Nos. 19-840, 19-1019

In The

Supreme Court of the United States

CALIFORNIA, ET AL.,
Petitioners,
v.
TEXAS, ET AL.,
Respondents.

TEXAS, ET AL.,
Petitioners,
v.
CALIFORNIA, ET AL.,
Respondents.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF CALIFORNIA, ET AL., AND U.S. HOUSE OF REPRESENTATIVES

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INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 60 years of experience in the industry. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As a result, AHIP's members have broad experience working with virtually all health care stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the nation's health care and health insurance systems, and a unique understanding of how those systems work.

Health insurance providers are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA"). AHIP has participated as *amicus curiae* in other cases to

[1] This brief is filed with the written consent of all parties. No counsel for any party authored this brief in whole or in part, and no person or entity other than *amicus curiae*, its members, or its counsel made a monetary contribution intended to fund its preparation or submission.

explain the practical operation and impacts of the ACA. *See, e.g.*, *King v. Burwell*, No. 14-114 (U.S. July 22, 2014); *National Fed'n of Indep. Bus. v. Sebelius*, Nos. 11-393, 11-398, 11-400 (U.S. Aug. 12, 2011). Likewise here, AHIP seeks to provide the Court with its deep expertise and experience regarding the operation of health insurance markets, the changes made by the ACA, the impact of those changes on American families and businesses, and the effects of the decision below on health insurance providers and all Americans. AHIP's perspective will provide the Court with a more comprehensive understanding of the seismic consequences of a holding that the individual mandate cannot be severed from the remainder of the ACA, thereby rendering the entire ACA invalid.

INTRODUCTION AND SUMMARY OF ARGUMENT

Since its passage in 2010, the ACA has transformed the nation's health care system. It has restructured the individual and group markets for purchasing private health care coverage, expanded Medicaid, and reformed Medicare. Health insurance providers (like AHIP's members) have invested immense resources into adjusting their business models, developing new lines of business, and building products to implement and comply with those reforms. As a result, 20 million more Americans—including those with preexisting conditions—now have affordable coverage for the first time, and millions more enjoy better and more comprehensive coverage.

The courts below nevertheless deemed unconstitutional the ACA's so-called individual

"mandate." Although AHIP strongly disagrees with that conclusion, the focus of this brief is on severability and the bid to invalidate the rest of the ACA. Make no mistake: invalidation of the ACA would wreak havoc on the entire health care system. Congress could not have intended that result in 2010, when it enacted one of the most comprehensive and far-reaching pieces of health care legislation in over 50 years. And Congress did not intend that result in 2017, when it zeroed out the tax payment for forgoing health coverage without repealing any other ACA provision. In light of that manifest congressional intent, the "answer" to the severability question "is quite simple—indeed, a severability analysis will rarely be easier." Cal. Pet. App. 98a (King, J., dissenting). As Judge King underscored, "little guesswork is needed to determine that Congress believed the ACA could stand in its entirety without the unenforceable coverage requirement." *Id.*

Reinforcing that conclusion, this brief outlines the "potentially devastating effects on the national healthcare system and the economy at large" that would follow from judicially striking 900-plus pages of legislative text from the U.S. Code. Cal. Pet. App. 106a (King, J., dissenting). Given AHIP's expertise with operation of the health care markets and its insight into what would happen to health insurance providers and the people they serve if the ACA were invalidated, AHIP is uniquely positioned to shed light on why "[i]t is unlikely that Congress would want a statute on which millions of people rely for their healthcare and livelihoods to disappear overnight with the wave of a judicial wand." *Id.*

Wholesale invalidation of the ACA would presume Congress's cavalier indifference to the impacts unleashed on the health care system—including for the estimated 297 million Americans with health coverage. That number includes Americans who purchase coverage on exchanges and in the private market without regard to preexisting conditions; Americans receiving coverage through their employer; lower-income Americans in states that have expanded the Medicaid program; and older Americans and those with disabilities receiving benefits through Medicare.

A finding of inseverability would also undo scores of reforms that have reset the American public's expectations about the availability, value, and scope of health care coverage. To name a few: It would eliminate guaranteed coverage for individuals with preexisting conditions; the assurance that young adults can stay on their parents' plans until age 26; the prohibition on annual or lifetime benefit limits; and the provision of preventative care at no out-of-pocket cost. It would abolish the ACA's premium tax credits, on which millions of people now rely to obtain affordable coverage. And it would cut off billions in funding for expanded Medicaid programs in 36 states and the District of Columbia, jeopardizing the coverage of the 13 million newly eligible people they cover. Rolling back the ACA's Medicare reforms—including resurrecting Medicare Part D's prescription drug "donut hole" and rescinding key payment changes—would cast a cloud of uncertainty over the health care of seniors and disabled individuals.

Inflicting such widespread disruption to the nation's health care system would cause significant uncertainty and instability in the best of circumstances. Doing so in the midst of a global health pandemic and economic turmoil—which have placed and will continue to place staggering demands on American families and all manner of health care stakeholders—would be reckless and dangerous.

The current public health crisis has engendered unprecedented levels of uncertainty in the lives of nearly every American and throughout the health care sector. As of submission of this brief, scientists, government officials, and the health care sector are working to understand the near- and long-term scope, scale, and duration of the pandemic. For example, it remains unknown precisely how many Americans have been or will become infected with COVID-19; what level of testing is needed to manage a comprehensive response; whether long-term immunity is possible; and whether and when any treatments and/or vaccines will be developed and ultimately deployed. Further exacerbating the situation is the unknown answer to how long the pandemic will last, including any subsequent waves of infection, particularly in light of the still-developing consequences of reopening the nation state-by-state.

The wide range of estimates attempting to quantify the health care costs of the pandemic reflect that uncertainty. Depending on the overall infection rate, early estimates place the cost for COVID-19 testing and treatment through 2021 anywhere from 60 billion to as much as a half-trillion dollars. Such estimates, however, struggle to account for the

millions of Americans that are forgoing preventative care, treatment for chronic conditions, and non-emergency procedures due to stay-at-home orders, repurposed or overwhelmed medical facilities, or unease about exposure and safety. This reality impedes early detection and treatment of disease, even as health insurance providers have taken swift and decisive steps to remove barriers to care by: (i) eliminating patient cost-sharing for COVID-19 testing and treatment; (ii) waiving administrative requirements to accelerate patient access to services and transfers to alternate care facilities; (iii) expanding telemedicine programs to deliver routine care without copays while reducing infection risks; and (iv) advocating for special enrollment periods in the ACA exchanges, support for small businesses, and funding for the uninsured.

Meanwhile Americans are left wondering what will become of them, their loved ones, and their livelihoods during these deeply unsettling times. As of early May, over 33 million Americans (and growing) filed for unemployment. Following this unprecedented surge in job loss, the national unemployment rate is expected to hit 15% to 20%, and a sustained economic recovery may take many months (or longer).[2] Because most Americans obtain health

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[2] *See* Bowen Garrett & Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage* 1, ROBERT WOOD JOHNSON FOUND. (2020), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2020/rwjf461095 (hereinafter "COVID-19 Recession"); Ashley Kirzinger & Mollyann Brodie, *When Will the Unemployed Go Back to Work? Many Laid Off Workers Expect To Get Jobs Back*

insurance through their employer, mounting joblessness inevitably will be followed by a rise in the number of uninsured—possibly 12 to 40 million people.[3] Whatever the ultimate numbers, there will continue to be an acute and unprecedented need for individuals to replace their employer-sponsored health coverage.

Fortunately, the comprehensive coverage afforded under the ACA provides one meaningful measure of security. Even before the pandemic, it was well understood that the ACA's individual market has "given millions *** peace of mind knowing that coverage would be available should they need it" and that "a stable, functioning individual market is important *** as a safety net for millions of people going through career and life transitions."[4] Indeed, the ACA was enacted in the wake of the 2008 recession and offered a critical new and expanded safety net in the midst of a housing crisis and surge in unemployment. In the coming months, millions of

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in the Short-Term but Experts Caution About Long-Term, KAISER FAMILY FOUND. (May 4, 2020), https://www.kff.org/coronavirus-policy-watch/when-will-the-unemployed-go-back-to-work/ (citing April 2020 Congressional Budget Office report).

[3] *See COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State* 1, HEALTH MGMT. ASSOCS. (2020), https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf (hereinafter "COVID-19 Impact").

[4] Sabrina Corlette et al., *The ACA's Effect on the Individual Insurance Market*, 39 HEALTH AFF. 436, 436, 442 (2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01363 (hereinafter "ACA's Effect").

individuals are expected to turn to the ACA exchanges in order to secure coverage. Likewise, nearly 60% of ACA exchange enrollees have an income between 100% and 200% of the federal poverty level. Without employment income, many of them—including millions of newly unemployed individuals previously receiving coverage through their employer—will look to Medicaid. That program could see 11 to 23 million new enrollees, particularly in states that implemented Medicaid expansion under the ACA and now consider job loss as part of Medicaid eligibility.[5]

These sobering consequences of COVID-19 put into stark relief the fact that the ACA's provisions continue to function meaningfully—and, indeed, are indispensable—separate and apart from a (currently unenforceable) individual mandate. The ACA ensures that if you lose your job, you can still get coverage. The ability to sustain coverage during such transitions has never been more necessary or utilized than now. Invalidating the ACA provisions that make that continuation of coverage possible would dangerously compound the disruption caused by the ongoing pandemic and further undermine the health and financial well-being of millions of Americans.

At bottom, whether viewed on its own terms or through the instructive lens of the pandemic, the ACA is not a tapestry that unravels by pulling upon a single individual-mandate thread. Quite the opposite, the ACA's multitude of wide-ranging reforms, which rest on a variety of statutory foundations scattered across the U.S. Code, affect *every* health insurance market

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[5] COVID-19 Impact, *supra* note 3, at 1-2; *see also* COVID-19 Recession, *supra* note 2, at 1.

(not just the individual market) and *every* American with coverage (not just those who purchased coverage on the exchanges).

Recognizing that inescapable fact, the federal government (despite failing to defend the individual mandate) initially agreed in the district court that the rest of the ACA is severable—with one notable exception: the provisions that together guarantee coverage, at the same premiums, regardless of health status or preexisting conditions.[6] But that compromise position comes with its own practical problems: Eliminating the vital preexisting-condition protections would upend the individual markets and throw individuals and health insurance providers back to an obsolete system that cannot be revived without serious disruption to American lives and the nation's economy. (The government had another change of heart in the Fifth Circuit and essentially embraces Texas's all-or-nothing approach.)

As a legal matter, Texas and the federal government incorrectly conflate Congress's assessment in 2010 (shared by AHIP at the time) for initial implementation of the new individual market with Congress's assessment in 2017 (confirmed by empirical evidence) that the market would remain stable absent an enforceable individual mandate. At its inception, the individual mandate was intended to

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[6] These ACA provisions are often referred to as the "guaranteed-issue" (42 U.S.C. § 300gg-1) and "community-rating" (*id.* § 300gg-4) requirements, but they also subsume the separate requirement to cover preexisting conditions (*id.* § 300gg-3). For convenience, this brief at times refers to them collectively as the "preexisting-condition provisions."

work alongside the guaranteed-issue and community-rating provisions to avoid an adverse selection "death spiral" spurred by the risk that healthier individuals would forgo purchasing insurance until needed.

But circumstances have changed. Just before the 2017 amendment, in light of sustained demand for coverage, the Congressional Budget Office ("CBO") predicted that a straight repeal of the individual mandate—without repealing any other ACA provision—would not destabilize the individual marketplace. That prediction has borne out: the individual marketplace has remained stable in 2020 even after the individual mandate had been watered down through a variety of exemptions, further weakened through non-enforcement mechanisms, and ultimately rendered unenforceable by zeroing out the tax payment. Texas and the federal government ignore both that real-world experience and Congress's conspicuously narrow amendment.

In short, the ACA has shifted the paradigm for health care coverage in this country. It has extended quality, affordable coverage to tens of millions of American families—regardless of their health status—through a complex and comprehensive set of reforms. No industry has been more directly impacted by the ACA than health insurance providers, which have invested vast resources to participate in the relevant markets, comply with the law's myriad reforms, and organize their businesses to operate in a revamped health care system. This Court should not countenance the unwarranted attempt to sweep that all away.

ARGUMENT

Congress did not intend and could not have intended to put at risk the entirety of the ACA—undermining both private and public health care coverage for hundreds of millions of Americans—when it zeroed out the tax payment for forgoing coverage. By that point, the ACA's sprawling reforms, which reach virtually every corner of the health care system and affect virtually every health care recipient, had become firmly entrenched—and are only more so today. Regardless of what Congress had intended in 2010, there can be no doubt that, given the present realities of the nation's ACA-based health care system, the amending Congress in 2017 could not have intended the far-reaching consequences that would follow from invalidating the ACA (in its entirety or in significant part).

A. Wholesale Invalidation Of The ACA Would Result In Massive Disruption To Patients And Other Health Care Stakeholders

1. The ACA is sweeping in its scale and scope.

The ACA affects nearly every American, including the estimated 297 million people in our nation that enjoy either private or government-sponsored health insurance coverage.[7] That is why the ACA is widely regarded as the most significant

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[7] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2018*, at 1 (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

health care legislation enacted since the Social Security Act amendments that created the Medicare and Medicaid programs in 1965. Its wide-ranging provisions—many of which are entirely unrelated to the individual mandate—span 974 pages and cut across statutes including the Social Security Act, the Public Health Service Act, the Medicare Act, the Medicaid Act, ERISA, the Indian Health Care Improvement Act, the Federal Food, Drug, and Cosmetic Act, and the Internal Revenue Code.

Beyond the individual mandate and preexisting-condition provisions, the ACA adopted several major reforms, including: (i) restructuring the individual and group markets, providing financial assistance for individuals and families earning under 400% of the federal poverty level, offering tax credits to certain small employers who offer coverage, prohibiting annual and lifetime limits on benefits, and allowing young adults to stay on their parents' plans until age 26; (ii) expanding Medicaid to cover lower-income adults; and (iii) enhancing Medicare by (*inter alia*) phasing out a longstanding gap in prescription drug coverage and reforming payments. Many states have passed conforming legislation and new laws dependent on the ACA's provisions as well.[8]

Since the ACA's enactment, the number of people without health care coverage has decreased by over 20

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[8] National Conference of State Legislatures, *2011-2014 Health Insurance Reform Enacted State Laws Related to the Affordable Care Act* (updated June 17, 2014), http://www.ncsl.org/research/health/health-insurance-reform-state-laws-2013.aspx#2014_laws.

million—a figure that does not account for the fact that the number of uninsured people would have risen higher without the ACA.[9] In 2019, over 10 million Americans were enrolled in health plans offered on ACA exchanges, in addition to the millions who enrolled in individual market coverage apart from the exchanges.[10] Enrollment through the individual market, including the ACA exchanges, has accounted for approximately half of the overall ACA reduction in the uninsurance rate.[11] In addition, from July 2013 to April 2019, enrollment in Medicaid expansion states increased by 13 million (34%).[12] These coverage gains are widely shared across almost all demographic groups.[13] Indeed, post-ACA data indicate a reduction

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[9] *See, e.g.*, Namrata Uberoi et al., *Issue Brief: Health Insurance Coverage and the Affordable Care Act, 2010-2016*, ASPE (Mar. 3, 2016) (finding that the ACA expanded coverage to 20 million Americans, via Medicaid expansion and subsidized coverage through exchanges), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf.

[10] Centers for Medicare & Medicaid Services, *Effectuated Enrollment for the First Half of 2019* (Dec. 11, 2019), https://www.cms.gov/newsroom/fact-sheets/effectuated-enrollment-first-half-2019.

[11] *See, e.g.*, Center on Budget & Policy Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act (hereinafter "ACA Accomplishments").

[12] Medicaid & CHIP Payment Access Commission, *Medicaid Enrollment Changes Following the ACA* (last visited May 11, 2020), https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (hereinafter "Medicaid Changes").

[13] ACA Accomplishments, *supra* note 11 (noting coverage gains across income level, age groups, racial and ethnic

in coverage disparities for racial and ethnic minority groups, specifically African-American and Hispanic communities.[14]

Ten years after its historic passage, the ACA's coverage expansions and market reforms have helped both to improve access to health care and to increase Americans' financial security.[15] "Those who gained coverage had measurable improvements in their financial situation as well as their ability to obtain needed care"—including "people with preexisting health conditions" who "were no longer 'locked out' of the insurance market as a result of inaccessible, inadequate, or unaffordable offers of coverage."[16]

It should go without saying that, with increased access to affordable health care, health care outcomes have improved. Studies show that Medicaid expansion, among other things, "increased early-stage cancer diagnosis, improved cardiovascular health, and reduced mortality for certain groups of nonelderly adults."[17] The ACA's dependent care provisions

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backgrounds, urban and rural households, and among healthy and sick individuals).

[14] Thomas C. Buchmueller & Helen G. Levy, *The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care*, 39 HEALTH AFF. 395, 399-400 (2020), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01394.

[15] ACA's Accomplishments, *supra* note 11.

[16] ACA's Effect, *supra* note 4, at 441.

[17] Aparna Soni et al., *How Have ACA Insurance Expansions Affected Health Outcomes? Finding from the Literature*, 39 HEALTH AFF. 371, 375-376 (2020),

likewise "improved self-reported health, increased early-stage cancer diagnosis, reduced poor birth outcomes, and decreased opioid mortality for young adults."[18]

At a macro level, "yearly spending growth generally has been slow by historical standards since the ACA's passage."[19] According to the Centers for Medicare & Medicaid Services, "the annual expenditure growth rates in the years following the ACA's implementation were generally lower than in the years before the ACA: Average annual national health spending grew 4.3 percent in 2010-18" (or 3.6 percent on a per capita basis), "compared to 6.9 percent in 2000-09."[20] Thus, "cost growth for health services in Medicare, Medicaid, and even Marketplace plans seems to be settling into a 'new normal' slower rate."[21]

The ACA is also remarkable in the sheer amount of health care funding it delivers. It provides billions of dollars through advance premium tax credits, small business tax credits, and Medicaid payments in the form of federal financial participation.

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https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01436.

[18] *Id.*

[19] Melinda Beeuwkes Buntin & John A. Graves, *How the ACA Dented the Cost Curve*, 39 HEALTH AFF. 403, 405 (2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01478 (hereinafter "Cost Curve").

[20] *Id.* at 404.

[21] *Id.* at 410.

Among many other things (*see* Part A.2, *infra*), the ACA has also allowed rural hospitals to remain open (through Medicaid expansion funding) that could otherwise close.[22] Another provision created "the independent, not-for-profit Patient-Centered Outcomes Research Institute," which "aims to establish a rigorous evidence base for helping determine which emerging medical technologies are clinically effective."[23] The ACA's Prevention and Public Health Fund is the nation's first mandatory funding stream dedicated to improving the public health system and "supports critical services, including lab capacity to test for outbreaks of flu or virus-borne diseases such as Zika, responses to emerging public health threats such as the opioid epidemic, and chronic health threats such as damage to children through exposure to lead."[24]

Given its sweeping reach, it is no surprise that even a partial repeal of the ACA has been calculated to increase the number of uninsured individuals by

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[22] Adam Searing, *Study Documents How Medicaid Expansion Helps Keep Rural Hospitals Open*, GEORGETOWN UNIV. HEALTH POLICY INST. (Jan. 12, 2018), https://ccf.georgetown.edu/2018/01/12/study-documents-how-medicaid-expansion-helps-keep-rural-hospitals-open/.

[23] Rena Conti et al., *How the ACA Reframed the Prescription Drug Market and Set the Stage for Current Reform Efforts*, 39 HEALTH AFF. 445, 446 (2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01432 (hereinafter "Prescription Drug Market").

[24] Decl. of Henry J. Aaron ¶ 42 (D. Ct. ECF No. 15-1); *see* Centers for Disease Control & Prevention, *Prevention and Public Health Fund* (last visited May 11, 2020) https://www.cdc.gov/funding/pphf/index.html.

over 30 million and to increase the cost of uncompensated care significantly.[25] And those estimates pre-date the arrival of the COVID-19 pandemic, which make the numbers materially worse. *See* pp. 5-8, *supra*. To put it simply, the ACA's extraordinary scale and scope make its effects much like a bell that cannot be unrung—at least not without inflicting widespread and considerable pain on individuals, families, states, businesses, and the nation's economy.

2. Invalidation of the ACA would have serious consequences in disparate areas wholly untethered to the individual mandate.

The far-reaching impacts of inseverability demonstrate why the ACA's hundreds of freestanding provisions—the vast majority of which have nothing to do with the individual mandate—should remain in effect even if this Court (like the courts below) has reservations about the mandate's constitutionality. Congress could not have contemplated anything else in 2010, and decidedly did not in 2017. The following

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[25] *See, e.g.*, Larisa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUND. (Mar. 28, 2018), http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review (hereinafter "Medicaid Expansion"); Congressional Budget Office, *H.R. 1628, Obamacare Repeal Reconciliation Act of 2017* (July 19, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf (hereinafter "CBO Report").

sections highlight examples of the potential outcomes in four health care markets reshaped by the ACA.

Although each market is discussed separately, together they provide a continuum of coverage for Americans experiencing significant changes in personal, financial, or employment circumstances. The ACA was designed to afford individuals and families seamless transitions in and out of these markets during such changes. The ACA, for example, created a "no wrong door" approach allowing consumers seeking coverage to complete a single streamlined application to determine eligibility for and enroll in programs—including Medicaid, the Children's Health Insurance Program, and exchange-offered Qualified Health Plans—rather than navigate multiple agencies and systems to access coverage. With declines in employer-based coverage, increases in Medicaid enrollment, upticks and attrition in the marketplaces, and increased numbers of uninsured accompanying COVID-19, the ACA's facilitation of coverage across markets is more important than ever.

a) Individual Market

AHIP member plans are collectively responsible for providing comprehensive and affordable health care coverage to 80% of people purchasing coverage in the individual market (on and off the exchanges). If the ACA were invalidated, those participating in or connected to the individual market would face tremendous coverage disruption, financial losses, and uncertainty.

Such a declaration would halt payments made in connection with the ACA's advance premium tax credits, by which the federal government subsidizes

(on a prospective basis) a sizeable portion of enrollees' monthly insurance premiums if their household incomes meet certain criteria. 26 C.F.R. § 1.36B-2. Eliminating those tax credits—resulting in a sudden spike in monthly premiums—would make coverage unaffordable for many of the 9.3 million Americans who rely on them.[26] The approximately 5 million people who pay the whole cost of their individual market coverage without any tax credits, in turn, would be affected by deterioration of the risk pool. State regulators would then be faced with coverage lapses for millions of people, the possible withdrawal of health insurance providers from the individual market, as well as potential health plan insolvencies and failures.

The CBO's review of the proposed Obamacare Repeal Reconciliation Act of 2017, which would have repealed the ACA without any replacement, is instructive. The CBO concluded that the proposal would have two principal effects on health care coverage and premiums. First, "[t]he number of people who are uninsured would increase by 17 million in 2018" with 10 million dropping out of the individual market, and by "32 million in 2026" with 23 million dropping out of the individual market.[27] Second, "[a]verage premiums in the nongroup market (for individual policies purchased through the

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[26] Centers for Medicare & Medicaid Services, *Early 2019 Effectuated Enrollment Snapshot* (Aug. 12, 2019), https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot.

[27] CBO Report, *supra* note 25, at 1-2, 8, 10.

marketplaces or directly from insurers) would increase by roughly 25 percent—relative to projections under current law—in 2018. The increase would reach about 50 percent in 2020, and premiums would about double by 2026."[28] Again, those numbers (as dire as they are) do not account for the dawn of the COVID-19 pandemic. *See* pp. 5-8, *supra*.

In addition, health insurance providers themselves would face waves of disruption and destabilization—both immediate and longer term—if the ACA were abruptly invalidated. Health insurance providers would find themselves operating in an environment where the established rules of the road have been displaced. That vacuum would cast into doubt the viability of existing products designed for and approved under an ACA-based health care system. For example, many state laws (including the laws of certain state challengers here) require health insurance providers to lock in rates prospectively for a full plan year and to provide coverage for a fixed period of time.[29] Health insurance providers have little choice but to make actuarial assumptions about risk pool mix and anticipated enrollment numbers based on the continued existence and enforcement of the ACA. Invalidation of the ACA would thus leave health insurance providers (among others) in an immediate bind: it is unclear whether they would be permitted to recalculate rates or design different products based on the new actuarial realities created by such a result.

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[28] *Id.* at 1.

[29] *E.g.*, CAL. INS. CODE § 10901.9(c)(2) & CAL. HEALTH & SAFETY CODE § 1399.811(c)(2); LA. REV. STAT. ANN. § 22:1098.

More broadly, health insurance providers (like any complex enterprise) require enough lead time to develop strategies and offerings. Not only would they be forced to abandon the core ACA-based business models that they have painstakingly implemented over the past several years, but they lack any clear replacement regime around which to develop new ones.

Invalidating the ACA would also impose a daunting burden on the states. Absent new and comprehensive federal health care legislation, the task of addressing the resulting disruption and destabilization presumably would fall to individual states. State officials would be required to address a host of cascading problems threatening the stability of their local insurance markets and testing the limits of already strained state budgets and health systems—all in the midst of fighting a global pandemic. While some states have enacted laws that mirror discrete pieces of the ACA and operate their own state-based exchanges, others have not. And some aspects of the ACA have no state analog; for example, no state has established a premium tax credit program akin to that established under the ACA.

b) Group Plans

AHIP member plans are responsible for providing about 70% of large and small group health coverage in the United States. Such "group" coverage includes health plans offered by employers of all sizes to their employees, as well as coverage purchased by small businesses under the ACA's Small Business Health Options Program. In 2018, 178 million Americans received health insurance through their employer;

employer-based group health insurance thus remains the nation's single largest source of health care coverage.[30] The ACA made numerous changes to this type of coverage, such as promoting improved and better accessible employer-based and other group coverage, all of which would be stripped away if the ACA were invalidated.[31]

For "large group" health plans that cover more than 51 employees (or more than 101 employees, depending on the state), the ACA penalizes an employer if it does not offer an adequate plan option and at least one of its employees has purchased subsidized insurance through an exchange. *See* 26 U.S.C. § 4980H(a). Such provisions ensure that most Americans, consistent with our nation's decades-long approach to providing coverage, will be covered by health insurance through typical employment mechanisms.

In addition, the ACA applied guaranteed-issue and community-rating protections to the small group market in a manner that materially changed how coverage is offered. Prior to those reforms, a small business could experience significant premium increases after one employee became unexpectedly

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[30] Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2018*, at 3 tbl.1 (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[31] Kaiser Family Foundation, *Health Reform Glossary* (last visited May 11, 2020), https://www.kff.org/glossary/health-reform-glossary/#glossary-g.

sick and required expensive care.[32] Such reforms have stabilized premiums for small businesses offering health insurance by cutting annual increases by more than half.[33] That protection is more important than ever given the devastating toll of COVID-19 on small businesses. More accessible and reliable coverage for small businesses also alleviates "job lock," so that people have the freedom to start or work for small businesses without being unable to obtain affordable health insurance.[34]

c) Medicaid

Nearly 60 AHIP member plans work with states to offer Medicaid managed care products that improve quality, provide access to necessary care, and save billions of taxpayer dollars by facilitating the delivery of more cost-effective services. Currently, 36 states and the District of Columbia have expanded Medicaid (or are in the process of doing so) pursuant to the ACA. Eliminating the ACA's expansion of Medicaid would cause states to lose federal funding that covers most of

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[32] Vanessa C. Forsberg, *Overview of Health Insurance Exchanges* 7-10, CONG. RESEARCH SERV. (June 20, 2018), https://fas.org/sgp/crs/misc/R44065.pdf.

[33] U.S. Department of Health & Human Services, *Fiscal Year 2017, Budget in Brief* 115 (Feb. 2016), https://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf.

[34] Adam Looney & Kathryn Martin, *One in Five 2014 Marketplace Consumers Was a Small Business Owner or Self-Employed*, U.S. DEP'T OF THE TREASURY: TREASURY NOTES BLOG (Jan. 12, 2017), https://www.treasury.gov/connect/blog/Pages/One-in-Five-2014-Marketplace-Consumers-was-a-Small-Business-Owner-or-Self-Employed.aspx.

the expenses for 13 million expansion enrollees.[35] Expansion states would be unable to absorb the loss of that revenue (even temporarily) and may have no choice but to eliminate coverage for millions of people—at a time when they need it most, *see* pp. 5-8, *supra*.[36]

The immediate loss of Medicaid coverage could be disastrous for patients, including those undergoing potentially lifesaving treatments or in need of expensive prescription drugs. Without coverage, many expansion enrollees would forgo preventative care and seek much more costly health care as a last resort from emergency rooms and public hospitals. Recent studies document that increased coverage through the Medicaid expansion resulted in a $6.2 billion reduction in uncompensated health care costs for hospitals from 2013-2015.[37] Combined with COVID-19 coverage losses in the employer-sponsored market, a significant increase in uncompensated costs means health care providers would face billions of dollars of bad debt that may force many to close. That eventuality would only further reduce access to care for millions of Americans, particularly in rural and low-income areas.

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[35] *See* Medicaid Changes, *supra* note 12; *see also* CBO Report, *supra* note 25, at 6 (estimating that repeal sans replacement would cause "net reduction of $842 billion in federal outlays for Medicaid" from 2017-2026).

[36] *See* CBO Report, *supra* note 25, at 8, 10 (estimating that straight repeal of the ACA in 2017 would result in 4 million fewer people with Medicaid coverage in 2018, and 19 million fewer people with Medicaid coverage in 2026).

[37] *See* Medicaid Expansion, *supra* note 25.

A decision that eliminates coverage for the expansion population also would have adverse impacts on Medicaid plan sponsors that have made multi-year investments in hiring care management and member service staff, contracting with thousands of health care providers, implementing state operations, and expanding information systems to accommodate their projected expansion membership and health care utilization. Plans and the local organizations they partner with could be forced to cut jobs in operational areas where staffing levels vary with enrollment and to absorb losses in administrative areas with fixed staffing costs.

A judicial roll-back of the ACA's Medicaid provisions would also have systemic consequences. For instance, it would cast into doubt the general standards for determining Medicaid eligibility. Under the ACA, eligibility and rate setting are based on a complex set of state and federal laws. Eligibility for most Medicaid categories currently centers on an individual's Modified Adjusted Gross Income ("MAGI"). *See* Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 57 (Mar. 23, 2012). Striking down the ACA would call into question the continuing status of MAGI and, by extension, Medicaid eligibility—not only for the expansion populations, but also for traditional Medicaid enrollees. It would also wipe out millions of dollars in investments by states, together with Medicaid managed care plans, to adapt their systems to those ACA standards.

Finally, a finding of inseverability could result in Medicaid programs incurring higher prices for

prescription drugs. The ACA increases prescription drug rebates, extends federal drug rebates to Medicaid populations in managed care plans, and expands discounts (previously limited to public hospitals and not-for-profit clinics that chiefly treated uninsured patients) to children's hospitals, freestanding cancer hospitals, critical access hospitals, and rural referral centers.[38] For example, in 2009, at pre-ACA rebate levels, Medicaid fee-for-service programs had net expenditures of $15.7 billion on gross drug charges of $25.4 billion, an effective discount of 38.2%. In 2014, at post-ACA rebate levels, Medicaid fee-for-service programs had net expenditures of only $8 billion on gross drug charges of $21.4 billion, an effective discount of 62.6%.[39] Although rebate levels in a given year can be affected by various factors, including the mix of brand and generic drugs in the year, they "are now an important source of savings for states and the federal government."[40]

d) Medicare

Nearly 80 AHIP members offer Medicare Advantage plans, most of which include Medicare Part

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[38] Prescription Drug Market, *supra* note 23, at 446 (explaining that Medicaid Drug Rebate Program "increase[d] the mandatory minimum Medicaid rebates to 23.1 percent for brand-name drugs and 13.0 for generics, up from 15.1 percent and 11.0 percent, respectively," and that pharmaceutical companies "must provide another rebate that adjusts for inflation to protect government payers from significant price increases").

[39] Medicaid & CHIP Payment Access Commission, *Issue Brief, Medicaid Spending for Prescription Drugs* 3 fig.1 (Jan. 2016), https://www.macpac.gov/wp-content/uploads/2016/01/Medicaid-Spending-for-Prescription-Drugs.pdf.

[40] Prescription Drug Market, *supra* note 23, at 446.

D prescription drug benefits. AHIP members also offer stand-alone Part D prescription drug coverage. These programs leverage private-sector innovation to offer greater choice, value, and financial security in the Medicare program. If the ACA falls, the Medicare Advantage and Part D programs would face major disruption, undermining stability and coverage for America's seniors.

Under those programs, health insurance providers receive prospective monthly payments that the Centers for Medicare & Medicaid Services set on an annual basis. The ACA made a number of material changes in the methodology used to calculate those payments; their status would be called into question immediately. That, in turn, could disrupt coverage for more than 47 million seniors and individuals with disabilities currently covered by Medicare Part D and for the more than 24 million people enrolled in Medicare Advantage plans.[41]

With respect to Medicare Part D, the ACA phased in increased coverage to reduce patient out-of-pocket

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[41] Centers for Medicare & Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report* (Apr. 2020), https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/contract-summary-2020-04. As of enrollments accepted through March 6, 2020, 24.1 million enrollees are in Medicare Advantage plans, and 21.5 million of these enrollees receive drug coverage through these plans. A total of 47.2 million enrollees are in plans that offer drug coverage (21.5 million in Medicare Advantage and almost 25.7 million in stand-alone prescription drug plans or other plan types).

spending in what is colloquially known as the "donut hole" created during Part D's enactment as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[42] In general, in 2010 before enactment of the ACA, beneficiaries received no financial assistance for prescription-drug spending between $2,830 and $6,440, which "posed affordability challenges for many beneficiaries, including those with multiple chronic conditions and those using high-price specialty drugs."[43] Under the ACA, this gap in coverage began to phase out; beneficiaries went from paying 100% out-of-pocket in the "donut hole" in 2010 to paying just 25% out-of-pocket in 2019.[44] In addition to increasing plan coverage for drug costs in this phase of the benefit, the ACA also established the Coverage Gap Discount Program, which requires companies selling brand-name drugs and biologics to provide a discount to such beneficiaries.[45]

The ACA's invalidation would likely spell an abrupt end to the Coverage Gap Discount Program and other ACA modifications to Part D that would leave beneficiaries again responsible for paying 100%

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[42] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101, 124 Stat. 1029, 1036-1037 ("HCERA").

[43] Prescription Drug Market, *supra* note 23, at 446 (footnotes omitted).

[44] *Id.* The "donut hole" phase out was originally set to end in 2020, but occurred a year earlier under the Bipartisan Budget Act of 2018. *Id.*

[45] *Id.* The Bipartisan Budget Act of 2018 included a provision that increased the amount covered under the Coverage Gap Discount Program. *Id.*

of prescription drug costs in the "donut hole." The resulting financial hardship for many seniors and individuals with disabilities, especially those who live on a fixed income, would be substantial.[46] And given that affordability is a primary driver of people not taking recommended prescriptions, the return of the "donut hole" would increase clinical complications and adverse health outcomes for that already vulnerable population.

With respect to Medicare Advantage, the ACA altered the benchmarks used to calculate federal payments to health insurance providers; created a quality bonus payment based on plan performance to incentivize high-quality health plans; and tied rebate levels to quality for those plans that submit bids below the benchmarks for their service area.[47]

Doing away with the ACA would do away with all those reforms and existing rules, undermining the stability of the program and leaving in flux how Part D and Medicare Advantage plans would be paid the $30 billion they are owed *each month*.

B. The ACA's Preexisting-Condition Provisions Would Continue To Function Properly Without The Mandate In Today's Individual Market

1. The above discussion should make abundantly clear that the tower of reforms that the ACA has

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[46] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* 422 fig.14-6 (Mar. 15, 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf.

[47] *See* HCERA § 1102, 124 Stat. at 1040.

instituted would not come tumbling down by removing the individual mandate. Virtually all the reforms are built on foundations separate and apart from the mandate. And "[g]iven the breadth of the ACA and the importance of the problems that Congress set out to address, it is simply unfathomable *** that Congress hinged the future of the entire statute on the viability of a single, deliberately unenforceable provision." Cal. Pet. App. 103a (King, J., dissenting).

The same had not always been true for the ACA's guaranteed-issue and community-rating requirements. At the ACA's inception in 2010, Congress found the individual mandate "essential to *creating* effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I) (emphasis added). That carefully chosen language, however, cannot be read as a declaration that the guaranteed-issue and community-rating requirements could *never* be effective without the mandate. Texas and the federal government conflate the initial *creation* of individual markets under the ACA with their *continuation* years after becoming established fixtures of the health care landscape.

But Congress did not. In 2017, Congress amended the individual mandate provision—zeroing out the tax payment so as to render the mandate unenforceable—without amending the guaranteed-issue and community-rating provisions. For good reason: Albeit a valid concern circa-2010-2012, the risk of an adverse-selection "death spiral" in mandate-less markets—in which healthier individuals wait to

purchase coverage until they need it while generally less healthy or older individuals enter the market, thereby causing premiums to skyrocket and plan providers to exit—has been overtaken by real-world facts. Just prior to the amendment, the CBO itself had predicted that, if Congress "repeal[ed] th[e] [individual] mandate starting in 2019 *** and ma[de] no other changes to current law," then "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade."[48]

Despite the zeroing out of the tax payment (amidst other ACA-related uncertainty), data show that the individual markets have demonstrated a continued resiliency—and, in many instances, have shown signs of increasing steadiness—as states and health insurance providers have responded to a shifting market composition.[49] The 2019 and 2020

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[48] Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[49] The Centers for Medicare & Medicaid Services acknowledged the stability of the individual market in their 2020 open enrollment press releases. *See, e.g.*, Press Release, Premiums for HealthCare.gov Plans Are Down 4 Percent but Remain Unaffordable to Non-Subsidized Consumers (Oct. 22, 2019), https://www.cms.gov/newsroom/press-releases/premiums-healthcaregov-plans-are-down-4-percent-remain-unaffordable-non-subsidized-consumers; Press Release, Federal Exchange Enrollment Remains Stable for the Third Consecutive Year in a Row (Dec. 20, 2019), https://www.cms.gov/newsroom/press-releases/federal-exchange-enrollment-remains-stable-third-consecutive-year-row.

individual market plans and rates approved by state regulators account for the operation of the preexisting-condition provisions absent any tax penalty, *i.e.*, *without an enforceable individual ACA mandate*.[50] Yet "insurer participation [in ACA exchanges] grew in 2019, and premium increases were much lower" than in prior years, "with premiums for lowest-price offerings in many rating areas even decreasing."[51] The trend of declining average-lowest-silver-plan premiums continued in 2020.[52]

The overall data are unsurprising in light of the fact that the individual mandate had already been weakened substantially through a plethora of hardship and other exemptions as well as other non-enforcement mechanisms, and that premium subsidies continue to incentivize participation. As recently explained, "[t]he structure of the ACA's financial subsidies have kept enrollment through the ACA's Marketplaces relatively stable," which "[i]n turn *** has helped maintain significant insurance

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[50] *See, e.g.*, Department of Financial Services, New York State, Press Release: Proposed 2019 Health Insurance Premium Rates for Individual and Small Group Markets (June 1, 2018), https://www.dfs.ny.gov/about/press/pr1806011.htm; Office of the Health Insurance Commissioner, State of Rhode Island, Press Release: 2019 Requested Commercial Health Insurance Rates Have Been Submitted to OHIC for Review (May 30, 2018), http://www.ohic.ri.gov/documents/2018%20Rate%20Review%20Documents/2018%20Rate%20Review%20Process%20Press%20Release%20-%20Requested%20Rates.pdf.

[51] ACA's Effect, *supra* note 4, at 440; *see* Cost Curve, *supra* note 19, at 408 ("[S]ome insurers have entered new markets in 2019 and 2020.").

[52] ACA's Effect, *supra* note 4, at 440.

company participation" and facilitate "expan[sion] [of] their areas of participation in recent years or [an] announced *** intention to do so."[53]

The reality is that health insurance providers have designed and submitted actuarially sound products, and are continuing to participate in the individual market, without an enforceable mandate. The same holds true for most individuals. In the face of that empirical proof, there is simply no basis to conclude that the guaranteed-issue and community-rating provisions remain inextricably intertwined with the individual mandate today. To the contrary, shifting to a marketplace that eschews those provisions would only upend a steadying market, not save it.

2. To be sure, before the ACA's implementation, AHIP took the position in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) ("*NFIB*"), that decoupling the mandate from the preexisting-condition provisions could destabilize the individual insurance market. But as just explained, "the legislative considerations *** necessarily shifted" between 2010 and 2017. Cal. Pet. App. 112a (King, J., dissenting). Before the ACA's individual-market reforms had taken hold, AHIP was understandably concerned that "Congress's effort to make affordable insurance universally available would have stopped at the starting gate." AHIP *Amicus* Br. in Supp. of Reversal of Severability J. 16 n.6, Nos. 11-393, 11-398, 11-400 (U.S. Jan. 6, 2012).

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[53] *Id.* at 441.

Since then, the question of whether health insurance markets could be *created* in the absence of a mandate has given way to a different question in this case: whether those now-established markets would *remain* viable. As it did in *NFIB*, AHIP is answering the question before it by looking to the best available evidence in the context of existing circumstances and its own experience. AHIP's current advocacy for severability of the guaranteed-issue and community-rating provisions thus is not a changed position, but instead answers a different question reflecting different circumstances.

AHIP is not alone in its reassessment. Those same changed circumstances are reflected in Congress's decision—consistent with the CBO's analysis and against the backdrop of stably functioning individual health care markets—to eliminate the tax payment for forgoing health coverage *without* altering the preexisting-condition provisions. That "unusual insight into Congress's thinking," Cal. Pet. App. 105a (King, J., dissenting), is crucial to the severability analysis.

CONCLUSION

Over the course of a decade, the ACA has fundamentally reshaped the nation's health care system. Congress in 2017 chose not to disturb that paradigm shift—including the promise of affordable coverage for those with preexisting conditions—when defanging the individual mandate without repealing any other part of the ACA.

Texas and the federal government would have this Court wield an axe in responding to Congress's scalpel. But invalidation of the ACA would flout

Congress's manifest intent, with profound consequences for our health care system and the hundreds of millions of people it serves. This Court must reject that outcome.

Respectfully submitted.

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