No. 11-398

In The Supreme Court of the United States

DEPARTMENT OF HEALTH
AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

STATE OF FLORIDA, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF *AMICI CURIAE* OF HSA COALITION, INC. AND THE CONSTITUTION DEFENSE FUND, A PROJECT OF FREEDOMWORKS FOUNDATION IN SUPPORT OF RESPONDENTS (MINIMUM COVERAGE PROVISION)

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BRIEF *AMICI CURIAE* OF HSA COALITION AND THE CONSTITUTION DEFENSE FUND, A PROJECT OF FREEDOMWORKS FOUNDATION IN SUPPORT OF RESPONDENTS

Amici HSA Coalition, Inc. and the Constitution Defense Fund, a project of FreedomWorks Foundation, submit this brief and respectfully request that the Eleventh Circuit's decision be affirmed.

INTEREST OF *AMICI CURIAE*[1]

HSA Coalition, Inc. is a § 501(c)(6) organization whose mission is to defend health savings accounts against legislative and other attacks, as well as to improve current law so as to permit more Americans to have the option to choose a health savings account.

The Constitution Defense Fund promotes limited government and the protection of civil liberties by advocating for America's founding constitutional principles in the public arena. The Fund is a project of FreedomWorks Foundation, a § 501(c)(3) nonprofit, nonpartisan organization with more than one million

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No person or entity, other than the *Amici*, its donors or members, or its counsel, has made a monetary contribution to the preparation or submission of this brief. All parties filed blanket *Amicus* consent letters.

members dedicated to the principles of individual liberty and economic freedom. The Foundation educates citizens about and promotes constitutionally limited government and the adoption of free-market policies that inure to the benefit of consumers and citizens generally, including the establishment of a patient-centered health care system.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 199 (PPACA or Act), substantially reduces individual choices in health care decisions. The PPACA penalizes high-deductible plans by making them pay a rebate. This will eliminate such plans and force health insurance into a standardized government-plan model.

The PPACA takes the option of using a health savings account to fund a high-deductible health insurance plan off the table. The Act significantly diminishes individuals' freedom of choice by eliminating this widely used and effective option.

Milliman, Inc., one of the premier actuarial firms, has completed an actuarial study on the medical loss ratio provision of the PPACA that requires health plans to pay out approximately 80% of premiums in claims. That study shows that the detrimental impact of the medical loss ratio requirements is likely to be greater on high-deductible health plans, including

those with HSAs, than other types of comprehensive medical plans.

By eliminating high-deductible (i.e., low-premium) consumer-driven health care plans, the PPACA eliminates a key option available to individuals when they make personal health care decisions. The aggressive constitutional posture of the PPACA will produce an unjustifiable loss of individual liberty.

ARGUMENT

Through Article I of the Constitution, the People vested in Congress the limited legislative power to regulate interstate commerce:

> All legislative Power, herein granted shall be vested in a Congress of the United States. . . .
>
> . . . .
>
> The Congress shall have Power . . . To regulate Commerce with foreign Nations, and among the several States. . . .

U.S. Const. art. I, §§ 1, 8, cl. 3.

The Commerce Clause granted the limited power to regulate commercial transactions and the channels and instrumentalities of commerce. It has never included the power to direct private parties to engage in commerce in the first place. *See generally Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1 (1824) (holding Congress

could regulate voluntary private steamboat business); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937) (holding Congress could regulate voluntary commerce between workers and their employers' businesses); *United States v. Lopez*, 514 U.S. 549 (1995) (striking down statute making voluntary possession of firearm in school zone a federal crime); *United States v. Morrison*, 529 U.S. 598 (2000) (striking down portion of statute making volitional sexual assault a federal crime).

The step from regulating commerce to directing it is not an academic one. The step taken by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 199 (PPACA or Act), has real, practical consequences for individuals making intimate, personal health care decisions for themselves and their children. The PPACA impacts the individual's decision of what doctor, what hospital, and what medicine she can choose.

The Government's brief has failed to recognize, let alone address, the substantial infringement of individual liberty effected by the Legislative direction of health care choices under the individual mandate. If the individual mandate is upheld, an individual no longer has the ability to make many critical health care decisions. Instead, the Government makes these decisions for her by approving which plans may participate in the Exchanges and thus which options are available to individuals. To obtain the Government's necessary approval, health insurance plans must meet a lengthy list of requirements and restrictive standards. If these plans do not qualify, an

individual cannot purchase them through the Exchange. While an individual remains free to choose among plans within the Exchanges, the lack of a full range of insurance products makes these choices illusory at best.

The Act's restriction of health care choices to government plans is a far cry from what Americans were promised.[2] One type of health care choice particularly impacted by the Act and the Government's regulations are Health Savings Accounts (HSA) and high-deductible health insurance plans. A new study by Milliman, Inc – the only actuarial study of the Medical Loss Ratio regulations – confirms that the Act and its regulations have taken away an individual's choice in health insurance decisions, and is replacing it with a limited, standardized array of government-approved options. This is only a first step in removing health care decision-making from individuals. In fact, former advisors in the Obama Administration warned last month that a radically new system is on the horizon.

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[2] Americans were forced to rely on these promises because Congress "had to pass the [health care] bill so that you can find out what is in it." Nancy Pelosi, Speech before the 2010 Legislative Conference of the National Association of Counties (March 9, 2010).

I. To Effect The Individual Mandate, Health Plans Must Be Standardized And Alternatives Must Be Removed, Resulting In The Loss Of Individual Freedom Of Choice.

A. The PPACA Defines The Benefits That Must Be Offered, Sets The Losses That Must Be Paid, And Mandates That Individuals Participate.

Under the PPACA, only qualified health benefit plans which meet specific government-established criteria can be sold within the state Exchanges.[3] Plans which do not meet these specific criteria may be sold outside the Exchanges, but individuals purchasing these plans will not be eligible for the subsidies provided for under the PPACA. *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071.

A "qualified health plan" is a health plan that is certified by each Exchange through which it is offered. It must provide the essential benefits package, as defined by the Secretary of Health and Human Services. It must be offered by a licensed issuer that agrees to offer at least one silver plan and one gold plan, agrees to charge the same premium whether the plan is sold through the Exchange or outside of it, and complies with all other requirements of the Secretary of Health

[3] The term "Exchanges" refers to the health benefit exchanges that each State must create and operate. 42 U.S.C. § 18031(b).

and Human Services and the Exchange. 42 U.S.C. § 18021(a)(1).

Each qualified health plan must meet the "essential health benefits" requirements by covering the following general categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care. 42 U.S.C. § 18022(b)(1). The scope of benefits has yet to be determined by the Secretary of Health and Human Services.

Health plan coverage levels are also strictly defined. All qualified health plans must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. *Id*. § 18022(d)(1)(A). Plans that provide benefits at the 60% level are bronze plans. *Id*. § 18022(d)(1)(A). Silver, gold and platinum level plans provide benefits that are actuarially equivalent to 70%, 80% and 90% of the full actuarial value of benefits under the plan, respectively. *Id*. § 18022(d)(1)(B), (C), (D).

The PPACA also establishes minimum "Medical Loss Ratio" standards for all insurers. *See id*. § 300gg-18(b). The Act specifies that in the large group market, insurers must spend at least 85% of the amount of premiums collected on direct patient care through the payment of medical claims. *Id*.

§ 300gg-18(b)(1)(A). In the small group and individual markets, insurers must spend at least 80% of premiums collected on direct patient care. Any insurer that does not meet the 80% or 85% minimum must pay rebates to insureds. *Id*. § 300gg-18(b)(1)(B). The Act requires the Secretary to implement the minimum medical loss ratio requirements. *Id*. § 300gg-18(b)(3). The Secretary recently promulgated regulations to do so. *See* Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76594 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) (final rule with comment period).

For example, if an individual buys a health plan with no deductible that costs $5,000, and has $4,000 in medical expenses, the plan is in compliance with the medical loss ratio because 80% of the premium is used for medical claims. By contrast, an individual buys a policy with a $1,000 deductible with $4,000 in premiums, and has the same $4,000 in medical expenses. The individual pays the first $1,000 of medical expenses directly to cover the deductible, while the health plan pays the remaining $3,000. This $3,000 is only 75% of the $4,000 premium, so the plan does not meet the minimum medical loss ratio of 80% and must pay a rebate. *See* Greg Scandlen, National Center for Policy Analysis, *New Regulation Threatens Agents, HSA Plans* (Dec. 12, 2011). The medical expenses and the total cost of coverage are the same under both plans. What is not the same is the burden placed on the consumer-driven health plan. The low deductible plan meets the medical loss ratio, while the high-deductible plan does not. By forcing the

high-deductible plan to pay a rebate, the Act will remove such plans from the Exchanges.

In addition, Exchanges must submit justifications of any premium increase prior to implementation. 42 U.S.C. § 18031(e)(2). Exchanges must take into account a justification of premium increases when certifying plans. *Id*. § 18031(e)(2). These pertinent provisions of the PPACA effectively place decisions about how health insurance must look into the hands of government bureaucrats and out of the hands of participants in the market.

The individual mandate requires most individuals to have minimum acceptable coverage (as defined by the Government). The PPACA exempts several categories of individuals from the individual mandate penalty, including individuals whose required annual premium contribution exceeds 8% of their household income for the taxable year are exempt from the individual mandate penalty. PPACA § 1501; 48 U.S.C. § 5000A(e). The required contribution for coverage is the amount required to maintain coverage either in an employer-sponsored health plan or in a bronze-level plan offered on an Exchange. *See* 48 U.S.C. § 5000A(e)(1)(A). Only eligible individuals who purchase insurance through a stated-based exchange may receive a subsidy.[4]

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[4] The Act allows the federal government to set up a federally-run Exchange if the State fails to implement an Exchange. PPACA § 18041(c)(1). It is not clear whether individuals who

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If a non-exempt individual fails to purchase a government-approved health plan, the individual must pay a penalty. *Id*. § 5000A(b)(1). The annual penalty is either a flat dollar amount, or a percentage of the individual's income, if higher than the flat rate. *Id*. § 5000A(c)(1). The percentage-of-income figure is capped at the national average premium amount for bronze-level plans in the Exchanges. *Id*.

B. Consumer-Driven Health Plans Provide Individuals With More Freedom Of Choice.

A consumer-driven health plan is the combination of a pretax payment account with a high-deductible health plan. *See* Bureau of Labor Statistics, United States Department of Labor, *Consumer-Driven Health Care: What Is It, And What Does It mean for Employees and Employers?* (Oct. 25, 2010). Consumer-driven health plans are a three-tier payment system, consisting of a savings account, out-of-pocket payments, and an insurance plan. *Id*. The savings account is an account that allows enrollees to pay for services, as well as the insurance plan deductible, using pretax dollars, funded either by the individual or an employer. *Id*. The second tier is the "coverage gap," that is, the difference between the amount of money in

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purchase insurance from a federally-run Exchange are eligible for subsidies because the text of the PPACA states that only state-based Exchanges may distribute subsidies.

the pretax account and the deductible, and which must be covered by the insured. *Id*. If health care expenses exceed the deductible amount, the high-deductible health insurance plan kicks in, and operates as a traditional health plan does. *Id*.

High-deductible plans, while generally having high annual deductibles and higher annual out-of-pocket maximums than traditional plans, have lower premiums as well as the ability to open a health savings account (HSA) to use tax-free savings for medical expenses. *Id*. Most high-deductible health plans cover preventive care services without requiring enrollees to first meet the deductible. *See* AHIP Center for Policy and Research, *January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)* 2 (June 2011).

HSAs were authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, and are designed to help consumers save to defray current and future medical out-of-pocket costs. HSAs are the fastest growing health or finance product. *See* AHIP Center for Policy and Research, *January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)* 4 (June 2011). Over 3 million previously uninsured people are covered by HSAs. *See* Kaiser Family Foundation, *Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families*, 7 (Oct. 2006) (citing AHIP, Press Release, *Over 3 Million*

Enrolled in High-Deductible/HSA Plans (Jan. 26, 2006)).

HSA plans, a subset of consumer-driven plans, provide individuals with incentives to manage their own health care costs by coupling a tax-favored savings account used to pay medical expenses with a high-deductible health plan that meets certain requirements for deductibles and out-of-pocket expense limits.[5] *See* AHIP Center for Policy and Research, *January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)* 4 (June 2011). Unused amounts roll over to the next year without penalty. *See* Bureau of Labor Statistics, United States Department of Labor, *Consumer-Driven Health Care: What Is It, And What Does It Mean for Employees and Employers?* (Oct. 25, 2010). Individuals may invest funds in HSAs in stocks or other types of investments permitted for Individual Retirement Accounts. *See id*. In 2010, 73% of accountholders contributed more than they spent during each month in 2010, and account balances grew for all groups, with 35% of accounts having balances over $1,000. *See* AHIP, *Health Savings Accounts and Account-Based Health Plans: Research Highlights* 4 (November 2011). Ninety-four percent of individuals with an HSA will spend less than $5,000 in medical expenses annually, making them an attractive affordable option for healthy

[5] Under current law, an individual must have a high-deductible health plan to open an HSA, or to contribute to one. Therefore, the lack of high-deductible plan products will eliminate the ability of individuals to choose an HSA.

individuals. HSA Council, Inc., *Health Savings Accounts: Account-based solutions for affordable health care*, http://hsacoalition.org/wp-content/uploads/2011/11/Nov-2011-HSA-Council-Leave-behind.pdf.

With the rise in health care costs, coupled with a desire to take more control of their health care decisions, an increasing number of individuals are using consumer-driven health plans, and in particular, HSA/high-deductible health plans. As of January 2011, 11.4 million people were covered by HSA/high-deductible health plans, a 3.4 million increase since January 2009. *See* AHIP Center for Policy and Research, *January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)* 6 (June 2011). HSA/high-deductible health plan coverage accounted for 13.5% of all new health insurance enrollment in the small group market. *See id*. at 8. In January 2011, HSA-eligible products accounted for 6.1% of newly issued health insurance policies purchased in the individual market. *See* AHIP, *Health Savings Accounts and Account-Based Health Plans: Research Highlights* 1 (November 2011).

Consumer-driven health plans have an important place in the market. They provide comprehensive coverage for high-cost medical events, and can be coupled with a tax-advantaged method to build savings for future medical expenses. With consumer-driven health plans, individuals have greater flexibility and discretion over how these health care benefits are used. The U.S. Office of Personnel Management has recognized that a consumer-driven plan "provides

you with greater freedom in spending health care dollars the way you want." U.S. Office of Personnel Management, *High Deductible and Consumer-Driven Health Plans*, http://www.opm.gov/insure/'archive/05/guides/70-01/hdcd.asp. Studies have found that individuals with HSA accounts are more engaged in their health care decisions. *See* AHIP, *Health Savings Accounts and Account-Based Health Plans: Research Highlights* 6-7 (November 2011).

C. Supporters Of The PPACA Promised HSAs Would Continue As A Viable Option For Individuals.

During the legislative battle, supporters of the PPACA touted the availability in the Exchanges of low-cost, consumer-driven plans at the bronze level. President Obama has repeatedly assured Americans that "the Government is not going to make you change plans under health reform." *See*, *e.g.*, The White House Blog, *Facts Are Stubborn Things* (Aug. 4, 2009). The President was even more specific in his assurance that HSAs would remain a viable choice when, in a March 2, 2010 letter to Congressional leaders, he wrote:

> I believe that high-deductible health plans could be offered in the exchange under my proposal, and I'm open to including language to ensure that is clear. This could help to encourage more people to take advantage of HSAs.

Letter on Health Insurance Reform from Barack Obama, President, to Congressional Leaders (March 2, 2010). Secretary Sebelius also boasted about the

availability of HSAs and the discretion of States to offer products desired by their residents:

> The Affordable Care Act puts states in the driver's seat because they often understand their health needs better than anyone else. . . . States have discretion, for example, to offer a wide variety of plans through their exchanges, including those that feature health savings accounts.

Kathleen Sebelius, *How the Affordable Care Act empowers states*, Washington Post (Feb. 10, 2011). These assurances are contradicted by the findings of an independent study which show the almost-certain elimination of HSAs from the Exchanges as a result of the Medical Loss Ratio regulations.

D. A Milliman Study Finds That The Impact Of The Medical Loss Ratio Requirements Is Likely To Be Greater On High-Deductible Health Plans.

Clearly, the individual mandate burdens the ability of individuals to freely make a choice not to purchase health insurance.[6] Those uninsured individuals

[6] The Medical Loss Ratio regulations are but one example of how the PPACA, and its implementing regulations, are causing a loss of liberty. *See* Opinion, *ObamaCare's Great Awakening,* Wall Street Journal (Feb. 8, 2012) ("When politics determines who can or should receive what benefits, and who pays what for it, government will use its force to dictate the outcomes that it wants – either for reasons of cost, or to promote its values. . . ."). The Government's decision to interpret "essential health benefit"

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mandated to purchase health insurance will most likely purchase bronze or silver plans, which are the least expensive options within the Exchanges. Supporters of the Act made promises that consumer-driven health plans, such as HSAs, which provide individuals a large degree of choice and autonomy, as well as lower cost, would be eligible for inclusion in the Exchanges. In fact, it was widely believed at the time of the Act's passage that HSAs would be used with the bulk of the bronze plans offered, thus limiting the burden of purchasing health insurance through the availability of low-cost, consumer-driven options in the exchanges. However, in a classic inside-the-Beltway bait-and-switch, the promised HSAs and high-deductible health plans in the individual and small group markets are effectively excluded from the Exchanges.

In December 2011, the Medical Loss Ratio regulations were promulgated. *See* Medical Loss Ratio Rebate Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76594 (Dec. 7, 2011). The purpose of the medical loss ratio requirement is

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to include birth control is another. *See* PPACA §§ 1001, 1302(b); U.S. Department of Health and Human Services, News Release, *A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius* (Jan. 20, 2012). In implementing the birth control mandate, the Administration, despite promises of compromise, narrowly defined the "conscience exception" for religious organizations. The Administration's continuing regulation of all choices related to health care, justified under the Commerce Clause, is truly alarming.

to reduce non-medically related costs, such as administrative expenses, as well as alleged windfall profits. This medical loss ratio regulation dictates to insurance companies selling "fully insured" policies (e.g., those purchased by individuals, small businesses and some larger businesses) that they must spend at least 80% (or 85% for policies sold to larger companies) of the premiums they collect as medical claims. Thus, insurance companies must pay at least $80 of every $100 in premiums collected on medical claims. The remaining $20 is left to cover administrative expenses, such as brokerage fees, fraud detection, marketing, as well as surplus and profits.

Milliman, Inc., one of the premier actuarial firms, has completed an actuarial study of the medical loss ratio interim final regulations, and has found that the impact of the medical loss ratio requirements is likely to be greater on high-deductible health plans, including those with HSAs, than other types of comprehensive medical plans. *See* Milliman, Inc., *Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans/HSAs in Individual and Small Group Markets* 3 (January 6, 2012), http://www.regulations.gov/#!documentDetail;D=CMS-2011-0179-0044.

The Milliman study's Executive Summary notes four primary issues of concern for high-deductible health plans:

1. **The MLR formula doesn't take into account contributions to HSAs.** Many

HDHPs are accompanied by an HSA, which covers much of the first-dollar costs before the plan's deductible is reached. HSA contributions are currently not reflected in the MLR calculations.

2. **HDHPs may not be able to raise rates fast enough to keep up with rising costs.** HDHPs will require larger annual rate increases than typical/average medical plans because medical inflation will have a greater impact on HDHPs claim levels than plans with lower deductibles.

3. **HDHPs have less premium dollars to cover their fixed expenses.** Every plan has fixed expenses that it covers with premiums. Since HDHPs have lower premiums than other plans, a greater percentage of the premium must be used to pay these fixed expenses. For example, $400 of fixed expenses represents 40 percent of a $1,000 premium, but only 20 percent of a $2,000 premium and only 8 percent of a $5,000 premium. Therefore, it is harder for lower premium plans such as HDHPs to keep its non-claim expenses below 20 percent of its adjusted premiums as the MLR rule requires.

4. **HDHPs have less predictable claims experience that could increase the risk of paying rebates.** High-deductible insurance plans pay fewer claims than plans with low deductibles. But when HDHPs pay claims, the claim dollar amounts tend to be larger. This lower-frequency/high-payment creates

> less actuarial predictability, which can result in high claims in one year and low claims in another. If the plan has low claims, it may not meet the 80 percent MLR and be required to pay rebates. If the plan has high claims, it may lose money that it cannot "make up" in other years.

HSA Council, Inc., Press Release, *Milliman Study Confirms MLR Threat To HSAs*, http://www.aba.com/aba/documents/abia/MillimanReportPressRelease.pdf (emphases in original).

The Milliman study provides several bases for concluding that "without some type of reform, the feasibility of [HSAs and high deductible health plans] under the PPACA seems poor." Milliman, Inc., *Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans/HSAs in Individual and Small Group Markets* 8 (January 6, 2012), http://www.regulations.gov/#!documentDetail;D=CMS-2011-0179-0044. First, the claim portion of the premium dollar is necessarily lower for high-deductible health plans than that for average deductible plans because the high-deductible plan requires the insured to pay more of the cost of care. *See id*. To achieve the minimum loss ratio, the high-deductible health plan's expenses and administrative costs must be lower on a dollar basis than they are for typical health plans. *See id*. Yet, high-deductible health plans are not designed to achieve this. Therefore, "a uniform [Medical Loss Ratio] requirement of 80% for individual and small group adversely affects companies that write a significant amount of higher-deductible business." *Id*. at 6. The medical loss ratio requirement necessitates the

cutting of administrative expenses even more, which may "create disincentives to offer such lower-cost plans, particularly if the insurer cannot generate reasonable risk margins." *Id*. at 6.

Second, due to the high deductible, fewer policyholders have claims in a year, and when they do, the typical claim amounts are higher for high-deductible plans. *See id*. at 3. This variability can lead to high claims in one year and low claims in another. *See id*. It also increases the likelihood that high-deductible plans will fail to meet the 80% medical loss ratio in those years of low claims, and therefore, be required to pay rebates. *See id*. As the Milliman study shows, if the plan is priced to meet the minimum medical loss ratio threshold of 80%, in any given year, there is close to a 50% chance that the claim experience will result in medical loss ratios above 80%. *See id*. at 7. There is also close to a 50% chance that the insurance carrier will need to pay a rebate even though its plan was priced properly to meet the 80% medical loss ratio threshold. *See id*. The carrier will then need to pay a rebate, further limiting its ability to amass the surplus needed to offset high claim payment years.[7] *See id*.

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[7] The administrative cost of processing and sending thousands of rebate checks will only make it more difficult for a high-deductible health plan to meet the Medical Loss Ratio. *See* Merrill Matthews, *ObamaCare Hidden Price Controls Will Hammer Insurers* (Feb. 7, 2012) ("Wisconsin Insurance Commissioner Ted Nickel says that just processing those rebate checks could cost a small fortune for companies with thousands of policyholders – and makes no economic sense if the rebate checks are small.").

Third, the medical loss ratio calculations do not account for the inclusion of HSAs within high-deductible plans. High-deductible health plans are often accompanied by an HSA, which is used to cover much of the first-dollar costs before the high-deductible plan's deductible is reached. *See id*. However, the amounts paid out of an HSA are not permitted to be included in the plan's calculation of its medical loss ratio. Given that 94% of those with an HSA will spend less than $5,000 in medical expenses annually, only expenses from roughly 6% of those with an HSA are counted in the medical loss ratio formula. Thus, it is almost mathematically impossible for HSA/high-deductible plans to meet the medical loss ratio in most years.

There is concern that discrimination against HSA plans seems intentional.[8] High-deductible plans are not designed to pay claims below the deductible, nor are they designed to meet a high medical loss ratio. If a high-deductible plan, i.e., a bronze plan, is designed (and priced accordingly) to pay 60% of the cost of benefits, it is arbitrary and discriminatory to require it to pay 80% of its premiums as medical claims. *See* HSA Consulting Services, LLC, *MLR Regulation Creates Challenges for Future of Affordable Coverage* 5 (Dec. 27, 2011). Yet, the interim final regulations do

[8] Through public comments and meeting, HHS officials were repeatedly warned that the regulations would effectively put HSAs out of business. *See*, *e.g*., HSA Council, Inc., *Comments to the Department of Health and Human Services on the Medical Loss Ratio* (Jan. 31, 2011).

not permit a plan to include, for purposes of its medical loss ratio calculation, any claims incurred for benefits covered below the deductible.[9] *See*, Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76574, 76593 (Dec. 7, 2011) (final rule with comment period) (setting out formula for calculating an issuer's medical loss ratio).

Finally, the Milliman study finds that the PPACA's "unreasonable rate increase" provisions may make it difficult for high-deductible health plans to increase plan premiums. *Id*. at 3. Such rate increases will be necessary if high-deductible health plan deductibles do not increase with medical inflation because the expected annual costs under the high-deductible health plan will increase faster than under a lower deductible plan. *See id*.

II. The PPACA's Provisions And Implementing Regulations Standardize Benefits, Force Consumer-Driven Plans Out Of The Exchanges, And Thereby Take Away The Individual's Freedom Of Choice.

In January 2012, former advisors to the Obama Administration warned of the impending continued

[9] Although claims incurred for benefits covered below the deductible cannot be included for purposes of the medical loss ratio calculation, the plan will still incur administrative costs to process these claims, thereby making it even more difficult to reduce its administrative expenses to meet the 80% Medical Loss Ratio.

loss of autonomy and liberty in this area. They predicted that the American health insurance industry will be extinct by 2020 and will be replaced by "accountable care organizations."[10] Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance Companies*, The New York Times (Jan. 30, 2012) [Emanuel & Liebman]. According to these former advisors, with the advent of accountable care organizations "a new system is on its way, one that will make insurance companies unnecessary" and "health insurers superfluous." *Id*. The "final bonus" they argue is that accountable care organizations will relieve consumers of the need to choose among insurance plans, because these are choices "that few of us are any good at making." *Id*.

The reason that supporters of the PPACA must take away the autonomy and choices of individuals is because "[w]henever consumers have a choice among different insurance arrangements, there is a tendency for people to choose a level of insurance based on their expected need for what is being covered (in this case health care)." Kaiser Family Foundation, *Snapshots: Health Care Costs: Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models* (November 2006).

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[10] An accountable care organization is an organization of health care service providers (e.g., doctors, hospitals, and other providers) that agrees to be accountable as a single agent for the quality, cost, and overall care of enrolled health insurance beneficiaries. The accountable care organization is accountable to third-party payers for the quality, appropriateness and efficiency of the health care provided. PPACA § 3022.

Therefore, to achieve the goals of the individual mandate, regulators must necessarily burden, indeed, take away, most individual autonomy and choice. To accomplish this, consumer-driven health plans must effectively be put out of business. It is no wonder then, that 67% of the American public support the repeal of the individual mandate. *See* Kaiser Family Foundation, *Kaiser Health Tracking Poll* 4 (March 2011). If the still-to-come "essential benefits" and "actuarial value" regulations contain the same bias against consumer-driven plans as does the medical loss ratio regulations, it is clear that no viable low-cost bronze plans will qualify for the Exchanges. However, when these regulations put the nail in the coffin of consumer-driven health plans, the public should not be surprised. In short, the individual mandate will replace individual choice with the government's choices.

A. With Fewer Viable Low-Cost Choices In The Exchanges, Especially At The Bronze Level, Plans Become Standardized, Resulting In No Real Choice For Individuals Complying With The Mandate.

As the Milliman study concluded, the PPACA and implementing regulations unduly burden HSAs and high-deductible health plans. Therefore, insurance companies will be incentivized to offer more expensive plans with more first-dollar coverage in order to easily meet the medical loss ratio requirement or leave the market entirely. *See* Congressional Budget Office, *Budgetary Treatment of Proposals to Regulate Medical Loss Ratios* (Dec. 13, 2009) (discussing the effect of

this "powerful regulatory tool"). As a result, the exchanges will be dominated by more expensive plans. *See id*. ("Such responses would reduce the types, range of prices, and number of private-sector sellers of health insurance. . . .").

If HSAs and high-deductible health plans are effectively eliminated from the Exchanges, the burden on both the individual and the State, in terms of loss of liberty and autonomy and of cost, will grow. The elimination of low-cost, consumer-driven plans will dramatically reduce the affordability of coverage and significantly add to the cost of income-based subsidies provided under the Act.[11] *See* HSA Consulting Services, LLC, *MLR Regulation Creates Challenges for Future of Affordable Coverage* 7 (Dec. 27, 2011).

With few, if any, viable low-cost options, an individual will be forced by the mandate to go outside the Exchange to purchase low-cost insurance, stay within the Exchange and purchase a less discretionary and more expensive plan, or forgo insurance altogether and pay the penalty. All three options result in an unjustifiable loss of individual liberty.

If healthy individuals either forgo insurance or purchase coverage outside of the Exchange, the less healthy will be left in the Exchange, with only the option of more expensive plans.

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[11] Subsidies are based on the weighted average premiums for silver plans. *See* HSA Consulting Services, LLC, *MLR Regulation Creates Challenges for Future of Affordable Coverage* 7 (Dec. 7, 2011).

Even individuals participating in employer plans are impacted by the elimination of low-cost, consumer-driven health plans. Should employers decide to pay the penalty for not providing health insurance to its workers, even larger numbers of individuals will be dumped into the individual and small group markets. And they will find only the standardized, expensive plans left in the Exchanges from which to choose.

B. The Asserted Goals Of The Individual Mandate Are Insufficient To Justify This Loss Of Liberty.

Healthy individuals, when faced with few viable low-cost choices may simply pay the penalty and remain uninsured (at least until they become sick), thus thwarting the mandate's goal of reduction of the number of uninsured. Or, these healthy individuals will find coverage outside of the Exchange. If the Exchange has a disproportionate share of less healthy individuals remaining, adverse selection will result.[12] As a result, the exchange risk pool will become a less healthy group with greater overall health care expenses. *See* Janet Bauer, Oregon Center for Public Policy, *The Active Purchaser Imperative* (Sept. 8,

[12] Adverse selection results when healthy and less healthy individuals separate into different insurance risk pools. *See* Janet Bauer, Oregon Center for Public Policy, *The Active Purchaser Imperative* (Sept. 8, 2011). Healthy individuals are more often able to choose low-cost, consumer-driven plans, while less healthy individuals tend to choose plans with more generous coverage, even though they have higher premiums. *Id*.

2011). To meet the increased amount of health care expenses, the plans in the Exchanges will be forced to increase premiums for the remaining less healthy individuals, thus thwarting the PPACA's asserted goal of more affordable health care for all Americans.[13] When the cost of the remaining plans in the Exchanges increases to account for the risk of the less healthy individuals remaining in the Exchanges, those less healthy individuals will then need increased subsidies to continue to afford coverage.

The discrimination against high-deductible health plans, HSAs, and other consumer-driven plans will result in some insurance companies going out of business. Even prior to the interim final Medical Loss Ratio regulations, the first company to begin providing HSAs laid off 130 workers to begin streamlining for the post-Act marketplace. *See* Assurant Health Press Release, *Assurant Health Announces New Organizational Structure* (Aug. 19, 2010). Post-implementation, some health insurers are dropping out of the individual market completely, while others are cutting back. Merrill Matthews, *ObamaCare Hidden Price Controls Will Hammer Insurers* (Feb. 7, 2012). One report states that "'20,000 small groups, representing as many as 200,000 members' will lose

[13] If only 4 out of 1,000 people leave the Exchange, it could result in a 5% difference in the average per-person cost. *See* Bauer, *supra* note 12 (citing Kaiser Family Foundation, *Snapshots: Health Care Costs: Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models* (November 2006)).

their coverage" as a result of failure to meet the Medical Loss Ratio. *Id*. This result, while plainly in line with the Obama Administration's goal of making insurance companies unnecessary and health insurers superfluous, *see* Emanuel & Liebman, is at odds with the Government's argument that the mandate "'is necessary' to the end of regulating insurers' underwriting practices without running insurers out of business." Pet. Br. (minimum coverage provision) at 30 (quoting Pet. App. 231a (Marcus, J.)).

Finally, the effective elimination of low-cost, consumer-driven plans from the Exchanges will lead to a less efficient market. Individuals will have fewer choices, and those large companies that are able to remain in the individual and small group markets will face less competition.

CONCLUSION

The Act takes one small step from regulation to direction of commerce, but one giant leap for governmental power over the life and health of every American. Its real consequence for individuals making health care decisions is sharply restricted personal choice and a substantial infringement of individual liberty.

The judgment of the court of appeals invalidating the minimum coverage provision should be affirmed.

Respectfully submitted,

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