



## ***King v. Burwell: State Options***

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### **I. Overview:**

State officials are watching closely the *King v. Burwell* Supreme Court case. That case challenges the legality of federal subsidies provided to individuals in the 34 states that did not establish state-based health insurance exchanges. Eligible individuals in these states now receive health insurance coverage and subsidies through the Federally-Facilitated Marketplace (FFM). While the outcome of the case is uncertain, a pro-*King* decision might end the federal government's ability to provide subsidies in these FFM states. Such an outcome could leave millions of Americans without affordable health insurance coverage, disrupt state health insurance markets and expose a state's health providers to new financial losses due to unpaid claims and uncompensated care. Facing this uncertainty and needing to prepare for these significant risks and an expected June ruling by the Court, state policymakers are beginning to explore options that respond to their political and policy interests. This issue brief identifies and explores options states might pursue.

#### ***King V. Burwell***

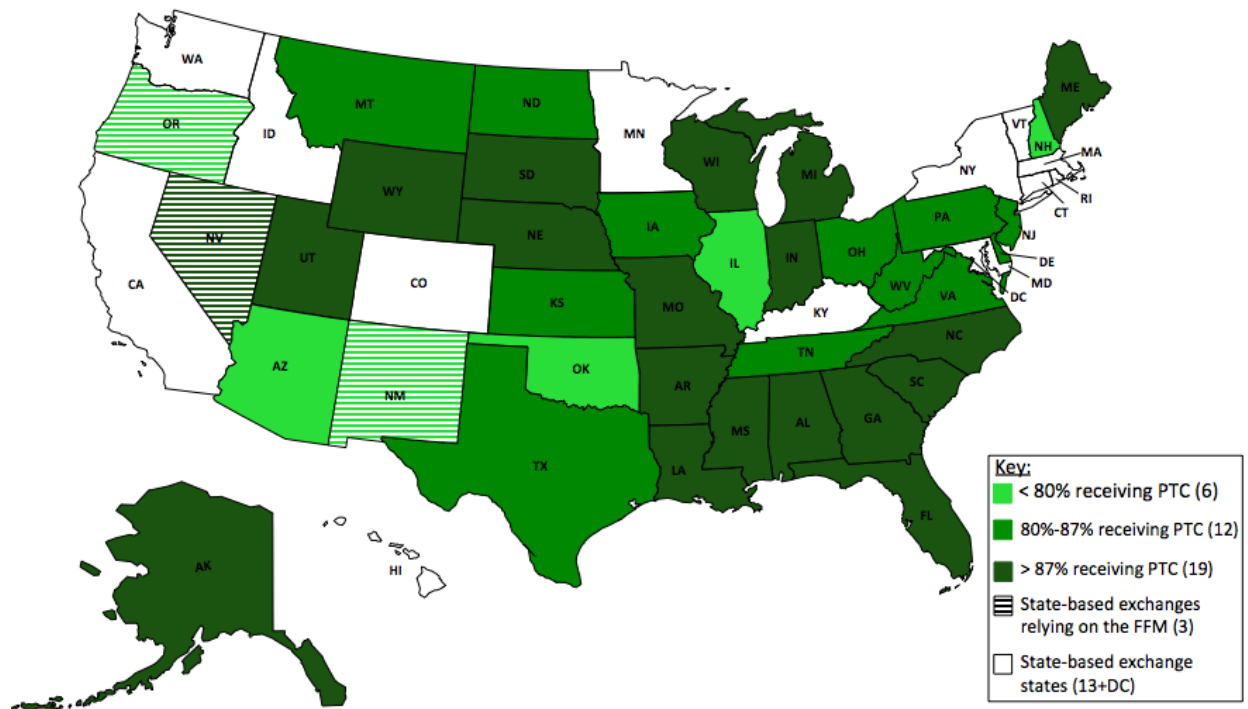
*King v. Burwell* is a case argued before the Supreme Court on March 4, 2015 that questions whether the Patient Protection and Affordable Care Act (ACA) permits the federal government to provide financial assistance (in the form of premium tax credits) to individuals through the federally established health insurance exchange (known as the Federally-Facilitated Marketplace (FFM)) in states that have not established their own state-based exchange. The plaintiffs in this case, led by King, are four Virginia citizens who claim they do not want to purchase health insurance and would be exempt from the ACA's tax penalty if federal subsidies did not make health insurance coverage affordable in their state. These plaintiffs claim that the Internal Revenue Service overstepped its legal authority under Section 1321 of the ACA in determining that the federal government could provide subsidies to citizens in states that did not opt to establish state-based exchanges. If the Supreme Court rules in *King's* favor, the plaintiffs are asking the court to eliminate federal financial assistance for individuals living in states that have not established state-based exchanges. The scope of a pro-*King* decision is unclear and could impact only the 34 states that have not opted to host a state-based exchange, have a broader impact on the three other states that use FFM services, or impact all states. It may also have a broader impact on the federal government's ability to provide exchange services to states. The Supreme Court is expected to issue its decision in the case by late June 2015.

### **II. What *King v. Burwell* Could Mean for States:**

#### ***Impact on Consumers***

There are roughly 7.3 million individuals enrolled in federally supported exchange health insurance coverage in the 34 states that did not establish state-based exchanges.<sup>i</sup> On average 87 percent of individuals enrolled through the FFM are receiving premium tax credits (PTC) that subsidize the cost of coverage. The percentage of enrollees receiving a subsidy is higher in 18 states, mostly in the South (see map below).<sup>ii</sup>

**Percent of Federally-Facilitated Marketplace (FFM)  
Enrollees Receiving Premium Tax Credits (PTC), By State**



Source: Arpit Misra and Thomas Tsai, *Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the Healthcare.gov Platform*. (HHS Assistant Secretary for Planning and Evaluation, February 2015), 5.

The level of subsidy being provided is substantial; the average PTC awarded for FFM enrollees is \$268 per month, amounting to 72 percent of the health insurance premium paid. Without that subsidy, coverage might be unaffordable to most of the 7.3 million individuals now enrolled through the FFM in these 34 states, which may result in many dropping coverage and becoming uninsured.<sup>iii</sup> Without subsidies consumers will need to weigh the cost of the ACA penalties if they drop coverage against the cost of higher premiums. Still it is probable that those who retain coverage are likely to be in poorer health, which may result in higher premium rates and a more volatile individual insurance market.

***Impact on Insurance Markets***

The Urban Institute estimated that the elimination of federal subsidies may increase the number of uninsured by 44 percent due to higher premium rates.<sup>iv</sup> Those opting to retain coverage are likely to be individuals in poorer health, increasing the risk profile for those remaining insured and raising costs for insurers, which could lead to higher premiums over time.

Another RAND study predicted that premiums may increase in FFM states by 45 percent and enrollment may fall by 70 percent as a result.<sup>v</sup> If insurers are not permitted to raise rates in the near term, actuaries are predicting that enrollees' likely

adverse selection of coverage after a pro-*King* decision could result in insurers having insufficient funds to cover claims among the less healthy enrollees who retain coverage, creating volatility in the state individual health insurance market.<sup>vi</sup> One analysis disputes these claims, estimating a much smaller average premium increase of 4.7 percent and suggesting market volatility will be far less than claimed because the exchange individual market represents a relatively small percentage of business for most larger health insurance issuers and few of these larger issuers are operating in enough FFM states to create a significant financial impact.<sup>vii</sup>

Loss of subsidies could lead some insurers to leave the market or fail, thus increasing market consolidation and limiting consumer choice.<sup>viii</sup> And if the Court's decision takes effect immediately, the impact on the actuarial soundness of rates could be significant and increase demands on state guaranty funds as well as the ACA's risk mitigation programs, such as reinsurance and risk corridors.

### ***Impact on Health Care Providers and Costs***

Some experts estimate that a pro-*King* decision could result in a significant drop in 2016 health care spending for hospitals, physicians and prescription drugs in FFM states, from \$27.1 billion to \$5.3 billion.<sup>ix</sup> Under these estimates uncompensated care costs are also expected to grow to \$12 billion above current spending levels.<sup>x</sup> These experts predict that the newly uninsured will primarily be middle-income individuals who will seek care through charity and government programs, increasing the demand for services and thereby straining state budgets.<sup>xi</sup> Uninsured individuals typically pay 30 percent of medical costs, leaving an estimated 70 percent of the cost of care uncompensated.<sup>xii</sup>

Current programs and providers that support uncompensated care, such as hospitals and health center safety net providers, may be strained under this scenario. Safety net hospitals

#### **Some States Disproportionately Affected**

Although 34 states depend on the FFM for subsidies, a few states will likely be disproportionately affected, according to estimates: taken together, residents of Florida, Texas, North Carolina, Georgia, and Pennsylvania make up half of the Americans in danger of losing subsidies in 2016. While a recent Urban Institute brief estimates states could lose \$28.8 billion in federal financial assistance in 2016, just two of the more densely populated states, Texas and Florida, represent nearly one-third of that total, \$4.4 billion and \$3.9 billion respectively. Because of differences in income distribution and premium cost, Wyoming and Alaska would lose the most in average per-person tax credits with \$5,360 and \$5,570 per year respectively.

Source: Linda J. Blumberg, Matthew Buettgens, and John Holahan, *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums*, 1, 5,6.

that serve large numbers of uninsured individuals, rely on federally funded Disproportionate Share Hospital (DSH) payments to offset uncompensated care costs, but these DSH payments are scheduled to be phased down by \$35 billion between 2017 and 2024 under the ACA.<sup>xiii</sup> Although these ACA reductions in DSH payments were made anticipating that increased access to affordable coverage would reduce the need for uncompensated care, the lower payments may increase pressure on safety net providers if more individuals become uninsured under a pro-*King* decision. The increased demand for uncompensated care and decreased funding may put more pressure on states to keep hospitals and consumers afloat and may further fray states' health care services safety net.

### ***State Capacity to Respond***

The timing of the Supreme Court's decision in June poses several challenges for states that wish to respond to a pro-*King* decision. At that point in the year, state legislatures in nearly all FFM states will have already adjourned legislative sessions. Special sessions can be convened if there is sufficient political will and the funding to support the added cost. Governors may also review opportunities to act under existing legislative authority, obviating the need for additional legislative action. With only four months between the decision and the next open enrollment period for exchange health insurance coverage on November 1, 2015, states seeking to offer new coverage options will need to act quickly to provide options for the 2016 plan year.<sup>xiv</sup>

Available time for states to implement a change in exchange status or structure or to negotiate new coverage approaches with insurers is extremely limited. Most states that established their own exchanges before 2014 needed at least 1-2 years to create the electronic, procedural and staff infrastructures to make them operational. It seems unlikely that most states would be able to implement new status or significant structural changes in only four months. And states that already implemented exchanges had the benefit of significant Federal funds to assist in start-up, funds that are no longer available.

### **III. State Policy Options Post-*King*:**

Faced with potential increases in the uninsured, higher premiums, and lost provider revenues, the 34 states in which the FFM provides coverage and subsidies need to weigh options for future action. Some state leaders opposed to the Affordable Care Act may chose to take no action; others may seek opportunities that can be implemented quickly to reduce the impact on their states; and still others may seek short term remedies and/or longer term alternatives. Because the outcome of *King v. Burwell* is uncertain, states must be prepared for a variety of scenarios and many state legislatures have already begun contingency planning and considering action related to exchange establishment, as noted in Appendix A. And while Congress may consider federal options should the Court rule against FFM subsidies, states could see an immediate impact and many will want to be ready to take action. This section reviews a number of policy options states may consider to prepare for the *King* decision and its implications.

### State Options

1. No State Exchange Action
2. Create State-Based Exchange to Replicate FFM Coverage Options
  - a. Traditional State-Based Exchange
  - b. State-Designated Exchange
  - c. Supported State-Based Exchange
  - d. Contracted State-Based Exchange
  - e. Regional Exchange
  - f. State-Private Exchange
3. Other Coverage Options

**1. No State Exchange Action:** Some state leaders have historically opposed ACA implementation in their state. Some will view the decision as a federal issue requiring federal action. Between the ACA's enactment in 2010 and 2013, 21 states had enacted laws or other measures that opted out, opposed, or challenged implementation in the state, indicating a strong climate of political opposition to the ACA in many states.<sup>xv</sup> In recent queries to governors by Reuters, governors from five states (Louisiana, Michigan, Nebraska, South Carolina, and Wisconsin) indicated they did not have any plans to establish a state-based exchange in response to a pro-*King* decision.<sup>xvi</sup> However, at least one of these governors, Governor Haley from South Carolina, recently indicated that South Carolina may consider setting up an exchange, suggesting that some governors' position on this issue may shift.<sup>xvii</sup>

**2. Create State-Based Exchange to Replicate FFM Coverage Options:** If the Supreme Court rules that subsidies can only be provided through state based exchanges, there are a number of ways a state might seek to establish an entity that could be considered a state-based exchange. This section provides an overview of federal exchange requirements and reviews possible models that could meet federal requirements. For each model, we consider operational and legal issues impacting state action, any challenges related to financing or other barriers, and key steps needed for states to implement the model.

#### Federal Requirements for a State-Based Exchange:

Section 1311 of the ACA provides minimum statutory requirements for states to establish a health insurance exchange that facilitates the purchase of individual health insurance coverage in qualified health plans (QHPs). (See Text Box, below) In addition, regulations issued by the Secretary of HHS interpreting the statute added requirements for state-based exchanges (SBEs). Under these rules, states must submit an Exchange Blueprint that is approved by the Department of Health and Human Services (HHS) and pass an operational readiness assessment before the exchange can become operational.

The Blueprint demonstrates how an exchange will meet the operational requirements of the elected exchange model and includes two components: 1) a letter of declaration of exchange model from the state's governor, and 2) an application of readiness to perform exchange functions, including a compilation of attestations, descriptions of processes, and supporting documentation and reference files that could demonstrate the exchange's

ability to perform specific exchange operations.<sup>xviii</sup> Regulations further require that a state have an approved or conditionally approved Exchange Blueprint and its operational readiness assessment completed at least 12 months prior to the exchange’s first effective date of coverage.<sup>xix</sup>

Along with other regulatory requirements that are not prescribed in statute, HHS has broad discretion in design of the Blueprint,<sup>xx</sup> and HHS has already demonstrated flexibility in adapting requirements of the Blueprint to address new and emerging models of health insurance exchanges (*e.g.*, Partnership, Supported State-Based Exchange). It is possible that HHS might revisit, allow for phased compliance, or otherwise adapt these requirements in light of *King* to allow for state exigencies.

Additional federal rules allow state-based exchanges to use federal government services to conduct the following required functions:

- Premium Tax Credit and cost-sharing reduction determination;
- Providing exemptions from the health insurance mandate and tax penalty;
- Risk adjustment programs; and
- Reinsurance programs.

By explicitly allowing states to use federal services, these regulations may have laid the groundwork for the federal government to provide the structural information technology platform that is now being provided to three state-based exchange states: Oregon, Nevada, and New Mexico. These states, now referred to as Supported State-Based Exchanges (SSBEs), host state-based exchanges that use the FFM IT platform, healthcare.gov, as its eligibility portal and determination system. Building on this precedent, the Secretary of HHS could opt to expand the scope of permissible federally hosted and shared services for SBEs for other models, discussed below, through regulatory or subregulatory guidance

**Minimum Federal SBE Requirements for States**

At a minimum, Section 1311 of the ACA requires that SBEs:

- Be operated by state-established government agency or non-profit entity
- Comply with federal requirements regarding coverage offerings and required benefits
- Consult with stakeholders, including consumers, individuals/entities experienced in facilitating enrollment, small business and self-employed representatives, State Medicaid offices, and advocates of the hard to reach pops
- Publish average costs of licensing, regulatory fees, and any other payments required by the exchange, and administrative costs
- Perform a list of functions, at a minimum including:
  - Procedures to certify, recertify and decertify qualified health plans (QHPs)
  - Provide a toll-free telephone hotline to respond to assistance requests
  - Maintain an Internet website providing standardized comparative QHP information
  - Assign a rating to QHPs
  - Use a standard format for presenting health benefits plan options
  - Inform individuals of eligibility requirements for Medicaid, CHIP or other state/local public programs and screen and enroll in coverage
  - Provide a calculator to help enrollees determine cost of coverage after premium tax credits and cost-sharing reductions
  - Grant certifications of exemptions from tax penalties and be able to transfer relevant enrollment information to the Treasury Secretary
  - Establish a navigator program
  - Be self-sustaining financially beginning January 1, 2015

or other means. If administrative action is needed, it will have to be done quickly to allow states to take action before the 2016 open enrollment period begins on November 1, 2015.

### Leveraging the FFM Investment

HHS' Center for Consumer Information and Insurance Oversight (CCIIO) has led the implementation of the FFM, including the creation of an IT platform (healthcare.gov) and the federal data services hub, establishing contracts and oversight of participating issuers, providing a centralized call center, and providing grants for assistance to navigators in participating states. Work to establish the FFM among several federal agencies represented an investment of approximately \$946 million from FY 2010 through March 2014, with the development of healthcare.gov and the data services hub requiring just under a third of that investment (an estimated \$309 million).<sup>xxi</sup> If federal subsidies were no longer available for individuals purchasing coverage through the FFM under a *King* decision, it is unclear how and whether the FFM might continue to function, and the extent to which federal IT platform and determination services would remain available to states at low or no cost. Given the significant investment of taxpayer funds and the expertise established among federal agency staff running the FFM, states and federal agencies may think creatively about leveraging this investment should future coverage options be needed. Some of these ideas are included in the options discussed below.

**a. Traditional State-Based Exchange:** A traditional SBE is an exchange where the state performs the required functions to host the exchange, including those outlined under Section 1311 of the ACA. The ACA provides that states have the option to establish an SBE and does not provide a time limit for establishment, so there are no legal barriers if a state opted to establish a new SBE post-*King*. However, establishing a traditional SBE requires a significant time and resource investment from states.

For most states, establishing an SBE has required a multi-year effort involving the creation of a governance structure and intensive collaboration with stakeholders, consumers, and state and federal government agencies to build an exchange that could optimally serve consumers. A state-based exchange also requires significant financial investments to build the core components of an exchange, including eligibility and enrollment systems, consumer support functions, and a plan management infrastructure. Recognizing this requisite financial investment, the ACA provided substantial federal funding to enable states to build exchanges through planning, establishment, and innovator grants.<sup>xxii</sup> On average, each state-based exchange received approximately \$240,877,128 in federal grant funding to support its exchange build, with total amounts ranging from \$1,065,212,950 (California) to \$105,290,745 (Idaho).<sup>xxiii</sup> The law also set clear guidelines for these awards, barring the release of any awards after January 1, 2015.<sup>xxiv</sup>

States seeking to establish new exchanges without comparable federal grants will need to identify new funds, either from general fund, assessments, other federal matching programs, or other sources, to develop and establish a new exchange. Massachusetts was able to establish a similar exchange without federal grants prior to the ACA, financing the exchange build with a state appropriation, leveraging

funds to support affordability from a Section 1115 waiver, and sustaining operations under a premium assessment on marketplace products.<sup>xxv</sup> A state seeking to pursue a traditional SBE model after 2015 would need to have comparable political support to fund this investment. If a state opted to pursue this model, it may also need to comply with the requirements of the federal Exchange Blueprint process, or obtain permission to waive these requirements.

*Summary:* Due to the significant costs, time, the need to enact legislation or promulgate an executive order, and other resources needed to establish an SBE, establishing a new SBE in 2015 does not appear to be a viable option for most states.

**b. State-Designated Exchange:** Under this model, a state can seek to designate the FFM as the state-based exchange for purposes of drawing down federal subsidies. At least one state, New Hampshire, is already considering this model and has proposed legislation in its 2015 session that would formally designate the FFM as New Hampshire's state-based exchange.<sup>xxvi</sup> Under the state-designated exchange model envisioned by New Hampshire, all technical and operational exchange functions would remain with the federal government.<sup>xxvii</sup> In essence, by enacting such a law, a state would allow the FFM to continue as it operates today in that state.

The ACA does not appear to bar HHS from allowing a state to designate the FFM as its SBE and could be read to allow states some discretion. Section 1311(d)(1) of the ACA states that “[a]n Exchange shall be a governmental agency or nonprofit entity *established by the state.*”<sup>xxviii</sup> Under this language, a state appears to have some authority to designate the FFM because it is part of a governmental agency and the state is establishing its authority to fulfill exchange functions.

This model assumes the FFM would continue to finance all of its current functions although it is uncertain whether a *King* decision might change the current FFM structure or approach. In addition, states that have been historically opposed to the ACA might face political challenges in pursuing a state-designated exchange. However, some states that have previously forgone an SBE may find this model attractive because it allows residents to maintain coverage while delegating exchange financial and operational responsibilities to the federal government.

To implement this model, states would need to either enact a law or have the Governor promulgate an Executive Order designating the FFM as its state exchange for the purposes of drawing down federal subsidies and identifying the exchange functionalities designated to federal and state agencies. States pursuing this model may also want to explore legal and operational considerations with the Centers for Medicare and Medicaid Services (CMS).

*Summary:* This model offers some advantages in that it would allow for a simple, low-burden, low-cost way for the state to sustain the coverage model and subsidies now in effect under the FFM, but still requires the enactment of a law or promulgation of an executive order to effectuate the model.

**c. Supported State-Based Exchange:** A supported state-based exchange (SSBE) describes a SBE that uses federal technology (healthcare.gov) as its IT system foundation. Currently, the SSBE is a transitional exchange model granted to three states (Oregon, Nevada, and New Mexico) through an agreement between the state and federal government. This model was created to support states as they transitioned to a functional IT system to support their SBE. Current SSBE states attained their status by submitting an Exchange Blueprint to CCIIO for approval. The Blueprint defined the roles and responsibilities of the state and federal government.

In negotiating these responsibilities, CCIIO has demonstrated flexibility and a willingness to accommodate states to help them overcome some of the financial and regulatory hurdles of establishing and sustaining an exchange. For example, CCIIO allowed Oregon to:

- Use the federal IT platform at no cost;
- Retain plan administration fees paid by participating issuers;
- Eliminate state application processing (and associated costs); and
- Potentially receive additional outreach funding for enrollment and renewals.

Some other exchange functions in SSBE states are either shared or clearly retained by the state. Consumer assistance is bifurcated, with SSBE staff handling state-specific questions and federal customer service staff handling questions related to healthcare.gov. Most plan management functions, including plan certification, plan suspension, and plan standards and certification processes, are performed by SSBE staff. However, CCIIO likely retains some aspects of plan management, including grading qualified health plans.

This SSBE model could offer advantages to states that wish to host an SBE and perform many of the exchange functions, but lack the IT system infrastructure to sustain an exchange. One possible challenge with this model may be financing. The three operational SSBEs were financed by federal grants. As noted above, these federal establishment grants are no longer available. Therefore, states implementing the SSBE option will have to provide adequate resources to support the exchange functions the state will need to assume and may be expected to provide state-based IT exchange functions over time.

States wishing to establish an SSBE would likely have to either enact legislation or promulgate an executive order establishing an exchange. They would also need to negotiate the terms of shared functions with CCIIO, likely memorialized in an Exchange Blueprint agreement. As noted above, HHS may revisit Blueprint requirements and the future scope and cost of federal FFM services is uncertain and may change post-*King*.

*Summary:* The SSBE model is a flexible model that may be attractive to states that have the capacity to perform some functions of an SBE but where the cost and time associated with IT development is the most significant barrier to establishing a SBE. While its cost burden is unclear, depending in part upon what the Federal

government may continue to pay for, it is likely a higher cost model than the state-designated exchange model and will require legislative or executive action to implement.

**d. Contracted State-Based Exchange:** A contracted SBE model allows a state interested in moving from the FFM to a state-based model to contract with another state that operates an SBE to perform some or all required exchange functions, to manage costs and to allow for the timely implementation of required systems. This option may be most attractive to states that want to quickly launch their own SBE, but need to do so without the support of federal establishment grants.

The ACA authorizes states to establish their own exchange or to delegate one or more exchange functions, but limits the state's capacity to contract out exchange services to "eligible entities."<sup>xxix</sup> These entities are defined to include either: (1) a person incorporated under or subject to the laws of one or more states that has demonstrated individual health insurance market experience and is not a health insurance issuer; or (2) a Medicaid agency.<sup>xxx</sup> Under this language, it appears that states have the authority and capacity to contract with existing SBEs to perform certain functions.

Existing SBEs have been discussing ways to share certain exchange functions, either to save costs or promote long-term sustainability. These ideas and early successes could be leveraged moving forward by states seeking to adopt this companion SBE model. For example, IT development has been the most significant cost and most complicated challenge related to the establishment of SBEs. However, several states have successfully launched IT platforms that can offer a model for other states, and Connecticut has already made its IT platform available to Maryland. New states would not need to invest the same significant resources into IT development, and by contracting with another state to provide IT functions or sell an IT model, the burden of IT system development could be reduced even further.

Functions related to consumer outreach could also be purchased or shared at no cost, including resources to support consumer assistance like outreach materials, staff and assister training materials, call scripts for call centers, or other background materials targeted to consumers including plan calculator tools.

States may also choose to contract for certain business operation functions, including hosting a website, providing notices to participants, management and evaluation of exchange work. However, some states may wish to reserve certain functions, like eligibility decision support, for existing state staff or systems. States would be able to contract for plan management tools to support compliance with exchange requirements, including workflows, screening tools, exams, and methods for determining difference and discriminatory practice in benefit design.

In pursuing this approach a state would still need to set up its own SBE, which entails enacting legislation or promulgating an executive order, establishing a governance structure and securing financing to support exchange functions.

Establishing an SBE could be time- and resource-intensive and will require substantial state financial investments, even though many of these functions may be contracted out or operated in a more cost-effective way under this multi-state model.

*Summary:* While contracting out major exchange functions appears to provide opportunities for states to lessen the cost and infrastructure burdens associated with SBEs, this contracted SBE model requires significant collaboration with other states, time to contract and the establishment of an SBE, both of which will require substantial state resource investments to accomplish. Given the possible complexities of these arrangements, it is unclear whether this model would be a viable short-term solution for most states in the limited time states will have post-*King*, but it may offer an option for longer-term planning.

**e. Regional Exchange:** The ACA allows states to establish a regional exchange, either independently with a consortium of states or by building on an existing state-based exchange as the foundation for the regional model. A regional exchange would allow states to share some or all functions of an exchange, with a central entity hosting the exchange. The ACA provides clear authority for states to pursue this option under Section 1311(f), which explicitly provides that states can create a regional exchange model.<sup>xxxix</sup>

Regional exchanges could allow states to leverage existing or off-the-shelf IT models to build or expand the exchange, similar to the Contracted SBE model discussed above. One example of a successful joint procurement by multiple states to support common IT needs was the Medical Assistance Provider Incentive Repository (MAPIR) tool, a software tool developed for 13 states that interfaces with participating states' Medicaid Management Information Systems to manage and support provider incentive payments under Medicaid.<sup>xxxix</sup> Other functions, like consumer assistance and plan management, could be shared among states in similar ways as the Contracted SBE noted above. Additionally, some IT vendors have indicated that they can allow states to share a rules engine decision tool, but sustain separate secure IT systems for confidential information about beneficiaries, which might allow states to find a balance between a regional model and one that allows states to manage their own data.

NASHP reviewed state considerations in whether to opt for a regional exchange model in a 2013 issue brief, which provided an analysis of some advantages and considerations in a regional approach.<sup>xxxix</sup> Many of the identified advantages of a regional model remain important for states in a post-*King* environment, including that they could provide economies of scale with resulting cost savings, could offer an improved program design, could benefit consumers by providing a unified approach to messaging and coverage options across a region, and could lower administrative burdens for issuers and other stakeholders interfacing with the new exchange.

There are important challenges states pursuing this model would have to overcome, mostly arising from the need for interstate collaboration across disparate state

structures and interests. Separate state governments, with different processes, would need to identify ways to efficiently collaborate on shared procurement related to the exchange, establish a framework for fairly distributing costs and assigning functions, and create a representative governance structure among participating states. All decisions regarding the running of the exchange will likely have to be passed through each state's legislature, and many states have legislative sessions with different lengths that could make full collaboration difficult. Additionally, working with vendors in a timely way, which is critical to operational success, could be complicated when those vendors will need to engage multiple states in decision-making.

For regional exchanges, there may also be some advantage for states to be geographically proximate to allow insurers to operate in a similar geographic area and ensure access across state lines by citizens of regional partner states. However, regional states will have to find political and policy alignment in pursuing a regional approach, which may be difficult and resource-intensive. State officials and experts have also questioned whether risk pooling is viable across state lines. States seeking to establish a regional exchange may want to consider options across a continuum of functionalities to determine which approach is most viable given the needs of the states involved.

*Summary:* Although the regional exchange model may offer states opportunities for sharing costs, expertise and resources, it may not be a viable model in the near term for states seeking an alternative coverage model post-*King* because of the time, resources, and political alignment needed to develop a cross-state model.

**f. State-Private Exchange:** A new model that states may consider, pending federal approval, would be to adapt and designate private exchanges to serve as the state-based exchange in a new state-private exchange model. Private exchanges are health insurance market entities typically sponsored by one or more health insurance companies that are similar to public exchanges in structure and services, but cannot provide federal subsidies to individuals and are not subject to federal and state SBE requirements. Under Section 1311(f)(3) of the ACA, private health benefit exchanges that are sponsored by health insurance issuers are not able to either function as an SBE or contract with states to provide exchange functions.<sup>xxxiv</sup>

However, Florida has a unique state-established private exchange for the individual market that may offer a model for adapting a private exchange to become the state's SBE. Established by state law in 2008, Florida Health Choices is a non-profit corporation created by the state that provides a centralized web portal where individuals can shop for and compare health insurance plans. Florida Health Choices is governed by a 15-member board appointed by the Governor, President of the Senate, and Speaker of the House, subject to certain exclusions such as a bar on appointing health insurers, agents, and brokers.<sup>xxxv</sup> In addition to the board, the exchange has multiple steering committees to provide stakeholder input and is managed on a day-to-day basis by a CEO, Administrative Services Director, and Accounts Director. Because Florida's exchange was established by the state and is

run by a non-profit corporation, it might be eligible to either become the state's SBE or provide certain exchange functions under contract as an "eligible entity."

Financing for Florida Health Choices was initially provided by the state through appropriations to support the establishment of the exchange. The exchange is otherwise designed to be self-sustaining under an administrative surcharge on the products sold through the exchange, which is not to exceed 2.5 percent. Florida's private exchange provides functions and services similar to those required for an SBE, including: a web based portal for individuals and employers to shop for and compare plans; an online calculator; ability to find an agent; customer service centers; and information on public health care programs such as CHIP and Medicaid.

A state seeking to convert a private exchange like this one into a state-private exchange eligible for financial subsidies would likely need to make some changes to the exchange structure and operations. One of the most significant hurdles for converting a private exchange would be the ACA's bar on an exchange's ability to offer any plans that are not qualified health plans (QHPs). Currently, Florida Health Choices is not subject to this restriction and may offer any plan that meets the ACA's minimum essential benefit requirements but that are not necessarily QHP-certified. The exchange would need to review the plans it currently offers and either certify the plan as a QHP or eliminate it from exchange participation. Other requirements the state would have to address include increased stakeholder engagement, specifically with the unique populations defined in the ACA; publication of administrative costs; establishment of a navigator program; and, a process for processing and granting exemptions to the coverage requirement. Since these additional requirements are primarily operational modifications, the cost and burden of amending the existing structure to satisfy the ACA requirements for an SBE should be low.

Taken as a whole, the investment and time needed to modify a current private individual insurance exchange to become a state-private exchange may be manageable for states like Florida that already have one in place. In states without a comparable model in place, enacting legislation and providing adequate appropriations could involve the same hurdles of creating an SBE in time for the 2016 open enrollment period. In either situation, legislative action is required which means states will need a hospitable political climate and interested partnering insurers to support this approach.

*Summary:* Florida and other states with private individual exchanges that are not run by insurers may see some advantages in modifying their current private exchange. States without similar exchanges would need more significant investments of time and funds, making this model less viable.

**3. Other Coverage Options:** Some of the 34 states that did not establish an SBE may wish to use a *King* decision that eliminates federal subsidies to call for alternative approaches to make coverage affordable and cover the uninsured as part of a longer-term strategy. States wishing to pursue an alternative coverage approach have a number of options, rooted in

public and private coverage approaches.<sup>xxxvi</sup> Those options include, for example, the Basic Health Plan or State Innovation Waivers available in 2017 and sometimes referred to as Section 1332 of the Affordable Care Act, any of these options are likely to be a longer-term strategy for states and are less likely to offer near-term viable solutions in response to *King*.

#### IV. Conclusion

*King v. Burwell* is a landmark Supreme Court decision that has the potential to unravel the coverage gains made under the ACA to date, to disrupt state health insurance markets, undermine the health care safety net, and result in significant financial losses to hospitals and providers. For these reasons, state officials are watching closely as this case unfolds and may want to consider options to mitigate their coverage losses if a pro-*King* decision is issued. In response, states may choose to do nothing, await federal solutions, protect the status quo, shift to establishing their own state-based exchange, or pursue alternative coverage approaches. While none of these options offers immediate and complete remediation and some may be less viable given state financial and political environments, states are considering these and other options as they plan for their future in this uncertain environment in the coming months.

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<sup>i</sup> Arpit Misra and Thomas Tsai, *Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the Healthcare.gov Platform*. (HHS Assistant Secretary for Planning and Evaluation, February 2015), 5. This report includes estimates and information for the 37 states using healthcare.gov as an IT platform, which includes 34 FFM states and three federally supported state-based exchanges (SSBEs) that use healthcare.gov as their IT platform. The 7.3 million estimate of enrollments noted here does not include the three SSBE state enrollments.

<sup>ii</sup> Ibid.

<sup>iii</sup> Other estimates of subsidy losses that might result from a pro-*King* decision differ. Some are higher, suggesting that as many as 7.5 to 9.3 million individuals might lose subsidies. 7.5 million estimate: Caroline Pearson, *Nearly 7.5 Million Consumers Could Face Premium Increases as a Result of Supreme Court King v. Burwell Ruling* (Avalere, February 26, 2015), 1.; 9.3 million estimate: Linda J. Blumberg, Matthew Buettgens, and John Holahan, *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums* (The Urban Institute and The Robert Wood Johnson Foundation, January 1, 2015), 1. Another estimate suggested only 5.5 million individuals would likely lose subsidies due to attrition of those who initially enrolled in FFM coverage. Edmund F. Haislmaier, *King v. Burwell: Assessing the Claimed Effects of a Decision for the Plaintiffs*, (Heritage Foundation, February 20, 2015). The Urban Institute estimates 8.2 million individuals may become uninsured as a result of losing subsidies. Heritage disputes this claim without offering an alternative estimate, conceding that while some may become uninsured many individuals will be motivated enough to seek coverage replacement, either through employer coverage or by purchasing coverage.

<sup>iv</sup> Ibid, 7

<sup>v</sup> Christine Eibner and Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act* (Rand Corporation, 2014).

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- <sup>vi</sup> American Academy of Actuaries, letter to Secretary of the U.S. Department of Health and Human Services, Sylvia Mathews Burwell, *Premium rate filing implications of King v. Burwell*. February 24, 2015.
- <sup>vii</sup> Edmund F. Haislmaier, *King v. Burwell: Assessing the Claimed Effects of a Decision for the Plaintiffs*. Some also suggest that two groups, the higher income individuals receiving lower subsidies (with 300-400 percent FPL family income) and young adults, who make up nearly one-fourth of the FFM exchange market, may experience substantially lower impact on premium costs if subsidies are eliminated and therefore might be more likely to retain coverage post-*King*.
- <sup>viii</sup> Some experts are also suggesting that the controversy and uncertainty arising from *King* may deter smaller insurers and new players in the exchange markets in the 34 FFM states from offering coverage options in the 2016 plan year. Because plan filings are due in May, 2015, before the Court's decision will be announced, these experts predict fewer plan offerings in FFM states as a result of *King*. Brett Norman, *Big Insurers Likely to Push Ahead; Small Insurers May "Hit Pause,"* Politico (Politico, March 12, 2015)
- <sup>ix</sup> Matthew Buettgens, et al., *Health Care Spending by Those Becoming Uninsured if the Supreme Court Finds for the Plaintiff in King v. Burwell Would Fall by at Least 35 Percent* (The Urban Institute, February 12, 2015), 1.
- <sup>x</sup> *Ibid.*
- <sup>xi</sup> Joel Ario, Michael Kolber, and Deboarah Bachrach, *King v. Burwell: What a Subsidy Shutdown Could Mean for Consumers* (Commonwealth Fund, February 24, 2015).
- <sup>xii</sup> Matthew Buettgens, et al., *Health Care Spending by Those Becoming Uninsured if the Supreme Court Finds for the Plaintiff in King v. Burwell Would Fall by at Least 35 Percent*.
- <sup>xiii</sup> Steven Ross Johnson, *ACA Cuts to DSH Payments Could Prove To Be Hurdle for Providers*, Modern Healthcare (Modern Healthcare, 2014).
- <sup>xiv</sup> American Academy of Actuaries, *Premium rate filing implications of King v. Burwell*.
- <sup>xv</sup> National Conference of State Legislatures, *State Legislation and Actions Opting-Out or Opposing Health Reforms*, (NCSL: July, 2013)
- <sup>xvi</sup> David Morgan, *Obamacare rescue ruled out by some states, others weigh options* (Reuters, February 17, 2015).
- <sup>xvii</sup> Sondyha Somashekhar, Jason Millman and Lena H. Sun, *At Least 6 Republican States Revisit Their Opposition to Obamacare* (Washington Post, February 27, 2015).
- <sup>xviii</sup> <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html>
- <sup>xix</sup> 45 CFR § 155.106.
- <sup>xx</sup> 45 CFR § 155.105.
- <sup>xxi</sup> The United States Government Accountability Office, *Healthcare.gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management* (Washington, DC, July 2014).
- <sup>xxii</sup> Centers for Medicare and Medicaid Services, The Center for Consumer Information and Insurance Oversight, *Funding Opportunities; Establishment Grants* (Washington, DC).
- <sup>xxiii</sup> The Kaiser Family Foundation, *Total Health Insurance Exchange Grants* (Washington, DC, 2014).
- <sup>xxiv</sup> Patient Protection and Affordable Care Act, 42 U.S.C §18031(a)(4)(B).
- <sup>xxv</sup> Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, *The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions* (The Commonwealth Fund, May 2009).
- <sup>xxvi</sup> New Hampshire House Bill 548, introduced March 11, 2015.
- <sup>xxvii</sup> Under New Hampshire's proposed legislation, HB 548, "[s]tate agencies or departments may interact with the federal government with respect to operation of the federally-facilitated exchange for New Hampshire, and may, subject to availability of funding, perform any exchange functions necessary to ensure continued eligibility of New Hampshire citizens for premium tax credits and cost-sharing reductions under title I, subtitle E, part I of the A." While this legislation allows New Hampshire state agencies to take on additional exchange functions to enable its residents to retain federal ACA subsidies, it is unclear to what extent the state will opt to do so. On March 11, 2015, the NH Legislature voted 237-131 (an additional 30 representatives voted "other" or abstained) to "inexpedient to legislate" HB 548. This action results in the bill dying in committee.
- <sup>xxviii</sup> Patient Protection and Affordable Care Act, 42 U.S.C § 18031(d)(1).
- <sup>xxix</sup> Patient Protection and Affordable Care Act, 42 U.S.C. § 18031(f)(3)(A).
- <sup>xxx</sup> Patient Protection and Affordable Care Act, 42 U.S.C. § 18031(f)(3)(B).
- <sup>xxxi</sup> 42 U.S.C. § 18031(f).
- <sup>xxxii</sup> Abby Arons et al., *State Sharing of Insurance Exchanges: Options, Priorities and Next Steps from the West Virginia Regional Exchange Study* (NASHP, June 2013), 15.

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xxxiii Ibid.

xxxiv Patient Protection and Affordable Care Act, 42 U.S.C. § 18031(f)(3).

xxxv Under the Florida law establishing the exchange (FRS § 408.910), health insurers are not permitted to serve on the exchange board (see FRS 408.910 § 11(a)(5)).

xxxvi For more information on possible public coverage options, see: Swartz, Claudia, Angelique Hrycko, Tom Dehner and Juan Montanez, *Responding to King v. Burwell: What Claudia Swartz, et al., Responding to King v. Burwell: What Policy Levers Can States Pull to Maintain Coverage if the Supreme Court Sides with King?* (Health Management Associates, March 4, 2015). States could also pursue options with a more significant private market component, including establishing new private exchanges to improve shopping and comparison options for consumers, levying new fees to support uncompensated care pools, providing vouchers for private insurance coverage, or allowing buy-in to a public or state employee market. A state might also seek to establish a new three-share program under which employers, the state, and individuals contribute toward the cost of purchasing insurance.

## Appendix A: 2015 State Legislative Activity – Health Insurance Exchanges

State legislatures have considered bills regarding health insurance exchanges each year since the Affordable Care Act (ACA) was enacted. But the upcoming U.S. Supreme Court decision in the case of *King v. Burwell*, which challenges whether the ACA’s premium subsidies can be made available in states with exchanges run by the federal government, could have significant implications for states that have chosen not to operate a state-based exchange.

This chart describes bills that have been introduced in states’ legislatures in 2015 that either call for or prohibit the establishment of a state-based exchange, as well as other related bills. It is important to note that the bills reflected in the chart below are in the preliminary stages of legislative action. State Refor(u)m will be tracking state activity related to the topic and will update the chart as information becomes available, and NASHP has issued a policy brief outlining options for states if the U.S. Supreme Court rules in favor of *King*. Know of a bill that we should add to this compilation? Your feedback is central to our ongoing, real-time analytical process, so tell us in a comment below, or email [acardwell@nashp.org](mailto:acardwell@nashp.org). The National Conference of State Legislatures is also tracking state action to address health insurance exchanges on [this page](#).

State	2015 Bills	Exchange Orientation <i>Bills listed here either create a state-based exchange or designate the federal exchange as the state’s exchange (State); take action to support the federal exchange by prohibiting the creation of state-based exchange or repealing the state-based exchange (Federal); or outline other actions or requirements (Other)</i>	Exchange Leadership <i>For bills creating state-based exchanges, which state agency is identified to lead the exchange</i>	Exchange Financing <i>For bills creating state-based exchanges, sources identified to finance exchange</i>	Exchange Functions <i>For bills creating state-based exchanges, whether bill identifies specific functions that will be assumed by state or federal agencies</i>	Bill Status <i>Date of introduction or enactment</i>

AR	<a href="#">SB 343</a>	<b>Federal:</b> Prohibits establishment of a state-based exchange	N/A	N/A	N/A	Introduced 2/11/15; delivered to Governor 3/12/15
AZ	<a href="#">HCR 2026</a>	<b>Other:</b> Stipulates that AZ residents enrolled in the exchange are not eligible for subsidies because AZ did not establish a state-based exchange	N/A	N/A	N/A	Introduced 2/3/15
FL	<a href="#">SB 1498</a>	<b>State:</b> Establishes state-based exchange, if U.S. Supreme Court rules in favor of <i>King</i>	Agency for Health Care Administration	Not mentioned	Exchange may contract with eligible entities to perform any exchange functions	Introduced 3/3/15
IN	<a href="#">SB 417</a>	<b>State:</b> Requires the state insurance commissioner to design, implement and administer a state health exchange, including the establishment of a SHOP exchange  Directs state insurance commissioner to determine by no later than 10/31/15 if any additional legislation is necessary to implement the exchange and to apply for federal certification of the exchange not later than 1/1/16. The exchange would make qualified health plans available with effective dates no later than 1/1/18	Department of Insurance	Yes; exchange may charge assessments or user fees to carriers and receive appropriations from the legislature to support operations  Bill directs commissioner to apply for federal grant funds for exchange development if they become available	Not mentioned	Introduced 1/12/15

ME	<a href="#">LD 815</a>	<b>State:</b> Establishes a state-based exchange; coverage available no later than 1/1/17	Commissioner of Professional and Financial Regulation (establishes the exchange)	Directs the exchange executive director to apply for federal grant funding  Establishes the Health Benefit Marketplace Enterprise Fund to deposit any funds advanced for initial operating expenses, payments from employers and individuals, and any federal, public or private funds	Exchange may contract with eligible entities for any of its functions, and may enter into any information-sharing agreements with federal and state agencies to carry out responsibilities, including the federally-facilitated marketplace  Exchange directed to implement a system to coordinate activities with federal, state and municipal governments	Introduced 3/10/15
MN	<a href="#">SF 1232</a>	<b>Federal:</b> Proposes to repeal state-based exchange	N/A	N/A	N/A	Introduced 3/2/15
MS	<a href="#">SB 2768</a>	<b>Federal:</b> Prohibits ACA implementation	N/A	N/A	N/A	Introduced 1/19/15; failed 2/3/15
MO	<a href="#">HB 601</a> and <a href="#">SB 51</a>  <a href="#">HB 870</a>	<b>Federal:</b> Prohibits the establishment of a state-based exchange  <b>State:</b> Indicates that if individuals cannot receive federal subsidies through the federal exchange, the state is authorized to establish a state-based exchange	N/A  Department of Insurance, Financial Institutions & Professional Registration	N/A  Not mentioned	N/A  Not mentioned	Introduced 1/21/15 & 1/22/15  Introduced 2/10/15

MT	<a href="#">HB 256</a>	<b>Other:</b> Indicates establishment of a state-based exchange can only be authorized by the state legislature	N/A	N/A	N/A	Introduced 1/20/15
NH	<a href="#">HB 548</a>	<b>State:</b> Designates the federal exchange as the exchange for the state; effective 60 days after passage	See state role in Exchange Functions column	Participating issuers will be subject to assessments or user fees imposed by federal government	<p>Technical exchange functions will be operated by federal government</p> <p>Depending on availability of funding, state agencies may perform exchange functions needed “to ensure continued eligibility of New Hampshire citizens for premium tax credits and cost-sharing reductions”</p> <p>State agencies are also permitted to perform plan management and consumer assistance functions, such as plan certification, plan quality rating, and Navigator program operation</p>	Introduced 1/8/15; inexpedient to legislate 3/11/15

NJ	<a href="#">S 540/A 3953</a>	<b>State:</b> Establishes a state-based exchange	Department of Banking and Insurance will host exchange, but exchange will be independent of supervision of the department and governed by a board of directors	Bill permits marketplace to apply a uniform surcharge on qualified health plans and a uniform assessment on carriers not contracting with the marketplace; board is also authorized to seek grants from the federal government or private foundations  Bill establishes a trust fund within the Department of the Treasury to collect monies from carriers or other funds received through grants to support marketplace activities	Board will implement marketplace functions; board may contract with professional service firms	Introduced 1/14/14 & 12/4/14 for the 2014-2015 legislative session
PA	<a href="#">HB 330</a>	<b>State:</b> Establishes a state-based exchange; qualified health plans available no later than 1/1/17	Department of Insurance (governed by a 14 member board, consisting of: - 3 Governor-appointed members of the general public; - 4 Senate members; - 4 House members; - Secretaries of Budget, Health and Human Services; Department of Insurance Commissioner	Exchange may charge assessments or user fees to carriers or otherwise may generate necessary funding to support operations	Exchange may contract with eligible entities to perform any exchange functions; an eligible entity includes the state Department of Human Services  Exchange may engage in information-sharing agreements with federal and state agencies to carry out exchange functions	Introduced 2/4/15

RI	<a href="#">H 5329</a>	<b>Federal:</b> Proposes to repeal state-based exchange on 1/1/16	N/A	N/A	N/A	Introduced 2/5/15
SC	<a href="#">H 3020</a>	<b>Federal:</b> Prohibits establishment of state-based exchange	N/A	N/A	N/A	Introduced 1/13/15
	<a href="#">S 103</a>	<b>Federal:</b> Prohibits establishment of state-based exchange by declaring the ACA exceeds congressional authority	N/A	N/A	N/A	Introduced 1/13/15
TN	<a href="#">SB 72/H B 61</a>	<b>Federal:</b> Prohibits the establishment of a state-based exchange, if U.S. Supreme Court rules in favor of <i>King</i>	N/A	N/A	N/A	Introduced 1/15/15
	<a href="#">HB1 209/SB11 24</a>	<b>State:</b> Requires the state to establish a state-based exchange, if U.S. Supreme Court rules in favor of <i>King</i>	Not designated	Not mentioned	Not mentioned	Introduced 2/12/15
TX	<a href="#">HB 817</a> and <a href="#">HB 818</a>	<b>State:</b> Calls for state officials to negotiate with federal government to establish a state-based exchange	Health and Human Services Commission and/or the Department of Insurance	Not mentioned	Not mentioned (bills note that the state-based exchange must be similar to the health benefit exchange described in ACA)	Introduced 1/21/15
VT	<a href="#">H 177</a>	<b>Federal:</b> Proposes to repeal state-based exchange on 1/1/16	N/A	N/A	N/A	Introduced 2/10/15

