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King v. Burwell: What State Lawmakers Should Do

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

Reject a State Exchange

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

Adopt Consumer-Focused State Reforms

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

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

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

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

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

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

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

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

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

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

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

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

1. Nina Owcharenko and Edmund F. Haislmaier, "*King v. Burwell*: An Opportunity for Congress and the States to Clear Away Obamacare's Failed Policies," Heritage Foundation *Issue Brief* No. 4360, February 27, 2015, http://www.heritage.org/research/reports/2015/02/king-v-burwell-an-opportunity-for-congress-and-the-states-to-clear-away-obamacares-failed-policies.
2. Edmund F. Haislmaier, "Less Than Meet the Eye: The Obamacare Exchange Regulations," The Daily Signal, July 12, 2011, http://dailysignal.com/2011/07/12/less-than-meets-the-eye-the-obamacare-exchange-regulations/.
3. Nina Owcharenko and Edmund F. Haislmaier, "Medicaid Expansion and State Health Exchanges: A Risky Proposition for the States," Heritage Foundation *Issue Brief* No. 3802, December 12, 2012, http://www.heritage.org/research/reports/2012/12/obamacares-medicaid-expansion-and-state-exchanges-risky-for-states.
4. See Dale H. Yamamoto," Health Care Costs—From Birth to Death," Society of Actuaries, Health Care Cost Institute *Independent Report Series* No. 2013-1, June 2013, http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf.
5. James T. O'Connor, "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," Milliman, Inc., April 25, 2013, http://www.ahip.org/MillimanReportACA2013/.
6. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress set in place rules for employer-group coverage that specified that individuals switching from one group plan to another could not be denied new coverage, subjected to preexisting-condition exclusions, or charged higher premiums because of their health status. While Congress required that both individual and group plans be guaranteed to be renewable, it did not generally apply HIPPA's group-market rules to the individual market. The one exception was for workers who lost group coverage and subsequently exhausted any available continuation coverage. Those workers (and their dependents) were then entitled to obtain individual coverage at standard rates, with no preexisting-condition exclusions. However, even in those circumstances, Congress allowed states the alternatives of assigning such individuals either to a particular insurer or to a state high-risk pool. Prior to the ACA, 19 states and the District of Columbia used the "federal fallback" of providing choice of any individual-market policy, three states used the "assigned carrier" option, and the remaining 28 states covered such individuals through a state high-risk pool.
7. For specifics on how new individual-market rules could be aligned with HIPAA group-market rules, see Edmund F. Haislmaier, "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms," Heritage Foundation *Backgrounder* No. 2703, June 22, 2012, http://www.heritage.org/research/reports/2012/06/saving-the-american-dream-the-us-needs-commonsense-health-insurance-reforms.
8. State of Maine, Sections C-2, C-3, C-4 and C-5. The Maine legislation does not apply to coverage regulated by Vermont, because at the time that Maine enacted its legislation, Vermont was pursuing a plan to create a state-based, single-payer health insurance system.

Conclusion

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

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