THE CONSEQUENCES OF *KING V. BURWELL*: HOW A FEDERAL EXCHANGE COULD BLOCK AN OBAMACARE TAX INCREASE

By Dan Greenberg and Marc Kilmer
6/19/15

EXECUTIVE SUMMARY

Sometime this month, the United States Supreme Court will issue a decision in the matter of *King v. Burwell*;[1] that decision will likely have a substantial impact on the future of Obamacare.[2] More precisely, *King* will probably determine whether the citizens of the 38 states with federal Obamacare exchanges -- such as Arkansas[3] -- may receive Obamacare insurance premium subsidies through those exchanges. If the Supreme Court holds for the plaintiffs and finds that Obamacare subsidies may only flow through state exchanges (and, thus, not through Arkansas's exchange), that decision will have enormous positive consequences for our state:

- The economic growth created by removal of Obamacare's regulatory shackles will cause 16,000 new jobs to be added to the Arkansas economy two years from now, with an additional 4,000 Arkansas jobs by 2024.[4]
- Individual Arkansans could be free of as much as $241.5 million in Obamacare mandate penalties.[5]
- Arkansas businesses could be free of as much as $1.268 billion in Obamacare mandate penalties.[6]

The two figures provided immediately above are the maximum possible gains from eliminating those two Obamacare mandates, and the maximum gains from eliminating those mandates will not be completely realized. But even our most cautious assumptions suggest that ***eliminating Obamacare mandates would benefit Arkansas's economy by $302 million[7] -- a figure that is nearly twice the amount of the subsidies that a victory for the plaintiffs in* King *might jeopardize.***

Much of the media coverage over *King* has focused on the possible loss of Obamacare premium subsidies. However, many more Arkansans (and, more generally, many more Americans) will benefit if the court sides with the plaintiffs. When compared to what Arkansas beneficiaries might lose -- roughly $164 million in Obamacare premium subsidies in a year[8] -- the potential gains to the public of a win for the plaintiffs in *King* (which would, to repeat, bar Obamacare insurance mandates and subsidies from federal-exchange states like Arkansas) are significantly larger. When we examine the entire set of costs and benefits, ***any reasonable estimate demonstrates that a win for the plaintiffs in this case is a net benefit for Arkansas.*** In this scenario, Arkansas's choice of

(continued on other side)

a federal exchange (as compared to a state exchange) will have been a blessing in disguise. Although we cannot ignore the fraction of Arkansans who would face a significant increase in insurance costs in such a circumstance (probably between 2% to 3% of Arkansas households[9]), we must also examine *King's* possible impact on the entire population of Arkansas -- and the available data demonstrates that Arkansans as a whole are almost certainly better off if the plaintiffs prevail in *King.* Establishing a state exchange in that circumstance would be functionally identical to a tax increase; more precisely, it would vacuum wealth from Arkansas's economy, destroy much of that wealth, and redistribute the remainder to a small group of people. In fact, the use of higher taxes to redistribute wealth inefficiently to small, concentrated groups of beneficiaries is pervasive in the American political system, but few view such a structure as especially praiseworthy.

If the *King* plaintiffs prevail and the Supreme Court holds that Obamacare subsidies may not flow through federal exchanges, that would mean that the previous practices of the Obama Administration -- which directed subsidies to flow through both state and federal exchanges -- were illegal, and that transmission of Obamacare subsidies through federal exchanges must end. But (to repeat) ending those subsidies will affect more than just their recipients: indeed, that consequence will benefit not only the people who are currently required to purchase health insurance under the threat of Obamacare's individual mandate, but also the companies (and their employees) which must currently comply with the employer mandate -- because those companies are currently required either to offer "qualified and affordable" health insurance or to pay a crippling fine.

BACKGROUND

Earlier this year, the Supreme Court heard arguments in *King v. Burwell*. The parties disagree about how to interpret the powers of federal exchanges under Obamacare. Obamacare requires the federal government, through health care exchanges, to provide subsidies to individuals purchasing insurance policies through those health care exchanges. The legislation specifies that these subsidies are only available in exchanges "established by the State," and it allows each state to set up its own exchange -- as long as that state follows Obamacare's statutory requirements. If a state fails to meet those requirements, or otherwise fails to pursue the option of establishing its own exchange, then the federal government will establish and run an exchange for that state.

Although the plain text of the law demonstrates that Obamacare subsidies can only be offered through state-established exchanges, the Internal Revenue Service (IRS) concluded that the subsidies can be offered through either state or federal exchanges, issuing regulations to that effect. The plaintiffs in this case are asking the courts to overturn the IRS's interpretation and to require the IRS to follow the plain text of the law.

A conservative perspective, as expressed by Congressman Paul Ryan, is that "Congress wields the power of the purse; more and more, the Administration is acting like a purse-snatcher."[10] The perspective of the Obama Administration, supporting the IRS, is that Obamacare's interpretation should be based on the interpreter's understanding of "the intent and meaning and the overall structure of the statute."[11] Because it is hard to see how a principled Supreme Court decision for the defendants would avoid the consequence that unelected federal bureaucrats can tax and spend without approval by Congress, a prediction that the Supreme Court will decide for the plaintiffs in this case has some weight. Appellate courts have previously differed as to whether the IRS's interpretation is legitimate; later this month, the Supreme Court will serve as the final arbiter.

Although the legality of Obamacare subsidies is at the center of the case, there is more at stake. Over 200,000 Arkansans would be exempt from the individual mandate if they did not have access to Obamacare subsidies. Businesses and their employees are also affected by these subsidies: any business with more than 50 full-time employees (or their equivalent) is subject to a large fine (or tax), so long as even one of that business's employees buys insurance with an Obamacare subsidy. In a state without the subsidies, this penalty disappears.

HOW VICTORY FOR THE PLAINTIFFS IN *KING V. BURWELL* COULD SUPERCHARGE ARKANSAS'S ECONOMY

Some Arkansans will be worse off financially in the event of a *King* plaintiff victory; however, many more Arkansans would be better off. Notably, the nation has seen far more discussion of the costs than the benefits of a plaintiff's victory; below, we provide a brief account of how best to calculate both those costs and those benefits. Those who would benefit from a plaintiff's victory include:

people who would no longer be compelled either to purchase insurance or pay a fine;
businesses with more than 50 employees;
and the employees of those businesses.

When we examine the magnitude of these beneficiary groups and the consequences of a plaintiff victory in *King,* available data demonstrates that the economic benefits to Arkansas of a plaintiff victory would far outweigh the costs.

What would happen in Arkansas if the plaintiffs won in *King?*

Individual Benefits

Obamacare requires people either to buy health insurance or to pay a fine. This individual mandate, levied in the form of a tax, is a substantial burden, but it only applies

if individuals have access to health insurance plans that do not cost more than 8.05% of their income in 2015.

According to a recent American Action Forum study, 205,858 Arkansans would become exempt from the individual mandate if the *King* plaintiffs prevail.[12] Otherwise, these Arkansans face an average penalty of $1,175, which adds up to a total potential savings of $241,562,375.

Business Benefits

Obamacare mandates that any large employer (more precisely, one which employs over 50 full-time employees or their equivalent) that fails to offer "qualified and affordable" health insurance must pay a fine. Insurance policies must meet extensive criteria to be "qualified and affordable." A company cannot merely offer any health insurance and escape the fine. It must bring its health insurance up to Obamacare standards, which has resulted in significant cost increases for employers and consumers.[13]

The fine (or tax) for not complying with this law is $2,000 for every person employed by the company, excluding the first 30 people. Large employers that offer health insurance, but who have at least one employee who uses Obamacare premium subsidies,[14] must also pay a fine. That fine is the less expensive of either (a) $3,000 for each employee using Obamacare subsidies or (b) $2,000 per employee, excluding the first 30. For 2015, the Obama Administration increased the employee exclusion from the first 30 employees to the first 80 employees.[15]

Because of this increased exclusion, the employer mandate does not affect as many business owners as it will in 2016. However, a significant financial liability -- that, in theory, adds up to $1.268 billion -- looms over large businesses in the state for 2015.[16] That figure will expand next year. Not every business will pay its share of this penalty, but every large business in the state could be vulnerable to it as long as these health insurance subsidies remain in effect.

If the *King* decision eliminates the employer mandate for federal-exchange states, this would be very good news for business owners and workers. Growing companies that have not yet reached the 50-employee threshold currently face a difficult choice: hire more workers (and bear an expensive penalty), or stifle future growth (so as to avoid the penalty). The continued existence of the mandate penalizes economic expansion by means of a sizable tax, with an arbitrary threshold, on American businesses.

Eliminating the employer mandate would also make Arkansas a relatively advantageous place to do business. Companies in a state-exchange state will continue to face the threat of the employer mandate. The mandate's absence would make Arkansas

both an attractive place for existing businesses to relocate and a more attractive place to start (or build) a large company.

Benefits to Arkansas's Economy at Large

An American Action Forum study predicted that under a victory for the plaintiffs in *King*, Arkansas could see more than 16,000 new jobs added to the Arkansas economy two years from now, with an additional 4,000 Arkansas jobs by 2024.[17] The study also found that there may be positive effect on wages:

> AAF estimates that the ACA's regulations have reduced annual wages for employees of small and medium sized businesses by $830 to $940 each, totaling $13.6 billion in the *King* states. There will be fewer administrative burdens when employers offer full-time employment to qualified employees who will have the opportunity to become specialized and therefore more efficient in their work. We might also expect to see more job growth in these states as employers expand their businesses and offer more hours without the cost of complying with the ACA.[18]

Individual Costs: Two Estimates

Although many individuals and businesses in Arkansas will benefit on net if the plaintiffs prevail in *King v. Burwell,* some may not: namely, some of the recipients of Obamacare subsidies to purchase policies on the exchange. These subsidies will disappear, as will the subsidies of those eligible for Obamacare aid in the majority of the fifty states.

Producing a precise estimate of those who receive subsidies is difficult. The federal government only releases information on the number of policies sold, not the number of people covered. Any particular policy might cover one person; alternately, it might cover an entire family with multiple children. But the available data allows us to make reasonable forecasts about the size of the group that receives Obamacare subsidies.

According to the federal Department of Health and Human Services (HHS), 52,784 Arkansans paid for a plan through the insurance exchange through March 31 of this year, with 48,100 qualifying for subsidies.[19] The average monthly subsidy is $284. That means that Arkansas beneficiaries could lose, in total, $163,924,800 a year.[20] The data provided by the federal government does not shed light on how many of these 48,100 policyholders receive significant subsidies (or, conversely, how many receive minimal subsidies). To state the obvious, someone who receives a monthly subsidy of $200 will be affected much more by its disappearance than someone who receives a monthly subsidy of $5.

In order to examine how many Arkansans will face a significant financial loss in the event of the absence of Obamacare subsidies, we used two different methods to estimate the size of this group.

Cost Estimate I: Conclusions from Statewide Data

Our first cost estimate used statewide population data to identify the number of people who receive the most significant benefits by income status. Obamacare provides subsidies to those living in households under 400% of the federal poverty level (FPL), with the amount of each subsidy based on the monthly payment of a "benchmark" plan. The Kaiser Family Foundation has explained how this "benchmark" plan is used to calculate the subsidy:

> The "benchmark" for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state's Marketplace. If the cost of the enrollee's benchmark silver plan exceeds their premium cap, then the federal government will pay any amount over the cap. The amount of the tax credit, therefore, is equal to the difference between the individual or family's premium cap and the cost of the benchmark silver plan.[21]

Obamacare provides significant subsidies for those residing in households making under 200% of the FPL. At the 200% of FPL level, the premium cap is 6.34% of the household's income. At 400%, the cap reaches its top level of 9.56% of the household's income.[22]

Here's an example of how this works for an (imaginary and hypothetical) individual. Consider a single male who lives in Harrison, Arkansas. If that person makes $23,300 (which puts him at 200% of the FPL), he will receive roughly $97 per month (or $1,168 per year) as his insurance subsidy. But if that person makes $30,855 (which puts him at 267% of FPL), he will only receive $1 a month as his insurance subsidy.[23] That is because the cost of the silver plan -- which is the "benchmark" plan that subsidies are based on -- is low enough that the subsidy runs out at a lower income level than the maximum of 400% of FPL.

If we take 200% of FPL as the boundary between what we might call "significant" subsidies and "minor" (or no) subsidies, then we can calculate how many Arkansans would be significantly affected if the *King* plaintiffs prevail.

Notably, people cannot receive subsidies if they earn too little or earn too much. Medicaid (or the "private option") covers Arkansans who are under 138% of FPL, and

these individuals earn too little to be eligible for insurance subsidies. According to the Census Bureau, this sub-138% group is 28% of the state population. However, 15% of the state's population is between 138% of FPL and 200% of FPL, and another 28% of the population is between 200% of FPL and 400% of FPL.[24] It is the members of these latter two groups -- a total of 43% of the state's population -- who are eligible for subsidies.

As mentioned above, the federal government only releases the raw number of policies sold in Arkansas -- which tells us that 91.1% of the policies sold in Arkansas receive Obamacare subsidies. The federal government does not reveal those subsidies' absolute or relative size. But, to repeat, we know that the policyholders who receive subsidies live in households making between 138% of FPL (the income level where Medicaid / the private option ends and the subsidies begin) and 400% of FPL (where Obamacare cuts off subsidies). If we assume that these policies were selected in proportion to the demographic characteristics of this purchasing group (let's call it the "purchase pool"), then we can make reasonable assumptions about the percentage who receive significant subsidies.

Roughly 35% of the population in this purchase pool lives in households making between 138% of FPL and 200% of FPL. The remaining 65% of the population in the purchase pool lives in households making between 200% of FPL and 400% of FPL.[25] That means, assuming that the policyholders selecting the plans through the exchange have the same demographic characteristics as the wider population as a whole, 35% of the plans would be purchased using significant Obamacare subsidies.

According to the federal Department of Health and Human Services (HHS), 52,784 Arkansans purchased a plan through the insurance exchange through March 31 of this year.[26] Ninety-one percent of these plans, or 48,100, were eligible for Obamacare subsidies. If 35% of these subsidy-eligible plans were selected by individuals who lived in households under 200% of FPL, then only 16,835 of them would be significantly affected if the *King* plaintiffs prevail.[27]

The bottom line here is that the Arkansans who would be significantly affected by subsidy loss -- 16,835 Arkansas households -- is a small fraction of the 1,129,723 households in Arkansas.[28] Notably, this population is roughly 1.5% of the total households in Arkansas.

Cost Estimate II: Conclusions from Local Data

Our second cost estimate examined the population of those who would lose Obamacare subsidies in Arkansas by using the available data from every ZIP code in Arkansas where more than 50 policies were sold through the health insurance exchange (the threshold for which the federal government provides specific information by ZIP

code). Because the federal government released information for only 228 of the state's 709 ZIP codes, that means that over two-thirds of the state's ZIP codes had fewer than 50 policies sold in them per district. In essence, there are vast areas of the state where few people will be affected by the loss of insurance subsidies.

For this analysis, we assumed that those who purchased policies through the Obamacare exchange reflected the income distribution of the ZIP code as a whole, and then drew two sets of inferences. First, what conclusions could we draw if all of these policies were purchased by single (not joint) tax filers? Second, what conclusions could we draw if all of these policies were purchased by an individual in a joint-filing household?[29]

According to the data provided by HHS, 59,045 policies were selected in Arkansas through February 15.[30] As it turns out, only 52,784 of those selecting these policies actually paid for them (thus constituting what are called "effectuated enrollments"), and 48,100 policies qualified for subsidies.[31] Of those, using our model, 37,518 would receive subsidies larger than $91 a month if they had been purchased by single individuals.[32] Of the total subsidy population, 6.9% -- or 3,319 -- would receive subsidies worth $14 a month or less. A total of 10,582 policies -- or 22% of the total subsidy population -- would receive minor subsidies (which we define as $90 a month or less). Taken together with the 4,684 policies outside the subsidy population, that leaves 15,266 households that receive either minor or no subsidies. Alternatively, if all of these policies had been purchased by individuals from two-income families, 32,227 would receive subsidies larger than $91 a month. Of the total subsidy population, 6.7% -- or 3,223 -- would receive subsidies worth $13 a month or less. A total of 15,873 -- or 33% of the total subsidy population -- would receive minor subsidies. Taken together with the 4,684 policies outside the subsidy population, that leaves 20,557 households that receive either minor or no subsidies.

Again, because there are 1,129,723 households in Arkansas, only a small percentage in each of these estimates would be significantly harmed by a victory for the *King* plaintiffs. Therefore, our second cost estimate suggests that somewhere around 2.9% to 3.3% of households would face a significant impact from the loss of Obamacare subsidies.

Cost Estimates Compared: Methodological Considerations

Our first cost estimate, which draws inferences from statewide data, likely underestimates the number of subsidy recipients affected by the *King* decision: that is because it does not account for local variations in pricing for the benchmark plans. This is important because subsidies are based on the pricing of these plans, as explained above. Our second cost estimate, which uses local ZIP code data, likely overestimates the

number of subsidy recipients affected by the *King* decision: that is because it underestimates the number of people who are eligible for Medicaid.[33] The data only allows us to model what would happen if individuals, not families, purchased these policies. (See the footnotes below for a more detailed explanation.)

More comprehensive data from HHS would give us a better answer about the real number. Until we have more fine-grained information, however, our examination of these two models suggests that between 35% and 78% of those receiving subsidies would be significantly affected by a decision for the *King* plaintiffs. Because our first model (which finds only 35% of policyholders facing a significant subsidy loss) likely underestimates the negative impact of a *King* decision, and our second model (which finds up to 78% of policyholders facing a significant subsidy loss) likely overestimates that impact, the true answer is presumably somewhere in between those two figures. Although our models have some limitations, they also demonstrate that the significantly subsidized population is a relatively tiny fraction of the set of citizens of Arkansas -- and that there is a substantial fraction of the subsidized population which would not bear a severe impact in the event that those subsidies ended.

Available data on the uninsured in Arkansas from 2013,[34] before people could use the health insurance marketplace, also indicates that a relatively small number of Arkansans would be affected by a loss of subsidies. According to this data, roughly half of the state's uninsured would be eligible for Medicaid under the private option, because they live in households under 150% of the federal poverty level. Another 35.2% would either qualify for modest or no subsidies, since they are in households over 200% of the federal poverty level. Only 13.9% of the total uninsured population (or 64,303 Arkansans) were uninsured that year and lived in households making between 150% and 200% of the federal poverty level. Those individuals would benefit from significant subsidies in order to purchase insurance on the exchange. Given the state's population of 2.9 million at that time, that is 2.2% of the state population who could be affected in a significant way by a victory for the plaintiffs in *King*.

Comparing Costs With Benefits

In our analysis, we looked at the potential benefits to the Arkansas economy that a victory for the *King* plaintiffs may bring. We also considered the cost to the economy in the form of lost subsidies that will happen to a small number of households under this scenario.

When we conclude that individual Arkansans could be free of as much as $241.5 million in Obamacare mandate penalties, or that Arkansas businesses could be free of as much as $1.268 billion in Obamacare mandate penalties, these figures mark the maximum benefits that the state could see. The actual effects will be smaller. That is

because many of the Arkansans who would be free from the individual mandate penalty already have insurance from an employer, and so they would not pay the penalty regardless of outcome of the *King* decision. Likewise, many businesses will not face employer mandate penalties, because they already offer health insurance.

Obviously, making predictions about the future is a difficult business. As John Theis once warned in a different context, "I'd just ask you to remember that revenue estimates are, in fact, estimates."[35] And it is important to underscore that the figure of $1.510 billion in potential benefits to the Arkansas economy is an upper limit. Because we do not know with precision how many businesses would affected by the employer mandate penalties or how many individuals would be affected by the individual mandate penalties, we cannot estimate with certainty how big the positive economic effects from *King* could be. But even the most conservative assumptions suggest that the benefits of mandate elimination would vastly outweigh the costs of Obamacare subsidy loss.

Therefore, let us (conservatively) assume that 80% of these potential benefits do not materialize. That would mean that Arkansas would only see $301.9 million in economic benefits. ***Those benefits are nearly twice the size of the $163.9 million in Obamacare subsidies that the* King *decision might jeopardize.*** The only way that the loss of subsidies wouldn't be outweighed by the gains from mandate elimination is if we make assumptions that seem to us to be patently unrealistic: we would have to assume that nearly 90% of the potential benefits do not materialize in order to equal the loss of $163.9 million in Obamacare subsidies. Given the complicated and burdensome nature of both the individual and employer mandates -- mandates which have been the focus of widespread and sustained complaints both from the business community and the general public -- we'd suggest that such an outcome could only be the product of an unrealistically conservative forecast. And even if the loss of $163.9 million in Obamacare subsidies outweighed the direct benefits from ending the employer and individual mandate, we'd want to take into account the job creation benefits we discussed above and the savings to taxpayers that we discuss below.

It is therefore difficult to see why any conservative policymaker would ever want to establish a state exchange, given that it amounts to a simple wealth transfer from one sector of the state's population to another. Such a wealth transfer would have two aspects. First, even assuming very conservative estimates, that transfer would be highly inefficient, in that about half the wealth involved in it would be destroyed in the process. Second, it would be functionally identical to what people informally call "welfare" -- because it would simply take a large amount of wealth out of the state's economy, destroy much of it, and transfer the remainder to a small class of relatively poor people. Such a transfer might be attractive to some Arkansas policymakers, but presumably not to those elected officials who have been critical of the central values of Obamacare. In

short, when we weigh the costs of subsidy loss against the benefits of mandate loss, the argument that the benefits are larger is extremely strong.

HOW TO HELP THE VICTIMS CREATED BY THE OBAMA ADMINISTRATION

Although the nation's welfare would likely be advanced by a verdict for the plaintiffs in *King,* the interests of the population that have been heavily subsidized by Obamacare also merit attention. One implication of a plaintiff's victory in *King* would presumably be that the Obama Administration's decisions have created a class of victims who, for the last several years, have made consequential decisions and altered their expectations because of illegal Obamacare subsidies that were wrongly distributed by the Administration in defiance of the plain text of federal law. No matter what the true size of the heavily subsidized population is, it is worth noting that President Obama could begin to solve the terrible problems that his Administration has created for them, and even provide them significant relief, with the stroke of a pen. In the event of a plaintiff's victory in *King*, the Obama Administration could unilaterally shrink this population's problems by giving them the option to purchase lower-cost insurance. As the Cato Institute's Michael Cannon has noted, "those enrollees will be able to switch to lower-cost 'catastrophic' plans -- if the Obama administration allows it."[36]

Congress and the president could also work together to make health insurance more affordable for not only this group, but also for every American, by removing some of Obamacare's regulations. As the Heritage Foundation's Nina Owcharenko has explained, "At their root, Obamacare's costly regulations, dictating what insurers can sell and what individuals and employers can buy, have resulted in premium costs going up, not down." The Heritage Foundation has calculated that removing just some of these restrictions could save a 21-year-old Arkansan who purchases insurance $995 a year, and a 63-year-old Arkansan $383 a year.[37] Since the average yearly Obamacare subsidy in Arkansas is $3,408, removing these regulations would have the effect of restoring 30% of their buying power for those affected (and lowering the insurance costs of everyone in the state's individual and small group insurance market).

One can reasonably conclude that the Obama Administration is playing politics with these enrollees by refusing to discuss any contingency plan based on a victory by the *King* plaintiffs. HHS Secretary Sylvia Burwell is on record as insisting that "we don't have an administrative action that we believe can undo the damage,"[38] even though the Administration could allow these enrollees access to lower-cost catastrophic plans. The Administration could also work with Congress to reduce insurance restrictions, which would lead to lower prices. The Obama Administration apparently prefers to encourage enrollees to continue to rely on these subsidies and to agonize over their fate, rather than to discuss a contingency plan that would mitigate the increased costs they might face as a result of *King*. If the Obama Administration loses this case, it would be disappointing if

these enrollees were not allowed to purchase lower-cost policies -- especially if the Administration's continued support of this roadblock to coverage were driven by a desire to score political points based on the suffering of the poor.

NO MATTER WHAT HAPPENS IN *KING*, A STATE EXCHANGE IS A BAD IDEA

In the event of a victory for the *King* plaintiffs, interest groups will immediately start pressuring Arkansas policymakers to establish a state-run exchange. As discussed above, the state as a whole will benefit immensely if it sticks with a federal exchange. But our cost-benefit analysis presented above is only one of many reasons to oppose the establishment of a state exchange in Arkansas.

State legislators should note that an exchange would blow a hole in Arkansas's state budget; a federal exchange, in contrast, requires the federal government to pick up the tab. As analyst Elizabeth Stelle has noted, "Creating a state exchange -- or even a hybrid exchange -- would be costly. Annual operating budgets for state exchanges, according to *The Washington Post*, are $28 to $32 million, not including start-up costs which the federal government may not provide."[39] Some states spent well over a hundred million dollars on setting up their exchanges. Maryland, for instance, spent $170 million but had to scrap that exchange completely because it failed to work.[40]

In July of 2014, Arkansas state exchange director Cheryl Smith Gardner informed state legislators that she planned to request federal grants of $91 million to $133 million in order to set up Arkansas's state exchange;[41] if Arkansas establishes a state exchange, a sizable portion of this original cost will be imposed on state taxpayers every year, given the recurring necessity of continuing eligibility verification for each Obamacare participant and the necessity to pay salaries, benefits, and the variety of routine expenses that come with operating a health insurance exchange. And, given Arkansas's dismal track record of expensive and embarrassing failure in its system of eligibility determinations, there is some reason for concern about the efficiency of Arkansas's eligibility determinations in the future.[42]

Indeed, a *Washington Post* article from earlier this year provides a portrait of widespread implementation failures and previously unanticipated costs across the nation in state Obamacare exchanges; as it states, "nearly half of the 17 insurance marketplaces set up by the states and the District under President Obama's health law are struggling financially."[43] Hawaii, Nevada, Oregon, and New Mexico have switched from a state exchange to a federal exchange.[44] Minnesota and Vermont are considering doing the same. Massachusetts had to completely redo its state exchange. Other states are having serious difficulty with achieving the necessary funding to pay for exchanges that are more expensive and enroll fewer individuals than anticipated. Maryland, which had to

scrap its state exchange and start over again after a catastrophic launch, will likely request a taxpayer bailout next month.

Many states are trying to address these financial difficulties by imposing fees on the insurance plans sold through them. These fees are, naturally, passed onto consumers, raising the cost of the supposedly "affordable" policies (and thus raising subsidy amounts). These states include Kentucky, Colorado, Maryland, and the District of Columbia. In fact, a majority of the state health insurance exchanges charge a percentage fee based on the plan's cost. Other states are looking at imposing such a fee to help recoup costs.[45] Proponents of establishing a state exchange in Arkansas have argued that a federal exchange is disfavored because of the fees it could impose. Given the prevalence of this practice in the financing of state exchanges, this is an argument that is difficult to take seriously. Some states, such as Kentucky, even apply this fee to policies sold outside their health insurance exchange.

A state exchange certainly does not increase state policymakers' control over insurance providers or create better customer service. The federal government will control either a state or federal exchange. Obamacare empowers the HHS Secretary to impose "such … requirements as the Secretary determines appropriate" upon state exchanges;[46] it specifies that states "may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary";[47] it grants the Secretary ultimate authority to reject or approve a state exchange.[48] Furthermore, the notion that our state cannot control the performance of Arkansas insurance providers under a federal exchange is groundless; Arkansas policymakers can always resort to making a determination about whether insurance providers are in good standing, a judgment which determines whether they can keep their licenses to do business in the state.

Finally, if Arkansas legislators did implement a state health insurance exchange in response to a *King* decision, it may not be helping those who lost insurance subsidies as much as they think. The Foundation for Government Accountability points out the hidden trap in these subsidies:

> ObamaCare imposes a type of bait-and-switch provision on families and individuals for whom life circumstances change that requires those taxpayers to repay a portion or all of the credit they received. If mistakes are made, the IRS can move to collect back taxes with penalties and interest. Although Congress has set caps on the amounts citizens would have to pay back based on their income level, it has changed those rules twice since the law was signed.[49]

Above, we provide only an abbreviated summary of the many legal and policy difficulties that will be created if Arkansas tries to switch to a state exchange.[50] They are numerous.

The bottom line is that the establishment of a state exchange in Arkansas would be a rejection of conservative governance, in that it would take place against a national background of widespread state-exchange failures in principle and in practice.

While it is unlikely that voters are familiar with all of these arguments against a state exchange, they nonetheless realize that it is a bad idea. According to a poll by the Foundation for Government Accountability, 50% of voters (and over 75% of Republican voters) say they would be less likely to re-elect legislators who move to set up state health insurance exchanges. Only 27% of voters say they would be more likely to re-elect legislators who choose a state exchange.[51] A more recent FGA poll surveyed only Obamacare enrollees who lived in federal-exchange states like Arkansas. When that population was asked "If the Supreme Court rules that the IRS overstepped its authority and that Obamacare subsidies are illegal in these 34 [federal exchange] states, how should states respond?" 55% of enrollees (and 73% of Republican enrollees) answered that states should ask Congress to make changes to Obamacare; only 32% of enrollees chose the option of setting up state-funded Obamacare exchanges. That poll found extremely large support for the proposition that Congress, if it reopens the law, should "make major changes that will improve the law for everyone"; this proposition was endorsed by 73% of the enrollees, 79% of Republican enrollees, 68% of Democratic enrollees, and 82% of split-ticket enrollees. One of the least popular solutions to Obamacare's problems appears to be the Administration's proposal that lawmakers should reform Obamacare by making changes that only help previous subsidy recipients: the proposition that Congress should (as the President has put it) "just add four words to the law" and thereby equalize state and federal exchanges did not even receive double-digit support.[52] Policymakers who are attentive to public opinion on health care reform will find that, in this instance, it is in sync with healthy public policy.

In any event, no matter what the Supreme Court decides in *King v. Burwell,* Arkansas policymakers mulling a state exchange would do well to evaluate the many concerns touched on above: they suggest that establishing a state exchange in Arkansas is courting disaster.

CONCLUSION

If the plaintiffs prevail in *King v. Burwell*, it will lead to significant changes for a large number of Arkansans (and Americans). Those who receive Obamacare subsidies to purchase health insurance through the federal exchange will most likely lose them. While many subsidy recipients will be harmed by the loss of such subsidies, it's worth repeating that that the Obama Administration could decide to allow them to purchase lower-cost insurance with the stroke of a pen. A victory for the plaintiffs in *King* would free many more Arkansans from the individual mandate, which would erase a large cumulative tax penalty. Large businesses would also be freed from the employer mandate, removing

potentially large tax liabilities. Elimination of the mandate would also give Arkansas businesses a competitive advantage over their counterparts in other states. This advantage would likely grow even larger in 2016, when the Obama Administration expands the employer mandate to even more businesses. The ultimate result of a plaintiff's victory in Arkansas would likely be more job creation in our state, coupled with a potential salary boost for a sizable number of current employees.

Some media commentators will present a one-sided view of the *King v. Burwell* story as a narrative about health insurance consumers losing their subsidies,[53] but the issue is much more complex: the numbers show that a plaintiff's win is a net benefit for Arkansas. In fact, there will be many more Arkansans who will benefit from this decision than will be harmed. It's important to have a clear-eyed view of both the financial hit that some Arkansans will take and the financial benefit that many more Arkansans will receive in the event that the *King* court finds for the plaintiffs. Indeed, Michael Cannon has estimated that a decision for the plaintiffs "would free from potential illegal taxation more than *ten times* as many people as lose an illegal subsidy."[54]

We hope that policymakers will acquire a balanced view of all the consequences of the *King* decision before trying to resolve the problems it illuminates. Such a balanced view would take into account the interests of all Arkansans, not simply those of a small class of subsidy recipients. A more sophisticated view of this controversy is that **the establishment of a state exchange entails a large Obamacare tax increase on the state of Arkansas;** our recommendation is that policymakers who are considering the establishment of a state exchange should appreciate that perspective and decide accordingly.

Dan Greenberg, a lawyer and former state legislator, is president of the Advance Arkansas Institute; Marc Kilmer is an Institute analyst.

---

[1] The Supreme Court will issue its decision in *King* no later than June 30, 2015.
[2] Obviously, the formal name of the legislation that created Obamacare is the Patient Protection and Affordable Care Act
[2] Obviously, the formal name of the legislation that created Obamacare is the Patient Protection and Affordable Care Act
(PPACA), Public Law 111-148. PPACA was signed into law by President Obama in March of 2010 and is, of course, frequently (if colloquially) referred to as Obamacare.
[3] Although Arkansas's exchange has sometimes billed itself as a "hybrid" or "partnership" exchange, rather than a state or federal exchange, our exchange has historically been understood as a federal exchange by all relevant decision-makers. The relevant federal statute, § 1321(c) of PPACA, only anticipates two kinds of exchanges: state and federal.
[4] See section entitled "Benefits to Arkansas's Economy at Large" below.
[5] See section entitled "Individual Benefits" below.
[6] See section entitled "Business Benefits" below.
[7] See section entitled "Comparing Costs With Benefits" below.
[8] See section entitled "Individual Costs: Two Estimates" below.
[9] See section entitled "Cost Estimates Compared: Methodological Considerations," below.
[10] "Burwell: End to Health Aid Shifts Burden," *Arkansas Democrat-Gazette*, June 11, 2015.
[11] Remarks by President Obama in Press Conference after G7 Summit," The White House, Office of the Press Secretary, June 8, 2015.

https://www.whitehouse.gov/the-press-office/2015/06/08/remarks-president-obama-press-conference-after-g7-summit

[12] Brittany La Couture and Douglas Holtz-Eakin, “TaKing Stock: The Potential Impact of King v. Burwell,” American Action Forum, May 13, 2015, specifically this chart:
http://americanactionforum.org/high-maps/individuals-exempt-from-individual-mandate-penalty-by-state-if-ruling-in-fa

[13] See, for instance, Devon Herricks’s paper, “The Effects of the Affordable Care Act on Small Business,” NCPA, June 12, 2014. http://www.ncpa.org/pub/st356

[14] More precisely, at least one employee must both qualify to use the exchange and must also purchase subsidized health insurance in it.

[15] “Obamacare Employer Mandate,” Obamacare Facts.
http://obamacarefacts.com/obamacare-employer-mandate/

[16] According to the U.S. Census Bureau, there were 2,877 businesses employing over 100 workers in Arkansas in 2012 (the last year for which this information is provided). The employer penalty applies to companies that employ more than 50 workers, but in 2015 it effectively applies to companies that employ more than 80 workers because it excludes the first 80 employees from the calculation of penalties. The Census Bureau does not release the number of companies that employ more than 80 employees, so for the purposes of this paper, we use companies that employ more than 100 employees. Collectively, these employed 634,153 workers. If we multiply this figure of 634,153 by the Obamacare fine of $2,000 per person, that could leave the state’s large businesses facing a cumulative liability of $1,268,306,000. We recognize that this calculation leaves out any company that employs between 80 and 100 workers, even though they would be affected by this law. We also recognize that any company affected by this penalty would b allowed to exclude 80 employees this year when calculating the penalty. However, given the limitations of the data, we feel the $1,268,306,000 figure is the closest we can get to an upper limit on the cumulative penalty faced by Arkansas businesses due to the employer mandate.

[17] “TaKing Stock.” The figures come from the embedded map in the web version of the paper.

[18] “TaKing Stock,” p. 6.

[19] “March 31st Effectuated Enrollment Snapshot,” Centers for Medicare and Medicaid Services, June 2, 2015.
http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

[20] Multiplying the 48,100 who qualify for subsidies by the average subsidy of $284 per month, and then multiplying that product by 12, leads to the conclusion that the yearly sum of Arkansas subsidies is $163,924,800.

[21] “Explaining Health Care Reform: Questions About Health Insurance Subsidies,” Kaiser Family Foundation, October 27, 2014. http://kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/

[22] Ibid.

[23] Calculations made using the Kaiser Family Foundation’s Health Insurance Marketplace Calculator:
http://kff.org/interactive/subsidy-calculator/

[24] Figures derived from the Census Bureau’s Current Population Survey and the Kaiser Family Foundation’s Distribution of Total Population by Federal Poverty Level:
http://kff.org/other/state-indicator/distribution-by-fpl/

[25] As mentioned above, the purchase pool comprises 43% of the state population, made up of the 15% percent of the state’s population that is between 138% of FPL and 200% of FPL and the 28% of the population that is between 200% of FPL and 400% of FPL.

[26] “March 31 Effectuated Enrollment Snapshot.”

[27] It is possible that individuals who receive significant subsidies purchase insurance through the exchange in a rate higher than their proportion of the population. However, given the limitations of the data released by HHS, it is impossible to determine the ratio of those who qualify for significant subsidies or those who qualify for no subsidies. HHS merely reports those who qualify for a subsidy, no matter how small, versus those who qualify for no subsidy at all.

[28] Arkansas QuickFacts, U.S. Census Bureau:
http://quickfacts.census.gov/qfd/states/05000.html

[29] A detailed analysis of who would be affected by the *King v. Burwell* case isn’t possible, given the limitations of the data. The federal government only releases the raw number of policies sold in a given ZIP code. It does not reveal how many policies in a given ZIP code receive subsidies or how large the subsidies are. Apart from the information on ZIP codes, HHS also releases the total number of statewide policies that were selected, and that 91% of the policies sold in Arkansas receive Obamacare subsidies, but it does not reveal their absolute or relative size.

An explanation of our methodology for the ZIP code analysis follows. We compared the number of subsidies sold per ZIP code and then looked at IRS data for that ZIP code. We assumed the purchase of subsidies was equally distributed in each $1000-level of income, up to $50,000. We calculated the distribution of individuals in each income band by looking at IRS data on the raw number of filers, then calculating how many would be evenly distributed in each band starting at $10,150 (the minimum income level that a single filer must earn to file taxes) or $20,300 (the minimum income level that a joint filer must earn to file taxes).

After excluding for individuals who were eligible for Medicaid, we then determined what percentage of these individuals were eligible for a high subsidy (over $91 a month) and a low subsidy (under $91 a month). Assuming that the

individuals in each ZIP code purchased policies that reflected this same distribution, we then took those percentages and applied them to the number of policies sold in a jurisdiction.

The IRS data was of limited use because it gave us information on income per tax filer, not poverty level. Both Medicaid and Obamacare's insurance subsidies are based on poverty level, not income. We could use single filers and joint filers to make an approximation of poverty levels, but we could not do that with head of household tax filers.

Because of the these limitations, we modeled only two scenarios: that every person who purchased a policy was either a single person or someone in a two-income family. We recognize that in the real world, many of these policies were purchased for families. Unfortunately, there was no way to determine how many or produce a statistical model for family policies using the available data.

We recognize that these limitations necessarily limit the accuracy of our estimates. That is why we used two models. Using these two models produces differing results because they look at the data in different ways. The ZIP code model is a more detailed analysis of the available enrollment numbers and income levels per ZIP code. Unfortunately, as described above, much of the data to obtain a comprehensive picture is not available. The total population model includes a wider range of people in it than the ZIP code model, but it does not allow for a detailed analysis by income and enrollment.

[30] "Plan Selections by ZIP Code in the Health Insurance Marketplace," Department of Health and Human Services, April 2015. http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/EnrollmentByZip/rpt_EnrollmentByZip_Apr2015.cfm

[31] While HHS released the total effectuated enrollment for Arkansas, it did not release the effectuated enrollment by ZIP code. However, for the purpose of this model, we can use the ratio for significant/minor subsidies that we came up with using earlier data and apply that ratio to the effectuated enrollment numbers provided by HHS. The data for each ZIP code was important to determine the ratio, but once we have this ratio it can be used on updated data.

[32] The amount of $91 is necessarily arbitrary, but we did have some reasons for choosing it. For one, a person at 200% of FPL would receive close to this amount, making this a good figure to use in order to sync with the other model. Another reason is that we felt someone losing $1,200 a year in subsidies would see significant hardship, but a lesser amount would begin moving into the moderate hardship area.

[33] HHS released data on policies sold per ZIP code, but the Census Bureau does not release data on the percentage of residents in each ZIP code that live at various levels of poverty. However, the IRS provides data on reported income per ZIP code. For single individuals and joint filers, we can use this data to come to an approximate idea how many live in poverty. However, because the poverty level changes based on the number of individuals in each household, we cannot use this data to approximate how many families with children are in each poverty level. There are clearly many households with children in these ZIP codes who qualify for Medicaid. These households qualify for Medicaid at a higher rate of income than do individuals or families with two income-earners. Because this model excludes these families who would qualify for Medicaid, it necessarily overestimates the number of people who would qualify for subsidies -- because if a household qualifies for Medicaid, it cannot receive subsidies.

[34] U.S. Census Bureau, American Fact Finder, Selected Characteristics of the Uninsured in the United States.

[35] Interview with John Theis, November 25, 2014. Theis is Assistant Commissioner of Revenue (Policy and Legal) for Arkansas's Department of Finance and Administration.

[36] Michael Cannon, "Jobs Depend on Obamacare Defeat," The Cato Institute, March 4, 2015. http://www.cato.org/publications/commentary/jobs-depend-obamacare-defeat

[37] Nina Owcharenko, "This New Data Tells the Real Story Behind King v Burwell," The Daily Signal, June 8, 2015. http://dailysignal.com/2015/06/08/this-new-state-data-shows-the-real-story-behind-king-v-burwell/

[38] Rachana Pradhan and Brett Norman, "No Easy Fix if Supreme Court Halts Obamacare Cash," *Politico*, March 2, 2015. http://www.politico.com/story/2015/03/supreme-court-obamacare-white-house-115631.html

[39] Elizabeth Stelle, "State Health Care Exchange: A Disastrous Contingency Plan," Commonwealth Foundation, May 8, 2015. http://www.commonwealthfoundation.org/policyblog/detail/state-health-care-exchange-a-dangerous-contingency-plan

[40] Aaron Davis and Mary Pat Flaherty, "Maryland Officials Were Warned for Year of Problems with Online Health Insurance Site," *The Washington Post*, January 11, 2014. http://www.washingtonpost.com/local/maryland-news/maryland-officials-were-warned-for-a-year-of-problems-with-online-health-insurance-site/2014/01/11/f094ad94-6a98-11e3-8b5b-a77187b716a3_story.html

[41] Andy Davis, "State Creating Own Exchange Gets Price Tag," *Arkansas Democrat-Gazette,* August 30, 2014.

[42] Near the end of last month, Arkansas Department of Human Services Director John Selig testified that the state's project to create a computerized enrollment and eligibility verification system for Medicaid, food stamps, and other programs has already cost roughly $100 million in taxpayer funds but is not yet functional. Selig estimated that its cost would be roughly $200 million. Despite repeated questions from legislators, Selig declined to name any state employees responsible for this debacle, instead stating that he was ultimately responsible for it. He explained that "I didn't want to spend a lot of money on additional vendors to manage this project. I think in hindsight that was probably wrong. That's on me. I was trying to save money, and I think saved a dime and spent a dollar." Andy Davis, "System's Cost Up to $200M, Legislators Told," *Arkansas Democrat-Gazette,* May 29, 2015.

[43] Sun, Lena and Niraj Chokshi, "Almost Half of Obamacare Exchanges Face Financial Struggles in the Future," *The Washington Post*, May 1, 2015.

http://www.washingtonpost.com/national/health-science/almost-half-of-obamacare-exchanges-are-struggling-over-their-future/2015/05/01/f32eeea2-ea03-11e4-aae1-d642717d8afa_story.html
[44] Gill, Lauren, "What Hawaii can learn from Nevada's switch to the federal health insurance exchange healthcare.gov," Pacific Business News, June 9, 2015.
http://www.bizjournals.com/pacific/blog/2015/06/what-hawaii-can-learn-from-nevada-s-switch-to-the.html
[45] McGuire, Colleen, "How Much Are You Paying In State Health Exchange Fees?" Healthcare.com, May 15, 2015.
https://blog.healthcare.com/health-insurance/how-much-are-you-paying-in-state-health-exchange-fees/
[46] 42 USC § 18041 (a)(1)(D).
[47] 42 USC § 18031 (k).
[48] 42 USC § 18041 (c).
[49] "Too Risky to Exchange?" The Foundation for Government Accountability, September 26, 2013.
http://thefga.org/research/too-risky-to-exchange/
[50] Although this question is outside the scope of our paper, the language of § 1321(c) of PPACA implies that switching to a state exchange is now illegal and impossible; this raises issues of statutory interpretation that may be settled by the *King* decision.
[51] "After *King v. Burwell*: Voters' Opinions on Obamacare, Exchange Subsidies, and Needed Reforms," Foundation for Government Accountability, March 26, 2015.
http://thefga.org/download/KvBMemoPoll-final.pdf
[52] "After *King v. Burwell*: What Federal Exchange Enrollees Want," Foundation for Government Accountability, June 16, 2015.
http://thefga.org/research/research-after-king-v-burwell-what-federal-exchange-enrollees-want/
[53] See, for instance, Thomas Gounley, "Are Your Obamacare Subsidies About To End?", *Springfield News Leader*:
http://www.news-leader.com/story/news/local/ozarks/2015/05/23/obamacare-subsidy-case-affect-missouri-greene-county/27867711/
Or see Greg Sargent, "Sick man Whose Obamacare Story Went Viral Could Be Thwarted by Supreme Court," *Washington Post*:
http://www.washingtonpost.com/blogs/plum-line/wp/2015/05/20/sick-man-whose-obamacare-story-went-viral-could-be-screwed-again-by-supreme-court/
[54] Michael Cannon, "King v. Burwell Would Free More than 57 Million Americans from the ACA's Individual & Employer Mandates," *Forbes*, July 21, 2014.
http://www.forbes.com/sites/michaelcannon/2014/07/21/halbig-v-burwell-would-free-more-than-57-million-americans-from-the-acas-individual-employer-mandates/