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The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums

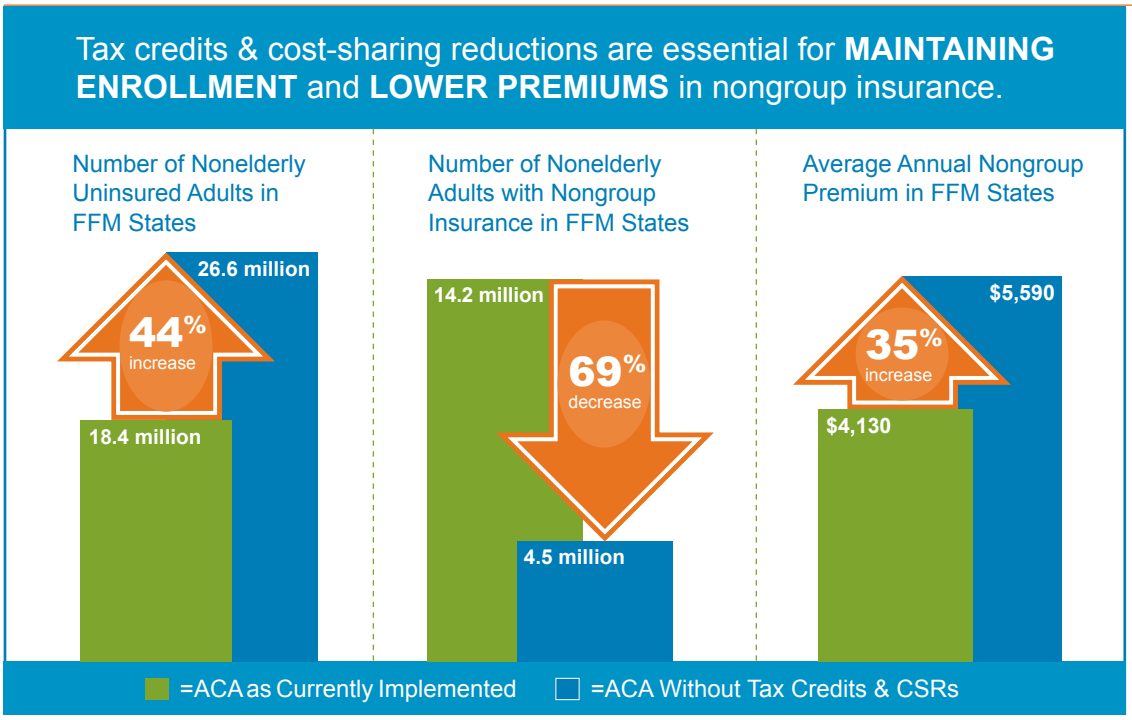
Linda J. Blumberg, Matthew Buettgens, John Holahan

Timely Analysis of Immediate Health Policy Issues JANUARY 2015

In-Brief

The Supreme Court will hear the King v. Burwell case in early 2015, in which the plaintiff argues that the Affordable Care Act (ACA) prohibits the payment of premium tax credits and cost-sharing reductions to people in states that have not set up state-managed marketplaces. We estimate that a victory for the plaintiff would increase the number of uninsured in 34 states by 8.2 million people (a 44 percent increase in the uninsured relative to the number uninsured under the law as currently implemented) and eliminate $28.8 billion in tax credits and cost-sharing reductions in 2016 ($340 billion over 10 years) for 9.3 million people. In addition, the number of people obtaining insurance through the private nongroup markets in these states would fall by 69 percent, from 14.2 million to 4.5 million, with only 3.4 million of these remaining in the ACA's marketplaces.[1]

If tax credits and cost-sharing reductions are eliminated, there will also be indirect effects. The mix of individuals enrolling in nongroup insurance would be older and less healthy, on average. The lack of tax credits would make coverage unaffordable for many. As a result, fewer people would be required to obtain coverage or pay a penalty because the cost of insurance would exceed 8 percent of income, the affordability threshold set under the law. With lower cost individuals and families leaving the market, average premiums in the nongroup insurance market would increase by an estimated 35 percent, affecting not just marketplace enrollees but those purchasing outside the marketplaces as well. For example, virtually all of the 4.9 million people (mostly with incomes over 400 percent of the FPL) who are estimated to buy nongroup insurance without financial assistance in 2016—under the law as currently implemented—would also face these large premium increases.[2]



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reduction. FFM stands for Federally Facilitated Marketplace and refers to the 34 states included in this analysis.

Introduction

The Supreme Court will hear oral arguments in the King v. Burwell case in the spring of 2015. The case challenges the Obama Administration's interpretation of the Affordable Care Act (ACA) as it relates to the legality of payments of tax credits and cost-sharing reductions for nongroup insurance coverage[3] through the new health insurance marketplaces (a.k.a., exchanges). The plaintiff argues that wording in the text of the law prohibits the federal government from providing this financial assistance to moderate income individuals if their state does not run its own marketplace but has instead left the responsibility of its administration to the federal government. Elimination of tax credits and cost sharing reductions has direct implications for affordability of coverage and household financial burdens and has indirect yet substantial implications for premiums in the nongroup insurance market.

The direct implications are straightforward: if tax credits and cost-sharing reductions are eliminated, the cost of purchasing coverage will increase for those with incomes up to four times the federal poverty level (FPL), which is $46,680 for a single adult and $95,400 for a family of four in 2015. Fewer people will therefore choose to enroll, and the number of insured individuals will decrease. Those who continue to purchase coverage will only be able to do so by incurring the full cost of the premium themselves, thereby increasing their health care financing burdens.

The premium increases, which will exacerbate the decline in insurance coverage beyond the direct effects, result from the interconnected nature of the ACA's tax credits and cost-sharing reductions with the nongroup market consumer protections and the individual responsibility requirement (a.k.a. the individual mandate). Eliminating insurance discrimination in pricing and coverage for those with health problems (e.g., through guaranteed issue, modified community rating, provision of essential health benefits) requires a mechanism to ensure that the pool of insured individuals includes the healthy as well as those with health problems. Without such a mix, a pool providing comprehensive insurance to all individuals at an average price would be more attractive to the sick than to the healthy. As a result, the average cost of coverage would be very high with many healthy individuals choosing to stay out of the market. Thus, the law includes an individual mandate (i.e., most individuals must obtain minimum essential coverage or pay a penalty) in order to induce the healthy to obtain and maintain coverage, thereby bringing down the average health care costs in the insurance pool. Fairness, however, dictates that individuals cannot be required to purchase coverage that they cannot afford, so tax credits are provided to make coverage affordable to most individuals. Cost-sharing reductions are also provided to tax credit recipients with incomes at or below 250 of the FPL in order to lower their deductibles, co-payments, and other out-of-pocket costs relative to what would otherwise be required in a silver (70 percent actuarial value) plan.

Because the insurance market reforms are interwoven with the measures to expand coverage, removing the tax credits would make coverage unaffordable for more individuals and exempt them from the individual mandate and reduce the number insured. Those most likely to drop coverage would be disproportionately young and healthy. Such a change in the mix of enrollees would increase the average cost of individuals remaining in the nongroup insurance market, increasing nongroup insurance premiums as a consequence. Since the ACA treats the nongroup market inside and outside the marketplace as a single insurance pool,[4] elimination of tax credits affects not just marketplace enrollees but all those covered by private nongroup insurance in the same geographic area.

Our analysis uses The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the changes in insurance coverage and premiums that would result from eliminating the premium tax credits and cost-sharing reductions for otherwise eligible individuals residing in Federally Facilitated Marketplace (FFM) states. In addition, we provide state-by-state estimates of tax credits and cost-sharing reductions that would be foregone, the number of people that would lose the financial assistance, and the increase in the number of people uninsured. This analysis updates our previous work on this topic using the most recent marketplace premium data and expands upon it with a complete assessment of the likely coverage and premium implications.[5]

Methods

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, tax credits for the purchase of health insurance, and insurance market reforms.[6] The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA for 2016. The model simulates full implementation equilibrium of the ACA in 2016 (i.e., knowledge of the law and its provisions are assumed to have peaked and individual and employer behavior to have fully adjusted to the reforms). Individuals age 65 and over eligible for Medicare are excluded from the analysis.

Marketplaces for which the federal government has taken on at least some of the responsibilities of administration are often referred to as FFMs. The delineation of FFMs from their State Based Marketplace (SBM) counterparts is challenging, since different states have taken on different degrees of marketplace administration and neither the text of the ACA nor the associated federal regulations provide a definition of the minimum responsibilities a state must take on to be considered to have a marketplace established by the state. For purposes of this analysis, we include 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but have taken responsibility for plan management nonetheless (8). We do not include states

that had created the legal framework for an SBM but for which technical problems led to use of the federal IT system. While some of these 34 states may decide to take the necessary steps to establish a state marketplace once the required steps are delineated, doing so would undoubtedly require the investment of significant state resources and the presence of sufficient political will. Given the high degree of uncertainty around state marketplace establishment, our analysis assumes no change in status of the 34 states.

The version of the model used for this brief incorporates a number of model enhancements from the results previously reported in a brief on tax credits in FFM states.[7] Most importantly, premium tax credits are based on final 2015 reference premiums for each state adjusted for inflation to 2016. Earlier estimates were based on national premiums computed before 2014 premiums were finalized. Premiums for 2014 were lower than many anticipated due to factors such as narrow networks and increased competition in many areas. Reference premiums for 2015 in most states generally saw increases lower than the long-term growth trend.[8]

There is, of course, some uncertainty surrounding the time path along which individuals, families, and employers will respond to policy changes brought about by the ACA. Consistent with the convention followed by the Congressional Budget Office (CBO) and others,[9] we assume that behavioral changes in response to reform will be fully realized by the third year of implementation in 2016. That process, however, could take longer. The Children's Health Insurance Program (CHIP) did not reach a steady state until five years after enactment. If full implementation of the ACA with tax credits and cost sharing reductions is slower than anticipated here, then the foregone credits and the increase in the number uninsured we estimate for 2016 would occur somewhat later. Alternatively, if marketplace enrollment is faster than we assume, the estimated loss of coverage and credits would occur sooner.[10] Marketplace enrollment at the end of the 2015 open enrollment period (February 15) will be informative in these regards. Our estimate of marketplace enrollment nation-wide in 2016 is somewhat lower than the CBO estimate—we estimate 20.6 million will be enrolled nation-wide in 2016 compared to CBO's 24 million.

Results

The findings presented below focus exclusively on the 34 FFM states defined above. Elimination of the premium tax credits and cost-sharing reductions in these states would have the direct effect of decreasing affordability and thus insurance coverage and would indirectly increase nongroup health insurance premiums via the change in the average health status of nongroup insurance enrollees.

Health Care Coverage in FFM States

In 2016, the ACA as currently implemented is estimated to reduce the number of uninsured people in FFM states by 14.4 million (Table 1)—18.4 million people remain uninsured compared to 32.8 million had the ACA not been implemented. We estimate the number of people with nongroup coverage will be 14.2 million compared to 7.3 million without the ACA. The large majority of nongroup enrollment will be in the health insurance marketplaces (13.6 million), the only place where refundable tax credits and cost-sharing reductions for the purchase of health insurance coverage are available.

Table 1. Health Insurance Coverage of the Nonelderly in FFM States

	Without Reform		ACA as Currently Implemented			ACA without Tax Credits & Cost-Sharing Reductions		
	Number	*Rate*	*Number*	*Rate*	*Change*	*Number*	*Rate*	*Change*
Insured	**143,122,000**	**81.3%**	**157,556,000**	**89.5%**	**14,434,000**	**149,405,000**	**84.9%**	**6,284,000**
Employer	102,470,000	58.2%	104,014,000	59.1%	1,544,000	106,142,000	60.3%	3,672,000
Nongroup *(Non-Marketplace)*	7,324,000	4.2%	642,000	0.4%	-6,682,000	1,066,000	0.6%	-6,258,000
Nongroup *(Marketplace)*	0	0.0%	13,584,000	7.7%	13,584,000	3,407,000	1.9%	3,407,000
Medicaid/ CHIP	27,733,000	15.8%	33,721,000	19.2%	5,988,000	33,195,000	18.9%	5,462,000
Other *(including Medicare)*	5,594,000	3.2%	5,594,000	3.2%	0	5,594,000	3.2%	0
Uninsured	**32,835,000**	**18.7%**	**18,401,000**	**10.5%**	**-14,434,000**	**26,552,000**	**15.1%**	**-6,284,000**
Total:	**175,957,000**	**100.0%**	**175,957,000**	**100.0%**	0	**175,957,000**	**100.0%**	0

Source: HIPSM 2014. ACA Simulated in 2016

Medicaid enrollment will be nearly 6 million higher due to the ACA. Some FFM states have expanded Medicaid eligibility, while others have not, and these estimates reflect their current decisions. The number of people with employer coverage will be slightly higher (1.5 million, or 1 percentage point) due to the ACA.

However, if the Supreme Court rules in favor of King and federal tax credits and cost-sharing reductions are eliminated in these states, health coverage would be dramatically different. About 8.2 million more people would be uninsured than would be the case with the financial assistance provided under the ACA as currently implemented. The nongroup market would only cover about 4.5 million people, far less than the 14.2 million enrollees with the tax credits and even less than the 7.3 million absent the ACA at all.

Medicaid and CHIP enrollment would be about 500,000 lower without tax credits and cost-sharing reductions. Many children eligible for Medicaid or CHIP have parents eligible for marketplace tax credits under the current implementation. Without tax credits, fewer parents would seek marketplace coverage and, as a result, fewer children would be screened for and enrolled in public insurance.

Table 2. Marketplace Coverage in FFM States, by Income

	ACA as Currently Implemented	ACA without Tax Credits and Cost-Sharing Reductions	Percentage Difference in Persons Covered
	Persons Covered	*Persons Covered*	
Income Relative to FPL			
<200% FPL	4,861,000	442,000	-91%
200-300% FPL	3,460,000	577,000	-83%
300-400% FPL	1,910,000	457,000	-76%
400%+ FPL	3,354,000	1,932,000	-42%
Total:	**13,584,000**	**3,407,000**	**-75%**

Source: HIPSM 2014. ACA Simulated in 2016

Note: A small percentage of individuals enrolling in marketplace coverage with incomes below 400 percent of the FPL purchase coverage without tax credits under the current implementation of the ACA. Many of these individuals have offers of affordable employer-based coverage in their families and some others, particularly single young adults in the 300-400 percent of the FPL range, face full premiums for silver coverage that are low enough that they fall below the level covered by the tax credits (i.e., the premium is less than their applicable percent of income cap).

FFM Enrollment by Income

Under a finding for King, enrollment in these 34 nongroup marketplaces would fall by 75 percent, with the most dramatic enrollment declines among the lowest income people otherwise insured there (Table 2). The number of FFM enrollees with incomes below 200 percent of the FPL would fall by over 90 percent, the number of enrollees between 200 and 300 percent of the FPL would fall by 83 percent, and the number of enrollees between 300 and 400 percent of the FPL would fall by 76 percent. Enrollment by higher income individuals (over 400 percent of the FPL) is estimated to fall by 42 percent. As a consequence,

Table 3. Premium Tax Credits and Cost-Sharing Reductions Lost in FFM States if the Supreme Court Finds for King

	Persons Losing Tax Credits	% of Total	Lost Premium Tax Credits (millions $)	% of Total	Lost Cost-Sharing Reductions (millions $)	% of Total	Total Lost Tax Credits & CSRs (millions $)	% of Total
Income Relative to FPL								
<200% FPL	4,848,000	51.9%	16,438.9	65.3%	3,232.6	87.9%	19,671.5	68.2%
200-300% FPL	3,127,000	33.5%	6,810.5	27.1%	445.7	12.1%	7,256.1	25.2%
300-400% FPL	1,370,000	14.7%	1,910.1	7.6%	0.0	0.0%	1,910.1	6.6%
Total:	**9,346,000**	**100.0%**	**25,159.4**	**100.0%**	**3,678.3**	**100.0%**	**28,837.7**	**100.0%**

Source: HIPSM 2014. ACA Simulated in 2016

Note: Those with incomes below 250 percent of the FPL who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

Table 4. Lost Tax Credits and Cost-Sharing Reductions and Increased Numbers of Uninsured Under a Decision in Favor of King, by State, 2016

	Number of People Losing Tax Credits	Total Value of Tax Credits & CSRs Lost (Millions $)	Average Value of Lost Tax Credits & CSRs Per Person ($)	Increase in the Number of People Uninsured
All FFM States	**9,346,000**	**28,837.7**	**3,090**	**8,151,000**
Alabama	165,000	547.1	3,310	124,000
Alaska	42,000	232.8	5,570	34,000
Arizona	266,000	456.1	1,720	237,000
Arkansas	128,000	418.8	3,280	95,000
Delaware	28,000	92.4	3,320	24,000
Florida	1,184,000	3,891.4	3,290	1,073,000
Georgia	461,000	1,524.9	3,310	435,000
Illinois	438,000	1,089.0	2,490	408,000
Indiana	225,000	924.5	4,110	195,000
Iowa	98,000	289.2	2,940	90,000
Kansas	166,000	419.0	2,520	135,000
Louisiana	214,000	857.4	4,010	199,000
Maine	62,000	257.0	4,150	50,000
Michigan	321,000	905.8	2,820	277,000
Mississippi	147,000	568.0	3,860	137,000
Missouri	299,000	1,006.8	3,370	228,000
Montana	70,000	192.3	2,760	61,000
Nebraska	97,000	282.3	2,900	83,000
New Hampshire	44,000	116.0	2,620	37,000
New Jersey	237,000	727.6	3,070	239,000
North Carolina	465,000	1,830.1	3,940	407,000
North Dakota	39,000	122.6	3,160	29,000
Ohio	497,000	1,510.1	3,040	459,000
Oklahoma	208,000	516.0	2,480	153,000
Pennsylvania	414,000	1,082.8	2,610	329,000
South Carolina	241,000	766.3	3,180	192,000
South Dakota	51,000	147.1	2,910	42,000
Tennessee	320,000	782.7	2,450	230,000
Texas	1,566,000	4,358.1	2,780	1,441,000
Utah	162,000	361.6	2,230	97,000
Virginia	321,000	1,071.4	3,340	280,000
West Virginia	41,000	146.3	3,550	49,000
Wisconsin	289,000	1,127.9	3,900	247,000
Wyoming	40,000	216.3	5,350	37,000

Source: HIPSM 2014. ACA simulated in 2016

Note: Those with incomes below 250 percent of the federal poverty level who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

the composition of these much smaller marketplaces would shift from predominantly lower income (61 percent below 300 percent of the FPL) to majority higher income (57 percent above 400 percent of the FPL). Nearly all of those with incomes below 400 percent of the FPL who would still enroll in the marketplaces absent tax credits are those who purchased nongroup coverage before the ACA was implemented.

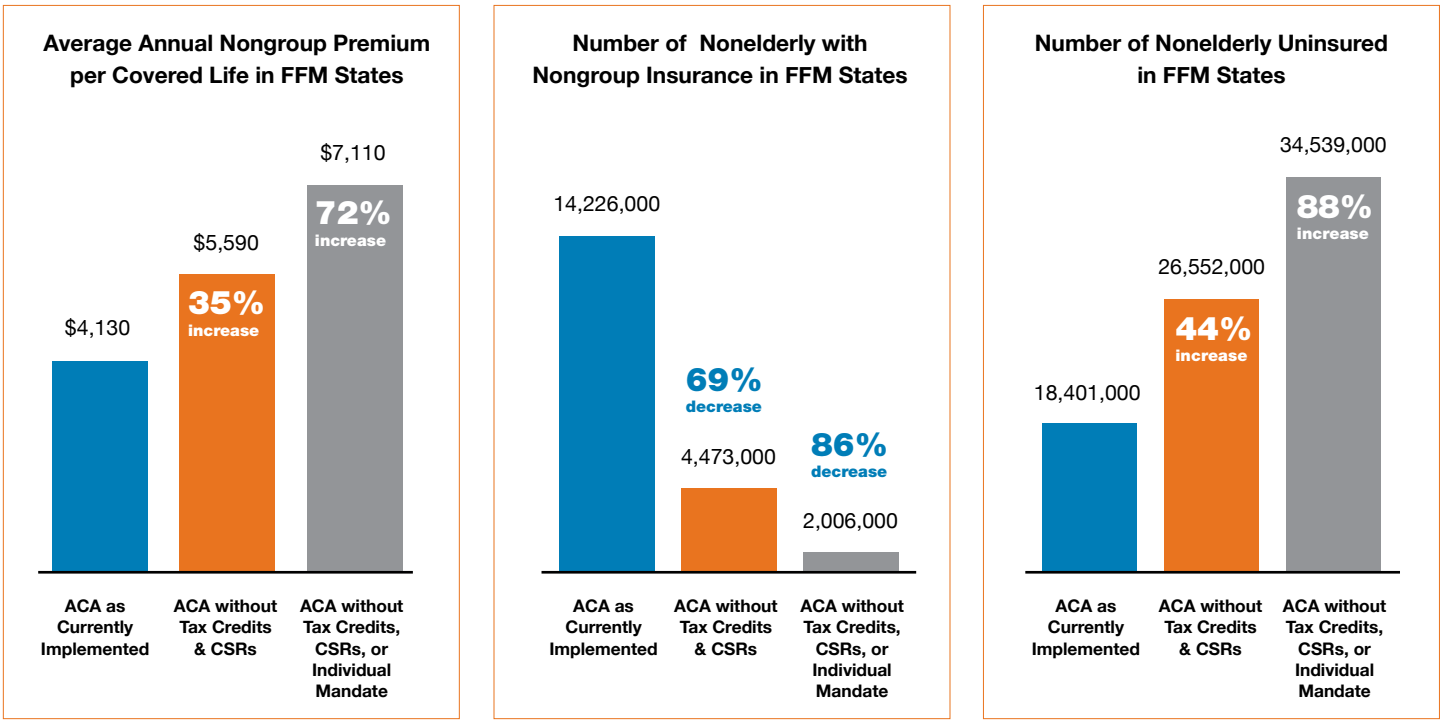
Lost Premium Tax Credits and Cost-Sharing Reductions Under a Supreme Court Finding for King

About 9.3 million people in FFM states would lose marketplace premium tax credits in 2016 if the Supreme Court finds for King (Table 3). Nearly 5 million of these people have incomes below 200 percent of the FPL, 3.1 million individuals have incomes between 200 and 300 percent of the FPL, and the remaining 1.4 million individuals have incomes between 300 and 400 percent of the FPL.

The value of the lost tax credits and cost-sharing reductions is about $28.8 billion in 2016. Foregone premium tax credits amount to $25.2 billion, while foregone cost sharing reductions amount to $3.7 billion. We estimate that, over a 10 year window, the loss of federal financial assistance would be about $340 billion.

In Table 4, for each FFM state, we show the total value of federal tax credits and cost-sharing reductions lost, the number of people who would lose them, the average loss per person who would otherwise receive them, and the number of people who would become uninsured should financial assistance be discontinued. The largest amount of aggregate foregone tax credits and cost-sharing reductions are, not surprisingly, in Texas ($4.4 billion) and Florida ($3.9 billion) because of the size of their populations. The average loss per person varies across states for two reasons. First, there are geographic differences in premiums—individuals of the same income facing higher premiums receive larger tax credits. Second, there are geographic differences in the distribution of income among those eligible

Figure 1. Nongroup Insurance Premiums, Coverage, and the Uninsured in FFM States, 2016



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reductions

for the credits—areas where higher percentages of those eligible are lower income will have larger average credits since the credits are larger for those in most financial need. The states with the highest average value of lost tax credits and cost-sharing reductions per person are Wyoming ($5,350 per year, about $446 per month) and Alaska ($5,570 per year, about $464 per month), both states with high average premiums. Average nongroup premiums in Arizona are well below average, and thus the average financial assistance lost per person in that state would be considerably lower ($1,720 per year, about $143 per month).

Nongroup Premiums in FFM States

Without federal tax credits, the population purchasing nongroup coverage would be in worse health, on average. As a result, premiums for nongroup coverage would be notably higher in FFM states than they would be with the credits in place. In 2016, the average premium per covered life would increase by 35 percent, from about $4,100 to roughly $5,600 absent marketplace tax credits and cost-sharing reductions (Figure 1). The ACA treats the nongroup market inside and outside the marketplaces as a single risk pool; thus, any policy change that affects premiums in the marketplaces also affects premiums outside them in the same way. The 4.9 million individuals estimated to purchase nongroup coverage fully at their own cost under the ACA as currently implemented would face this 35 percent premium increase. The 9.4 million individuals who would lose federal tax credits would see the out-of-pocket price of their insurance coverage increase by even larger relative amounts, taking both the changing average premiums and lost credits into account.

The Importance of the Individual Mandate

A decision disallowing premium tax credits and cost-sharing assistance would not rescind the ACA's individual mandate, which was upheld by the Supreme Court in July 2010. But millions more would be exempt from the individual mandate because their net cost of insurance would be more than 8 percent of family income. However, the affordability exemption from the requirement is tied to the cost of the lowest cost bronze level coverage available, coverage that is less comprehensive and significantly less costly than the silver level plans most individuals are purchasing thus far through marketplaces. As a consequence, many people would still be subject to the requirement to obtain insurance or pay a penalty.

Older adults with moderate incomes are more likely to be exempt from the individual mandate than younger adults since premiums vary by age, with older adults charged up to 3 times more than younger adults. Thus, the individual mandate plays a larger part in enrolling younger adults than older adults, even absent tax credits. The more young adults enrolled, the lower the average premium in the insurance market. As a result, the 35

percent premium increase would be even higher if not for the individual mandate. Eliminating the mandate would mean an even larger share of young people would leave the nongroup insurance market, further increasing the average health care costs of those remaining.

The Department of Health and Human Services has the authority to define hardship exemptions to the individual mandate requirement and could exempt some or all of those losing tax credit eligibility under a decision in favor of King, just as they have exempted otherwise eligible individuals who live in states not opting for the Medicaid expansion.[11] There is a clear rationale why such a choice would likely be seriously considered. In the absence of tax credits and the subsequent large increases in premiums across all plans, bronze level (60 percent actuarial value) coverage is the tier of plans most likely to still be deemed affordable for those required to obtain coverage or pay a penalty. These plans are generally characterized by large deductibles (e.g., $4000 to $5000 deductibles are not uncommon in this tier) and significant co-payments or co-insurance. Maintaining the individual mandate would require a segment of individuals in the FFM states to purchase coverage with much higher premiums without financial assistance, coverage that has out-of-pocket requirements sufficiently high that many of those with modest incomes would not envision being able to pay the deductibles should the need arise, rendering the policies of little value. Consequently, eliminating the requirement to have coverage or pay a penalty for those affected by a court decision in favor of King would undoubtedly have political and policy appeal.

If the individual mandate is eliminated in the FFM states, premiums per covered life would be 72 percent higher than under the ACA as currently implemented (Figure 1). Nongroup enrollment in those states would fall even more dramatically, to 2.0 million, 86 percent lower than under the ACA as currently implemented. This represents only about 1 percent of the nonelderly population in FFM states. Thus, elimination of both tax credits, cost-sharing reductions and the individual mandate would result in a textbook case of an adverse selection death spiral. Without either credits or the individual mandate, the number of uninsured people in FFM states would rise to 34.5 million, an 88 percent increase relative to the ACA as currently implemented.

Discussion

Elimination of federal premium tax credits and cost-sharing reductions in FFM states would increase the number uninsured by 44 percent and would shrink nongroup insurance markets to levels well below what would have been absent any implementation of reform. As the result of fewer individuals purchasing coverage and the consequent changes in the mix of health status among those remaining, average premiums in those much diminished markets would increase by 35 percent.[12] While HIPSM does not explicitly model the timing of market dynamics, we anticipate the estimated changes to occur quickly. Unlike regulatory changes alone that could take up to a few years to work through a market, eliminating financial assistance will make coverage unaffordable to many enrollees immediately, causing them to drop coverage upon receiving their much higher bills. Insurers can be expected to revise their premiums accordingly at the next opportunity. A forthcoming brief will analyze the characteristics of individuals likely to be affected. Not taken into account here is that such declines in enrollment and the resulting adverse selection is likely to discourage insurers from participating in the marketplaces as well as the larger nongroup markets outside the marketplaces. Areas experiencing increased insurer competition under the ACA's initial years are likely to revert to smaller numbers of insurers, potentially increasing premium costs even further. If the individual mandate is also eliminated in these states, their nongroup markets are unlikely to survive.

FFM states could preserve their tax credits and cost-sharing reductions by assuming responsibility for their marketplaces. As a practical matter, however, doing so would be extremely challenging for most of them. The deadline for states to apply for federal grants to assist the development of SBMs expired in November 2014, leaving the financing of such a change squarely on the states' shoulders. In addition, at least in the near term, the political environments in most of these states are not conducive to participating, and a number of states would be hard pressed to devote the human and financial resources necessary to establish and operate an SBM.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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Notes

1 Estimates presented in this analysis of the number of people of different types that would be affected by a finding for the plaintiff reflect effects at a point in time. Some individuals uninsured or enrolled in nongroup insurance during one part of the year are replaced by other similar individuals during other parts of the year, increasing the number of individuals affected if counting over the course of a year rather at a particular moment. In addition, these estimates also understate the number of people who would be affected over time by this change in implementation of the law. Individuals uninsured or enrolled in nongroup insurance in one year are not necessarily the same people uninsured or covered by nongroup in the following year (since some gain coverage while others lose coverage over time).

2 A small share of these individuals purchasing non-group insurance without a tax credit are expected to remain in grandfathered (non-ACA compliant) policies in 2016. This small share would not be affected by the increased premiums in the ACA compliant market until they ultimately left their grandfathered plans.

3 Nongroup, or individually purchased, insurance is private coverage bought independently as opposed to as part of an employer group.

4 The marketplace and non-marketplace insurance markets are treated as a single risk pool to prevent one market from experiencing adverse selection, a phenomenon where high cost individuals are disproportionately covered in certain plans or markets, greatly increasing the premiums for those selected against and risking their destabilization. Within the single risk pool, increases in the average health care costs of enrollees overall, even if the higher cost enrollees are disproportionately enrolled in some plans relative to others, will lead to increases in premiums charged by all nongroup plans, both inside and outside the marketplace.

5 Our current estimates of aggregate tax credits and cost-sharing reductions are lower than in our previous analysis due to the marketplace premiums being lower than originally anticipated. For the same reason, marketplace enrollment is higher in the current analysis. The earlier analysis is available at: Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Potential Implications for ACA Coverage and Subsidies." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413183-Halbig-v-Burwell-Potential-Implications-for-ACA-Coverage-and-Subsidies.pdf

6 For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities." http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

7 Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Halbig v. Burwell: Potential Implications for ACA Coverage and Subsidies." op cit.

8 John Holahan, Linda J. Blumberg, Erik Wengle, Megan McGrath, and Emily Hayes. December 2014. "Marketplace Insurance Premiums in Early Approval States: Most Markets Will Have Reductions or Small Increases in 2015." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413287-Marketplace-Insurance-Premiums-in-Early-Approval-States.pdf

9 Congressional Budget Office (CBO). April 2014. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act." Washington, DC: CBO. http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

10 Total marketplace enrollment may ultimately be lower than we estimated here if purchasers not eligible for tax credits continue to obtain nongroup coverage outside the marketplaces at higher rates than originally anticipated; however, that choice would not affect our estimates of the impact of the King decision on the uninsured, the number purchasing nongroup coverage in total, or nongroup premiums.

11 See point 12, in Healthcare.gov. "Hardship Exemptions from the Fee for Not Having Health Coverage." https://www.healthcare.gov/fees-exemptions/hardship-exemptions/

12 Our findings are roughly consistent in relative terms with those from a study by researchers at the Rand Corporation which simulated the effects of eliminating the ACA's tax credits nation-wide. They estimated a 43 percent increase in nongroup premiums, compared to the 35 percent estimated here, and a 68 percent decrease in ACA compliant nongroup insurance coverage, compared to the 69 percent reduction estimated here. See Christine Eibner and Evan Saltzman. 2014. "The Individual Health Insurance Market – The Effects of Young Adult Enrollment and Subsidies," RAND Corporation Research Highlight. Santa Monica, CA: RAND Corporation. http://www.rand.org/pubs/research_briefs/RB9798.html