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King v. Burwell

What a Subsidy Shutdown Would Mean for Consumers, Insurers, Providers and States

Joel Ario, Managing Director
Deborah Bachrach, Partner
Michael Kolber, Associate



Introduction

Virtually all commentators on *King v. Burwell* agree that a Supreme Court ruling against the government would be disruptive. Few, however, have focused on the real-world impact of the loss of health insurance subsidies for millions of people. In a four-part series prepared with the support of The Commonwealth Fund, Manatt Health examines the serious consequences of a decision that would terminate subsidies for residents of the 34 states that have federally run health insurance marketplaces. The series explores what a Subsidy Shutdown could mean from the perspectives of four key stakeholders: consumers, insurers, providers and states. The following shares the content of the complete series. To access The Commonwealth Fund Blog, click [here](#).

The Potential Impact on Consumers

More than 7 million people in states with federally run marketplaces currently receive subsidies. But if they suddenly had to pay unsubsidized premiums, most would no longer be able to afford their coverage. For example, a 40-year-old nonsmoker in Cheyenne, Wyoming, earning \$20,000 annually pays \$84 in premiums each month if she chooses the benchmark silver plan. If subsidies are terminated, she pays \$407 for the same plan—more than 20 percent of her wages. In the more competitive Miami insurance market, that same woman pays the same amount for the benchmark plan with the subsidy in place (\$84), but the price jumps to \$274 without it.

Consumers facing premium increases of this magnitude would **have to choose** between health insurance and food, rent, and other essentials. Most would **stop paying premiums immediately**. In the aggregate, a Subsidy Shutdown could result in as many as **9.6 million fewer people with coverage** through the individual market,

both inside and outside the marketplaces, by 2016—that’s a 70 percent decline. And patients who managed to cover their full-priced premiums for 2015 would likely face much higher premiums for 2016. Premiums are forecast to **increase 47 percent next year**, as healthy people drop their coverage and high-risk people retain it. Such a spike would drive even more people out of the market.

The net result would be an individual health insurance market **even more dysfunctional** than the one we had before the Affordable Care Act (ACA) was enacted: while health coverage was unaffordable or entirely inaccessible to those with preexisting conditions before the ACA, a Subsidy Shutdown-generated premium death spiral would put insurance out of reach for healthy and sick individuals alike. The consequences would be dramatic.

In many cases, going without health insurance would mean going without healthcare. Because only 13 of the 34 federal marketplace states have expanded eligibility for

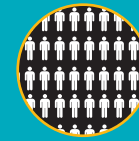
How would

Consumers

be affected if the Supreme Court ends health insurance subsidies?

If the Supreme Court rules in favor of the plaintiff in the King v. Burwell case, premium subsidies for millions in the 34 states with federally run marketplaces will end.

As a result, the U.S. could see:



9.6 million fewer people covered in the marketplaces and individual market*



47% jump in insurance premiums as healthy people drop coverage*



9,800 more preventable deaths a year because of a lack of healthcare†



Millions of consumers at increased risk of medical debt

Notes:

* E. Saltzman and C. Eibner, *The Effect of Eliminating the Affordable Care Act’s Tax Credits in Federally Facilitated Marketplaces* (Santa Monica, Calif.: RAND Corporation, 2015).

† B.D. Sommers, S. K. Long, and K. Baicker, “Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study,” *Annals of Internal Medicine*, May 2014. 160(9):585-93.

Source:

J. Ario, M. Kolber, and D. Bachrach, “King v. Burwell: What a Subsidy Shutdown Could Mean for Consumers,” *The Commonwealth Fund Blog*, Feb. 24, 2015.

Medicaid, there would be only a dramatically reduced public safety net available to millions of poor adults. Even states that have expanded Medicaid would be able to provide coverage only to individuals with incomes just above the federal poverty level. Middle-income individuals would be left to negotiate with providers for healthcare bargains, seek charity care, or draw down the limited resources of government programs and public foundations that support specific patient populations, such as the federal [Ryan White HIV/AIDS Program or the Breast and Cervical Cancer Treatment Program](#).

We already know that uninsured individuals are less likely to receive preventive care and twice as likely to delay needed care. For example, a woman who has coverage through the marketplace today is [three times more likely](#) to obtain an ultrasound for a breast lump or

abnormal mammogram than an uninsured woman. Because of medical breakthroughs in the treatment of AIDS, cancers, and other diseases, reliable access to health coverage is in many cases a significant factor driving health outcomes. Uninsured individuals [have worse health outcomes](#) and are more costly to the healthcare system. By one estimate, the Subsidy Shutdown [could result](#) in 9,800 preventable deaths annually.

For uninsured patients who manage to get care, the financial costs would be crippling. Medical debt is already the [single largest cause](#) of consumer bankruptcies, and it would only get worse as millions joined the ranks of the uninsured. The burden of being uninsured weighs most heavily on those with chronic disease: cancer patients are [two-and-a-half times more likely](#) to file for [bankruptcy](#) than other people.

The Subsidy Shutdown would have indirect economic

costs, too. Because health coverage is so closely linked to employment, the prospect of [“job lock”](#) is a concern. That occurs when workers stick with their current job, instead of engaging in entrepreneurial or otherwise more productive employment, just so they can keep their health benefits. Job lock harms small businesses, which often cannot afford to provide insurance and therefore can't recruit employees from larger businesses that can afford it. While pre-ACA federal laws took some steps to counter job lock, they had limited effect: before the ACA, [half the uninsured](#) were owners or employees of small businesses and their family members.

The ACA has given people who must buy coverage in the individual market nearly equal access to affordable health insurance as for people with group coverage. A Subsidy Shutdown would reverse that progress.

The Potential Impact on Insurers

Under the ACA, health insurers have been big winners, enrolling record-high numbers and earning strong profits. Consumers, meanwhile, are benefiting from increased competition in the marketplaces—with 25 percent more insurers participating in 2015 than 2014, with no increase in average nationwide [premiums](#).

A Subsidy Shutdown would [reverse these dynamics](#). More than [7 million people](#) in states with federally run marketplaces could lose their subsidies. Most of these people are likely to drop their insurance, because individuals are exempt from the coverage mandate if insurance is unaffordable. Those remaining in the marketplaces would be primarily the approximately 15 percent who buy health plans without a subsidy, and previously subsidized individuals with serious medical needs, who are better off paying high premiums than having no coverage at all.

Should a Subsidy Shutdown happen this summer, insurers would suddenly have a risk pool filled with high-need, high-cost people, after having priced

their 2015 premiums based on a balanced pool containing both healthy and sick people. Claims would quickly outpace premium revenue as insurers lose most of their low-cost, healthy customers but retain customers whose medical costs exceed their premiums.

Some insurers would try to exit the marketplace midyear, as they [may be permitted](#) to do under their contract with the federal government if there is a Subsidy Shutdown. The first carriers to consider leaving would be new market entrants that had been lured by the opportunity to build membership. These include Medicaid managed care organizations seeking to expand their footprint, regional health systems seeking to integrate healthcare delivery with insurance, and [nonprofit cooperatives](#) given federal start-up loans. Many of these new competitors would be unable to withstand negative cash flow, even for a few months.

Larger insurers, especially Blue Cross and Blue Shield plans and national for-profit insurers, may choose to brave the remainder of 2015, though their balance sheets would take

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70% decline in enrollment among people buying individual market plans*



Healthy customers dropping coverage, leaving a risk pool of sicker people who have **higher medical costs**



Insurers exiting the marketplaces, creating a **less competitive environment**

Notes:

* E. Saltzman and C. Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* (Santa Monica, Calif.: RAND Corporation, 2015).

Source:

J. Ario, M. Kolber, and D. Bachrach, "King v. Burwell: What a Subsidy Shutdown Could Mean for Consumers," *The Commonwealth Fund Blog*, Feb. 25, 2015.

another hit when they absorb disproportionately high-risk customers from any exiting insurers—as they’re required to do. One reason to stay is that, under federal law, an insurer that leaves a state’s individual health insurance market is prohibited from offering coverage in that market for five years. The federal government could relax this prohibition, but the states have similar bans and may choose to favor those insurers willing to remain in their market.

Regardless of how the 2015 disruption is managed, the challenges would be even bigger in 2016. By the time of the Subsidy Shutdown, insurance rates for 2016 would already have been set, but those rates will be too low for the risk pool. This would set the stage for a “[premium death spiral](#),” triggered by healthier individuals exiting the market. In fact, the RAND Corporation

estimates that rates could eventually [rise 47 percent](#) in the [absence](#) of subsidies. Because rates must be linked inside and outside the marketplace, rate increases would apply across the entire individual insurance market.

Insurance regulators have not determined whether they will allow insurers to change their rates in the event of a Subsidy Shutdown, but insurers would have the option of exiting the market on the eve of the 2016 open enrollment period. For this reason, insurers are already discussing with regulators about proposing two sets of rates at an earlier stage of the review process, perhaps this spring. Raising rates would help maintain insurer participation, but it certainly is no panacea: higher rates would drive more customers out of the market, further accelerating the death spiral of escalating rates and shrinking enrollment.

Federal law has risk stabilization provisions to combat adverse selection, including a temporary risk corridor program, in which the federal government subsidizes marketplace insurers that incur unexpectedly large losses, but these programs are not designed to overcome the loss of subsidies and, without statutory changes that make these programs much more generous than they currently are, they are unlikely to prevent death spirals.

Even if a Subsidy Shutdown were short-lived, the results could prove long-lasting. We likely would see a return to state insurance markets dominated by one or two large insurers. With prices for 2016 locked in at much higher levels, individual market enrollment could decline 70 percent overall, leading to [9.6 million people](#) losing their coverage.

The Potential Impact on Healthcare Providers

In the event of a Subsidy Shutdown, most of the more than 7 million people estimated to be currently receiving subsidies through the federally run marketplaces would find their premiums unaffordable and would likely **stop paying for insurance**. With so many of their recently insured patients suddenly without coverage, healthcare providers would quickly face financial shortfalls and ethical quandaries. Doctors' ethical and legal obligations may **prevent them from terminating** services during an ongoing course of treatment, even if patients have no way to pay the bills. In fact, HCA, the nation's largest for-profit hospital chain, reports that it **collects zero payment** from nearly 90 percent of its uninsured patients.

At the same time, state prompt-pay and continuity-of-care laws would not help providers or patients. These laws require insurers to pay doctors in a timely manner and prevent disruptive treatment changes when consumers change insurers, but they generally

do not impose obligations on insurers when individuals fail to pay their premiums.

Hospitals would be especially hard-hit. For the second time in three years, they would see **the bargain they struck** in the ACA undermined by the Supreme Court. As part of the legislative compromise to fund the law's coverage expansion, the major hospital trade associations agreed to \$269 billion in Medicare and Medicaid **payment cuts** over a decade, including lower reimbursement rates and reductions in payments for providing free care to uninsured patients. In exchange, hospitals, clinics, and physicians were to receive **millions of patients newly covered** under Medicaid or federally subsidized commercial insurance.

But in 2012, the **Supreme Court ruled** that states were not required to expand Medicaid eligibility under the ACA and, to date, 22 states have declined to do so. Should the Court rule that health plan enrollees in the 34 states with federally run marketplaces are not entitled to

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As a result, doctors, hospitals, and other providers could face:



More than 7 million patients losing subsidies, with most dropping coverage



More than \$9 billion in lost revenue a year*



Closures or reduced services among rural hospitals, community health centers, and nonprofit hospitals that serve low-income patients

Notes:

* M. Buettgens, J. Holahan, L. J. Blumberg 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* (Washington, D.C.: Urban Institute, February 2015).

Source:

J. Airo, M. Kolber, and D. Bachrach, "King v. Burwell: What a Subsidy Shutdown Could Mean for Consumers," *The Commonwealth Fund Blog*, Feb. 25, 2015.

subsidized coverage, hospitals, physicians, drug manufacturers, and other healthcare providers face the prospect of losing **more than \$9 billion in revenue each year**.

Rural hospitals might face the most severe consequences. Facing lower Medicaid and Medicare reimbursement, and with fewer newly insured patients than expected, **many rural hospitals are already closing**—a total of 43 since 2010, and **five in Georgia alone since 2013**. Without subsidized marketplace coverage, these failures would become even more common, especially in the 22 states that have not yet expanded Medicaid. At a minimum, hospitals and clinics

that survive would have to **reduce the scope** of public health and prevention services they provide in order to redirect their limited resources to treating acute health problems of newly uninsured patients.

Federally subsidized community health centers, which are required to provide primary care to patients regardless of their ability to pay, would suffer similar problems. The ACA **brought these clinics an influx of newly insured patients**, allowing them to **redirect resources** to care for the remaining uninsured and an expansion of social service offerings. A Subsidy Shutdown would force a cutback in these new services. There are more than

5,600 community health center locations in states with federally run marketplaces, serving a total of 12 million patients.

Nonprofit hospitals **are likewise required to have charity care** programs to help low-income patients pay hospital bills. But these programs would be overwhelmed by the 9.6 million people losing their health coverage inside and outside of the exchanges as a result of the loss of subsidies and the subsequent premium increases across the individual market.

Clearly, healthcare providers are another group that will be closely watching the Supreme Court next week when *King v. Burwell* is argued.

The Potential Impact on States

Just days after his inauguration last month, the Republican governor of Arkansas, Asa Hutchinson, had to decide whether to challenge many in his own party and seek renewal of the state’s innovative Medicaid expansion. In deciding to support renewal, Hutchinson considered both the human and financial costs of turning down millions of federal dollars and eliminating coverage for 200,000 Arkansans.

“The human side tugs at our heart strings and rightfully is a factor in this debate,” Hutchinson said.

Thirty-four governors across the country will need to weigh a similar choice if the Subsidy Shutdown occurs—though on a much bigger scale. In Florida alone, 1.6 million people **have selected plans** through the federal marketplace; in Texas, it’s 1.2 million. The vast majority of these enrollees receive subsidies that would end after a Subsidy Shutdown, and even those with unsubsidized coverage would soon face higher premiums. As many enrollees stop paying their premiums, hospitals and doctors will go unpaid and illness will go untreated. If there is no federal solution to the Subsidy Shutdown, it will be up

to governors to decide whether they are willing to take the steps necessary to establish a state marketplace and restore the subsidies.

The results could mirror what happened when the Supreme Court made the expansion of Medicaid eligibility voluntary in 2012. Three years later, 28 states and the District of Columbia **have expanded**, and several others are actively considering doing so. Because the cost of subsidies is borne entirely by the federal government—and is therefore in some respects a better deal for states than the Medicaid expansion—we would expect many of the 13 states that have already expanded Medicaid but still have a federally run marketplace to consider establishing a state marketplace to restore the subsidies. Nevertheless, there are logistical, political, and financial challenges to establishing a state marketplace, and there will undoubtedly be holdouts, at least for some time. In fact, there may be more than a dozen states willing to let their residents become uninsured again—which would lead to significant inequalities in coverage across states.

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If state governments don’t create their own marketplace they are likely to face:



Thousands of residents losing subsidies and quickly **becoming uninsured**



Hospitals, doctors, nurses, and other healthcare providers **going unpaid**



Insurers **raising rates dramatically** or exiting the individual market



Widening coverage inequalities across states

Source: J. Ario, M. Kolber, and D. Bachrach, “King v. Burwell: What a Subsidy Shutdown Could Mean for Consumers,” *The Commonwealth Fund Blog*, Feb. 24, 2015.

There is little doubt about what will happen to insurance markets in states that refuse to act in the face of a Subsidy Shutdown. History shows that the ACA's insurance market reforms, such as bans on preexisting-condition exclusions, will not work properly in the absence of subsidized coverage. Prior to the ACA's enactment, five states—Massachusetts, New Jersey, New York, Rhode Island, and Vermont—had provided consumers [guaranteed access](#) to individual health insurance but did not enact an individual mandate or sufficient subsidies to make coverage affordable. In every case, the results were [escalating prices](#) and shrinking enrollment, as premium increases drove young and healthy people out of the market. After New York implemented its reforms, the percentage of residents under age 65 who were uninsured actually [increased](#), from 14 percent to 20 percent, with premiums rising by as much as 40 percent. [Massachusetts](#) alone reversed the trend with a second round of reform that

supplemented guaranteed access with an individual mandate and broader subsidies, the so-called “three-legged stool” that subsequently became the model for the ACA.

After a Subsidy Shutdown, market deterioration would start in the marketplaces, as customers quickly drop their coverage upon [losing the subsidies](#) that were paying for about 70 percent of premiums on average. Healthier people would be among the first to drop their insurance, leaving sicker people in the marketplaces. Insurers would raise premiums dramatically or exit the state's individual insurance market altogether. Because premiums inside and outside the exchanges must be linked, the higher rates would affect the entire individual market—entrepreneurs, farmers, freelancers, and millions more who are between jobs, don't have employer health benefits, and don't qualify for Medicare or Medicaid. Many states would try to respond, but most would not have the resources to strengthen their safety nets

enough to handle a surge in newly uninsured citizens.

As with the law's Medicaid expansion, the U.S. Department of Health and Human Services is likely to be open to innovative approaches, so that states may be able to propose alternative paths to a state marketplace. However, this flexibility may not be sufficient for the dozen or more states that strongly oppose the ACA. In fact, five governors have already pledged not to address the loss of subsidies. Instead, the Subsidy Shutdown will only widen a growing gap between “have” and “have not” states.

For more information, contact:

Joel Ario
Managing Director
212.790.4588
jario@manatt.com

Deborah Bachrach
Partner
212.790.4594
dbachrach@manatt.com

Michael Kolber
Associate
212.790.4568
mkolber@manatt.com

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