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Timeline Related to Health Insurance and Exchange Rules: Backdrop to *King v. Burwell*

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Summary

The Supreme Court is expected to issue a decision in *King v. Burwell* by the end of June. The central issue in the case is whether the Affordable Care Act (ACA; P.L. 111-148, as amended) gives authority to the U.S. Department of the Treasury to make premium tax credits available to eligible individuals in every state (including the District of Columbia) or just the states that choose to establish their own health insurance exchanges (state-based exchanges, or SBEs).

As of the date of this report, the direction and scope of the Court decision is unknown. However, it is generally agreed that a Court decision favoring the plaintiffs would affect the health insurance options of millions of consumers, as loss of premium tax credits would affect the affordability of health insurance for the consumers who no longer have the credits. Such a decision and its effects may motivate insurers, consumers, legislators, and others (referred to as *stakeholders* in this report) to act.

To the extent stakeholders are motivated to respond to the Court's decision, this report provides a timeline that identifies selected 2015 dates related to exchange establishment and operation, legislative calendars, and regulation of the individual health insurance market, among other issues. This information may be useful for setting parameters around potential stakeholder actions.

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Background

On March 4, 2015, the Supreme Court heard oral arguments in *King v. Burwell*. A final decision is expected by the end of June.

The central issue in the case is whether the Affordable Care Act (ACA; P.L. 111-148, as amended) gave authority to the U.S. Department of the Treasury to make premium tax credits available to eligible individuals in every state (including the District of Columbia) or just the states that chose to establish their own health insurance exchanges (state-based exchanges, or SBEs).¹ While the direction and scope of the Court decision is not known,² if the Court decides that tax credits may be made available only in SBEs, such a decision may lead to the loss of tax credits in a majority of states where the federal government established the exchanges (federally facilitated exchanges, or FFEs).³ Given that several million individuals currently receive tax credits through FFEs, the Court decision could have major implications for individual consumers, exchanges, insurers, and other stakeholders.⁴

Loss of premium tax credits would directly affect the affordability of health insurance for the consumers who no longer have the credits. Some individuals may choose to drop coverage as a consequence or seek more affordable insurance, if available. Others may be motivated to continue to purchase coverage, even without a subsidy, either because the credit amounts they received were minimal or they have serious health care needs. Insurers may decide to change plan offerings or discontinue offering individual health insurance policies in a given state in anticipation of a reduction in overall enrollment. Consumers and insurers that continue to participate in exchanges and the market outside of exchanges⁵ may see premiums increase in response to the changes to the insurance *risk pool*.⁶ These consumer and insurer actions may, in

¹ Exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage. The ACA requires health insurance exchanges to be established in all states. A state can choose to establish its own state-based exchange (SBE). If a state opts not to, or if the Department of Health and Human Services (HHS) determines that the state is not in a position to administer its own exchange, then HHS will establish and administer the exchange in the state as a federally facilitated exchange (FFE). For additional information about the ACA exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by Namrata K. Uberoi.

² For a discussion of the legal question before the Supreme Court and conflicting lower court decisions that preceded the Court's review in *King v. Burwell*, see CRS Legal Sidebar, "Conflicting Court Decisions Throw Health Insurance Premium Tax Credits into Question." For discussions of possible legal issues the Supreme Court may consider in the decision, see CRS Legal Sidebars, "King v. Burwell: Can the Supreme Court delay the implementation of the upcoming ACA ruling?" and "King v. Burwell: Why Federalism May Play a Role in Implementing the Affordable Care Act."

³ According to HHS, 34 states have FFEs, 13 states have SBEs, and 3 states have SBEs but use the federal government's information technology platform (healthcare.gov) in 2015.

⁴ For additional information about *King v. Burwell* and potential implications of the Court decision, see CRS Report R43833, *Premium Tax Credits and Federal Health Insurance Exchanges: Questions and Answers*, by Jennifer A. Staman et al.

⁵ Exchanges are intended to simplify the experience of providing and obtaining health insurance. They are not intended to supplant the private market outside of the exchanges but to provide an additional source of private coverage.

⁶ In simplest terms, an insurance risk pool is a collection of individuals or groups (e.g., businesses) whose medical claims are combined for the purpose of developing premiums. For analyses that estimate the potential impact on premiums of a Court decision favoring the plaintiffs in *King v. Burwell*, see Evan Saltzman and Christine Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces*, Rand Corporation, (continued...)

turn, motivate Congress, the Administration, and/or states to address perceived adverse effects of the Court decision and address other related issues, such as the tax credit program's interaction with the ACA's other coverage provisions.

Given that a Court decision favoring the plaintiffs would directly affect the health insurance options of millions of consumers, which, in turn, may motivate insurers, legislators, and policymakers to act, this report provides the time frame in which decisions concerning exchanges and health insurance more broadly may occur, given current regulations and guidance. To the extent that consumers and others (referred to as *stakeholders* in this report) may be motivated to respond to the Court decision (and respond to other stakeholder actions), this report provides a timeline that identifies selected 2015 dates related to exchange establishment and operation, legislative calendars, and regulation of the individual health insurance market, among other issues. The report concludes with a table that augments the 2015 timeline by identifying relevant sources of information, such as statutory or regulatory citations related to exchanges. While this information may be useful to set parameters around certain stakeholder actions, this report is not meant as a guide to decisionmaking, nor does it attempt to identify all possible stakeholder responses to the upcoming Court decision.

While CRS does not predict a particular direction of the Court decision, certain underlying assumptions were made to simplify identification of important dates. Those assumptions include no retroactive effect of the decision and no delay for when the decision would go into effect.

As indicated above, the direction and scope of the Court decision is not known. Implications of the decision beyond issues related to private health insurance are outside the scope of this report. Moreover, the Court decision may maintain the status quo. Nonetheless, legislators and policymakers may be interested in addressing other issues related to the credits or the ACA more broadly. The dates and potential stakeholder actions included in this report may still apply under such a scenario.

Stakeholders

The potential for the Court decision to affect a number of different stakeholders reflects the current structure of the private market for health insurance and the interplay among key participants in the overall market. At the most basic level, the health insurance "market" works like any other market: with sellers and buyers of products. In this case, insurers sell health insurance plans for purchase by consumers and employers. The market for health insurance, like other forms of insurance, is regulated primarily at the state level. However, the federal government has expanded its role in the regulation of this industry, most recently with the enactment and continuing implementation of the ACA. The ACA itself contains multiple provisions that impose requirements on most of these stakeholders, create new stakeholders (e.g., exchanges), and link requirements across stakeholders.

(...continued)

2015, at http://www.rand.org/pubs/research_reports/RR980.html; and 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*, Urban Institute, January 2015, at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000062-The-Implications-King-vs-Burwell.pdf>.

The stakeholders are identified below, and their role in or potential to affect the private health insurance market is briefly described. To the extent any of the stakeholders respond to the Court's decision, their motivation and ability to do so is subject to a variety of parameters, including requirements and flexibilities under current law and the actions taken by other stakeholders. For example, if a state wanted to change its exchange type (i.e., from an SBE to an FFE or vice versa), it must follow a set process. The process includes submitting required documents to the Department of Health and Human Services (HHS) by certain dates and, in some cases, enacting a state law indicating that the activity is allowed by the state.

- **Congress** may be motivated to respond to the Court's decision through legislation.
- **Consumers** are expected to comply with the terms of their health insurance coverage, such as paying premiums. Changes to the conditions under which the consumer obtains health insurance may result in changes in how and whether consumers obtain coverage.
- **Employers** that are considered large are expected to comply with the ACA's employer mandate.⁷ The penalty associated with noncompliance is triggered only if an employee receives a premium tax credit.
- **HHS**, as the entity primarily responsible for issuing exchange-related regulations and guidance, defines the parameters under which all exchanges operate.⁸ For example, HHS is responsible for determining the process by which a state can elect to operate a state-based exchange. Additionally, HHS administers the federally facilitated exchanges.
- **Health insurance exchanges** (also referred to as marketplaces), whether state-based or federally facilitated, are expected to operate within the parameters established under the ACA and its implementing regulations, such as adhering to the annual and special open enrollment periods set in regulations. However, the ACA and its implementing regulations give exchanges some discretion over certain operational decisions, particularly with respect to how exchanges interact with insurers.
- **Private health insurers** offering coverage through exchanges must ensure that the coverage they offer complies with state and federal regulations and all exchange-related requirements, whether set by HHS or the exchange.
- **States**, in general, have the authority to regulate their private health insurance markets. Depending on the state, the authority may be more or less under the control of the state legislature. With respect to exchanges, a state that elects to operate an exchange must do so within established exchange parameters. These parameters are included in statute and described in regulations and guidance issued by HHS.

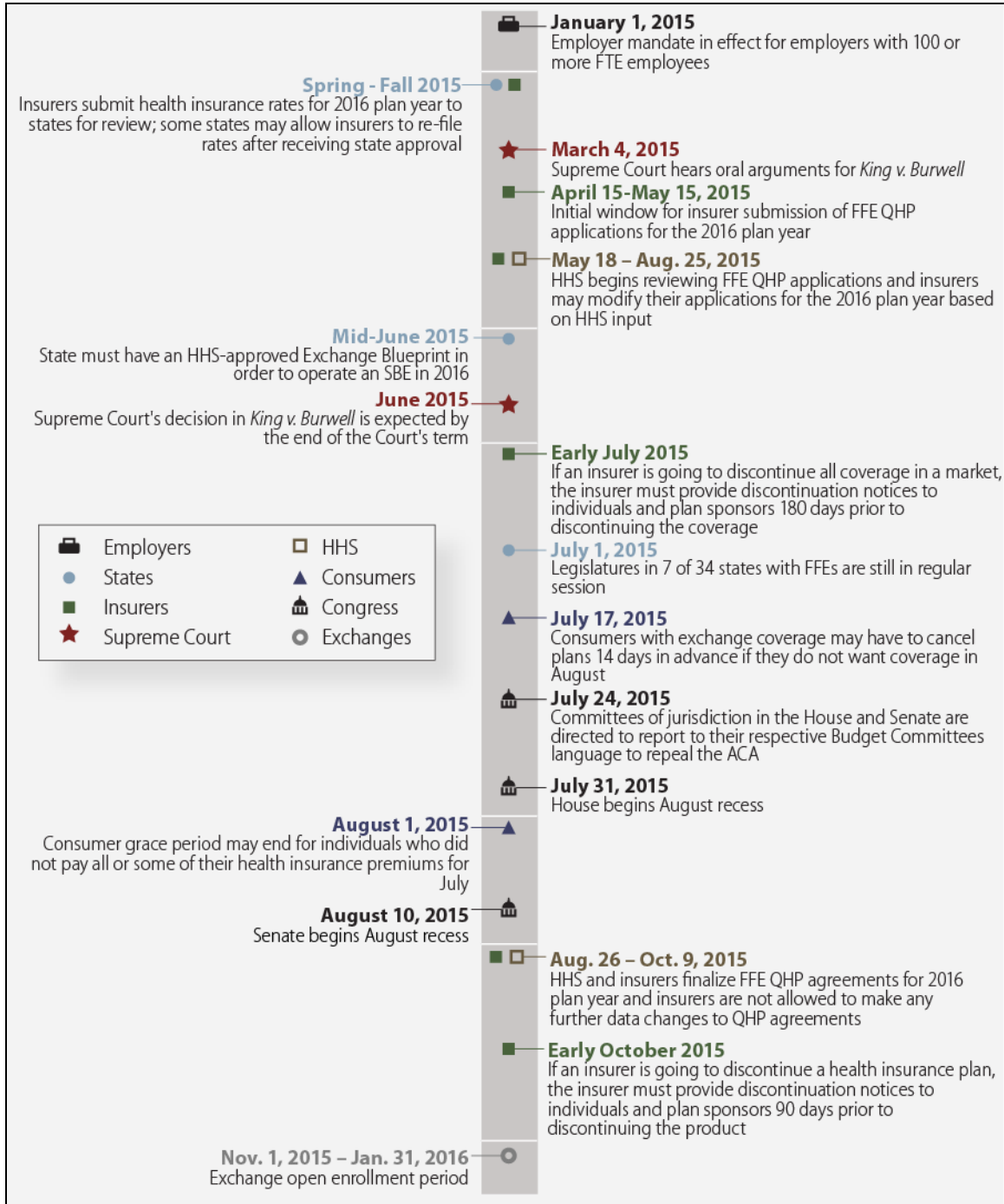
⁷ For additional information about the ACA's employer mandate and associated penalty, see CRS Report R43981, *Affordable Care Act (ACA): Employer Shared Responsibility Determinations and Potential Penalties*, by Julie M. Whittaker.

⁸ Given all of HHS's responsibilities with respect to exchange establishment and operation, some entities have considered possible actions HHS could take if the Court's decision favors the plaintiffs. For example, see Rachana Pradhan and Brett Norman, "No easy fix if Supreme Courts halts Obamacare cash," *PoliticoPro*, March 2, 2015, at <http://www.politico.com/story/2015/03/supreme-court-obamacare-white-house-115631.html>.

- **The Supreme Court** is expected to issue a decision in *King v. Burwell* by the end of its term in June 2015.

Figure 1 and **Table 1** show selected activities currently required to be carried out by one or more of the stakeholders and the time frame in which the activities are expected to occur. *These activities are not dependent on the Court decision*; instead, they represent the current status of regulations, guidance, and other time-sensitive rules that stakeholders may consider if and when they decide to respond to the decision.

Figure I. Timeline of Selected Stakeholder Activities Related to Health Insurance, Exchanges, and Other Relevant Issues, 2015



Source: CRS analysis of ACA regulations, guidance, and other source documents.

Notes: See **Table I** in this report for additional information about each of the activities identified in the figure.

Table I. Selected Stakeholder Activities Related to Exchanges and Other Relevant Issues, Key Dates, and Citations
(January 1, 2015-January 1, 2016)

Date	Stakeholder	Activity	Source
Jan. 1, 2015	Employers	Employer mandate in effect for employers with 100 or more FTE ^a employees ^b	Internal Revenue Bulletin 2013-31, Notice 2013-45, 79 <i>Federal Register</i> 8544
Spring - Fall 2015	States & Insurers	Insurers submit health insurance rates for 2016 plan year to states for review; some states may allow insurers to re-file rates after receiving state approval	Subject to state laws and regulations
Mar. 4, 2015	Supreme Court	Supreme Court hears oral arguments for <i>King v. Burwell</i>	Transcript of Oral Argument at 3-7, <i>King v. Burwell</i> , No. 14-114 (March 4, 2015) (Justice Ginsburg)
April 15 - May 15, 2015	Insurers	Initial window for insurer submission of FFE QHP applications for the 2016 plan year	Guidance: HHS, 2016 Letter to Issuers
May 18 - Aug. 25, 2015	HHS & Insurers	HHS begins reviewing FFE QHP applications and insurers may modify their applications for the 2016 plan year based on HHS input	Guidance: HHS, 2016 Letter to Issuers
Mid-June 2015 ^c	States	State must have an HHS-approved Exchange Blueprint in order to operate an SBE in 2016	45 C.F.R. §155.106
June 2015	Supreme Court	Supreme Court's decision in <i>King v. Burwell</i> is expected by the end of the Court's term	
Early July 2015	Insurers	If an insurer is going to discontinue all coverage in a market, the insurer must provide discontinuation notices to individuals and plan sponsors (e.g., employers) 180 days prior to discontinuing the coverage	45 C.F.R. §147.106
July 1, 2015	States	Legislatures in 7 of 34 states with FFEs are still in regular session; all states have procedures in place for calling special sessions ^d	National Conference of State Legislatures (NCSL)
July 17, 2015	Consumers	Consumers with exchange coverage may have to cancel plans 14 days in advance if they do not want coverage in August	45 C.F.R. §155.430(d)(2)
July 24, 2015	Congress	Committees of jurisdiction in the House and Senate are directed to report to their respective Budget Committees language to repeal the ACA	Concurrent Resolution on the Budget for Fiscal Year 2016
July 31, 2015	Congress	House begins August recess	House Calendar, MajorityLeader.gov

Date	Stakeholder	Activity	Source
Aug. 2015	Consumers	Consumer grace period may end for individuals who did not pay all or some of their health insurance premiums for July ^e	45 C.F.R. §155.430(b)(2)
Aug. 10, 2015	Congress	Senate begins August recess	Tentative 2015 Legislative Schedule, Senate.gov
Aug. 26 - Oct. 9, 2015	HHS & Insurers	HHS and insurers finalize FFE QHP agreements for 2016 plan year and insurers are not allowed to make any further data changes to QHP agreements	Guidance: HHS, 2016 Letter to Issuers
Early Oct. 2015	Insurers	If an insurer is going to discontinue a health insurance plan, the insurer must provide discontinuation notices to individuals and plan sponsors 90 days prior to discontinuing the plan	45 C.F.R. §147.106
Nov. 1, 2015 - Jan. 31, 2016	Exchanges	Exchange open enrollment period ^f	45 C.F.R. §155.410
Jan. 1, 2016	Employers	Employer mandate in effect for employers with 50 or more FTE employees ^a	79 Federal Register 8544
Jan. 1, 2016	Employers	Small employer definition in effect for employers with 100 or fewer employees	42 U.S.C. §18024(b)

Source: CRS analysis of ACA regulations, guidance, and other source documents.

Notes: QHP refers to *qualified health plan*, a health plan that is certified to meet all applicable requirements under the ACA to be sold through an exchange. FFE refers to *federally facilitated exchange*, an exchange established by the federal government. SBE refers to *state-based exchange*, an exchange established by a state.

- a. FTE refers to *full-time equivalent* employees as defined by the Internal Revenue Service for purposes of the ACA's employer mandate.
- b. The penalty for noncompliance with the employer mandate is triggered if an employee receives a premium tax credit through an exchange. As such, employers are affected by the availability of premium tax credits.
- c. According to regulations, a state must have an approved Exchange Blueprint "at least 6.5 months prior to the Exchange's first effective date of coverage ..." 45 C.F.R. §155.106.
- d. For more information about the procedures for calling special sessions in each state, see the National Conference of State Legislatures' Special Sessions webpage, at <http://www.ncsl.org/documents/ncsl/sessioncalendar2015.pdf>.
- e. A grace period refers to the time period when premiums have not been paid for coverage that is in force, but coverage may not be terminated by the insurer. Federal regulations provide that individuals receiving premium tax credits have a 90-day grace period before their coverage can be terminated. Individuals not receiving premium tax credits are subject to the grace periods in effect in their state, many of which are 30 days.
- f. Open enrollment period refers to the annual time period when consumers are allowed to switch health plans or enroll in coverage in the first place.

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