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States Should Start Planning Now for the Post-ACA World

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When the Supreme Court handed down its decision in *King v. Burwell* upholding the Obama Administration's interpretation of the law, some concluded that the intense debate over the Affordable Care Act (ACA or Obamacare) was coming to an end. Not surprisingly, President Barack Obama encouraged that interpretation in his response to the Court's decision, saying that "the Affordable Care Act is here to stay."[1]

In truth, the practical effect of the Court's ruling is merely to prolong the status quo. This means not only that the law's existing problems will continue, but that additional problems will arise as delayed provisions of the ACA take effect in coming years. Because many of the ACA's operational and political problems flow from basic design flaws in the legislation, state lawmakers can expect that Congress will, sooner or later, repeal and replace the ACA with simpler and more workable alternatives.[2] Those alternatives will likely involve returning to states authority that the ACA expropriated such as the authority to regulate insurance, removing the costly Medicaid expansion, and giving states more flexibility in restructuring and managing public coverage programs.

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Avoid ACA Risks

Given that the ACA is both operationally and politically unstable, state lawmakers would be advised to avoid assuming that it will continue as constituted. Rather, in the interim, they should minimize risks and costs by limiting their states' exposure and involvement. For instance, states should:

- **Steer clear of state exchanges.** The main purpose of the ACA's government-run exchanges is to administer the law's absurdly complicated coverage subsidies. By ruling in the *King* case that those subsidies may be paid through the federally run exchange (Healthcare.gov), the Supreme Court effectively eliminated any remaining rationale for states to establish and operate their own ACA exchanges.[3] Furthermore, whatever design Congress eventually adopts to replace the ACA subsidies will invariably be less complicated and likely be something that consumers can use to buy coverage through existing private channels, such as eHealthInsurance.com.

- **Reject the Medicaid expansion.** States should continue to resist efforts to adopt the ACA's Medicaid expansion, and states that have expanded should attempt to withdraw. The expansion requires additional state spending with higher costs accumulating over the long term at a time when Medicaid spending is already crowding out other important state priorities, such as education, transportation, and criminal justice. The expansion also adds millions of able-bodied working-age adults to a program that is struggling to adequately serve its needy and vulnerable existing enrollees.

- **Hold back on State Innovation Waivers.** States should refrain from overinvesting in strategies premised on obtaining State Innovation Waivers under Section 1332 of the ACA. While such waivers could offer states some flexibility,[4] Section 1332 does not provide for waiving several of the ACA's more costly insurance requirements. The waivers are also time-limited and conditioned on requirements that any alternative coverage and subsidy designs be equivalent to those specified in the ACA. Thus, for states to regain authority to enact more substantial changes, Congress would need to amend Section 1332 to expand its scope. However, at that point, rather than expanding the waivers to encompass more ACA provisions, it would be simpler (and preferable) for Congress to just repeal or replace those ACA provisions.

Put a Replacement in Place Before Repeal

A top priority for states should be to develop a package of alternative insurance reforms that would take effect upon repeal.[5] As the regulation of health insurance would devolve back to the states, some states could default back to their pre-ACA markets. However, now is the time for states to reevaluate their previous insurance market rules and refine those rules to ensure the market will be more affordable, offer better choices, and provide greater access. States should start by establishing commissions or legislative working groups to identify and prepare for this devolution. Broadly, states should:

- **Review state benefit mandates.** States should consider the cost of mandated benefits as a starting point for reconsidering the appropriateness of benefit requirements. A national actuarial study estimated that the ACA essential benefits were responsible for increasing individual market premiums by 3 percent to 17 percent.[6] 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.

- **Ensure appropriate age rating rules.** States should ensure that state insurance law is set to default automatically to a less restrictive age rating ratio for premiums in their individual and small-group markets. The natural variation in health costs between 64-year-olds and 21-year-olds is about five to one.[7] The ACA imposed an ill-advised narrow three-to-one age rating ratio. Setting a more appropriate variation would help to minimize disruption in a state's insurance market 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.

- **Establish coverage options for those with pre-existing conditions.** One of the fundamental flaws of the ACA was to impose a blanket federal prohibition on pre-existing conditions

1. Barack Obama, "Remarks by the President on the Supreme Court's Ruling of the Affordable Care Act," The White House, June 25, 2015, https://www.whitehouse.gov/the-press-office/2015/06/25/remarks-president-supreme-courts-ruling-affordable-care-act (accessed July 22, 2015).
2. Edmund F. Haislmaier, "Impact of *King v. Burwell*: The ACA's Key Design Flaws," Heritage Foundation *Issue Brief* No. 4350, February 20, 2015, http://www.heritage.org/research/reports/2015/02/impact-of-king-v-burwell-the-acas-key-design-flaws.
3. Several states that previously attempted to create their own exchanges are exiting what has proven to be a costly and problem-plagued arrangement. Others are likely to follow. Alyene Senger, "Nevada Gives Up on $91 Million Obamacare Exchange," *The Daily Signal*, May 28, 2014, http://dailysignal.com/2014/05/28/nevada-gives-91-million-obamacare-exchange/.
4. The Administration has yet to release its proposed rules and regulations relating to Section 1332. Moreover, it is likely that the flexibility will be narrowed, not expanded.
5. Maine offers an example of such pre-emptive legislation. An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services, H.P. 979 and L.D. 1333 Maine Legislature, May 17, 2011, http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0979&item=24&snum=125 (accessed July 22, 2015), and Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite,'" Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, http://www.heritage.org/research/reports/2011/07/health-care-reform-in-maine-reversing-obamacare-lite.
6. 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/ (accessed July 22, 2015).
7. 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 (accessed July 22, 2015).

exclusions under any circumstance. State lawmakers should learn from this failed experience and past experience in developing solutions to ensure that those with pre-existing conditions have access to coverage. First, states should ensure that the individual-market plans are guaranteed renewable, as established prior to the ACA. Beyond that, state lawmakers should review previous models. For example, many states had high-risk pools before the ACA and thus could reactivate their high-risk pools. Other states focused on organizing their high-risk insurance markets on a reinsurance model.[8] Still others might consider adopting individual-market rules that, similar to group-market rules, would permit someone who has purchased and maintained coverage to obtain new individual health insurance coverage regardless of health status or past medical history.[9] States would have great latitude in experimenting with a variety of old and new approaches.

- **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.[10] 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.

Remove Regulatory Barriers to Competition and Innovation

While the ACA expropriated long-standing state authority over some aspects of insurance regulation, it left state authority to regulate health care providers largely untouched. Thus, states can still independently implement policies that encourage the kinds of competition and innovation that can lower the cost and improve the quality of health care. For instance, states should:

- **Expand access to innovative care models.** Private-sector innovations continue to emerge even as the ACA attempts to consolidate control over the health care system. Alternative financing models—such as employers providing health benefits on a defined contribution basis through private insurance exchanges;[11] direct primary care practices, which eliminate costly overhead by charging their patients just a single monthly subscription fee;[12] and faith-based health care options[13]—are creatively rethinking the traditional system for financing health care. States should maximize that creativity by removing any statutory or regulatory obstacles that inhibit these or related efforts.

- **Remove restrictions on provider competition.** Similar to using influence to ensure inclusion in benefit packages, special interests also use regulation to inhibit competition and to protect the territory of certain players in the health care sector. Regulations such as certificate of need, scope of practice, and licensure can be

8. For a discussion of the Idaho model, see Bragdon and Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite.'"
9. For a discussion of insurance market rules and states, 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.
10. 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. See An Act to Modify Rating Practices, Maine Legislature, and Bragdon and Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite.'"
11. Robert E. Moffit, "Private Insurance Exchanges: How New York Employers and Policymakers Can Leverage New Reimbursement and Delivery Reforms," chap. 5, in Paul Howard and David Goldhill, eds., *New York's Health Care Revolution: How Employers Can Empower Patients and Consumers*, Manhattan Institute for Policy Research, [May 2015], http://www.manhattan-institute.org/pdf/NYHCR.pdf (accessed July 22, 2015).
12. Daniel McCorry, "Direct Primary Care: An Innovative Alternative to Conventional Health Insurance," Heritage Foundation *Backgrounder* No. 2939, August 6, 2014, http://www.heritage.org/research/reports/2014/08/direct-primary-care-an-innovative-alternative-to-conventional-health-insurance.
13. Phyllis Berry Myers et al., "Why It's Time for Faith-Based Health Plans," Heritage Foundation *Lecture* No. 850, August 24, 2004, http://www.heritage.org/research/lecture/why-its-time-for-faith-based-health-plans.

manipulated to prevent or restrict provider competition, driving up the cost of care and coverage. States should review standards to ensure that they are appropriate and remove special-interest policies that principally act to limit choice and restrict competition.

- **Adopt medical liability reforms.** Rules governing medical malpractice and the cost of medical liability insurance are driving up the cost of medicine and jeopardizing access to care. The ACA provides no legitimate path to reform.[14] The states, not the federal government, should lead efforts to establish a more rational approach to addressing medical liability. Many states have already confronted this issue and provide blueprints for others.

Conclusion

Regardless of the Supreme Court ruling and the President's proclamation that the ACA is "woven into the fabric of America,"[15] the ACA remains unworkable, unaffordable, and unfair, which is why it also remains unpopular. Thus, Congress will likely, sooner or later, repeal and replace the ACA's major components. State lawmakers should start planning now for another big shift in federal health care policy in the coming years.

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14. Randolph W. Pate, "President Obama's Medical Liability Reform Proposal: No Silver Bullet," Heritage Foundation *Issue Brief* No. 2614, September 15, 2009, http://www.heritage.org/research/reports/2009/09/president-obamas-medical-liability-reform-proposal-no-silver-bullet.
15. Obama, "Remarks by the President."