The Heritage Foundation

ISSUE BRIEF

No. 4350 | FEBRUARY 20, 2015

Impact of *King v. Burwell*: The ACA's Key Design Flaws

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On March 4, the Supreme Court will hear oral arguments in *King v. Burwell*, a challenge to an IRS ruling related to the Affordable Care Act (ACA) granting premium support subsidies to those enrolled in federal exchanges. While claims that a ruling in favor of King would disrupt coverage to millions,[1] it is important to recognize that the ultimate source of any dislocation would be a direct result of the ACA's fundamental design flaws.

Many of the ACA's key components—and in particular related to this case—the exchanges, the premium tax credits, the cost-sharing subsidies, and the individual and employer mandates—are complicated, confusing and disruptive. The complexity and cascade of adverse effects are the inescapable byproducts of major flaws in the legislation's basic design.

Design Flaw #1: Overly Generous Subsidies

One of the biggest mistakes in the design of the ACA was that Congress made the new premium tax credits overly generous, and then sought to limit the cost of the program by restricting eligibility for those new tax credits to a narrow subset of the population.

Specifically, the ACA offers substantial premium tax credits, but only to individuals who have incomes between 100 percent and 400 percent of the federal poverty level (FPL), and only if they also do not have access to another source of coverage, such as an employer-sponsored plan.

Even within those limits, this design still creates a major financial incentive for millions of Americans with employment-based coverage to shift to plans that qualify for the new, more generous, premium tax credits. Furthermore, in cases where most of an employer's workers have incomes in the 100 percent to 400 percent of FPL range, it also creates a corresponding incentive for such employers to discontinue their group plans so that their workers can qualify for the better deal offered by the new premium tax credits.

In an attempt to prevent those effects, Congress added mandates to the ACA that employers with 50 or more full-time workers offer their employees "minimum essential coverage" and make a "minimum contribution" toward the cost of that coverage, along with requirements that employers report to the government detailed information on their plans and the coverage status of each employee.[2]

Of course, this complicated design requires some kind of administrative mechanism to screen applicants and determine their eligibility—so Congress vested the new exchanges with responsibility for performing those complicated, confusing, and disruptive tasks.

Design Flaw #2: Complex Tax Credit Design

A second major design flaw in the ACA is its inordinately complex rules for calculating the amount of the premium tax credit for each recipient. Even

This paper, in its entirety, can be found at
http://report.heritage.org/ib4350

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when someone qualifies for a premium tax credit under the law's eligibility rules, calculating the correct amount is absurdly complicated. The amount varies not only based on the recipient's income but *also* according to the size of his family, and *also* according to the price of the second-lowest-cost Silver-level plan in the county where he lives.

Thus, another major administrative task assigned to the exchanges is calculating the correct premium tax credit amount for each qualified enrollee. Yet, such calculations create new complexities.

Because the premium tax credits are applied on a monthly basis, the amount must be *recalculated* every time there is a change in the enrollee's family income, or in the size of the enrollee's family, or in the premium for the "reference" plan in the county where the enrollee lives. Furthermore, all of those calculations must be redone, and any advance-payment amounts reconciled, on a new two-page, 36-line tax form (accompanied by a 15-page set of instructions containing three additional worksheets), which must be included with the enrollee's annual federal income tax return.[3]

The source of this administrative nightmare is the fundamental error made by the authors of the ACA when they specified that the amount of the premium tax credit be calculated based on the recipient's income relative to the FPL. There is no other comparable provision in the federal tax code that bases the amount of a tax, or a tax preference, on the filer's income relative to the FPL. That is because the calculation of income relative to the FPL is not compatible with the basic structure of the income tax system, which uses just four filing categories—(1) individual, (2) head of household, (3) married filing jointly, and (4) married filing separately. Furthermore, even in other cases where a tax benefit is calculated with reference to the number of dependents—such as personal exemptions or child tax credits—the calculation is simply the number of qualified dependents times the statutorily set amount per dependent.

Moreover, from the context of health care, measuring household income with reference to the FPL is also incompatible with how health insurance is generally priced—on the basis of "self only" or "family" (two or more related individuals) coverage.

Design Flaw #3: A Blanket Prohibition on Pre-Existing Condition Exclusions

Yet another major mistake made by the authors of the ACA was their ill-considered and ham-fisted approach to addressing the issue of access to health insurance for individuals with pre-existing medical conditions. In the process, they not only created a major *new* problem but also discarded an earlier—more sensible—approach that had been working successfully for the vast majority of Americans.

Before the ACA was enacted, people with pre-existing medical conditions being denied health insurance was only a problem in the individual market—which accounts for 10 percent of all private health insurance. It was not a problem for the other 90 percent of Americans with private coverage through employer plans.

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 pre-existing-condition exclusions, or charged higher premiums because of their health status.[4]

While Congress required that both individual and group plans be guaranteed to be renewable, it did not

1. Edmund F. Haislmaier, "*King v. Burwell*: Assessing the Claimed Effects of a Decision for the Plaintiffs," Heritage Foundation *Issue Brief* No. 4349, February 20, 2015, http://report.heritage.org/ib4349.
2. Internal Revenue Service, "DRAFT: Form 1094-C: Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns," October 15, 2014, http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf (accessed February 18, 2015); Internal Revenue Service, "DRAFT: Form 1095-C: Employer-Provided Health Insurance Offer and Coverage," October 15, 2014, http://www.irs.gov/pub/irs-dft/f1095c--dft.pdf (accessed February 18, 2015); and Internal Revenue Service, "DRAFT: 2014 Instructions for Forms 1094-C and 1095-C," August 28, 2014, http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf (accessed February 18, 2014).
3. Internal Revenue Service, "Form 8962, Premium Tax Credit (PTC)," http://www.irs.ustreas.gov/pub/irs-pdf/f8962.pdf (accessed February 18, 2015), and Internal Revenue Service, "Instructions for Form 8962 Premium Tax Credit (PTC)," http://www.irs.gov/pub/irs-pdf/i8962.pdf (accessed February 18, 2015).
4. For a detailed discussion of HIPAA insurance 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.

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 pre-existing-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.[5]

The fundamental mistake made by the authors of the ACA was discarding prior law and imposing on both the group and non-group markets a blanket federal prohibition on the application of pre-existing-conditions exclusions under *any* circumstances. Of course, as even the authors of the law understood, that change creates a new and destabilizing incentive for healthier individuals to delay purchasing health insurance until they need it. Consequently, to try to mitigate those effects, they added to the ACA a mandate on individuals to buy coverage.

Design Flaw #4: Rating Rules that Increase Premiums

Another error of the ACA was including a provision that limits age variation of premiums for adults to a maximum ratio of three to one. In other words, for the same plan, an insurer is not permitted to charge a 64-year-old a rate that is more than three times the rate it charges a 19-year-old.

The natural age variation in medical costs among adults is five to one, as the oldest group of (non-Medicare) adults consumes five times as much medical care as the youngest group.[6] Thus, the effect of this mandated "rate compression" is to force insurers to both artificially underprice coverage for older adults and artificially overprice coverage for younger adults.

Yet, while younger adults tend to be in better health, they also tend to earn less than older workers with more experience. That combination makes young adults more sensitive to changes in the price of health insurance and more likely to decline coverage if it becomes more expensive. That is also why the uninsured population consists disproportionately of young adults. According to the U.S. Census Bureau, in 2013, individuals aged 19 to 34 accounted for 45 percent of all uninsured adults.[7]

Thus, imposing rating rules that artificially increase health insurance premiums for young adults is not only unfair, but counter-productive, since it increases the costs of coverage for those most likely to already be uninsured.[8] Indeed, that was the experience in states that previously imposed misguided insurance rating rules similar to the ones that were later included in the ACA.[9] It also needlessly increases the cost of the ACA by necessitating larger premium subsidies to help lower-income young adults purchase artificially overpriced insurance.

Design Flaw #5: Costly and Prescriptive Benefit Mandates

Given that a central objective of the ACA's authors was to extend coverage to more of the uninsured, it was pure counterproductive folly to also

5. Kaiser Family Foundation, "State Health Facts: Non-Group Coverage Rules for HIPAA Eligible Individuals [for 2012]," http://kff.org/other/state-indicator/hipaa-rules/ (accessed February 18, 2015).
6. Oliver Wyman, "Impact of Changing Age Rating Bands in 'America's Healthy Future Act of 2009,'" September 28, 2009.
7. Jessica C. Smith and Carla Medalia, "Health Insurance Coverage in the United States: 2013," U.S. Census Bureau, "Table 2. Type of Health Insurance Coverage by Age: 2013," p. 7, September 2014, http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf (accessed February 18, 2015).
8. Even those predicting dire consequences from a Court ruling in favor of the plaintiffs in the *King* case implicitly recognize that this misguided provision of the ACA is a significant source of the dislocation they expect will occur. See Evan Saltzman and Christine Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces," RAND Corporation, 2015, http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf (accessed February 18, 2015). Saltzman and Eibner note, "Those who are young and healthy have a higher price elasticity for health insurance, meaning that they are more reactive to price and are more likely than older and less healthy people to forgo coverage if premiums are high."
9. Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets," Milliman, Inc., March 2012, http://www.ahipcoverage.com/wp-content/uploads/2012/03/Updated-Milliman-Report.pdf (accessed February 18, 2015).

impose additional benefit mandates and coverage requirements that inherently *increase* the costs of health insurance.

For instance, the ACA mandates coverage for "habilitative services," which virtually no plan previously covered.[10] Not only do increased coverage costs make it more difficult to insure the existing uninsured, they also risk pricing some of the currently insured out of coverage—potentially creating *new* uninsured individuals. Furthermore, they needlessly increase the cost of any premium subsidies.

Conclusion

The complexity and adverse effects of the ACA's key provisions have already increased costs and dislocated millions from coverage. Thus, it is the ACA's fundamental design flaws—not how the Supreme Court eventually rules in the *King* case—that are the ultimate source of disruption and will continue to plague the law's implementation.

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10. 42 U.S. Code § 18022(b)(1)(G).