent of the FPL. However, when household income increases by one dollar from $31,720 to $31,721, the household is liable to pay 3.02 percent of household income ($958) for the same plan. For an increase of one dollar of income, the household net premium increases by $320 (from $638 to $958), resulting in a net loss of $319 and an effective marginal income tax of *32,000 percent*!

**Table I**
**Premium Cap by Income, 2015**
**(Family of Four)**

| A Percentage of Federal Poverty Line | B Household Income | C Premium Cap as Percentage of Income |
|---|---|---|
| **100 - 133** | **$23,850 - $31,720** | **2.01** |
| **133 - 150** | **$31,721 - $35,775** | **3.02 - 4.02** |
| **150 - 200** | **$35,776 - $47,700** | **4.02 - 6.34** |
| **200 - 250** | **$47,701 - $59,625** | **6.34 - 8.1** |
| **250 - 300** | **$59,626 - $71,550** | **8.1 - 9.56** |
| **300 - 400** | **$71,551 - $95,400** | **9.56** |

Source: "Explaining Health Care Reform: Questions About Health Insurance Subsidies," Issue Brief, Kaiser Family Foundation, October 27, 2014, pages 2-3; author's calculations.

The net effect of the income increase and the premium increase does not balance until the household income reaches $32,097 (at which point the increase in both income and premiums is $359).

However, few would seek to work more hours if it resulted in no net increase in take-home pay. Even a 10 percent income increase (from $31,720 to $34,892) results in a marginal income

tax rate of 62 percent (an increase in premiums of $1,965 divided by an income increase of $3,172). A 15 percent income increase results in a marginal income tax rate of 18 percent ($878 increase in premiums divided by a $4,758 increase in income). At that tax rate, it is reasonable to conclude the extra work might be worth the effort. However, it is not that easy for people in this income range to just increase their hours 15 percent. This perverse effect riddles the design of Obamacare's tax credits all the way up to 400 percent of FPL (see Table I). It may be the most important reason for the stagnation of work among hourly employees.[3]

Some Obamacare supporters dismiss the argument that the high proportion of part-time workers not working at full capacity is a problem by noting that the effect is attributable to "voluntary" part-time work. However, the extremely high marginal income tax cliffs and notches in Obamacare explain why people are "voluntarily" working fewer hours than otherwise.[4]

**The Solution: Flat-rate, Means-tested Tax Credits.** NCPA has long championed a refundable health tax credit for every American. However, this is a fundamental reform well beyond the opportunity available after a *King v. Burwell* victory. What is reasonable to assume is that the president could consider reforming the design of Obamacare's tax credits to minimize the disincentive to work.

This could be achieved by reducing a fixed share of the tax credit for every dollar increase in income (which would effectively be a flat rate of income tax). This flat rate reform can be illustrated simply by households within each decile bounding the range within which tax credits

[3] For a very detailed technical discussion of the effects of all of Obamacare's labor killing marginal income tax "cliffs" and "notches," see Casey Mulligan, *Side Effects: The Economic Consequences of the Health Reform* (Flossmoor, Ill.: JMJ Economics, 2014).

[4] John R. Graham, "Obamacare and Employment," *NCPA Health Policy Blog*, National Center for Policy Analysis, September 8, 2014, http://healthblog.ncpa.org/obamacare-and-employment/, accessed June 1, 2015.

are currently paid [see Table II]. The $23,850 household receives a tax credit of $9,654, which is actually $508 *more* than it receives under Obamacare. Five of the 10 households appear slightly worse off than under Obamacare [see Column F]. However, even the worst off household is only $431 worse off, about $34 a month. This is the $71,551 household, which most would consider middle class.

## Table II
## Premium Tax Credits and Net Premium for Households by Income, 2015
## (ACA and Budget-neutral, Flat-rate Reform)

| | Obamacare | | Flat Rate Reform | | |
|---|---|---|---|---|---|
| A | B | C | D | E | F=E-C |
| Household Income (Deciles) | Net Premium | Tax Credit | Net Premium | Tax Credit | Difference in Tax Credit |
| $23,850 | $479 | $9,146 | $479 | $9,654 | $508 |
| $31,800 | $967 | $8,658 | $1,044 | $8,581 | -$77 |
| $39,750 | $1,905 | $7,720 | $2,116 | $7,509 | -$211 |
| $47,700 | $3,024 | $6,601 | $3,189 | $6,436 | -$165 |
| $55,650 | $4,181 | $5,444 | $4,262 | $5,363 | -$81 |
| $63,601 | $5,461 | $4,164 | $5,334 | $4,291 | $127 |
| $71,551 | $5,994 | $3,631 | $6,407 | $3,218 | -$413 |
| $79,501 | $7,600 | $2,025 | $7,480 | $2,145 | $120 |
| $87,451 | $8,360 | $1,265 | $8,552 | $1,073 | -$192 |
| $95,401 | $9,625 | $0 | $9,625 | $0 | $0 |

Source: Kaiser Family Foundation, "Health Insurance Marketplace Calculator." Available at http://kff.org/interactive/subsidy-calculator/. Access verified June 1, 2015; author's calculations. Household of two 35-year old nonsmoking adults and two children. Gross premium for second least expensive Silver plan is $9,625.

The tax credit phases out at a rate of 13.49 percent. That is, every $100 increase in household income would result in a decrease of $13.49 in tax credit. There are no "notches" or "cliffs": It is a straight line. Each household listed as an example in Table II has an income $7,950 higher than

the household before it, and each experiences a reduction in tax credits of $1,073 under the flat rate reform. Relative to Obamacare, *everybody* wins because *nobody* has an incentive to limit his working hours because of a reduction in take-home pay.

Further, this flat rate reform also satisfies a budget constraint [see Table III].To illustrate, suppose there are 100 households of this size, of which 20 earn $23,850, 20 earn $31,800, and so forth [see Column B].[5] The total amount spent on tax credits for these households is $713,325 under both Obamacare and the flat rate reform [see Columns C and D]. Moving from this illustration to the real world, the actual flat rate at which the tax credit would phase out for Obamacare's approximately 10 million beneficiaries depends on detailed data on the income distribution of households actually receiving tax credits, which is not yet available.[6] The budget constraint illustrated here does not reduce spending versus the status quo. However, if this reform were included with others described in this proposal, spending could be reduced.

**Table III**
**Budget Constrained Premium Tax Credits, Obamacare and Budget Neutral Flat Rate Reform, 2015 (N=100)**

| A | B | C | D |
|---|---|---|---|
| **Household Income (Deciles)** | **Number of Households (N=100)** | **Obamacare** | **Flat Rate Reform** |

[5]This is the same model household introduced above: Two 35-year old nonsmoking parents and two children. The distribution is estimated from the distribution of actual Obamacare enrolment by household income in "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," ASPE Issue Brief, U.S. Department of Health & Human Services, March 10, 2015, page 14.

[6] It is not possible with publicly available data to model a complete distribution of current Obamacare beneficiaries' household size and income. The administration has released some data on age and income distribution, but not household composition.

| | | | |
|---|---|---|---|
| **$23,850** | **20** | **$182,920** | **$193,081** |
| **$31,800** | **20** | **$173,160** | **$171,627** |
| **$39,750** | **20** | **$154,400** | **$150,174** |
| **$47,700** | **15** | **$99,015** | **$96,540** |
| **$55,650** | **15** | **$81,660** | **$80,450** |
| **$63,601** | **2** | **$8,328** | **$8,581** |
| **$71,551** | **2** | **$7,262** | **$6,436** |
| **$79,501** | **2** | **$4,050** | **$4,291** |
| **$87,451** | **2** | **$2,530** | **$2,145** |
| **$95,401** | **2** | **$0** | **$0** |
| **Total** | **100** | **$713,325** | **$713,325** |

Household of two 35-year old nonsmoking adults and two children. Gross premium for second least expensive Silver plan is $9,625. Distribution of households estimated from "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," U.S. Department of Health & Human Services, ASPE Issue Brief, March 10, 2015, page 14.

This flat rate reform should be acceptable to both Republicans and Democrats, both of whom endorse means testing Medicare Part B and Part D premiums.[7] This flat rate reform *alone* would result in minor changes to Obamacare's cash flows with significantly positive effects on beneficiaries' incentives to work.

# Problem: Obamacare Benefits Go to Health Insurers, Not People

Although Obamacare plans have high deductibles and many Obamacare plans are eligible for Health Savings Accounts, they are not "consumer driven" as properly defined.[8] Obamacare's plans are regulated by "metallic" tiers: A Bronze plan must pay for 60 percent of beneficiaries'

[7] Medicare Part B and D means testing imposes "notches" or "cliffs" similar to those currently under Obamacare. It is more important to remove them from Obamacare, because the affected population is earning wages, not pension income.

[8] Paul Howard and Yevgeniy Feyman, "Health Savings Accounts Under the Affordable Care Act," Medical Progress Report No. 18, Manhattan Institute for Policy Research, October 2014.

expected medical expenses over year. For Silver, Gold, and Platinum, the proportions are 70 percent, 80 percent and 90 percent.

These bands have a small amount of flexibility, but not much. A Bronze plan can cover 58 percent to 60 percent of medical expenses, a Silver plan 68 percent to 72 percent, and so forth. However, any plan outside these very narrow bands is illegal. Suppose a person would prefer to pay directly for one-fourth of his expected medical expenses and buy insurance for three-fourths. That is forbidden under Obamacare.[9] Scholars have recently estimate minimum actuarial values increase the cost of the least expensive plans by 8 percent.[10]

Further, there is compelling evidence that health insurers are designing plans with benefits that adhere to the regulations but seek to enroll the healthy and shun the sick, and that this feature is worse in 2015 than 2014. For example, drugs for HIV, cancer and multiple sclerosis are almost always on the most expensive tier of plan's formularies, demanding 40 percent co-pays.[11]

Even organizations that strongly support Obamacare have recognized its beneficiaries struggle to pay for care under these conditions. Families USA reports that:

> "Lower- to middle-income adults who were insured for the full year were significantly more likely than those with higher incomes to forgo needed care because they could not

[9] Robert Graboyes, "Why Your Health Plan Was Cancelled: Health Insurance and the Affordable Care Act," Mercatus Center, September 22, 2014.

[10] Edmund F. Haislmaier and Drew Gonshorowski, "Responding to King v.; Burwell: Congress's First Step Should be to Remove Costly Mandate's Driving Up Premiums," Issue Brief No. 4400, The Heritage Foundation, May 4, 2015.

[11] John R. Graham, "Obamacare Health Plans Shun the Sick More in 2015 than 2014," *NCPA Health Policy Blog*, National Center for Policy Analysis, http://healthblog.ncpa.org/obamacare-health-plans-shun-the-sick-more-in-2015-than-2014/, accessed June 3, 2015.

afford it: Nearly one-third (32.3 percent) of lower- to middle-income adults didn't get needed medical care (excluding dental care) because they could not afford it."[12]

The Commonwealth Fund characterizes a household as "underinsured" if it spends at least 10 percent of household income on health care (or five percent for poor households, or if its deductible is at least 5 percent.) Whether or not one thinks this is a meaningful measurement, Obamacare has not reduced it. The percentage of adults with individual policies who were underinsured rose from 17 percent in 2003 to 45 percent in 2012, and then declined slightly to 37 percent in 2014. "The decline in 2014 was not statistically significant."[13]

One reason these problems persist is that every penny of the billions of dollars taxpayers are paying to underwrite Obamacare goes to health insurers. Not one penny goes to the beneficiaries themselves, so they can decide which health goods and services to pay for directly and how much to pay in health insurance premiums.

As well as the tax credits discussed above (which are used only to discount premiums), the federal government reduces out-of-pocket costs for Obamacare beneficiaries whose household incomes are below 250 percent of the FPL. However, just like the tax credits, the cost sharing subsidies are paid to health insurers, who apply them to beneficiaries' out-of-pocket spending. Beneficiaries are effectively prevented from exercising true consumer choice by making their own decisions about value for money.

[12] "Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care,: Families USA, May 2015, page 14.

[13] Sara R. Collins, *et al.*, "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014,"Commonwealth Fund, May 2015, page 3.

**Solution: Give Benefits to Patients, Not Health Insurers.** For fiscal year 2015, premium tax credits will be about $19 billion and cost-sharing subsidies about $2.5 billion.[14] Combined they are about $21.5 billion. The ratio of cost-sharing subsidies to tax credits should remain approximately constant going forward, although Obamacare spending overall increases significantly in 2016 and future years.

Whatever amount is budgeted for subsidies by Congress in response to a *King v. Burwell* victory, these two accounts should be merged into one, and allocated directly to households. Each household will make its own decision about how much to spend directly on medical goods and services, and how much to spend on premium for health insurance.

# Obamacare Exchanges

*King v. Burwell* came about because of disputed understandings of state versus federal exchanges. However, government exchanges themselves are unnecessary bureaucracies that add no value to consumers' shopping for their own health plans. There is no more need for the Department of Health & Human Services to run a health insurance exchange than there is for the Department of Motor Vehicles to run an auto insurance exchange or the Department of Housing & Urban Development to run a homeowners' insurance exchange.

[14] Author's estimate using data and estimates from "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," Congressional Budget Office, March 9, 2015, table 1; Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as amended," Centers for Medicare & Medicaid Services, Office of the Actuary, April 22, 2010, table 1; Matthew Buettgens and Caitlin Carroll, "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care," Urban Institute, January 2012, page 5; and Angela Boothe and Brittany La Couture, "The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors, and Risk Adjustment," American Action Forum, January 9, 2015.

**Problem: Exchanges Are Expensive and Unnecessary Bureaucracies.** Despite most exchanges not operating as horribly in 2015 as in 2014, customer service is still poor, and exchanges are not educating consumers about the consequences of their choices, according to a recent survey by researchers from Wharton Business School:

> "....when users were provided with non-standardized plans sorted by price, an overwhelming 60% relied on a simple rule of thumb for making their selection: choose the plan with the lowest monthly premium. This emphasis on premium cost defeats the entire purpose of the exchanges.
>
> "The portals also came up short in helping consumers understand what they were purchasing. Research has shown that health insurance consumers have only a limited understanding of technical aspects of how health insurance works. …… only 14% of consumers were able to correctly answer four multiple-choice questions about the most important terms in health care: deductibles, copays, premiums and maximum out of pocket costs."[15]

In the event of a *King v. Burwell* decision against Burwell, states will have to establish their own exchanges to keep tax credits flowing, unless Congress changes the law. However, current state-based exchanges are failing:

> "Nearly half of the 17 insurance marketplaces set up by the states and the District under President Obama's health law are struggling financially, presenting state officials with an

[15] Daniel Polsky and Heather Howard, "What Window Shopping the Health Insurance Exchanges in Year Two Revealed About the State of the Consumer Experience," *Issue Brief*, Vo. 3, No. 1 (February, 2015), pages 1-6.

unexpected and serious challenge five years after the passage of the landmark Affordable Care Act.

"Many of the online exchanges are wrestling with surging costs, especially for balky technology and expensive customer call centers — and tepid enrollment numbers. To ease the fiscal distress, officials are considering raising fees on insurers, sharing costs with other states and pressing state lawmakers for cash infusions."[16]

Most recently, Hawaii just decided to shut down its exchange by September 30, after receiving over $200 million in federal funding to set up and operate it for less than two years. It will have to spend another $30 million to migrate to the federal exchange.[17]

The federal government granted $5 billion to states through October 14, 2014, to help them set up exchanges.[18] Only a minority of states went ahead and set them up. As of this year, there is no more federal money to maintain these exchanges. States will have to find operating money somewhere else, and many have chosen to tax Obamacare beneficiaries with surcharges on their premiums. However, identifying stable funding sources for the millions of dollars it takes to operate an exchange every year has proven politically challenging in most state legislatures.[19]

As for states using the federal healthcare.gov exchange, the federal government is now levying a 3.5 percent "user fee" on insurers to fund healthcare.gov's rapidly growing operating

[16] Lena H. Sun and Niraj Chokshi, "Almost half of Obamacare exchanges face financial struggles in the future," *Washington Post*, May 1, 2015.

[17] Kristen Consillio, "Ige administration plans to use federal exchange for Obamacare, *Honolulu Star Advertiser*, May 13, 2015.

[18] Annie L. Mach and C Stephen Redhead, "Federal Funding for Health Insurance Exchanges," Congressional Research Service, October 29, 2014, page 2.

[19] Paul Demko, "States struggle to fund Obamacare exchanges in 2015," *Modern Healthcare*, June 14, 2014.

costs — from $1.4 billion in 2014 to $1.8 billion this year. Last January, the Office of the Inspector General of the U.S Department of Health & Human Services issued the latest in a series of reports examining the contracting processes for the federal exchange, concluding that the administration "chose contract types that placed the risk of cost increases solely on the Government."[20]

**Solution: Get Government Out of the Exchange Business.** We know that the state and federal governments can walk away from these exchanges and that private brokers, like eHealthInsurance.com or Getinsured.com, will do the job at no cost to taxpayers.

They did it in the individual market for health insurance before Obamacare, and they continue to do it for Medicare Advantage plans. Indeed, while Obamacare exchanges have devoured eHealth's private individual health insurance brokerage business, its Medicare Advantage business is doing well, increasing 46 percent last year.[21]

Indeed, Obamacare exchanges are so bad that venture capitalists are funding new private exchanges to fill the gap — with no operating costs to taxpayers:

> "Looking to provide health insurance to the 53 million Americans who don't get benefits from their employers, Stride Health has raised $13 million in new funding.
>
> "For the freelancers and independent contractors who make up one third of the U.S. labor force, Stride offers a hassle-free alternative to Healthcare.gov.

[20] Daniel R. Levinson, "Federal Marketplace: Inadequacies in Contract Planning and Procurement," OEI-03-14-00230, U.S. Department of Health & Human Services, Office of the Inspector General, January 2015, page 10.

[21] John R. Graham, "eHealth, Inc.: Obamacare's Biggest Winner Becomes Its Biggest Victim," *Forbes*, March 18, 2015.

> "After you enter your own data, including age, gender, location, and illness history, Stride's forecasting model evaluates how much care you'll use throughout the year, prices it on every health plan, and couples it with the coverage price to show you the total cost of each plan."[22]

Unfortunately, Stride Health and other brokers — whether online, on the phone or in person, still have to direct people to government exchanges, because that is the only way for them to benefit from tax credits.

This constraint should be abolished, so that beneficiaries apply for tax credits from the IRS, as we do for other personal income tax credits. This reform is independent of both the individual amount of any tax credit and the appropriated budget allocated for tax credits overall.

# Reforming Obamacare Mandates

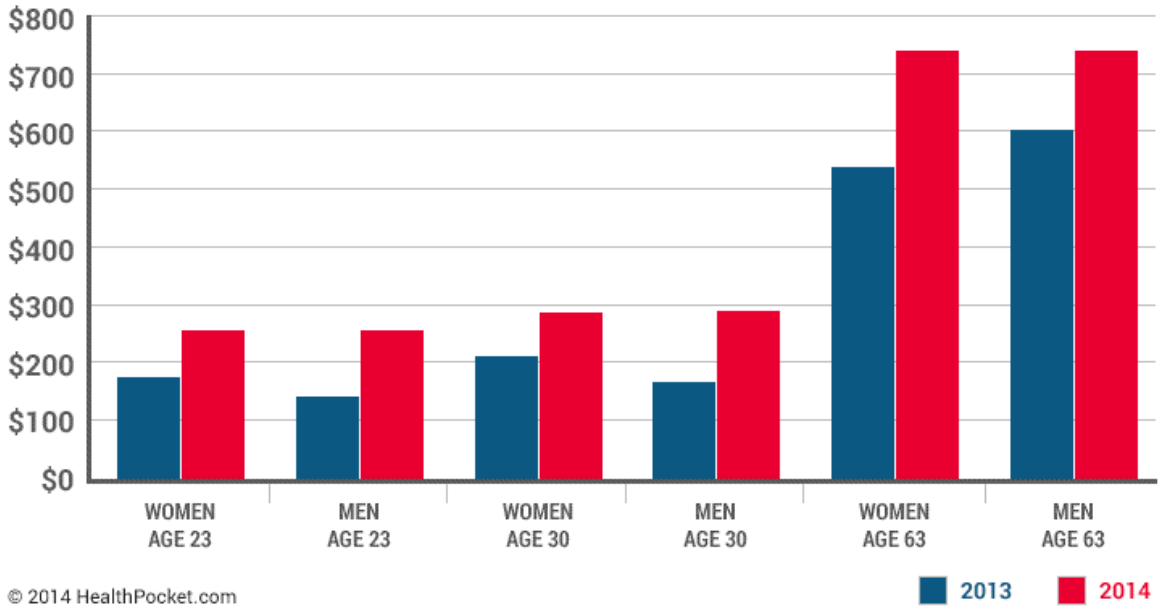
HealthPocket, an online insurance broker, measured the increase in premiums for every age group in 2014 versus the pre-Obamacare individual market, and concluded that they increased by double digits for every age group [see Figure I].[23]

[22] Christine Magee, "Stride Health Raises $13M To Be The HR Platform For Freelancers," *TechCrunch*, May 2, 2015.

[23] "Without Subsidies Women & Men, Old & Young Average Higher Monthly Premiums With Obamacare," HealthPocket, InfoStat, October 29, 2014.

**Figure I**

**AVERAGE MONTHLY PREMIUM COSTS BEFORE AND AFTER THE AFFORDABLE CARE ACT**




**Problem: Obamacare's Mandates Drive Up Costs.** What is remarkable is the increase in rates for 63-year olds: 37.5 percent for women and 22.7 percent for men [see Figure II]. Obamacare forbids accurate pricing by age. The difference in rates between young adults and older ones can be no greater than three to one. This must raise rates for younger people, because the actuarial consensus is that average health spending for 63-year olds is five times that of 22-year olds.[24]

Politically, the purpose of squeezing the age bands is obvious: The younger person, who is unlikely to vote, subsidizes the older person, who is much more likely to vote. Obamacare disguises these true premiums by offering health insurers tax credits to reduce the net premium people pay, thus fooling many into thinking that premiums have gone down.

[24] John R. Graham, "Government Accountability Office Confirms Health Insurance Rating Rules Hike Premiums for Young People," *NCPA Health Policy Blog*, National Center for Policy Analysis, August 6, 2013, accessed June 1, 2015.

**Figure II**

| | ♀ WOMAN AGE 23 | ♂ MAN AGE 23 | ♀ WOMAN AGE 30 | ♂ MAN AGE 30 | ♀ WOMAN AGE 63 | ♂ MAN AGE 63 |
|---|---|---|---|---|---|---|
| 2013 | $178 | $145 | $216 | $168 | $539 | $603 |
| 2014 | $258 | $258 | $292 | $292 | $741 | $741 |
| **Difference** | **44.9%** | **78.2%** | **35.1%** | **73.4%** | **37.5%** | **22.7%** |



Another issue is the difference in changes for men versus women. Obamacare's supporters made a big show about outlawing "discrimination" against women, and forcing insurers to charge the same rate for both sexes. Premiums for women of child-bearing age had been higher primarily because of the costs of childbirth. However, this turns around after child-bearing age: Men have higher costs.[25] So, Obamacare caused a higher increase in premiums for older women than older men [see Figure II].

The Government Accountability Office confirms that preventing accurate pricing of health-insurance by age imposes higher premiums on young people.[26] Before Obamacare, some states imposed limits on age rating even tighter than Obamacare, while others states did not forbid accurate premium pricing by age. For a 30-year old, non-smoking male, monthly premiums in the three most expensive states were $2,564 (Massachusetts), $2,232 (New Jersey) and $1,986

[25] "How Will Premiums Change Under the ACA?," American Academy of Actuaries, Issue Brief, May 2013, page 3.

[26] The Range of Base Premiums in the Individual Market by State in January 2013," Government Accountability Office, July 23, 2013.

(New York). For the same man, premiums in the three least expensive states were $349 (Nebraska) and $363 (Georgia and Texas).

The difference was not driven solely by forbidding insurers from charging accurate premiums to young people. Nevertheless, forcing an average 30-year old man to pay the extra $2,215 monthly ($26,580 per year) to bear the burden of his elders' higher health spending is unfair. New York forced health insurers to charge the same premium to all adults. Massachusetts and New Jersey allowed insurers to blend age with other factors such that the most expensive premiums can be double the lowest.

Obamacare imposes three to one age bands nationwide. Actuarial consensus is that the average 62-year old incurs five times the medical costs of the average 22-year old.[27] Scholars at the Heritage Foundation conclude that Obamacare's age rating restrictions increase premiums for younger adults by about one third.[28]

Obamacare also imposes mandatory benefits, called Essential Benefits Mandates, to a degree previously unprecedented by the federal government. These so-called essential benefits fall into

[27] "Rate Regulation," National Association of Insurance Commissioners & The Center for Insurance Policy and Research, undated. Available at http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf. Access verified August 6, 2013.

[28] Edmund F. Haislmaier and Drew Gonshorowski, "Responding to King v.; Burwell: Congress's First Step Should be to Remove Costly Mandate's Driving Up Premiums," Issue Brief No. 4400, The Heritage Foundation, May 4, 2015.

10 categories, such as ambulatory services and pediatric services.[29] The Heritage Foundation concludes that benefit mandates increase premiums by an average of 9 percent.[30]

**Solution: Remove Obamacare's Mandates, Especially Age Bands**. Although removing all Obamacare's mandates would reduce the price of health insurance significantly, it is unlikely that a *King v. Burwell* victory would lead to such an opportunity, because the president could easily grandstand by accusing Congress of wanting to take away benefits. Given the limited opportunity, Obamacare's age bands would be the best target to engage. This would have the added benefit of significantly reducing the amount of taxpayers' dollars required for Obamacare tax credits.

Although we do not know the correlation between age and income in the exchanges themselves, we know that younger households earn less than older ones. For example, in 2011, the median household income for households with a head of household between 15 and 24 was about $25,000.[31] People ages 18 through 24 comprise 11 percent of 2015 Obamacare exchange enrollees.[32] These people are surely almost entirely subsidized by Obamacare's tax credits.

Take an example from the administration itself:

[29] Justin Giovannelli *et al.*, "Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements," Commonwealth Fund, October 2014.

[30] Edmund F. Haislmaier and Drew Gonshorowski, "Responding to King v.; Burwell: Congress's First Step Should be to Remove Costly Mandate's Driving Up Premiums," Issue Brief No. 4400, The Heritage Foundation, May 4, 2015.

[31] Author's calculations from "Current Population Survey 2012 Annual Social and Economic Supplement," U.S. Census Bureau, 2012, table number HNC-02.

[32] "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," U.S. Department of Health & Human Services, ASPE Issue Brief, March 10, 2015, page 23.

> "For example, the amount that a 27-year-old woman with an income of $25,000 (218 percent of the FPL) would pay for the second-lowest cost silver plan is capped at $145 per month. If she lived in Jackson, Mississippi, the premiums for the second-lowest cost silver plan available would cost her $336 per month before tax credits. Therefore, the amount of the premium tax credit would be $191 per month—the difference between specified contribution to the benchmark plan and the actual cost of the benchmark plan. Her use of the tax credit would not be restricted to the second-lowest cost silver plan. She could apply the $191 per month tax credit toward any plan of her choosing in any metal level. By applying her tax credit to the lowest-cost bronze plan in Jackson, which is priced at $199 per month, she could obtain Marketplace coverage for just $8 per month after tax credits."[33]

If the age rating restrictions were lifted, the premium for the second-lowest cost silver plan could easily be expected to drop to $270, a reduction of $66. The tax credit would drop by the same amount. $66, which amounts to a drop of over one third from $191. Aggregated over the entire Obamacare population, this would dramatically reduce Obamacare's claim on taxpayers.

# Individual and Employer Mandates

The employer mandate, which penalizes employers of at least 50 full-time employees (defined as working at least 30 hours a week) that do not offer health benefits, is so unpopular the administration has already delayed it one year. The problem with the employer mandate is

[33] Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," U.S. Department of Health & Human Services, ASPE Issue Brief, March 10, 2015, page 4. FPL stands for Federal Poverty Level.

that it causes employers who do not offer benefits to cut back workers' hours and refrain from hiring more workers, lest they trigger the mandate.

Several large firms have announced that they would reduce hours for part-time workers to less than 30 (Land's End, Regal Entertainment, Wendy's and SeaWorld). In a different response, Trader Joe's and Target stopped providing coverage to part-time workers (those typically working fewer than 30 hours per week), believing most would be better off with subsidized coverage in Obamacare exchanges.[34] Smaller firms, which the media do not follow closely, are surely behaving similarly.

In August 2014, the Federal Reserve Bank of New York surveyed employers in that state, specifically about the effects of Obamacare:

- Twenty percent expected to increase the proportion of part-time workers, versus only five percent who expect to go the other way.
- About 22 percent planned to cut wages and benefits, versus only six percent who planned to increase them.
- With respect to benefits, 68 percent (two-thirds) of business leaders planned to cut the range of services covered or size and breadth of their provider networks.[35]

The Federal Reserve Bank of Philadelphia released similar results for the Mid-Atlantic states. Because of Obamacare:

[34] Linda J. Blumberg, John Holahan and Matthew Buettgens, "Why Not Just Eliminate the Employer Mandate," Urban Institute, May 2014, page 2.

[35] "Empire State Manufacturing Survey/Business Leaders Survey: Supplemental Survey Report," Federal Reserve Bank of New York, August 2014.

- 18.2 percent of employers reported that they cut workers, versus 3.0 percent who hired more.

- 18.2 percent reported that the proportion of part-time workers was higher, versus 1.5 percent who lowered the proportion of part-timers.

- 41.2 percent reported the range of medical coverage is lower, versus 2.9 percent who increased coverage.

- 26.5 percent reported that the size and breadth of their provider network was lower, versus zero who broadened their network.[36]

Casey Mulligan, an economist at the University of Chicago, concludes that 3.6 million to 6.9 million workers will effectively have their work hours taxed 100 percent or more as a consequence of the employer mandate.[37] The Urban Institute, a supporter of Obamacare, opposes the employer mandate. Urban Institute researchers estimate repeal would have a very small effect on coverage (reducing the total number of Americans covered from 251.1 million to 250.9 million) and reduce revenues by $4 billion in 2016, but remove labor market disincentives that are hurting employment.[38]

Given the administration's previously demonstrated willingness to relieve the burden of this mandate, an overall repeal would be a reasonable goal in the wake of *King v. Burwell*.

[36] "Business Outlook Survey," Federal Reserve Bank of Philadelphia," August 2014.

[37] Casey Mulligan, *Side Effects: The Economic Consequences of the Health Reform* (Flossmoor, IL: JMJ Economics, 2014), location 1051.

[38] Linda J. Blumberg, John Holahan and Matthew Buettgens, "Why Not Just Eliminate the Employer Mandate," Urban Institute, May 2014, page 4.

**The Individual Mandate.** A *King v. Burwell* victory would make Obamacare policies in most of the country "unaffordable" and thereby relieve 11.1 million people of the extremely unpopular mandate.[39] Any legislative response that re-imposes the mandate would be political kryptonite for this Congress.

However, the most popular provision of the law is the prohibition against health insurers taking pre-existing conditions into account when setting premiums or scheduling benefits. Obamacare's supporters insist the two features go hand in glove. Because the law forces health insurers to accept any applicants without taking pre-existing conditions into consideration, it must be coupled with an individual mandate.

If not coupled with a penalty (or fine or tax) for not having health insurance, people would simply wait until they get sick or injured and then buy health insurance. This leads to a so-called death spiral as health insurers increase their premiums in response to individuals' behavior. It is an impeccable theory, but it does not hold up in a system run by politicians.

In 2012, the Congressional Budget Office (CBO) estimated 6 million people would pay fines amounting to $9 billion for not complying with the individual mandate in 2016. In 2014, CBO reduced its estimates to 4 million people and $6 billion.[40] The mandate is shriveling away because it is politically painful for the administration, which is bending over backwards *not* to impose penalties. As Joseph Antos and Michael Strain of the American Enterprise observed:

[39] Brittany La Couture and Douglas Holtz-Eakin, "TaKing Stock: The Potential Impact of *King v. Burwell*," American Action Forum, May 13, 2015.

[40] "Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update," Congressional Budget Office, June 2014.

> "…. the law counts on most of the scofflaws turning themselves in. If you do not have insurance and think you owe the tax, then you will be asked to check a box to that effect on your tax return. If you choose to ignore the mandate, you might also choose not to check the box. But even those who do confess that they do not have insurance may not be liable for the new tax. Illegal aliens, Native Americans, prisoners, those who are without insurance for less than 3 months, those who do not have to file an income tax return, anyone who faces a hardship or cannot find affordable coverage, and others are all exempt."[41]

In fact, it is government handouts, not penalties, which drive Obamacare enrollment: Over four of five Obamacare enrollees benefit from tax credits which artificially reduce premiums.[42] To be sure, some people would drop Obamacare without an individual mandate. Some 62 percent of 2015's new Obamacare enrollees said they got insured because "someone told me I would have to pay a penalty if I don't get coverage."[43] However, it is too easy to exaggerate this consequence.

Supporters of the individual mandate point to a 2012 analysis by scholars at the Urban Institute, which estimated Obamacare without the individual mandate would insure 14 to 16 million fewer than with a mandate.[44] However, this analysis is outdated because it anticipated 15.3 million people in Obamacare exchanges (of which 55 percent would receive tax credits) and

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[41] Joseph Antos and Michael R. Strain, "Health Care's New Rules: If You Don't Buy Insurance, Will You Really Pay the Tax?" *The Health Care Blog*, July 27, 2012, http://thehealthcareblog.com/blog/2012/07/27/health-cares-new-rules-if-you-dont-buy-insurance-will-you-really-pay-the-tax/, accessed June 1, 2015.

[42] "March 31 Effectuated Enrollment Snapshot," Centers for Medicare & Medicaid Services, June 2, 2015.

[43] "2015 OEP: Insight into consumer behavior**,"** McKinsey & Company, March 2015, page 7.

[44] Matthew Buettgens and Caitlin Carroll, "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care," Urban Institute, January 12, 2012.

a reduction of 5.8 million in employer-based plans. Actual Obamacare enrollment is about 10 million people, of which 85 percent are receiving tax credits.[45] The number of people with employer-based benefits *increased* by 8 million from September 2013 to February 2015.[46]

Further, relief from the individual mandate, *with no other changes* to Obamacare as currently executed, has significant social benefits. One argument in favor or compulsory insurance is that the uninsured impose costs on society by presenting at emergency rooms, provoking a crisis of so-called uncompensated care. This argument is unsubstantiated.

Even according to the Urban Institute's analysis, removing the individual mandate would increase spending on uncompensated care (for newly uninsured individuals) by $20 to $23 billion in one year. However, spending by government, employers and individuals would drop by $69 to $82 billion. The benefits of repealing the individual mandate would be at least three times greater than the cost. This is corroborated by the CBO, which estimated repealing the individual mandate would *reduce* deficits by $464 billion in the 10 years through 2024.[47]

## Increasing Chances of Success after *King v. Burwell*

As Congress develops an Obamacare reform in the wake of a *King v. Burwell* decision, it will benefit from a shrinking cost estimate for Obamacare. The CBO's latest budget baseline, published in March 2015, estimates the gross cost of Obamacare's various private insurance

[45] "March 31 Effectuated Enrollment Snapshot," Centers for Medicare & Medicaid Services, June 2, 2015.

[46] John R. Graham, "Economic Growth Improved Health Coverage More Than Obamacare Did," *NCPA Health Policy Blog*, National Center for Policy Analysis, May 11, 2015, http://healthblog.ncpa.org/economic-growth-improved-health-coverage-more-than-obamacare-did/, accessed June 2, 2015.

[47] "Estimate of the Budgetary Effects of S. 40, the American Liberty Restoration Act, as introduced on January 22, 2013," Congressional Budget Office, March 21, 2014.

subsidies and Medicaid spending for the years 2016 through 2025 will be $1.7 trillion. This is $286 billion less than it had estimated in January 2015.[48]

Even more impressive are the reductions in the cost of Obamacare from the CBO's original 2010 score.[49] The two estimates overlap for the seven years, 2015 through 2021. The original estimate was that Obamacare's gross cost would be $1.4 trillion over the period, and the net cost $1 trillion. These have shrunk to $992 billion and $751 billion, respectively, for reductions of 28 percent and 29 percent.

When the CBO issues a new baseline, it updates its estimate of Obamacare's insurance provisions. What it does *not* explicitly do is update its estimate of revenues from the host of other taxes in the Affordable Care Act. Further, previous estimates have not used so-called "dynamic scoring," which Congress has now directed CBO to use. Dynamic scoring takes into account changes in behavior that result from reducing taxes. The incoming director of the CBO has stated that dynamic scoring will reduce the cost of repealing Obamacare (or, presumably, any pieces of Obamacare).[50]

**Gathering Allies to Build a Bridge Out of Obamacare**. These developments indicate a bill responding to *King v. Burwell* could invite the CBO to reconsider Obamacare comprehensively, which could help efforts to repeal some of Obamacare's taxes, including:

[48] "Insurance Coverage Provisions of the Affordable Care Act— CBO's March 2015 Baseline," Congressional Budget Office, March 9, 2015.

[49] Douglas W. Elmendorf, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," testimony before the Subcommittee on Health, U.S. House of Representatives Committee on Energy and Commerce, March 30, 2011.

[50] John Wilkerson, "CBO Says Dynamic Scoring Would Lower the Cost of Repeal," *Inside Healthcare Policy*, June 3, 2015.

- the medical device excise tax,
- the health insurance tax,
- the Cadillac tax on employer-sponsored plans, and
- the "medicine cabinet" tax on over-the-counter drugs.

All these taxes are harmful, but their path to repeal is narrow and difficult because the interests advocating them with the most energy (for example, the medical device industry) are unwilling to propose cuts to Obamacare spending in exchange for tax relief. Thus, none of these taxes have been repealed. Indeed, repealing any or all of these taxes on their own, as is currently being considered in the House of Representatives, does not contribute to building a bridge out of Obamacare.

Bundling these tax cuts with limited patient-entered reforms, as described above, in a comprehensive, fiscally responsible, revenue neutral bill could induce corporate allies, who have been fully invested in Obamacare's success, to embrace — or at least tolerate — patient centered reforms in the wake of a *King v. Burwell* victory.

**Repealing the Death Panel**. Congress is also considering repealing the Independent Payment Advisory Board (IPAB). Bundling this into a bill responding to a *King v. Burwell* victory would greatly increase its chance of success. The IPAB is a board of 15 experts nominated by the president and confirmed by the Senate. These 15 have the power to cut Medicare by whatever means they see fit, if spending is projected to grow beyond a fixed rate of growth

The IPAB's first report was due on January 15, 2014, but it was not issued. The president has not nominated *even one* of IPAB's 15 members, despite having over five years to do so. This

demonstrates he recognizes how politically poisonous IPAB is. Although IPAB has nothing to do directly with *King v. Burwell,* repealing it in a bill responding to the lawsuit automatically gives that bill a greater public acceptance.

**President Obama Has Proposed Patient-Centered Reforms, Too.** Over the years, President Obama has also proposed a few patient-centered and taxpayer-friendly reforms which Congress has not taken up. A *King v. Burwell* victory gives both parties an opportunity to rectify this, with a legislative response that adds Medicare and Medicaid savings to Obamacare reform, leading to a very positive score by the CBO.

*Medicare bad debt*. The president's budget proposes $31 billion in savings over 10 years by reducing Medicare's coverage of bad debts owed hospitals and other facilities.[51] Currently, the federal government pays 65 percent of facilities' bad debts. As far back as 2011, President Obama proposed to reduce this to 30 percent. Doing so would not only reduce the burden on taxpayers, it would force hospitals to be more transparent with respect to communicating prices and payment obligations to Medicare beneficiaries.

*Medigap plans*. The president also proposes to increase deductibles for new Medicare beneficiaries, instituting a home-health deductible and adding a surcharge to Part B premiums for beneficiaries who buy Medigap (Medicare supplemental) plans. In his budget, these save $8.5 billion over 10 years.[52] The problem with Medigap plans is they fill in beneficiaries' deductibles and co-pays, making them insensitive to the total cost of the Medicare services they consume.

[51] "Fiscal Year 2016: Budget of the U.S. Government," Office of Management and Budget, February 2, 2015, page 107.

[52] "Fiscal Year 2016: Budget of the U.S. Government," Office of Management and Budget, February 2, 2015, page 107.

Discouraging beneficiaries from buying such plans will make them more cost conscious. Although a version of this was included in the Medicare Access and CHIP Reauthorization Act enacted in April 2015, it does not take effect until 2020. An earlier start would save taxpayers' money faster.

*Medicare Part D exclusive pharmacies*. The president has proposed allowing Medicare Part D drug plans to use more tools that would reduce the abuse of prescription drugs by opioid addicts in Medicare Part D.[53] This would reduce fraud, as described in a previously published NCPA proposal.[54]

*Medicaid provider taxes*. In his February 2012 budget, President Obama proposed reforms to Medicaid provider taxes. "Provider taxes" comprise a trick used by hospitals and states to increase their dependence on federal Medicaid money. Hospitals agree to submit to a special "tax" by the state. However, this tax flows into the state Medicaid program, which uses it to get more federal dollars. Therefore, every dollar the hospital is "taxed" actually increases its revenue by more than the tax! If this abuse had been stopped when President Obama proposed his reforms, the savings would have been $22 billion over 10 years.[55]

# Conclusion

[53] Fiscal Year 2016: Budget of the U.S. Government," Office of Management and Budget, February 2, 2015, page 107.

[54] Devon M. Herrick, "Medicare Drug Plans Need the Tools to Fight Prescription Drug Fraud," Policy Report No. 359, National Center for Policy Analysis, October 29, 2014.

[55] Fiscal Year 2013: Budget of the U.S. Government," Office of Management and Budget, February 13, 2013, page 36.

*King v. Burwell* creates an opportunity for Congress to enact small but significant reforms to Obamacare. If enacted fully, these reforms will:

- Reduce Obamacare's disincentives for workers to limit their hours and earnings.
- Give beneficiaries more control of the dollars spent on their health care.
- Free beneficiaries and taxpayers from Obamacare's unnecessary and expensive exchanges.
- Reduce the cost and increase choice of health insurance.
- Free employers to add hours and hire more workers without fear of being penalized.
- Reduce the cost to taxpayers of Obamacare, Medicare and Medicaid.

Even if the Supreme Court rules in favor the government and Health and Human Services Secretary Sylvia Mathews Burwell, these reforms would solve some of the problems created by the Affordable Care Act, while helping fulfill the goals of increasing health insurance coverage and reducing costs to consumers, employers and taxpayers.