Nos. 19-840 & 19-1019

IN THE

Supreme Court of the United States

THE STATE OF CALIFORNIA, *et al.*,
Petitioners,

v.

THE STATE OF TEXAS, *et al.*,
Respondents.

THE STATE OF TEXAS, *et al.*,
Petitioners,

v.

THE STATE OF CALIFORNIA, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR *AMICUS CURIAE* BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF PETITIONERS IN NO. 19-840 AND RESPONDENTS IN NO. 19-1019

ANTON METLITSKY
SHANE A. HUNT
O'MELVENY & MYERS LLP
7 Times Square
New York, N.Y. 10036
(212) 326-2000

K. LEE BLALACK, II
(*Counsel of Record*)
lblalack@omm.com
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

Counsel for Amicus Curiae

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INTEREST OF *AMICUS CURIAE*[1]

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-six independent, community-based and locally-operated Blue Cross Blue Shield health insurance companies (collectively, "Blue Plans"). Together, the Blue Plans provide health insurance to approximately 107 million people—nearly one-third of all Americans—in every zip code in all fifty states, the District of Columbia, and Puerto Rico. Blue Plans offer a variety of insurance products to all segments of the population, including federal employees, large employer groups, small businesses, and individuals. As leaders in the healthcare community for more than eighty years, Blue Plans seek to expand access to quality healthcare for all Americans and have extensive knowledge of and experience with the health insurance marketplace.

The Blue Plans are regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA"), and have been the leading providers of health insurance in the individual health insurance markets, including the government-sponsored exchanges created by the ACA. By the end of 2019, Blue Plans insured approximate-

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[1] Pursuant to Rule 37.6, no counsel for any party authored this brief in whole or in part and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

ly 4 million enrollees who obtained their health insurance through those exchanges.

BCBSA has a compelling interest in questions concerning the ACA's constitutionality in general, and questions regarding the validity of its "guaranteed issue" and "community rating" provisions in particular. Those provisions are crucial to ensuring affordable health insurance for individuals covered by the Blue Plans. As with many other organizations, BCBSA filed an *amicus curiae* brief in this Court in 2012 contending, based on then-available information, that the guaranteed issue and community rating provisions could not properly function in the individual insurance market without the ACA's so-called "individual mandate." *See Nat'l Fed'n of Indep. Bus.* ("*NFIB*") *v. Sebelius*, Nos. 11-393, 11-398, 11-400, Br. of Am. Health Ins. Plans & Blue Cross Blue Shield Ass'n As *Amici Curiae* In Support of Reversal of the Court of Appeals' Severability Judgment (U.S. Jan. 6, 2012) ("BCBSA Br."). BCBSA has a substantial interest in explaining how its views have evolved based on Blue Plans' subsequent experience participating in the ACA's individual market, and why the guaranteed issue and community rating provisions can and do function without a mandate to purchase insurance in the individual market. The actual experience of Blue Plans, and other providers of health insurance in the individual market after implementation of the ACA, demonstrates why the 2017 Congress could have rationally eliminated the individual mandate but retained the remainder of the ACA, including the guaranteed issue and community rating provisions.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

When Congress enacted the ACA in 2010, it adopted policies that touch on nearly every aspect of the healthcare system in the United States, including the health insurance markets. *See generally* ACA, Pub. L. No. 111-148. One of Congress's important goals was clear: to ensure that all Americans, including low- and middle-income Americans, those with pre-existing health conditions, and those otherwise lacking employer-provided insurance, have access to healthcare coverage through either a private insurer or the government. *See* 42 U.S.C. § 18091(2)(D).

To improve access to healthcare services for low- and middle-income Americans who do not obtain insurance through their employers, Congress created incentives for states to expand Medicaid, *see* 42 U.S.C. § 1396d(y)(1), and established subsidies to assist those at 400% or below the federal poverty level (the "FPL") to purchase insurance through government-sponsored marketplaces, *see, e.g.*, 26 U.S.C. § 36B. The program that Congress devised to ensure that Americans with pre-existing health conditions have access to affordable health insurance is more complex.

Before the ACA, health insurers could consider pre-existing health conditions when setting their premium rates, which often resulted in prohibitively expensive premiums or denial of coverage altogether for millions of Americans. Congress remedied this problem by adopting (i) the ACA's "guaranteed issue" provision, which prohibits insurers from denying

coverage based on enrollees' pre-existing health conditions, and (ii) the "community rating" provision, which prohibits insurers from raising premiums based on those health conditions. *See* 42 U.S.C. §§ 300gg *et seq*.

Before the ACA, several states had also enacted their own versions of guaranteed issue and community rating, and Congress sought to learn from their experiences. In particular, Congress was aware that the health insurance markets in states that had adopted similar provisions had collapsed when healthy people delayed purchasing insurance until they were sick—a phenomenon that is widely known as "adverse selection." If only sick people participate in a health insurance market, insurers must increase premiums to cover the higher costs associated with their care, and those higher premiums drive more healthy people out of the market. This cycle is often referred to as a "death spiral" and, if allowed to progress, it eventually causes health insurance markets to collapse.

Mindful of this challenge, Congress modeled the ACA on the approach taken by Massachusetts, which had successfully implemented guaranteed issue and community rating requirements without prompting an exodus of healthy individuals from the market. *See King v. Burwell*, 135 S. Ct. 2480, 2486 (2015) (citing *Hearing on Examining Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform: Hearing Before the S. Comm. on Health, Educ., Labor, & Pensions*, 111th Cong. (2009)). Like Massachusetts, Congress adopted a "mandate" to deter adverse se-

lection. Congress designed the mandate to discourage healthy Americans from waiting until they are sick to obtain coverage by giving them a choice between purchasing insurance or paying a tax. *See* 26 U.S.C. § 5000A(e).

Soon after its enactment, this Court considered whether Congress had the constitutional authority to enact the individual mandate and determined that the mandate was a lawful exercise of Congress's tax power because it could be construed as giving individuals the option of purchasing health insurance or paying a tax.[2] *NFIB v. Sebelius*, 567 U.S. 519 (2012). In December 2017, however, a different Congress passed the Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054 (Dec. 22, 2017) (the "TCJA"), which reduced to $0 the tax associated with the individual mandate—meaning that failing to purchase insurance no longer triggers an obligation to pay a tax to the government. *See id.* § 11081. As a result, the mandate now has no effect as a practical matter. Respondents[3] here sued, arguing that a mandate with no effect is an invalid exercise of Congress's tax power and that the mandate is inseverable from the rest of the ACA. The district court agreed, striking down the ACA in its entirety. A divided panel of the U.S. Court of Appeals for the Fifth Circuit affirmed in part, agreeing that the mandate is now unconsti-

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[2] In light of *NFIB*'s construction, the provision is not a "mandate" at all, since it does not force anyone to purchase health insurance. This brief nevertheless refers to the "mandate" for ease of reference.

[3] "Respondents" refers to the respondents in No. 19-840. "Petitioner States" refers to the petitioners in the same case.

tutional, but it vacated the district court's severability ruling and instructed the district court to reconsider that ruling in light of several additional principles it identified in its opinion.

BCBSA agrees with the arguments presented by the Petitioner States and the U.S. House of Representatives but writes separately to explain how an order of this Court invalidating the entire ACA a decade after its enactment would upend the health insurance markets in this country. Such a ruling would terminate scores of programs and regulations concerning the administration of healthcare in the United States, many of which have been in effect for nearly a decade and have little, if any, relation to the mandate. And it would do so in the middle of a national economic and public health crisis, where the ACA's individual markets—including its individual market regulations and subsidies for low-income Americans—ensure life-saving access to health care for millions of Americans. The ACA is particularly vital now for the millions of Americans who have recently lost their jobs and employer-provided health insurance, ensuring that those newly unemployed and their families still have access to quality and affordable health insurance coverage during a global pandemic.

Further, to estimate the effect of Respondents' arguments on the individual market for health insurance, BCBSA commissioned a study from noted actuarial experts Oliver Wyman, which modeled how the individual market would operate under varying assumptions. The Oliver Wyman analysis also relied on input from Blue Plan actuaries who have set

premiums and operated plans on the individual market for the past seven years. *See* Kurt Giesa & Peter Kaczmarek, Oliver Wyman, Potential Impact of Invalidating the Affordable Care Act on the Individual Market (May 13, 2020) (the "OW Study" or "Study").[4] The modeling conducted by OW has proved reliable; an earlier version of that model predicted 2020 enrollment that generally correspond with the actual preliminary 2020 enrollment figures released by CMS. See OW Study at 8a. And according to the OW model, invalidating the ACA—and in particular, its subsidies—would strip health insurance from millions of Americans, especially the low- and middle-income Americans, those with pre-existing medical conditions, and those lacking employer-provided insurance—that is, the very people the ACA was designed to protect. If the ACA is to be altered, it should be done by Congress in a tailored manner rather than through the blunt and disruptive instrument of judicial order.

Finally, BCBSA addresses the relationship between an enforceable mandate and the ACA's guaranteed issue and community rating provisions—provisions that the 2010 Congress and the entire healthcare industry (including BCBSA) once believed were inextricably linked to the mandate. Actual experience with the ACA over the past seven years shows that, in fact, an individual market subject to guaranteed issue and community rating re-

[4] The OW Study is included as an appendix to this brief, and is also available at https://www.oliverwyman.com/our-expertise/insights/2020/may/potential-impact-of-invalidating-the-affordable-care-act-on-the-.html.

quirements can and does function without a mandate because government subsidies incent enough low- and middle-income Americans—including those who are healthy—to purchase insurance.

Even two years after the mandate's tax was reduced to $0, Blue Plans have continued to provide millions of Americans with health care plans through the individual markets with no signs of the death spiral that they and the rest of the industry originally feared. This experience is supported by empirical modeling. The model in the OW Study concludes that Congress's decision to render the mandate unenforceable should only decrease the number of participants in the individual market from 13.5 million to 12.8 million—a decrease of 5.5%—and cause premiums to rise on average by only $13 per month. Study at 22a, 26a. In other words, while the market would function marginally more efficiently if there were a tax penalty that incentivized healthy individuals to purchase health insurance, there is no reason to believe that the market will collapse so long as Congress maintains the subsidies established by the ACA. That is, after all, why the 2017 Congress that enacted the TCJA maintained the ACA's community rating and guaranteed issue provisions, as well as its individual market subsidies, while at the same time rendering the mandate practically ineffective.

Respondents' severability analysis is, in short, deeply flawed. Thus, the Court should at the very least conclude that the mandate—even if unconstitutional—is severable from the remainder of the ACA.

ARGUMENT

I. RESPONDENTS ASK THIS COURT TO WREAK HAVOC ON THE HEALTHCARE SYSTEM IN THE UNITED STATES

The ACA spans "10 titles[,] stretches over 900 pages[,] and contain[s] hundreds of provisions," *NFIB*, 567 U.S. at 539, that touch on all aspects of the delivery of healthcare in the United States, including many that have nothing to do with the individual mandate, or even health insurance. The district court's decision, which Respondents ask this Court to adopt, would invalidate ***all*** of these provisions overnight. Such a decision would deprive millions of low- and middle-income Americans, as well as those with pre-existing medical conditions, of access to affordable and high-quality health insurance. It would also cause a host of other significant disruptions across the healthcare sector generally.

A. Adopting Respondents' Severability Analysis Would Deprive Millions of Americans of Affordable Health Insurance

Respondents' severability analysis would eliminate key provisions of the ACA that have been successful in expanding access to affordable healthcare to record numbers of low- and middle-income Americans, and those with pre-existing conditions.

1. To improve low-income Americans' access to healthcare, Congress encouraged states to expand Medicaid to cover Americans earning up to 138% of the FPL by promising that the federal government would pay for 90% of the additional cost. *See* ACA

§ 2001 *codified at* 42 U.S.C. § 1396d(y)(1); *see also NFIB*, 567 U.S. at 584. As limited by this Court, the Medicaid expansion preserved a "genuine choice" for states that "find[] the idea of expanding Medicaid genuinely attractive" to opt into the expansion. *NFIB*, 567 U.S. at 587-88.

As of 2020, 36 states and the District of Columbia had chosen to expand Medicaid. *See* Kaiser Family Found., Status of State Medicaid Expansion Decisions: Interactive Map (Apr. 27, 2020).[5] This has resulted in substantially increased coverage for low-income Americans; by 2017, more than 17 million *additional* adults across thirty-two states had enrolled in Medicaid. *See* Kaiser Family Found., Medicaid Expansion Enrollment.[6] Invalidating the ACA would eliminate this Medicaid expansion, forcing states to either pick up the entire cost of providing healthcare services to these beneficiaries or expel millions of people from the program with little notice. This disruption would have cascading effects across the healthcare sector; for instance, hospitals and other healthcare providers could expect to see a significant uptick in uninsured visits and other uncompensated care—one study estimated that Medicaid expansion decreased uncompensated care by as much as 41%. *See* Larissa Antonisse et al., Kaiser

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[5] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

[6] https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed Apr. 26, 2020).

Family Found., The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review (Mar. 28, 2018).[7] And while federal and state governments pick up some of this tab, *see* Teresa A. Coughlin, et al., Kaiser Family Found., Uncompensated Care for the Uninsured in 2013: A Detailed Examination (May 30, 2014) (estimating $53.3 billion in federal and state costs for uncompensated care in 2013),[8] a substantial portion is borne by both private insurers and those they insure, *see* 42 U.S.C. § 18091(2)(F) (estimating uncompensated care causes an average premium increase of $1,000 per family).

The recent public health crisis only underscores the importance of the Medicaid expansion. In response to the coronavirus pandemic, Congress expanded Medicaid to cover testing for the virus causing COVID-19, an essential intervention to increase access to testing. *See* Families First Coronavirus Response Act, Pub. L. 116-127 § 6004(a), 134 Stat. 178, 204-205 (Mar. 18, 2020) *codified at* 42 U.S.C. § 1396d(a)(3)(B) *and id.* § 1396o(2)(a)(2)(F)-(G). Invalidating this coverage and other benefits for millions of low-income Americans in the midst of a global pandemic would be devastating.

2. Eliminating the ACA wholesale would also undermine the individual market that Congress re-

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[7] http://kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review.

[8] https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

formed to ensure that Americans who are ineligible for Medicaid and do not receive insurance through their employer can nevertheless obtain health insurance, *even if they have pre-existing medical conditions or would otherwise not be able to afford insurance*.

The ACA accomplished that goal through two related mechanisms. First, the guaranteed issue and community rating provisions precluded health insurers from rejecting applicants because of pre-existing medical conditions or from raising their premiums based on those health conditions. *See supra* at 3-4. Second, the ACA's subsidies helped low- and middle-income Americans who do not qualify for Medicaid or have access to employer-sponsored coverage enroll in health care coverage through government-sponsored marketplaces—*i.e.*, the individual "Exchanges"—through which such individuals may choose from available policies offered by private insurers. Most relevant here, Congress established advanced premium tax credits ("APTCs") to assist enrollees at or below 400% of the FPL[9] pay for health insurance premiums on the Exchanges. 26 U.S.C. § 36B(c)(1)(A); 42 U.S.C. § 18082(c)(2)(B)(i).

Using commercially available data, the OW Study predicts that eliminating the ACA's subsidies, guaranteed issue, and community rating provisions would cause the individual market to collapse. *See* OW Study at 5a. Specifically, the Study found that,

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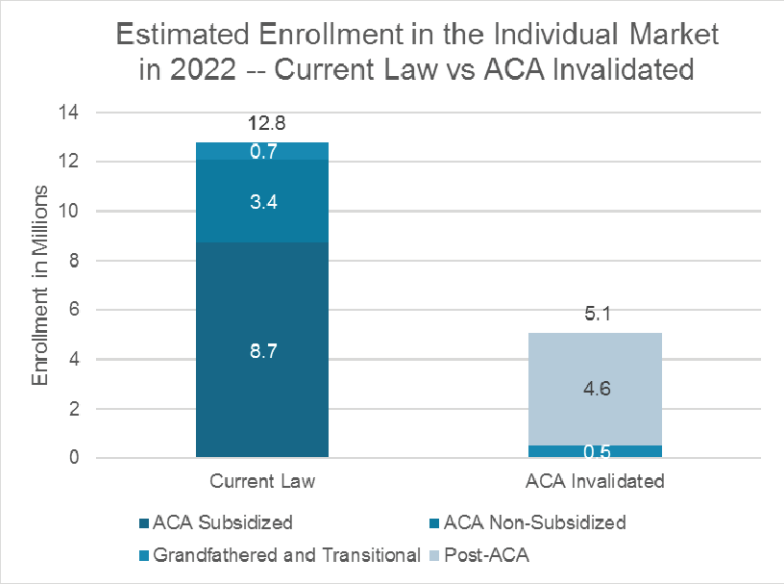
[9] The FPL is $12,760 for an individual or $26,200 for a family of four. *See* Annual Update of the HHS Poverty Guidelines, 85 Fed. Reg. 3060, 3060 (Jan. 17, 2020).

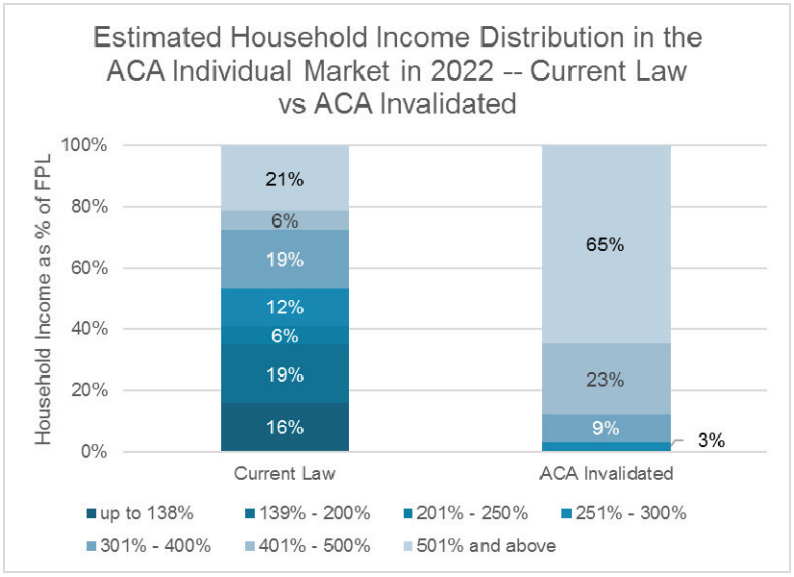
in the short-term, about three-fifths of the 12.8 million Americans currently enrolled in the individual market—that is 7.7 million people—would lose coverage without the ACA. *See* Study at 22a-23a.



Source: OW Study at 22a.

Eliminating the ACA would not only drastically decrease enrollment in the individual market, but would radically change its composition by excluding huge numbers of low- and middle-income Americans. Again, the ACA's subsidies have made health insurance affordable for Americans earning 400% or less of the FPL. *See supra* at 3, 12. The OW Study predicts that in 2022, under current law, the individual market will provide health insurance to 8.8 million Americans at or below 400% of the FPL, meaning that low- and middle-income Americans will represent roughly 72% of enrollees in ACA-compliant individual market plans. *See* Study at 11a. If the

Court accepts Respondents' invitation to eliminate the ACA in its entirety, however, only 556,000 low- and middle-income Americans will remain in the individual ACA market, comprising merely 12% of enrollees in ACA-compliant individual market plans. *Id.* at 23a. The OW Study confirms that eliminating the ACA would result in the individual market no longer serving the very Americans that Congress intended for the ACA to protect.



Source: OW Study at 24a.

Without the ACA, health insurance coverage in the individual market would also shift from less healthy and older Americans to healthier and younger enrollees who are less likely to need healthcare services. *Id.* at 25a-26a. The OW Study indicates that the proportion of enrollees under the age of twenty with coverage in the individual market

would double, from 16% to 32%.[10] *Id.* at 26a. The portion of enrollees over the age of fifty would plummet from 39% of the individual market to just 24%. *Ibid.* And the percentage of enrollees with fair or poor health would be cut in half. *Id.* at 20a-21a. In short, the OW Study confirms that adopting Respondents' arguments would profoundly alter the risk pool that health insurers must cover in the individual market. The market would become largely inaccessible to the population that Congress sought to help when it passed the ACA, including in particular those with pre-existing medical conditions and those of limited means. It would instead serve a healthier, younger, and more affluent risk pool.

These consequences would be dire in any circumstance, but they are especially ominous during this time of public health crisis and economic distress. A healthy individual market, especially with the ACA's subsidies, helps to ensure health care access in times of economic turmoil. OW Study at 9a-10a. One need look no further than the coronavirus pandemic the country currently faces. The U.S. Department of Labor reported nearly 12 million unemployment claims in its April 16, 2020 report, as compared to 1.78 million claims one month earlier. OW Study at 9a n.13. Because most Americans are covered under employer-sponsored health insurance, many of these households could lose health insurance coverage altogether, despite the fact that the country is facing the most dangerous public health crisis in over a century. Under the ACA, however, those losing em-

[10] The result may be different in states that have separate guaranteed issue requirements. Study at 17a-18a.

ployer-sponsored health insurance qualify for a special enrollment period that allows them to enroll in the ACA's individual market and maintain uninterrupted coverage. And those Americans whose incomes drop below 400% of FPL may qualify for subsidies to help make that coverage affordable, despite the lost income. OW Study at 10a. While it is too soon to report reliable data on the number of Americans who took advantage of this special enrollment period, Blue Plans have already observed an uptick in their enrollment on the Exchanges.

This access to private health insurance is valuable even absent an employer sponsor, as the COVID-19 crisis demonstrates. Like Medicaid, Blue Plans across the country are covering COVID-19 tests at no charge to patients and without any prior authorization requirements. *See* BCBSA, Blue Cross and Blue Shield Companies Announce Coverage of Coronavirus Testing for Members and Other Steps to Expand Access to Coronavirus Care (Mar. 6, 2020).[11] And Blue Plans have waived cost-sharing and prior authorization requirements through May 31, 2020 for treatments related to COVID-19. *See* BCBSA, Local Blue Cross and Blue Shield Companies Waive Cost-Sharing for COVID-19 Treatment (Apr. 2, 2020)[12]; *cf.* BCBSA, Media Statement: Blue Cross

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[11] bcbs.com/press-releases/blue-cross-and-blue-shield-companies-announce-coverage-of-coronavirus-testing.

[12] bcbs.com/press-release/local-blue-cross-and-blue-shield-companies-waive-cost-sharing-covid-19-treatment.

and Blue Shield Companies Announce Coverage of Telehealth Services for Members (Mar. 19, 2020).[13]

B. Invalidating the ACA Would Eliminate Numerous Provisions Designed to Ensure that Americans Can Access High-Quality Health Insurance

Apart from threatening to reverse the ACA's success in providing more Americans with access to healthcare, Respondents' severability analysis would also eliminate numerous ACA provisions that have improved the value of insurance coverage for millions of Americans. Especially in light of the Court's "prefer[ence]" to "sever [a statute's] problematic portions while leaving the remainder intact," *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006), it is utterly implausible to infer from Congress's decision in 2017 to render the mandate ineffective that this same Congress also intended these independent provisions to fall if the mandate was later deemed unconstitutional.

1. For instance, under Respondents' severability analysis, insurers could remove many of the benefit enhancements that the ACA required individual insurance plans to provide, including:

- *Essential Health Benefits*: The ACA requires small-group and individual plans to provide coverage in ten key categories including emergency services, pediatric services, and preven-

[13] bcbs.com/press-releases/media-statement-blue-cross-and-blue-shield-companies-announce-coverage-of-telehealth-services-for-members.

tative care, *see* 42 U.S.C. § 18022(b); *see also* 45 C.F.R. 156.100 *et seq*.

- *Minimum Coverage Value*: The ACA requires small-group and individual plans to cover at least 60% of the value of the health costs plan beneficiaries expect to incur. *See* 42 U.S.C. § 18022(d)-(e).
- *Cost Sharing Limits*: The ACA requires qualifying small-group and individual plans to limit enrollee cost-sharing. *See* 42 U.S.C. § 18022(c).

Congress enacted these provisions to enhance the quality of health insurance available in the individual market. All of these provisions would be invalidated if Respondents' argument is adopted by the Court.

2. Respondents' position would also require eliminating other ACA provisions that are intended to give more value to insureds participating in individual and group plans. For example:

- *Out-of-Pocket and Lifetime Spending Limits*: Limits on annual out-of-pocket spending ($7,900 for an individual, and $15,800 for family, in 2019), *see* 42 U.S.C. § 18022, and a prohibition on lifetime spending limits, *see* 42 U.S.C. § 300gg-11.
- *Clinical Trial Participants*: Plans cannot refuse to provide coverage for participation in a qualifying clinical trial. *See* 42 U.S.C. § 300gg-8.

- *Preventative Health Services*: Plans must cover certain preventative care procedures without co-payments or other cost-sharing. *See* 42 U.S.C. § 300gg-13.
- *Extension of Dependent Coverage*: Plans that offer dependent coverage must make this coverage available until a child is 26 years old. *See* 42 U.S.C. § 300gg-14.
- *Medical Loss Ratio*: To encourage efficiency, plans must submit to the government the percentage of premium revenue spent on medical claims, adjusted by quality expenditures. Plans are required to reimburse their members if they allocate too much money towards profits or other unqualified costs. *See* 42 U.S.C. § 300gg-18. The OW Study predicts that, without the ACA, insurers will spend up to 5% less of their premium revenues on medical claims. *See* Study at 19a.
- *Simple Benefit Summaries for Consumers*: Responding to concerns that consumers often did not understand the scope of the coverage they were purchasing, the ACA required health insurers to provide potential enrollees with a summary of benefits and coverage both at the time of application or re-enrollment, and when issuing the policy. *See* 42 U.S.C. § 300gg-15.
- *Rate Review*: The ACA required health insurers to justify to regulators rate increases above a certain percentage. *See* 42 U.S.C. § 300gg-94.

Even the 2010 Congress could not have thought these provisions were inseverable from the individual mandate, since all of them became effective *before* the individual mandate. *Compare* ACA § 1004 (providing for effective dates for reforms across 2010) *with id.* § 1501 (individual mandate phased in between 2014 and 2016). Certainly, the 2017 Congress—which rendered the mandate ineffective yet retained all of these provisions—did not believe these provisions were tied to the mandate.

Moreover, all of these ACA provisions were designed to address problems that *insured* Americans faced prior to the ACA; they had nothing to do with the adverse selection problem that was typically associated with the guaranteed issue and community rating provisions and that Congress feared might trigger a death spiral in the individual market.

For instance, Congress imposed the prohibition on annual coverage caps in response to stories from Americans like a forty-year-old father in Michigan with a heart condition for which his doctors prescribed drugs that cost $4,800 per month. Due to the cost of medication, this man exceeded his $10,000 annual cap on coverage within months and had to pay the remaining $47,600 out-of-pocket each year. *See* 155 Cong. Rec. S12745-02, S12756 (daily ed. Dec. 9, 2009). To take another example, Congress enacted the dependent coverage provision to protect young people like Sarah Posekany, who *lost* her insurance when she had to drop several college classes due to complications from Crohn's disease and therefore no longer qualified for her student health plan. Without coverage through her school or her parents, Ms.

Posekany could not afford medication and, as a result, ultimately had to undergo two additional surgeries. 155 Cong. Rec. S12524-03, S12529 (daily ed. Dec. 6, 2009).

Invalidating these and other similar provisions based on the decision by the 2017 Congress to eliminate the tax penalty for failure to purchase health insurance finds no support in the text of the statute or the legislative history.

3. The Respondents would have this Court also reverse Congress's effort to address a gap in the pre-ACA Medicare Part D program, which affords Medicare beneficiaries access to prescription drug coverage through private insurers. As originally enacted in 2003, Part D beneficiaries that exceeded an initial coverage limit were required to pay 100% of their drug costs until their out-of-pocket spending rendered them eligible for "catastrophic coverage." *See* Juliette Cubanski et al., Kaiser Family Found., Closing the Medicare Part D Coverage Gap: Trends, Recent Changes, and What's Ahead (Aug. 21, 2018).[14] By 2010, 3.8 million Part D enrollees paid an average of $1,858 per year due to this coverage gap. *Ibid.* By 2016, the number of beneficiaries who fell into the Part D "donut hole," as it is called, reached 5.2 million. *Ibid.*

When the 2010 Congress enacted the ACA, it planned to phase out the Part D coverage gap by 2020. *See* ACA § 3301(b) *codified at* 42 U.S.C.

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[14] https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/.

§ 1860D-14A. But the *same* Congress that passed the TCJA compressed the timeline to close the gap so that it would be eliminated in 2019. *See* Bipartisan Budget Act of 2018, Pub. L. No. 115-123 § 53116, 132 Stat. 64, 306-07 (2018). Invalidating the ACA would inexplicably impede this legislative effort and re-establish the coverage gap for millions of Medicare enrollees in Part D. Respondents offer no plausible explanation for why the 2017 Congress intended to repeal the ACA—the statute that had set in motion a process to close the Part D coverage gap—at the very same time it was amending the ACA to expedite the closure of that gap.

C. Repealing the ACA Through a Court Order Would Be Maximally Disruptive to Health Insurance Markets

Congressional efforts to modify the ACA—even substantially—would be materially less disruptive to health insurance markets and the delivery of healthcare in this country than a court order invalidating the ACA in its entirety. The Court needs only to review prior efforts to roll back or repeal the ACA to understand why. It ought to be dispositive of Respondents' severability argument that none of these efforts to repeal was ever enacted. That Congress rejected all of the bills proposing repeal shows that it did not intend to achieve the same result simply by lowering the tax penalty for failing to purchase health insurance to $0 while leaving the ACA's remaining provisions intact. But Congress's earlier efforts to roll back or repeal show that even those Members of Congress who *did* want to repeal the ACA did not intend to do so in the blunt and highly

disruptive manner of Respondents' proposed judicial remedy.

The Congressional plan to substantially alter the ACA that received the most support—but that was ultimately not adopted—provided for a graduated partial repeal of the law over the course of several years. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. (June 7, 2017) ("AHCA"). While the individual mandate would have been rendered unenforceable retroactive to 2016, *see id.* § 204, other modifications would have phased in for the 2018 benefit year, *see id.* § 134 (allowing greater premium variation based on age), *id.* § 202(c)(2) (restricting APTCs to Exchange plans), and still others for the 2019 benefit year, *see id.* § 133 (permitting insurers to penalize enrollees who fail to maintain continuous coverage); *id.* § 202(c)(4) (reducing APTCs beginning in 2019). The most impactful ACA provisions, however, would have remained in effect until the 2020 benefit year. *See, e.g.*, *id.* § 112 (Medicaid expansion); *id.* § 131 (cost sharing subsidies); *id.* § 112(b) (essential health benefits in Medicaid plans); *see also id.* § 214 (replacing premium tax credits). Moreover, the AHCA would have created a $100 billion fund to help stabilize the health insurance market through 2026, *see id.* § 132, and replaced the existing tax subsidies with new subsidies, *id.* § 214. The AHCA's implementation delays and other market stabilization measures would have afforded health insurers, healthcare providers and insureds the time needed to prepare for dramatically different market conditions—and time for Congress, federal agencies, and states to craft a replacement regulatory framework.

Judicial repeal, by contrast, would immediately inject chaos into health insurance markets and the delivery of healthcare in America. For instance, if this Court were to endorse Respondents' severability analysis and nullify the ACA instantly, health insurers may still have contractual obligations to continue covering their current enrollees for the remainder of the benefit year. For many plans, providing this coverage will no longer make economic sense because the Court will have eliminated the ACA's subsidies, which affect premium rates. *See infra* at 33-34; *see also King*, 135 S. Ct. at 2489 (recognizing the importance of the ACA's subsidies and their impact on premium pricing).

Even if the Court delayed its mandate until the next coverage year, health insurers would still not be able to plan properly. Before this case is fully briefed, many Blue Plans will have already submitted for review by relevant insurance regulators their proposed rates and benefit plans for the 2021 benefit year. *See* CMS, 2021 Draft Letter to Issuers in the Federally-Facilitated Exchanges, at 5 (Jan. 31, 2020) (setting application window from April 23, 2020 through June 17, 2020). To mitigate these types of concerns, the ACA created a phased implementation period. While some of the ACA's provisions became effective in 2010, *see supra* at 20, Congress afforded states, health insurers, and other stakeholders a four-year period to prepare for Medicaid expansion and the launch of the individual Exchanges—and even then, the Exchanges had a famously troubled roll-out. *See* U.S. Gov't Accountability Off., GAO-15-238, CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development

Best Practices, at 13-14 (Mar. 2015) (CMS rushed to meet statutory deadline causing widespread enrollment problems).[15] Immediate (or near-immediate) judicial invalidation—particularly in the midst of the current economic downturn—would throw insurance markets into massive turmoil. And there is absolutely no reason to believe that Congress could agree on a legislative solution that would avoid that turmoil. The adverse consequences for states, employers, insurers, and—most importantly—Americans insured under the ACA would be obvious.

* * *

In sum, if adopted, Respondents' severability analysis would deprive around 7.7 million Americans of health insurance in the individual market alone. And this group of newly uninsured Americans would disproportionately consist of those with pre-existing medical conditions, and low- and middle-income individuals who would find it difficult to purchase coverage without the ACA—the very people for whom a loss of insurance coverage would be especially disastrous. Indeed, these are the very people that Congress, both in 2010 and again in 2017, sought to protect by passing and then retaining the ACA. There is no evidence whatsoever that Congress even considered—let alone intended—these destabilizing consequences when it reduced to $0 the tax for failing to comply with the individual mandate.

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[15] https://www.gao.gov/assets/670/668834.pdf.

II. THE EXPERIENCE OF BLUE PLANS UNDER THE ACA SHOWS THAT, EVEN WITH GUARANTEED ISSUE AND COMMUNITY RATING, AN ENFORCEABLE MANDATE IS NOT ESSENTIAL TO THE CONTINUED FUNCTIONING OF THE INDIVIDUAL MARKET

When it enacted the ACA in 2010, Congress and the health insurance industry believed that an enforceable individual mandate was essential to preventing the adverse selection problem that caused massive market failures in some states that had previously adopted guaranteed issue and community rating requirements. *See* BCBSA Br. at 23-35; *see supra* at 2, 4-5. In the intervening years, however, actual experience has demonstrated that the individual market functions effectively (albeit less optimally) even when the mandate has no practical effect, so long as the government maintains the tax credits and other subsidies that the ACA established to increase low-income Americans' access to coverage. In other words, while the individual market would function better with an enforceable mandate, actual experience and the OW Study show that Congress could rationally decide in 2017 to reduce to $0 the tax for failing to purchase health insurance while still maintaining the guaranteed issue and community rating provisions at the heart of the ACA.

A. The Evidentiary Record Before BCBSA and Congress When the ACA Was Enacted

In 2010, BCBSA predicted that, if guaranteed issue and community rating provisions were in effect, an individual mandate was necessary for the ACA's individual market to function properly. *See generally* BCBSA Br. BCBSA and Congress were aware of numerous state healthcare reform efforts that had failed. *See* BCBSA Br. at 26-35; *King*, 135 S. Ct. at 2485-87 (discussing ACA's roots in a "long history of failed health insurance reform"). Maine, Washington, Kentucky, New Hampshire, New York, and Vermont, in particular, regulated their individual health insurance markets with guaranteed issue and community rating requirements, but they did not adopt an individual mandate. *See* BCBSA Br. at 26-35. As explained above, these state reforms resulted in sky-high premiums, correspondingly low enrollment rates, and ultimately an exodus of insurers from the individual market—the very type of death spiral that Congress sought to avoid. *See id.*

BCBSA and Congress also studied the legislative program enacted by Massachusetts, the only state to adopt guaranteed issue and community rating provisions that did not suffer from significant adverse selection. *See* BCBSA Br. at 32-35; *King*, 135 S. Ct. at 2486. Unlike the other states, Massachusetts penalized residents who failed to purchase health insurance, thereby deterring healthy residents from exiting the market and offsetting the cost to insurers of covering less healthy enrollees. Massachusetts, unlike the other states, also offered subsidies to help

low-income residents participate in the individual market. *King*, 135 S. Ct. at 2486.[16]

When Congress first enacted the ACA, it believed that the first of Massachusetts' two innovations—the penalty for failure to maintain coverage—was the secret to Massachusetts' success. *See* 42 U.S.C. § 18091(2)(D); *see also, e.g.*, *Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Comm. on Fin.*, 110th Cong., 2d Sess. (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (testifying that guaranteed issue and community rating "will only be successful if there is an insurance mandate to balance the risk in the insured population").

For the reasons explained below, however, these predictions were wrong. The Blue Plans' actual experience and the OW Study show that government subsidies are an effective means to create incentives

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[16] Congress also considered evidence indicating that it could mitigate adverse selection by establishing annual open-enrollment periods. *See Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong., 1st Sess. (2009) (statement of Am. Academy of Actuaries) (limiting open-enrollment periods is one way to increase enrollment and combat adverse selection); Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (Nov. 30, 2009) (limiting open-enrollment periods discourages healthy individuals from waiting to enroll until illness strikes); *see also* Proposed Rule, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 77 Fed. Reg. 70,584, 70,597 (Nov. 26, 2012) (consistent open enrollment periods for insurance marketplace intended to minimize adverse selection).

that ensure a functioning individual health insurance market that includes guaranteed issue and community rating requirements, even when there is no effective mandate.

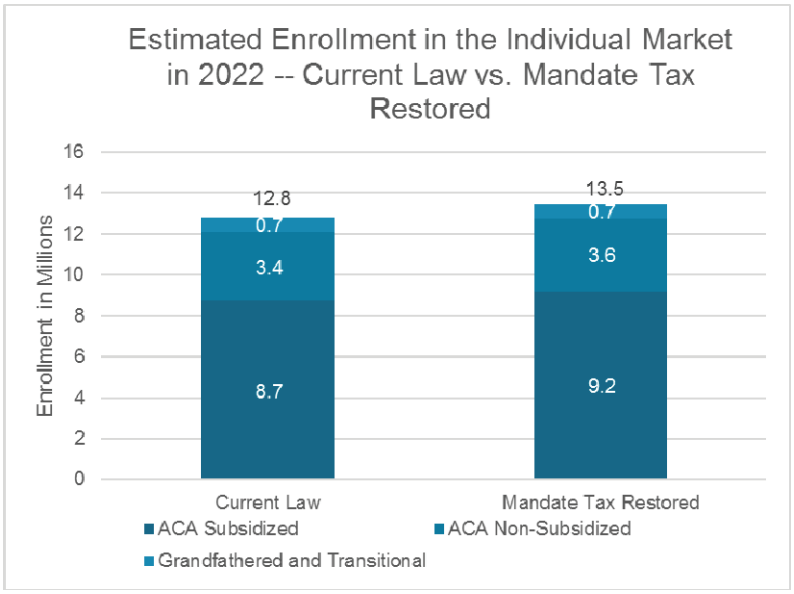
B. Without an Enforceable Mandate, Individual Markets Subject to Community Rating and Guaranteed Issue Requirements Can and Do Function If Married with Subsidies that Incent Participation by Healthy Enrollees

The experience of Blue Plans over the past seven years shows that the individual market works best using the model that Massachusetts pioneered and that the ACA copied—which includes *both* an individual mandate and subsidies for low-income individuals. But the evidence shows that such a mandate is not essential. The ACA's subsidies create powerful incentives that allow the individual market to function effectively, even when that market is subject to guaranteed issue and community rating requirements. These subsidies allow the individual market to provide critical benefits to 12 million Americans and create a risk pool that will not suffer from a so-called "death spiral."

As an initial matter, the past two years without the individual mandate has not produced the death spiral that the 2010 Congress and Blue Plans initially feared. On the contrary, government data suggests that 12.2 million enrollees were covered through the ACA individual market in 2019, including 8.9 million enrollees at or below 400% of the FPL. OW Study at 7a. And though final data for

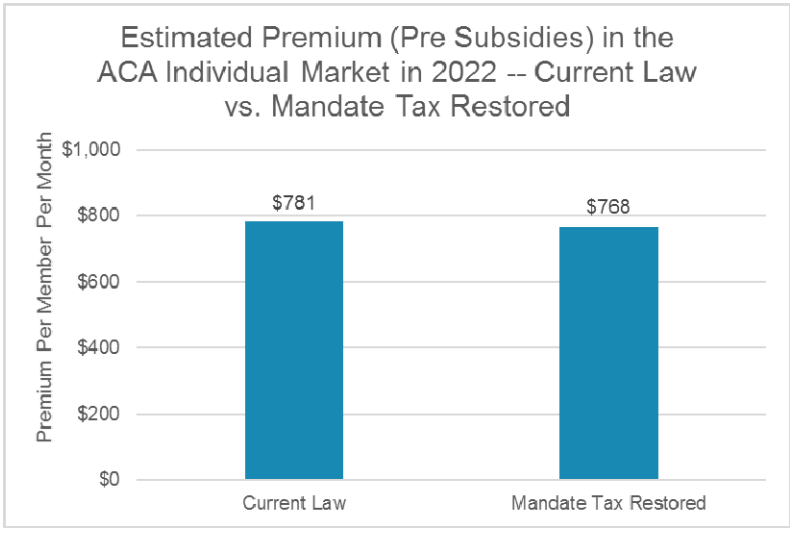
2020 is not yet available, initial enrollment data for this year is roughly similar to last year. *Id.*

These initial 2020 enrollment numbers are largely consistent with the predictions contained in a previous iteration of the OW Study. *See* OW Study at 8a. And the updated OW Study predicts that this trend of a stable individual market will continue, even if Congress does not restore the tax for failing to purchase health insurance. Specifically, it predicts that in 2022, an individual market with guaranteed issue and community rating provisions but no mandate will insure 12.8 million enrollees at an average premium of $781 per month, including 8.8 million Americans at or below 400% of the FPL. *See* Study at 11a. To be sure, this result is suboptimal to the outcome that OW's analysis shows the individual market could achieve with *both* subsidies and a tax for remaining uninsured. As the chart below demonstrates, the OW Study indicates that an individual market with both of these provisions would provide health insurance to 700,000 *more* Americans (including roughly 500,000 additional Americans at or below 400% of the FPL) than a market with subsidies but no enforceable mandate. *See* Study at 14a.



Source: OW Study at 14a.

This coverage would also cost on average $13 *less* per month in premiums. *Id.* at 26a.



Source: OW Study at 26a.

But while a market with both of these provisions would operate marginally *better*, the current market—*i.e.*, a market that includes a mandate without any practical effect—is still fully functional, and has come nowhere close to exhibiting the adverse-selection that Congress feared when it enacted the ACA.

These results make sense. The key to averting a death spiral is to ensure that a sufficient number of healthy Americans remain in the risk pool. While an effective mandate incents some healthy Americans to purchase individual insurance coverage, subsidies for low- and middle-income Americans are also a powerful mechanism to ensure that healthy people participate in the individual market. Indeed, the OW Study shows that with or without a mandate, around three-quarters of enrollees in the individual market are those who qualify for subsidies. *See* OW Study at 23a-24a. Thus, by offering low- and mid-income healthy Americans high-quality coverage at an affordable price, the ACA's subsidies effectively incent those individuals to remain in the market, preventing the death spiral that Congress sought to avoid when it enacted the ACA.

The continued functioning of the individual insurance market also makes sense for two additional reasons. First, even before it was eliminated, the individual mandate was tied to the Consumer Price Index, which has not kept up with increasing healthcare prices. The OW Study estimates that the minimum payment under the individual mandate would have only increased from $695 in 2018 to $745 in 2020, but the Study estimates that average annu-

al premiums for the least generous Exchange plans will increase from $3,396 per person in 2018 to $4,963 per person in 2020. OW Study at 13a. As a consequence, the individual mandate had become less and less effective over time at incentivizing the purchase of insurance.

Second, some states, including California, Massachusetts, New Jersey, Rhode Island, and Vermont, have themselves imposed an individual mandate on their residents to account for the federal government removing its mandate. *See, e.g.*, Cal. Gov. Code § 100705(d). While the details sometimes vary, many of these States' individual mandates mirror the former federal requirement. *See, e.g.*, Cal. Rev. & Tax. Code § 61015(b)-(c) (mandate payment of the greater of $695 or 2.5% of annual income). The actions of these States further reduce the impact of effectively eliminating a federal individual mandate. OW Study at 13a-14a.

Without the subsidies, however, an individual market with guaranteed issue and community rating requirements but no effective mandate would collapse. *See King*, 135 S. Ct. at 2493-94 ("The combination of no tax credits and an ineffective coverage requirement could well push a State's individual insurance market into a death spiral."). For instance, assume that health insurers keep plan premiums the same as they would be without any changes to the law: $781 per month or more than $9,372 per year on average. *See* Study at 11a. Without ACA subsidies, many low-income Americans simply cannot afford these premiums, and all but the wealthiest and most unhealthy Americans would exit the

market, causing rates to increase even further. *See id.* at 16a-17a. Ultimately, in this scenario, the individual market would never reach a stable equilibrium at which insurers could offer coverage and still pay claims, and the only surviving plans would be those that pre-date the ACA and were exempt from its reforms. *See id.*; *see also id.* at 22a.

* * *

In light of this real-world experience, it defies common sense to conclude that the individual mandate is non-severable from the guaranteed issue and community rating provisions merely because the 2010 Congress believed they were inextricably linked. The legislative intent at issue here in the intent of the *2017* Congress that enacted the TCJA and reduced the tax for failing to purchase health insurance to $0.

Over the last seven years, the experience of Blue Plans—which is supported by empirical analysis—has shown that individual markets with guaranteed issue and community rating requirements can function effectively without an enforceable mandate, provided the government offers subsidies to incent healthy individuals to continue purchasing coverage. Crucially, the 2017 Congress understood that fact as well—the Congressional Budget Office reported that an enforceable mandate was not essential to maintaining the stability of the individual market. *See* Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017).

Thus, a reasonable Congress could have believed that rendering the individual mandate ineffective

would *not* require jettisoning guaranteed issue and community rating so long as the ACA's subsidies were maintained. And this is exactly why the *actual* 2017 Congress *did* render the individual mandate ineffective while at the same time leaving these other crucial ACA provisions intact. Respondents' contention that the entire ACA rises or falls with what is left of the individual mandate simply ignores actual experience, and contradicts Congress's own actions in 2017.

That analysis is fundamentally flawed because "the touchstone of the severability analysis is legislative intent." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 545 (2010) (quotations omitted). No reasonable examination of the ACA's text, legislative history, or the actual experience of the last decade supports Respondents' argument that the 2017 Congress considered the individual mandate essential to the operation of the guaranteed issue and community provisions, much less the myriad and disparate other provisions that Congress adopted in the ACA to reform healthcare in this country. For that simple reason, this Court should reject Respondents' severability analysis and conclude that the individual mandate is severable from the remainder of the ACA, including its guaranteed issue and community rating provisions.

CONCLUSION

The decision of the Fifth Circuit should be reversed.

Respectfully submitted,

ANTON METLITSKY
SHANE A. HUNT
O'MELVENY & MYERS LLP
7 Times Square
New York, N.Y. 10036
(212) 326-2000

K. LEE BLALACK, II
(*Counsel of Record*)
lblalack@omm.com
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

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APPENDIX

POTENTIAL IMPACT OF INVALIDATING THE AFFORDABLE CARE ACT ON THE INDIVIDUAL MARKET – 2022 UPDATE

May 13, 2020

Kurt Giesa, FSA, MAAA
Peter Kaczmarek, FSA, MAAA

Contents

1. EXECUTIVE SUMMARY

We prepared this report for the Blue Cross and Blue Shield Association ("BCBSA") in support of its amicus curiae brief in California v. Texas[1] (the "Litigation"). Our report contains this Executive Summary, an Analysis using our Healthcare Reform Micro-Simulation Model ("HRMM") to illustrate the real-world impact of several possible outcomes of the Litigation on the individual market for health insurance, and an Appendix describing our methods.

In short, we find that the individual health insurance market would function marginally better if the Affordable Care Act's (the "ACA") individual mandate to purchase insurance is enforced through an individual mandate payment, as it was before the reforms enacted in 2017. Even without such a payment, however, an individual market that operates pursuant to the ACA's other key provisions will provide affordable health insurance to millions more enrollees than a market without these provisions. More specifically, we find the following:

- Even without an enforceable individual mandate, we expect that the premium and cost sharing assistance available to lower-income insureds will make it so that the individual market under the current ACA rules (i.e., the ACA without an individual mandate payment) could continue to provide coverage to around 12.1 million enrollees in 2022. Coverage would

[1] Case No. 19-840 (U.S.)

include 8.7 million enrollees with incomes below 400% of the federal poverty level ("FPL") qualifying them for the ACA's subsidies.

- Reinstatement of the individual mandate payments to the levels in effect for 2018 with indexing could increase ACA enrollment in 2022 by 0.7 million and decrease the market-wide average premium by 2%. The impact of reinstatement of the individual mandate payment is estimated to diminish over time as the penalty is indexed to the cost of living rather than the medical cost trend, which tends to increase at a faster rate.
- The ACA's two principal subsidies — advance premium tax credits ("APTCs") and cost-sharing reduction payments ("CSRs")[2] — are critical to the continued operation of the individual market. If the APTCs and CSRs that are currently available in the individual market were eliminated, but all other ACA requirements remained in place, issuers would not be able to set premium rates in the individual market without taking significant financial losses. This would trigger an exit of issuers from the ACA individual market, leaving only those individuals with pre-ACA, transitional and grandfathered plans with comprehensive major medical coverage through the individual market.

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[2] See sections 1401, 1402, and 14011-1415 of the Part I of Title I of the ACA: https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

- If all ACA requirements related to the individual market were invalidated, the operation of the individual market would be substantially disrupted. Only 0.7 million enrollees covered under transitional and grandfathered plans would maintain their comprehensive medical coverage in the individual market. Assuming (i) the return of pre-ACA state regulation regarding guaranteed issue[3] and premium rate restrictions[4] became effective and (ii) APTC and CSR subsidies were no longer available, we estimate that enrollment in the individual market would be just over one third of today's enrollment. This assumes that issuers have enough time to develop new health insurance products, to have those products approved by the relevant regulators, and to develop the operational capabilities (e.g., medical underwriting) to market and distribute those products.
- Compared to the demographic composition of the current individual market, without the ACA the demographic composition of enrollees in the individual market would be younger, healthier and mostly from households with incomes above 400% FPL. We estimate that most

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[3] https://www.kff.org/other/state-indicator/individual-market-guaranteed-issue-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://www.kff.org/other/state-indicator/individual-market-rate-restrictions-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

of those currently insured under the ACA who qualify for APTCs and CSRs would become uninsured if subsidies were no longer available, as would most individuals with pre-existing health conditions.

2. ANALYSIS: SCENARIOS MODELED AND RESULTS

In this section, we discuss the market impact of several potential changes to the ACA. We limit our analysis to the individual market; we do not consider the impact of these scenarios on other sources of coverage, including the employer-sponsored health insurance market or coverage under Medicaid or Medicare. We also focus on the 2022 benefit year. We believe that any immediate invalidation of the ACA during calendar year 2021 would raise complicated questions regarding the policies then in effect, and would ultimately cause a significant number of insured in the ACA individual market to lose coverage and would increase the number of uninsured before any alternative coverage options would be available.

As background, we estimate that roughly 12.2 million individuals were covered through the ACA individual market in 2019, both on and off the Exchanges.[5] Through the first half of 2019, about 8.9 million total insureds received APTCs to help cover the cost of their premiums, and about 5.3 million insureds also received CSRs to help cover the cost of deductibles and copays.[6] CMS reports that approximately 11.4 million individuals selected or were auto enrolled in an Exchange plan at the end of the 2019

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[5] Oliver Wyman calculations using the Interim Summary Report on Risk Adjustment for the 2019 Benefit Year. See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2019.pdf

[6] https://www.cms.gov/files/document/effectuated-enrollment-first-half-2019

open enrollment period.[7] This excludes individuals enrolling in ACA-compliant coverage off the Exchanges and also not does reflect the effectuated average enrollment during the calendar year. CMS reports this same number of individuals, 11.4 million, selected or auto enrolled in an Exchange plan at the end of 2020 open enrollment period.[8] Enrollment in the Exchange plans remains stable in 2020 without federal individual mandate payment.

In a prior iteration of this report, we estimated that 8.4 million insureds would receive APTCs in 2020, and that the ACA individual market enrollment would be 11.1 million.[9] Our projected APTC enrollment appears in line with actual results. However, we do not have a reliable data source to confirm the off-Exchange enrollment in 2020.

We used our HRMM to estimate the baseline market conditions in 2022 and then modeled the impact of the three separate scenarios described below. The HRMM has been updated to reflect the most recent data and regulations impacting the ACA individual market, including actual 2020 ACA individual premium rates, which decreased by three percentage

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[7] https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report

[8] https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf

[9] https://www.oliverwyman.com/our-expertise/insights/2019/apr/potential-impact-on-the-individual-market-of-invalidating-the-af.html

points compared to 2019,[10] approval of Section 1332 Waivers in additional states[11] and the introduction of an individual payment in California beginning in 2020.[12]

With the updated HRMM model, we estimate that the average number of insureds receiving APTCs in 2022 will increase slightly to 8.7 million. We estimate the total ACA individual market enrollment will be 12.1 million.

As a result of the significant job loss reported due to the COVID-19 pandemic[13] many households will face the loss of employer-sponsored health insurance coverage. Because our focus is on the long-term viability of the market, the impact of the COVID-19 pandemic is not incorporated into the baseline market conditions in 2022. It is worth noting, however, that households that lose employer-sponsored coverage

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[10] CMS 2020 Open Enrollment Report: Among consumers in the 38 states that use the HealthCare.gov platform the average premium before application of APTC decreased by three percent points.

[11] Approval of Section 1332 Waiver in CO and ND as of July 2019, DE, MT and RI as of August 2019: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

[12] Starting in 2020 California introduced a financial payment for not having health coverage https://www.coveredca.com/individuals-and-families/getting-covered/-and-exemptions/

[13] Department of Labor Unemployment Insurance Weekly Claims Report as of April 16, 2020 reported 11.98 million of insured unemployed compared to 1.78 million as of March 14, 2020: https://www.dol.gov/ui/data.pdf

and cannot qualify for Medicaid coverage or for COBRA coverage through their former employer can use the special enrollment period ("SEP") rules to gain access to comprehensive health insurance coverage in the ACA individual market. This is particularly important for those with relatively low incomes who would be unable to afford COBRA coverage, and those with pre-existing conditions or greater health care needs who would not be able to access health insurance coverage through short-term, limited duration plans. The APTCs and CSRs available in the ACA market can provide an affordable coverage option for households under financial stress. In addition to the standard SEPs, twelve states operating their own state-based Exchanges have recognized the need for access to coverage and have eased the enrollment process into ACA individual coverage during the COVID-19 pandemic. [14]

Baseline Scenario

Our baseline scenario assumes that all current ACA statutory provisions and regulations remain in effect, without any changes resulting from the Litigation. Premium rates in 2022 are based on the 2020 rates adjusted for increases in the cost and utilization of covered services[15] and assume a 2.2% decrease due

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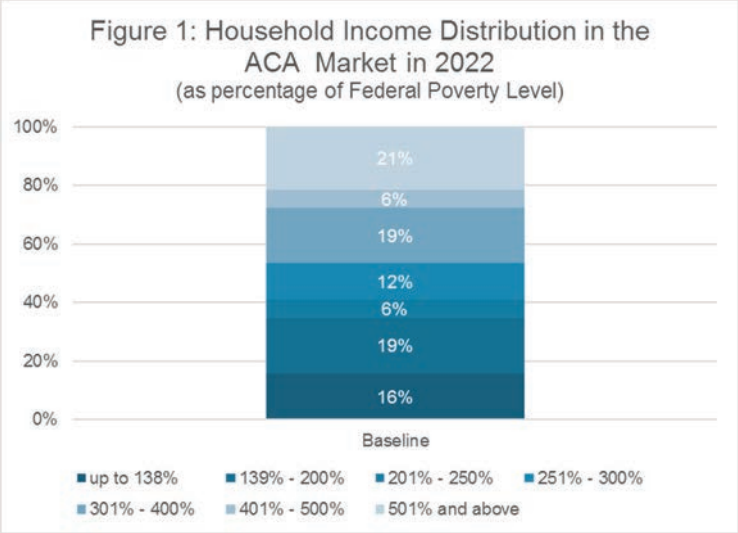
[14] For example, California allows anyone uninsured and eligible to enroll in health care coverage through Covered California through the end of June 2020: https://www.coveredca.com/newsroom/news-releases/2020/03/20/california-responds-to-covid-19-emergency-by-providing-path-to-coverage-for-millions-of-californians/

[15] We used 7% for this analysis. The recent median medical claim cost trends in the group market are between 6.9% and

to the repeal of the Section 9010 fee paid by health insurers for calendar years beginning after December 31, 2020.

Under the baseline scenario, we estimate that 12.8 million individuals will have coverage in the individual markets in 2022 at an average rate of $781 per member per month ("PMPM"), with roughly 0.7 million of those covered under non-ACA-compliant, grandfathered or transitional plans. Of the remaining 12.1 million covered under ACA-compliant plans, 8.8 million enrollees will have incomes less than 400% FPL and so will be eligible for APTCs. In Figure 1, we show the distribution of enrollment by income as a percentage of FPL.



8.5%, see Oliver Wyman's Carrier Trend Survey: https://www.oliverwyman.com/our-expertise/insights/2019/sep/Carrier_Trend_Report_July_2019.html.

Additionally, the market covers those at a variety of health statuses. Twenty-nine percent of those covered rate themselves with excellent health, while 32% rate themselves with very good health. Twenty-eight percent rate themselves with good health, 8% with fair health, and 2% with poor health.

Finally, the market is skewed to an older demographic. Thirty-nine percent of the market is age 50 or older; thirty-one percent is age 30 or younger.

We anticipate that without the individual mandate payments, the individual market will continue to cover a substantial number of low- and middle-income and unhealthy enrollees at rates that are affordable when subsidies are considered. Additionally, the ACA's age rating restrictions ensure that Americans retain access to health care as they age.

Scenario One: Reinstatement of the Federal Individual Mandate Payments

In Scenario One, we model the market assuming the individual mandate payment is restored effective January 1, 2022.[16] We assume the required payment will revert to the level that was in effect in 2018, indexed for inflation, and that all other ACA requirements remain unchanged from the baseline. We in-

[16] The Tax Cuts and Jobs Act set the individual mandate payment amounts to zero percent or $0 for months after December 31, 2018: https://www.congress.gov/115/plaws/publ97/PLAW-115publ97.pdf

clude this scenario to explore the impact on the individual market of Congress's decision to render the mandate unenforceable.

The individual mandate payment in 2018 was the larger of 2.5% of income or $695 per adult or $2,085 per family up to a maximum of the National Average Bronze Plan Premium ($3,396 per person).[17] For 2022, we estimated the per adult amount would increase to $745 or $2,235 per family based on the CPI-U index published in the National Health Expenditure Data projection[18] and rounding the amount of the increase to the next lowest multiple of $50. We assumed 2.5% of income would remain unchanged and we estimated the national average bronze plan premium at $4,963 per person for 2022. Under these assumptions, the value of the payment increases only modestly from 2020 to 2022. As a result, the federal individual mandate payment has a diminishing impact on enrollment and premium rates in 2022 compared to 2020. Additionally, the introduction of penalties at the state level, most notably in California starting in 2020, diminishes the impact of the reinstatement of the federal mandate in this scenario. Because state-level mandates provide at least some of the same incentive to maintain health insurance for residents of those states as a federal mandate, it decreases the relative

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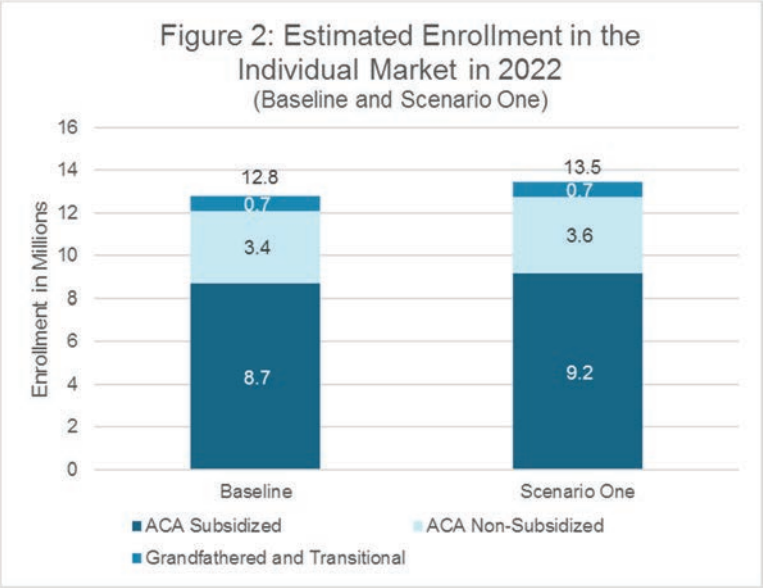
[17] IRS Instruction for Form 8965 for 2018 https://www.irs.gov/pub/irs-pdf/i8965.pdf

[18] National Health Expenditure Data report https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

impact of restoring a federal mandate. We have assumed states with state-based penalties would repeal those penalties if the federal individual mandate payment were reinstated.

If the individual mandate payments were reinstated for 2022, we estimate that an additional 0.7 million people would be covered, and market wide average premiums would decline by 2% relative to the baseline, to $768 PMPM, as the morbidity and demographics of the risk pool improve.



Reinstatement of the payment could improve the market, but again, the baseline scenario shows that the reinstatement of the individual mandate payment is not necessary to ensure that the ACA individual market remains viable.

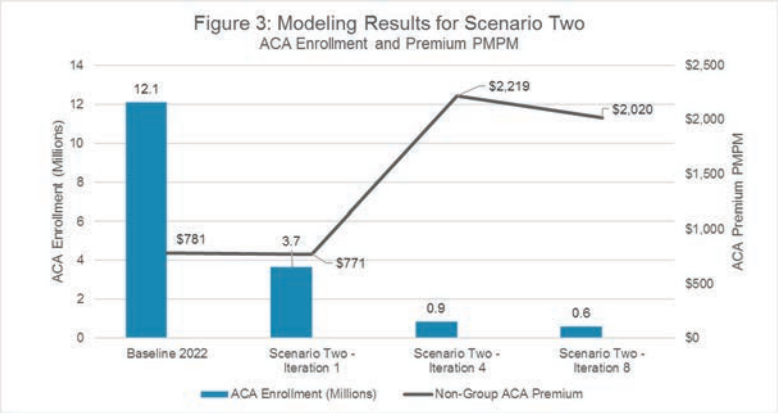
Scenario Two: Ending the Premium Tax Credits and Cost-Sharing Reductions

This scenario considers the impact on the ACA individual market if, beginning in 2022, APTCs and CSRs are no longer available to eligible enrollees. All new or returning enrollees would therefore have to pay the full cost of the premiums charged for ACA coverage without the benefit of subsidized premiums and reduced cost-sharing for qualifying low- and middle-income individuals. Under this scenario, all other variables remain the same as in the baseline, including the ACA's guaranteed issue and community rating requirements, and the absence of a federal individual mandate payment. Nevertheless, this scenario helps to examine the significance of the subsidies to the stable market outcome in the baseline.

Under this scenario, the model projects that the individual market would cease to function. We sought to model the premiums that would be necessary for issuers to cover the cost of members' benefits and the issuers' expenses under these market conditions. Our model, however, fails to reach equilibrium.

Essentially, the model sets an initial premium that individuals must pay to cover the expected cost of their benefits. Absent APTCs, individuals must pay the full cost of coverage, and so only those individuals with relatively high claims take advantage of the guaranteed issue requirement to gain access to coverage. The model reacts and adjusts premiums upward in the second iteration, searching for an equilibrium. The higher premiums cause the healthiest individuals in the risk pool to forgo coverage, so the model sets a higher premium in the third iteration to cover the

less healthy members who remain covered. This process continues and the model fails to converge on a reasonable premium. In simple terms, the modeling shows that issuers would be unable to participate in the market without suffering severe losses. We provide modeling results in Figure 3.



In iteration 1 in Figure 3, the massive loss in enrollment is due to the elimination of the APTCs and the resulting exit from the market of many of those with incomes less than 400% FPL. While premiums decline by about $10 PMPM in the first iteration, individuals qualifying for premium subsidies are losing subsidies worth more than $700 PMPM, so most of those eligible for APTCs leave the market. By the fourth iteration of our model, premiums increase by almost $1,450 PMPM, and the market again declines, until at iteration 8, only the oldest and sickest individuals remain. At this point, issuers would exit the market.

This result is not surprising to anyone familiar with health insurance markets. Under the baseline

scenario, we estimate that the average non-subsidized premium for silver metal level coverage in 2022 would be $719 PMPM, or roughly $8,600 per year. Obviously, it would be difficult for a large segment of the population to pay this amount on an annual basis without APTCs, and those most likely to enter the market at this premium level would be motivated to do so by an expectation that their claims would be significantly higher than the premium.

The result is that those who currently rely on APTCs for health insurance would likely be unable to find alternative coverage. Alternative options would be limited because the existing ACA rules would limit issuers' ability to offer comparable coverage at affordable premium rates. Ultimately, we project that more than 11 million individuals would become uninsured or under-insured.

Scenario Three: Elimination of All ACA Rules from the Individual Market

This scenario models the impact on the ACA individual market should the entire ACA be invalidated starting in 2022. Under this scenario, we assume that all federal regulations revert to their pre-ACA status. We also assume that issuers would have to apply the state individual market regulations regarding guaranteed issue and rating restrictions that were in effect prior to the full implementation of the ACA in 2010, as summarized by Kaiser Family Foundation.[19]

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[19] https://www.kff.org/other/state-indicator/individual-market-guaranteed-issue-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D and

To accomplish this, we modeled two distinct groupings of states:

1) States where guaranteed issue applies to all individuals, where there is a prohibition on rating for health status and gender, and age rating is restricted to 3:1 age bands, or is fully prohibited.[20]

2) States without the restrictions discussed above. In these states, we assume there is no guaranteed issue requirement, that issuers increase premiums up to two and half times the standard rate due to the health status of the enrollee and decline those who cannot pass underwriting, and that age rating is allowed up to 5:1.

This grouping does not reflect all the regulatory nuances in the individual market that were present prior to the enactment of the ACA in 2010, nor does it assume any potential future regulatory changes. For the purposes of our modeling, however, we believe that this grouping adequately reflects the conditions that would exist if the entire ACA were invalidated in 2022.

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https://www.kff.org/other/state-indicator/individual-market-rate-restrictions-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[20] These states include Maine, Massachusetts, New York, New Jersey, and Vermont.

Additionally, we assume that the average benefit level or actuarial value of the plans offered for purchase under this scenario would be 60% in all states, meaning that on average 40% of allowable claims would be covered by the enrollees as out-of-pocket expenses.[21] We make no adjustment in our modeling to reflect that issuers would not need to offer all essential health benefits currently required under the ACA[22] or other benefit requirements,[23] but again believe that this reasonably represents the conditions that would exist under the elimination of all ACA rules from the individual market for the purposes of our modeling.

Finally, we assume that issuers would price plans to a 75% average loss ratio (claims divided by premiums) in the states without guaranteed issue requirements, and to a 90% loss ratio in the five states with a guaranteed issue requirement. The 75% loss ratio reflects the fact that issuers in the states without guaranteed issue would no longer need to meet the ACA's 80% medical loss ratio standard and would likely sell their products primarily through agent and broker channels and so would incur higher marketing costs. The higher 90% loss ratio in the guaranteed is-

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[21] Oliver Wyman estimate based on the average deductible, coinsurance and out of pocket maximum limits for single PPO coverage in the individual market in 2009 based on AHIP report: https://kaiserhealthnews.files.wordpress.com/2013/02/2009individualmarketsurveyfinalreport.pdf

[22] Sections 1301-1302 of the ACA

[23] Section 1001 of the ACA Amendments to the Public Health Service Act

sue states assumes that issuers would be able to subsidize the plans sold in the individual market through gains in other lines of business, or would be required to reduce non-benefit expenses to 10% of premium in developing their premiums.

These results suggest a worse outcome when compared to the individual market that existed before the ACA was enacted in 2010.[24] Our model suggests that the 2022 individual market would be similar to the pre-ACA market with respect to the distribution by age and income, and that a large majority of those with pre-existing health conditions would lack access to coverage. The market would only cover about half the number enrollees that were covered in the individual market prior to the ACA. This, however, is likely because 2022 would be the first benefit year of the new market. We would expect the market to slowly grow over time, and to remain smaller than the market under the ACA.

We show the change in health status in Figure 4. Under the baseline, 10% of the 12.1 million insureds, or roughly 1.2 million individuals have self-reported health status of fair or poor, indicating a pre-existing medical condition. Under this scenario, where the size of the market declines to 4.6 million (see Figure 5), only 5% of enrollees would have a health status of fair, and essentially none would have a self-reported

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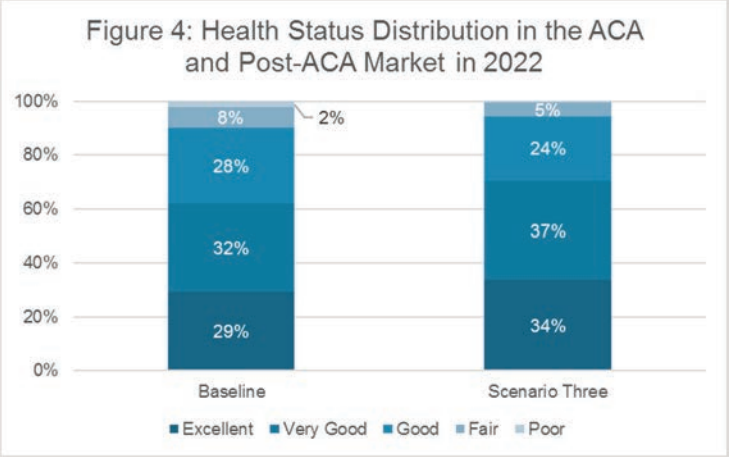
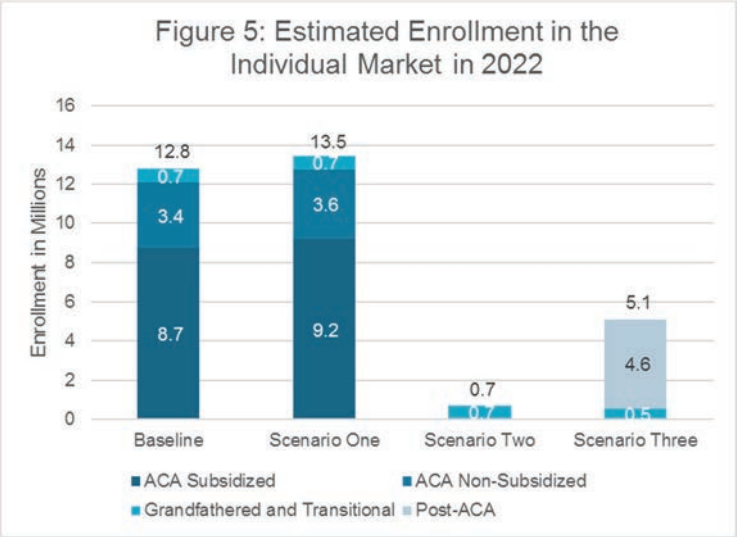
[24] See, for example, https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

health status of poor. This represents the loss of access to medical coverage of almost one million individuals in fair and poor health.



Comparing the Scenarios Across Key Metrics

In Figures 5 through 9 we compare each of the scenarios across key metrics including enrollment, demographic composition, and market average premiums.

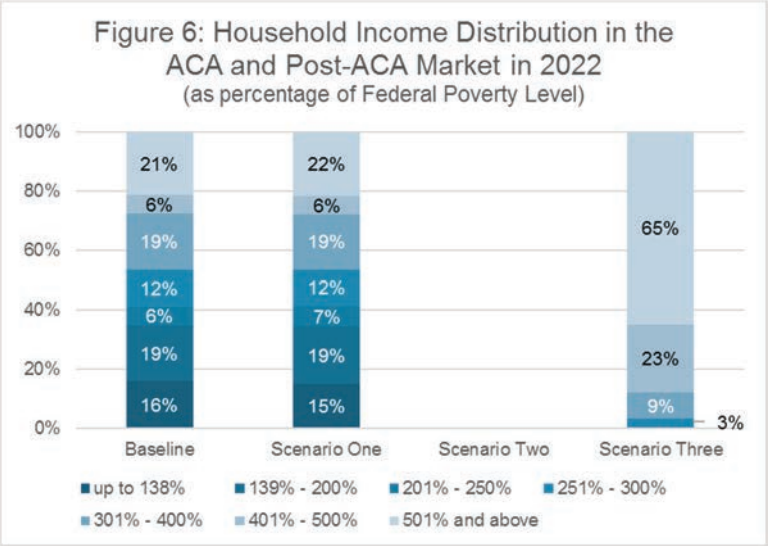


In Figure 5, we show that even without a federal individual mandate, the individual market provides health insurance for a substantial number of enrollees, including millions of low- and middle-income enrollees eligible for subsidies. Specifically, we expect 12.1 million individuals to have ACA coverage in 2022 under the baseline and that there will be another 0.7 million with grandfathered and transitional policies, for a total of 12.8 million individuals in the individual market in 2022.

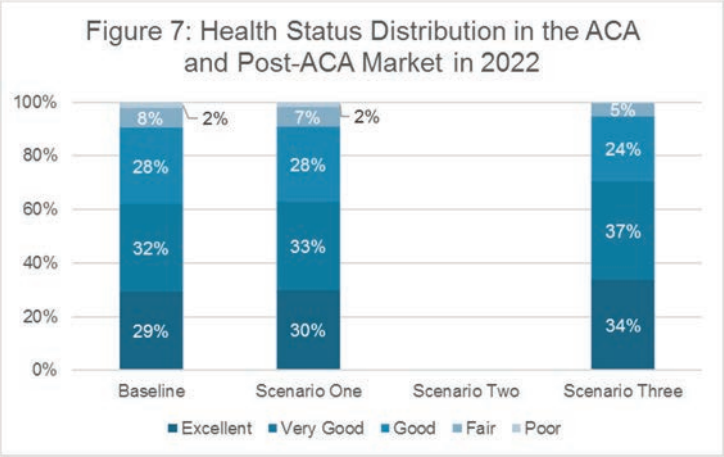
While functional under the baseline, the individual market would be marginally improved by restoring the individual mandate payment. Under scenario one, we project an increase in the ACA individual market enrollment of about 0.7 million enrollees, or roughly 5.5%. In contrast, taking away subsidies would destroy the individual market, and under scenario two, only the 0.7 million enrollees covered under transitional and grandfathered plans would maintain

their comprehensive medical coverage. Finally, without the ACA, we estimate the post-ACA market enrollment at 5.1 million, just below 40% of the baseline enrollment.

Figure 6 shows the make-up, by income, of the individual market under each of the scenarios. In the baseline scenario, there is substantial coverage for the lowest-income Americans. Individuals with incomes greater than 400% of FPL make up about one-quarter of the market. Restoring the individual mandate payment causes more higher-income Americans to participate in the market. This figure shows the effect of eliminating the ACA on individual health insurance for poor- and middle-income Americans. In scenario three, without the ACA, only 556,000 enrollees in the individual market, or 12%, have an income that is less than 400% of the FPL and three-quarters of those individuals have incomes at the upper end of that range, making between 301% and 400% of the FPL.

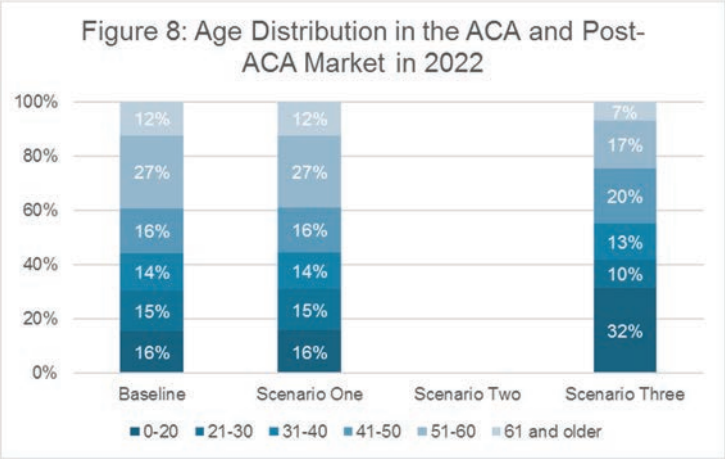


In Figure 7, we show the distribution of ACA individual market enrollees by health status. The model we use to produce these estimates classifies individuals into one of five health status buckets. Under scenario one, the health status profile of the ACA individual market is slightly healthier than under the baseline, suggesting that an individual mandate payment would incent more healthy people to participate in the individual market.

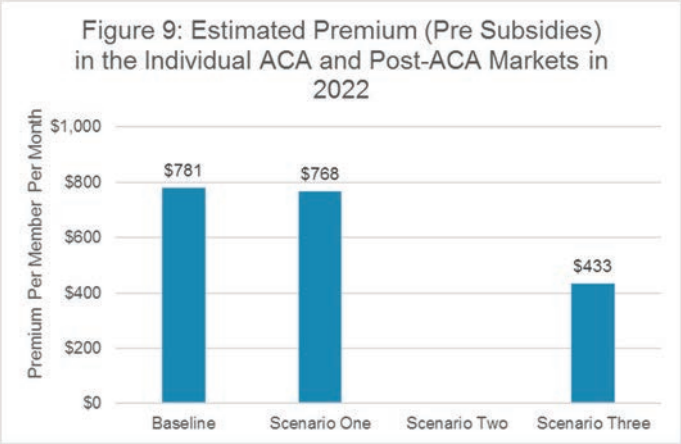


Abolishing the ACA would force many of the sickest enrollees to leave the market. Under scenario three, the post-ACA market has the highest share of enrollees in excellent and very good health status. And the percentage of enrollees with fair or poor health is cut in half. This results from the elimination of guaranteed issue and the resumption of issuers rating by health status.

In Figure 8, we see the importance of the ACA's reforms on coverage for older Americans. While the relative age of those covered does not change substantially between the baseline and scenario one, under scenario three, the proportion of those over age 50 in the individual market drops from nearly 40% to just 24%, and the proportion of those over 60 years old is cut nearly in half without the ACA.



In Figure 9, we show that reinstating the individual mandate payment in scenario one causes market-wide average premiums to decline by $13 PMPM, or about 2%. We estimate the average premium in scenario three at $433 PMPM. The lower premium under scenario three results from a combination of a healthier risk pool due to the exclusion of individuals with pre-existing medical conditions, a younger demographic, and lower actuarial value of the benefit plans.



3. REPORT QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

We prepared this report for the Blue Cross and Blue Shield Association for the purposes stated herein. This report is not to be used for any other purpose.

In this work, we have relied on publicly available data and information without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data and information we relied upon are both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

Our conclusions are based on data and information that we believe are appropriate for these purposes, and on the estimation of the outcome of many contingent events. Our estimates make no provision for extraordinary future events not sufficiently represented in historical data on which we have relied, or which are not yet quantifiable.

The sources of uncertainty affecting our estimates are numerous and include items such as changes in policies beyond those modeled here such as changes in outreach and advertising, changes in taxes, and changes in federal and state funding.

While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic

and statistical variations from expected values. We have not anticipated any extraordinary changes to the legal, social, or economic environment that might affect the results of our modeling. For these reasons, no assurance can be given that the emergence of actual results will correspond to the projections in this analysis.

The authors of this report are members of the American Academy of Actuaries and meet that body's Qualifications Standards to perform this work and render the opinions expressed in this report.

APPENDIX

Oliver Wyman Healthcare Reform Micro-Simulation Model

The Oliver Wyman Healthcare Reform Micro-Simulation Model (HRMM) is a leading-edge tool for analyzing the impact of various healthcare reforms or proposed legislation. Economic modeling that captures the flow of individuals across various markets based on their economic purchasing decisions is integrated with actuarial modeling designed to assess the impact various reforms are anticipated to have on the health insurance markets. It is this integration of economic and actuarial modeling that allows us to capture the complex migration likely to occur as a result of various market reforms.

The HRMM has three primary modules. The first module characterizes the current population; the second module calibrates the simulated population to the current market; and the third module projects the simulated population in future years given coverage options, choice, and market reforms.

Characterization of the current population

In the first module, the population module, the current population was built from several data sources. Data from the 2016 American Community Survey (ACS) was selected as the primary data source and serves as the population basis. The ACS includes information for each respondent's age, gender, income, insurance coverage type, employment status, geographic place of work, geographic place of residence, industry in which he/she is employed, and many other characteristics. The ACS requests information on

households, however our model is built on decisions made at the health insurance unit (HIU) level. An HIU is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. Therefore, when preparing the ACS data for our model, it is adjusted to reflect HIUs.

While there are various sources of data that could be used as a primary data source, we chose to rely on the ACS data for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. National analysis of this "Medicaid undercount" indicates that many individuals enrolled in Medicaid report their status as either privately insured or uninsured,[25] and the ACS applies logical edits to the data to adjust for this. Second, the ACS questionnaire includes the question, "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[26] In contrast, the Current Population Survey (CPS) conducted by the Census Bureau assesses insured status over an entire year. The presentation of the question by ACS is more consistent with the HRMM since it examines the popula-

[25] http://www.shadac.org/publications/snacc-phase-v-report

[26] https://www2.census.gov/programs-surveys/acs/methodology/questionnaires/2016/quest16.pdf

tion at a single point in time. Third, enrollees are legally obligated to respond to the ACS,[27] so the response rate is quite high (i.e., 95 percent in 2016).[28] Finally, the ACS includes measures that permit the calculation of standard errors from the sample.

The ACS data is supplemented and synthesized with several other data sources to approximate the current marketplace. Information from the Medical Expenditure Panel Survey (MEPS) is used to create the current employer market. Individuals identified as working for private employers are randomly categorized into employer group size segment (e.g., small employer groups) based on the distribution of group size using the MEPS data. Information from the insurer/employer component of MEPS is used to determine which employed individuals will be offered insurance coverage. The results from the 2015 MEPS insurance/employer component data were used to establish the distribution of groups by group size (i.e., small employers and large employers) and the rates at which coverage was offered by state at various group sizes. Membership reports from CMS are used to size the current Medicaid and Medicare populations.

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[27] https://www.census.gov/programs-surveys/acs/about/top-questions-about-the-survey.html

[28] https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/

Definition of Insurance Coverage Types

Individual Market

Major medical health insurance coverage purchased by HIUs from health insurers, whether purchased directly from health insurers, through an agent or broker, or via the federal Exchange. This purchasing option is evaluated for all individuals, except for those eligible for Medicare, Medicaid, Military and other government sponsored coverage. Individuals enrolled in transitional and grandfathered plans will be allowed to maintain such coverage as allowed by federal regulations.

Small Employer

Major medical health insurance coverage purchased by Small Group employers (i.e., employers with 2 to 50 employees) from health insurers, whether purchased directly from health insurers, through an agent or broker, or through the federal SHOP. This purchasing option is evaluated for an HIU if the primary or spouse is currently employed (i.e., under the age of 65) according to the employment information on the ACS record. The employer must be identified as offering health insurance coverage to employees for the HIU to evaluate employer-based coverage.

Large Employer

Major medical health insurance coverage either purchased by Large Group employers (i.e., employers with more than 50 employees) from health insurers, whether directly or through an agent or broker, or administered by a third-party administrator (TPA). This

purchasing option is evaluated for an HIU if the primary or spouse is currently employed and under the age of 65, according to the employment and demographic information on the ACS record; however, the employer must be identified as offering health insurance coverage to employees for the HIU to evaluate employer-based coverage.

Medicare

All individuals age 65 and older are assumed to be eligible for and enrolled in Medicare. Individuals eligible for Medicare are assumed to remain eligible for Medicare, and no other purchasing options are evaluated for them.

Medicaid/CHIP

This purchasing option is evaluated if the requirements for Medicaid eligibility are met based on family income reported on the ACS record. This option is not evaluated for those receiving Military coverage as indicated on their ACS record, regardless of income.

It is important to note that not all individuals eligible for Medicaid or CHIP choose to enroll in such coverage. There any many possible reasons why an individual may choose not to enroll in Medicaid. A Government Accountability Office study found that many do not enroll because of the perceived stigma associated with filing for public assistance. Others may choose not to enroll because they do not need access to medical services.

Other Government Coverage

Other government coverage includes individuals who are enrolled in TRICARE and other military coverage types. HIUs are identified as being eligible for military coverage types based on the ACS data.

Short Term Limited Duration (STLD)

Health insurance coverage purchased by HIUs from health insurers, whether purchased directly from health insurers, through an agent or broker. This purchasing option is evaluated for all individuals, except for those eligible for Medicare, Medicaid, Military and other government sponsored coverage.

Uninsured

Residents who are not covered by any of the health insurance coverage types described above or have coverage that does not comply with the federal minimum essential coverage requirement are considered uninsured.

Health status and expected health expenditures

Health status is strategically assigned to various sub-populations based on a statistical analysis of self-reported health status obtained from the CPS. The CPS provides the starting assumptions for the population morbidity because the data includes a self-reported health status indicator as well as fields classifying income, age, gender, coverage type and other categories. Respondents to the survey classify their health into one of five categories: excellent, very good, good, fair, and poor. It is important to note that the CPS data lacks credibility for select cohorts by age

and gender on a state level. As a result, the HRMM uses nationwide CPS data as the basis for assigning health status to state enrollees.

The model reflects the CPS classifications numerically by assigning a morbidity load to each category. The morbidity load is applied to expected health expenditure calculated based on state, age and gender specific allowable claims from MarketScan database. The estimated amounts reflect the expected health expenditure for each person in each modeled HIU.

Synthetic insurers

The HRMM assumes there will be one insurer in each of the individual, small group and large group health insurance markets. Information obtained from rate filings, the Supplemental Health Care Exhibits, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) were used to determine premium levels in the market and to assess the adequacy of the premium levels from 2016 through 2020.

For the individual market, the HRMM assumes the synthetic insurer offers silver metallic-level plans and one transitional/grandfathered plan. For metallic-level plans, the HRMM allows individual market enrollees to select the lowest cost silver plans available on the Individual Exchange. Premiums for other metal level plans have not been included in the HRMM. Premiums for the transitional/grandfathered plan are assumed to represent average benefit levels and are based on premiums obtained through rate filings. Additionally, premiums for the transitional/grandfathered plan are assumed to comply

with the rating rules of non-ACA plans (e.g., full underwriting, etc.). Individuals modeled to take up individual health insurance coverage are randomly assigned to metallic or transitional/grandfathered coverage, with the distribution of enrollees consistent with the distribution of individual market enrollees observed in 2016 in aggregate and by income range and age group.

For the group health insurance market, the HRMM assumes the synthetic insurer offers one silver metallic-level plan and one transitional/grandfathered plan for small employer-based coverage. The silver metallic-level plan is based on the lowest-cost silver plan available in the Small Business Health Options Program (SHOP). Premiums for the transitional/grandfathered plan are assumed to represent average benefit levels and are based on premiums obtained through rate filings. Additionally, premiums for the transitional/grandfathered plan are assumed to comply with the rating rules of non-ACA plans (e.g., rating bands, etc.). Individuals working for small employers offering health insurance coverage are randomly assigned metallic or transitional/grandfathered coverage, with the distribution of enrollees consistent with the distribution of small group market enrollees by product type (e.g., metallic level) observed in 2018. For large employer-based coverage, the synthetic insurer is assumed to offer one plan that reflects market average benefit and premium levels. It is important to note that premium levels for a given employer-based group will be reflective of the mod-

eled demographic and risk mix, using the demographic information from the ACS data and the assigned health status factors.

Premium levels for 2021 and beyond have been developed using a target loss ratio approach, and assumes the synthetic insurer will price to the following target loss ratios by market:

Health Insurance Market	Traditional Loss Ratio
Individual	80%
Small Employer	80%
Large Employer	85%
STLD	50%

Calibration of the HRMM

Once the current market landscape is known, the market migration module of the HRMM is calibrated to reflect the current market landscape. The calibrated market migration module projects the market into which HIUs will enroll, based on the options and corresponding premiums available to them.

The purpose of the calibration is to solve for the model parameters that replicate the characteristics (e.g., size, premium, claims cost, etc.) of the known insurance markets during the base period. This step is critical to ensure that the appropriate utility functions are utilized in the market migration module. While a utility function can model people's desire for consumption of healthcare services, as well as their aversion to financial risk, it cannot predict certain behaviors, such as why people eligible to enroll in Medicaid do not enroll, or why individuals with sufficient financial means to purchase health insurance chose

to be uninsured. It is because of these behaviors that the model calibration is important and necessary.

To perform this calibration, all the information resulting from the simulation module is considered except the known market in which the individual was enrolled in 2018 through 2019. Individuals with coverage through Medicare, military coverage and coverage through local, state or Federal government employers were excluded from the calibration, as individuals with these types of coverage are assumed to continue with those coverages throughout the projection. Individuals with Medicaid were also excluded because most individuals with this coverage are also assumed to continue to be covered by Medicaid.

For each of the remaining HIUs, the various coverage options available to them in 2018 through 2019 are examined and the utility associated with each option is calculated. If the primary and the spouse have access to employer-based coverage, the utility curves assume the HIU would select the lowest-cost premium option. The cost of individual health insurance coverage is calculated for each HIU, including HIUs that have access to employer-based coverage. HIUs with household incomes greater than the Medicaid income requirements are not allowed to evaluate the option of enrolling in Medicaid. Once an HIU has evaluated all premium options, the lowest premium is chosen, and the economic utility is calculated for that coverage and compared to the economic utility of being uninsured. The option with the greatest utility is selected and the HIU is assumed to enroll in that health insurance option.

The results were examined to ensure the appropriate number of people is simulated to have each type of current coverage (e.g., individual, small group, etc.). If the projected enrollment results did not replicate the known 2018 through 2019 distribution, the various parameters in the utility function were revised until the projected enrollment was consistent with the known enrollment at several key sub-population levels. This step is critical to the modeling as without such calibration the reliability of the results is diminished significantly. The model is calibrated to ensure the known market is replicated at several levels, such as by broad age and income ranges within various markets.

Projection of future populations

Once the model is calibrated, the model is ready to be used to project the markets into which individuals will enroll based on the coverage options available to them, and the resulting premiums for those markets. The process of determining which coverage option each HIU elects to enroll in is based on the application of economic utility maximization. Large Employer's coverage evaluation is performed for each year which premium data is known (i.e., 2018, and 2019). The employer's coverage decisions from 2019 are then assumed to continue in the future for Large Employers; however, the model will determine whether each HIU with employer-based coverage continues to meet the affordability requirement. Small Group Employer's coverage evaluation is performed for each year from 2018 to 2022. The response from employers and individuals to changes in premiums and other financial incentives is a critical element of the model.

The model incorporates the various aspects of the ACA and other economic assumptions that will impact premiums and enrollment. These items include but are not limited to:

- Premium and cost sharing subsidies available to low income individuals
- Individual coverage mandate and penalties for not taking coverage (unless exempt)
- Medicaid eligibility rules by state
- Application of an affordability test to determine whether individuals offered employer coverage are eligible for subsidized coverage in the Individual Exchange
- Changes in FPL in future years
- Medical inflation
- Consumer Price Index for All Urban Consumers (CPI-U) growth consistent with the National Health Expenditure Data (NHED)
- Wage inflation is assumed to be consistent with CPI-U growth
- Income tax rates specific to the state including state, federal, FICA, and Medicare taxes
- Differences in utilization between individuals with insurance and similarly situated individuals without insurance
- Transitional health benefit plans are assumed to continually be extended each year
- Regulatory changes, specifically in the ACA individual market, for example:

- Cost sharing reduction loading to Silver premiums starting in 2018, and
- Expansion of Short Term Limited Duration plans, and

Individual mandate payments set to $0 starting in 2019.The resulting simulated population is input into the calibrated market migration module, and the purchasing decisions for each HIU are modeled each year from 2018 through 2022. Individuals currently enrolled in Medicaid or Medicare, those having coverage through the military and those receiving coverage because of being an employee or a dependent of an employee that works for a local government entity or the state or Federal government are assumed to retain that coverage.

Incomes are assumed to increase with annual changes in the CPI-U, consistent with the statutory formula for projecting changes in FPL levels in Alaska, Hawaii and remaining states. Based on the income, family size and composition of each HIU, income as a percentage of FPL is calculated for each projection year. These FPL percentages are then used for:

- Determining whether the HIU is eligible for Medicaid or children within the HIU are eligible for CHIP
- Determining whether the HIU is eligible for premium subsidies within the Individual Exchange

- Determining whether the HIU is eligible for cost sharing subsidies within the Individual Exchange
- Determining whether the HIU is eligible for exemption from the individual mandate payment if they elect not to enroll in coverage

Determining whether the employer-sponsored coverage made available to the HIU is deemed "unaffordable" and as a result the HIU is eligible to enroll in the Individual Exchange and receive premium and potentially cost sharing subsidies. The market migration module evaluates several different options in which the HIU is eligible to enroll. The model calculates the utility for each one of these options. HIUs are only allowed to evaluate employer-sponsored coverage if they are currently enrolled in this market as the model does not assume new offerings of employer-sponsored coverage.

The potential options that are evaluated for each HIU (where eligible) include:

- All individuals in the HIU enroll in employer-sponsored coverage made available by the employer for the year modeled
    - Small employer groups offering transitional or grandfathered coverage will evaluate whether to switch to ACA compliant coverage based on the employer economic utility function, with the employee evaluating the selected premium amounts (net of employer contributions); please note, transitional plans are assumed to be continually extended each year

- All individuals in the HIU enroll in coverage within the Individual Exchange and receive premium subsidies and cost sharing subsidies, where applicable; the metal level purchased in the Individual Exchange will be based on the economic utility associated with the lowest-cost silver plans and if eligible CSR – variant plans
- All individuals in the HIU enroll in ACA compliant coverage with no subsidies; the metal level purchased will be based on the economic utility associated with the lowest silver plans
- All individuals enrolled in transitional or grandfathered plans enroll maintain their current coverage; please note, transitional plans are assumed to be continually extended each year
- All individuals in the HIU enroll in STLD plans for entire year subject to favorable health status

All individuals in the HIU elect to remain uninsured. The HRMM assumes a steady state population. This means the distribution of the overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period. The steady state population assumptions can be summarized as follows:

- The distribution of the population by income level (i.e. as a percent of FPL) in aggregate remains unchanged. Incomes are modeled to in-

crease each year based on salary inflation assumptions which are consistent with the change in CPI-U

- Significant migration of individuals of a specific age or gender into or out of each state is not assumed to occur
- The distribution of the overall population by health status, occupation, and family size are assumed to remain relatively constant through 2022, except for the impact aging of the population will have. The steady state assumption does not mean the health status of specific individuals will remain unchanged over time, only that the overall relative health status by specific subsets of the population (e.g., by FPL and age) do not change. However, as described below, we expect that people will move between various modes of insurance (e.g., small group, individual and uninsured) and that this migration will result in changes to the average morbidity of those markets. Similarly, the family composition of a given household may change; however, it is assumed that the overall distribution of the state's population by family composition does not change
- Impacts from COVID-19 pandemic are not incorporated into the baseline market conditions in 2022 The overall rate of employment over the period between 2019 through 2022 is assumed to be consistent with 2018 employment levels.

HIU utility

HIUs are assumed to make insurance purchasing decisions by evaluating the various options above and making an economically rational decision to select the option that maximizes the utility for the HIU. The utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under that option. The HRMM assumes the decision to take up coverage is based on the utility of the HIU and does not allow individual members within an HIU to enroll in different markets, with one exception. Individuals eligible for Medicaid and Medicare are assumed to enroll in such coverage and have been removed from the decision-making process for each HIU.

To model this behavior, a utility function and the associated parameters were selected. As previously described, the utility function and parameters selected were those that replicated the status quo upon application of the market migration module to the simulated population. The underlying utility functions utilized are as follows:

$$U1_{i,j} = -E\left(OOP_{i.j}\right) - Premium_{i,j} - r * VAR\left(OOP_{i,j}\right) + u * \left(H_{i,j}\right) + v_i$$

$$U2_{i,j} = -w * E\left(HEP_{i,j}\right) - p * Penalty_{i,j} - w * r * VAR\left(HEP_{i,j}\right) + w * u * \left(H_{i,j}\right)$$

In the equations above, U1 represents the utility of having the health insurance among available coverage options and U2 represents the utility of being uninsured. If U1 is greater than U2, the HIU selects coverage option j. If U1 is smaller than U2, the HIU selects being uninsured. However, we apply an inertia

factor in cases where the difference between utility value of prior year's option is only marginally different from the utility value of the new option. The inertia threshold is determined based on a percentage of the HIU's income. $OOP_{i,j}$ is the out-of-pocket health care expenditures for HIU i under purchasing option j, HEP_i represents the expected health care expenditures to be incurred if the HIU elects to be uninsured, r is the risk aversion coefficient, u is the perceived value of having access to health insurance, $(H_{i,j})$ is the perceived value associated with consuming health services, v represents a fix value of having health insurance and p represents the perceived value of individual mandate payment under the ACA or state specific mandate requirements.

In calibrating the model, we elected to vary the parameters $r$and u at seven different ranges of incomes to reflect the fact that individuals with higher incomes are more risk averse and have different perceptions of accessing health care services. We also varied the parameters for six different age ranges to reflect the fact that individuals with similar incomes may behave differently at different ages. For example, an early retiree with greater accumulated assets drawing income from a lifetime of investments may be more risk averse than a young individual with a similar income but more limited assets. We also applied a separate parameter w for health expenditure for HIUs between Group and Individual coverages to account for higher perceived cost of not having comprehensive Group coverage versus leaner coverage usually available in the individual market.

Oliver Wyman
411 East Wisconsin Avenue,
Suite 1300
Milwaukee, WI 53202-4412
414 223 2280