Nos. 19-840, 19-841

In The
Supreme Court of the United States

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

UNITED STATES HOUSE OF REPRESENTATIVES,
Petitioner,
v.
TEXAS, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

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

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

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

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

INTRODUCTION AND SUMMARY OF ARGUMENT

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

The lower courts nevertheless invalidated the ACA's individual mandate. Although AHIP strongly disagrees with that conclusion, the focus of this brief is on severability. In remanding rather than resolving the severability question, the decision below casts a long shadow of uncertainty over ACA-based investments and denies health insurance providers, states, individuals, and other stakeholders of much-needed clarity. Invalidation of the ACA would wreak havoc on the health care system. Congress could not have intended that result in 2010, when it enacted one of the most comprehensive and far-reaching pieces of health care legislation in over 50 years. And Congress did not intend that result in 2017, when it zeroed out the tax payment for forgoing health coverage without repealing any other ACA provision.

In light of that manifest congressional intent, the "answer" to the severability question "is quite simple—indeed, a severability analysis will rarely be easier." Cal. Pet. App. 98a (King, J., dissenting). As Judge King underscored, "little guesswork is needed to determine that Congress believed the ACA could stand in its entirety without the unenforceable coverage requirement." *Id.* But in insisting on a district court "do-over," the decision below unnecessarily "prolong[s] the uncertainty this litigation has caused to the future of this indubitably significant statute" and "ensures that no end for this litigation is in sight." *Id.* at 98a-99a, 113a. Such a "do-over" in the lower courts raises the prospect of years of further litigation. To avoid that undesirable limbo, AHIP urges this Court to grant certiorari, not wait years pending remand to confirm what Congress has unmistakably indicated through its actions: that the

ACA should continue in operation even in the absence of the individual mandate.

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

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

Inseverability of the individual mandate would also undo scores of reforms that have reset the American public's expectations about the availability and scope of health care coverage. To name a few: It would eliminate guaranteed coverage for individuals

with preexisting conditions; the assurance that young adults can stay on their parents' plans until age 26; the prohibition on annual or lifetime benefit limits; and the provision of preventative care at no out-of-pocket cost. It would abolish the ACA's premium tax credits, on which millions of people now rely to obtain affordable coverage. And it would cut off billions in funding for expanded Medicaid programs in 37 states, jeopardizing the coverage of the 13 million newly eligible people they cover. Rolling back the ACA's Medicare reforms—including resurrecting Medicare Part D's prescription drug "donut hole" and rescinding key payment changes—would cast a cloud of uncertainty over the health care of seniors and disabled individuals.

It is plain that most of those ACA provisions (among hundreds of others)—and the ramifications of eliminating them in one fell swoop—have nothing to do with the individual mandate. The ACA is not a tapestry that unravels by pulling upon a single thread (*i.e.*, the individual mandate). Rather, the ACA's multitude of wide-ranging reforms, which rest on a variety of statutory foundations scattered across the U.S. Code, affect *every* health insurance market (not just the individual market) and *every* American with coverage (not just those who purchased coverage on the exchanges).

Recognizing that inescapable fact, the federal government (despite failing to defend the individual mandate) initially agreed in the district court that the rest of the ACA is severable—with one notable exception: the provisions that together guarantee coverage, at the same premiums, regardless of health

status or preexisting conditions.[2] But that compromise position comes with its own practical problems: Eliminating the vital preexisting-condition protections would upend the individual markets and throw individuals and health insurance providers back to an obsolete system that cannot be revived without serious disruption to American lives and the nation's economy. (The government had another change of heart in the Fifth Circuit and essentially embraces the all-or-nothing approach of the other Respondents.)

As a legal matter, Respondents incorrectly conflate Congress's assessment in 2010 (shared by AHIP at the time) for initial implementation of the new individual market with Congress's assessment in 2017 (confirmed by empirical evidence) that the market would remain stable absent an enforceable individual mandate. At its inception, the individual mandate was intended to work alongside the guaranteed-issue and community-rating provisions to avoid an adverse selection "death spiral" spurred by the risk that healthier individuals would forgo purchasing insurance until needed. But circumstances have changed. Just before the 2017 amendment, in light of sustained demand for the quality, affordable coverage the individual marketplace offers, the Congressional Budget Office ("CBO") predicted that a straight repeal of the

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

individual mandate—without repealing any other ACA provision—would not destabilize that marketplace. That prediction has borne out: the individual marketplace has remained stable in 2020 even after the individual mandate had been watered down through a variety of exemptions, further weakened through non-enforcement mechanisms, and ultimately rendered unenforceable by zeroing out the tax payment. Respondents ignore both that real-world experience and Congress's conspicuously narrow amendment.

In short, the ACA has shifted the paradigm for health care coverage in this country. It has extended quality, affordable coverage to millions of Americans—regardless of their health status—through a complex and comprehensive set of reforms. No industry has been more directly impacted by the ACA than health insurance providers, which have invested vast resources to participate in the relevant markets, comply with the law's myriad reforms, and organize their businesses to operate in a revamped health care system. Until this case is resolved, however, continued investment and participation stands on unsure footing. This Court should grant certiorari.

ARGUMENT

Congress did not intend and could not have intended to put at risk the entirety of the ACA—undermining both private and public health care coverage for hundreds of millions of Americans—when it zeroed out the tax payment for forgoing coverage. By that point, the ACA's sprawling reforms, which reach virtually every corner of the health care system and affect virtually every health care recipient, had

become firmly entrenched—and are only more so today. Regardless of what Congress had intended in 2010, there can be no doubt that, given the present realities of the nation's ACA-based health care system, the amending Congress in 2017 could not have intended the far-reaching consequences that would follow from invalidating the ACA (in its entirety or in significant part).

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

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

The ACA affects nearly every American, including the 297 million people in our nation that enjoy either private or government-sponsored health insurance coverage.[3] That is why the ACA is widely regarded as the most significant health care legislation enacted since the Social Security Act amendments that created the Medicare and Medicaid programs in 1965. Its wide-ranging provisions—many of which are entirely unrelated to the individual mandate—span 974 pages and cut across statutes including the Social Security Act, the Public Health Service Act, the Medicare Act, the Medicaid Act, ERISA, the Indian Health Care Improvement Act, the

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

Federal Food, Drug, and Cosmetic Act, and the Internal Revenue Code.

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

Since the ACA's enactment, the number of people without health care coverage has decreased by over 20 million.[4] In 2018, over 10 million Americans were enrolled in health plans offered on ACA exchanges, in addition to the millions who enrolled in individual market coverage apart from the exchanges.[5] From July 2013 to April 2019, enrollment in Medicaid

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

[5] Kaiser Family Found., *Marketplace Effectuated Enrollment and Financial Assistance* (2019), https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance.

expansion states increased by 13 million (34%).[6] Beyond expanding coverage through the ACA, many states have passed conforming legislation and new laws dependent on the ACA's provisions.[7]

The ACA is also remarkable in the sheer amount of health care funding it delivers. It provides billions of dollars through advance premium tax credits, small business tax credits, and Medicaid payments in the form of federal financial participation. Among many other things (*see* Part A.2, *infra*), the ACA funds efforts to combat public health threats (through its Prevention and Public Health Fund) that could otherwise go unaddressed[8] and has allowed rural hospitals to remain open (through Medicaid expansion funding) that could otherwise close.[9]

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

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

[8] *E.g.*, Decl. of Henry J. Aaron ¶ 42 (ECF No. 15-1) (ACA's Prevention and Public Health Fund is only source of block grant that "supports critical services, including lab capacity to test outbreaks of flu or virus-borne diseases such as Zika, responses to emerging public health threats such as the opioid epidemic, and chronic health threats such as damage to children through exposure to lead").

[9] Adam Searing, *Study Documents How Medicaid Expansion Helps Keep Rural Hospitals Open*, GEORGETOWN UNIV. HEALTH POLICY INST. (Jan. 12, 2018),

Given its sweeping reach, it is no surprise that even a partial repeal of the ACA has been calculated to increase the number of uninsured individuals by over 30 million and to increase the cost of uncompensated care significantly.[10] To put it simply, the ACA's extraordinary scale and scope make its effects much like a bell that cannot be unrung—at least not without inflicting real and significant pain on individuals, families, states, businesses, and the nation's economy.

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

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

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https://ccf.georgetown.edu/2018/01/12/study-documents-how-medicaid-expansion-helps-keep-rural-hospitals-open/.

[10] *See, e.g.*, Larisa Antonisse et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUND. (Mar. 28, 2018), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/; Congressional Budget Office, *H.R. 1628, Obamacare Repeal Reconciliation Act of 2017* (July 19, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf (hereinafter "CBO Report").

decidedly did not in 2017. The following sections highlight examples of the potential impacts in four significant health care markets reshaped by the ACA.

a) Individual Market

AHIP's member plans are collectively responsible for providing comprehensive and affordable health care coverage to 79% of people purchasing coverage in the individual market (on and off the exchanges). If the ACA were invalidated, those participating in or connected to the individual market would face tremendous coverage disruption, financial losses, and uncertainty.

Such a declaration would halt payments made in connection with the ACA's advance premium tax credits, by which the federal government subsidizes (on a prospective basis) a sizeable portion of enrollees' monthly insurance premiums if their household incomes meet certain criteria. 26 C.F.R. § 1.36B-2. Eliminating those tax credits—resulting in a sudden spike in monthly premiums—would make coverage unaffordable for many of the 9.3 million Americans who rely on them.[11] The approximately 5 million people who pay the whole cost of their individual market coverage without any tax credits, in turn, would be affected by deterioration of the risk pool. State regulators would then be faced with coverage lapses for millions of people, the possible withdrawal of health insurance providers from the individual

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

market, as well as potential health plan insolvencies and failures.

The CBO's review of the proposed Obamacare Repeal Reconciliation Act of 2017, which would have repealed the ACA without any replacement, is instructive. The CBO concluded that the proposal would have two principal effects on health care coverage and premiums. First, "[t]he number of people who are uninsured would increase by 17 million in 2018" with 10 million dropping out of the individual market, and by "32 million in 2026" with 23 million dropping out of the individual market. CBO Report, *supra* note 10, at 1-2, 8, 10. Second, "[a]verage premiums in the nongroup market (for individual policies purchased through the marketplaces or directly from insurers) would increase by roughly 25 percent—relative to projections under current law—in 2018. The increase would reach about 50 percent in 2020, and premiums would about double by 2026." *Id.* at 1.

In addition, health insurance providers themselves would face waves of disruption and destabilization—both immediate and longer term—if the ACA were abruptly invalidated. Health insurance providers would find themselves operating in an environment where the established rules of the road have been displaced. That vacuum would cast into doubt the viability of existing products designed for and approved under an ACA-based health care system. For example, many state laws (including the laws of certain state challengers here) require health insurance providers to lock in rates prospectively for a full plan year and to provide coverage for a fixed period

of time.[12] Health insurance providers have little choice but to make actuarial assumptions about risk pool mix and anticipated enrollment numbers based on the continued existence and enforcement of the ACA. Invalidation of the ACA would thus leave health insurance providers (among others) in an immediate bind: it is unclear whether they would be permitted to recalculate rates or design different products based on the new actuarial realities created by such a result.

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

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

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

a premium tax credit program akin to that established under the ACA.

b) Group Plans

AHIP's member plans are responsible for providing 70% of large group health coverage and 71% of small group health coverage in the United States. Such "group" coverage includes health plans offered by employers of all sizes to their employees, as well as coverage purchased by small businesses under the ACA's Small Business Health Options Program. In 2018, 178 million Americans received health insurance through their employer; employer-based group health insurance thus remains the nation's single largest source of health care coverage.[13] The ACA made numerous changes to this type of coverage, such as promoting improved and better accessible employer-based and other group coverage, all of which would be stripped away under Respondents' position.[14]

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

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

[14] Kaiser Family Found., *Health Reform Glossary* (last visited Jan. 12, 2020), https://www.kff.org/glossary/health-reform-glossary/#glossary-g.

approach to providing coverage, will be covered by health insurance through typical employment mechanisms.

In addition, the ACA applied guaranteed-issue and community-rating protections to the small group market in a manner that significantly changed how coverage is offered. Prior to those reforms, a small business could experience significant premium increases after one employee became unexpectedly sick and required expensive care.[15] Such reforms have stabilized premiums for small businesses offering health insurance by cutting annual increases by more than half.[16] More accessible and reliable coverage for small businesses also alleviates "job lock," so that people have the freedom to start or work for small businesses without being unable to obtain affordable health insurance.[17]

c) Medicaid

Sixty AHIP member health plans work with states to offer Medicaid managed care products that improve quality, provide access to necessary care, and save billions of taxpayer dollars by facilitating the

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

[16] U.S. Dep't of Health & Human Servs., *Fiscal Year 2017, Budget in Brief* 115 (Feb. 2016), https://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf.

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

delivery of more cost-effective services. Currently, 37 states have expanded Medicaid (or are in the process of doing so) pursuant to the ACA. Eliminating the ACA's expansion of Medicaid would cause states to lose federal funding that covers most of the expenses for 13 million expansion enrollees. *See* Medicaid Changes, *supra* note 6; *see also* CBO Report, *supra* note 10, at 6 (estimating that repeal sans replacement would cause "net reduction of $842 billion in federal outlays for Medicaid" from 2017-2026). Expansion states would be unable to absorb the loss of that revenue (even temporarily) and may have no choice but to eliminate coverage for millions of people. *See* CBO Report, *supra* note 10, at 8, 10 (estimating that straight repeal of the ACA in 2017 would result in 4 million fewer people with Medicaid coverage in 2018, and 19 million fewer people with Medicaid coverage in 2026).

The immediate loss of Medicaid coverage could be disastrous for patients, including those undergoing potentially lifesaving treatments or in need of expensive prescription drugs. Without coverage, many expansion enrollees would forgo preventative care and seek much more costly health care as a last resort from emergency rooms and public hospitals. Recent studies document that increased coverage through the Medicaid expansion resulted in a $6.2 billion reduction in uncompensated health care costs for hospitals from 2013-2015. *See* Antonisse, *supra* note 10.

A decision that eliminates coverage for the expansion population also would have adverse impacts on Medicaid plan sponsors that have made multi-year

investments in hiring care management and member service staff, contracting with thousands of health care providers, implementing state operations, and expanding information systems to accommodate their projected expansion membership and health care utilization. Plans and the local organizations they partner with could be forced to cut jobs in operational areas where staffing levels vary with enrollment and to absorb losses in administrative areas with fixed staffing costs.

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

Finally, a finding of inseverability could result in Medicaid programs incurring higher prices for prescription drugs. The ACA increases prescription drug rebates and extends federal drug rebates to Medicaid populations in managed care plans. For example, in 2009, at pre-ACA rebate levels, Medicaid

fee-for-service programs had net expenditures of $15.7 billion on gross drug charges of $25.4 billion, an effective discount of 38.2%. In 2014, at post-ACA rebate levels, Medicaid fee-for-service programs had net expenditures of only $8 billion on gross drug charges of $21.4 billion, an effective discount of 62.6%.[18] Although rebate levels in a given year can be affected by various factors, including the mix of brand and generic drugs in the year, the ACA unquestionably reduced drug costs.

d) Medicare

Nearly 80 AHIP members offer Medicare Advantage plans, most of which include Medicare Part D prescription drug benefits. AHIP members also offer stand-alone Part D prescription drug coverage. These programs leverage private-sector innovation to offer greater choice, value, and financial security in the Medicare program. If the ACA falls, the Medicare Advantage and Part D programs would face major disruption, undermining stability and coverage for America's seniors.

Under those programs, health insurance providers receive prospective monthly payments that the Centers for Medicare & Medicaid Services set on an annual basis. The ACA made a number of material changes in the methodology used to calculate those payments; their status would be called into question immediately. That, in turn, could disrupt coverage for

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

more than 46 million seniors and individuals with disabilities currently covered by Medicare Part D and for the almost 23 million people enrolled in Medicare Advantage plans.[19]

With respect to Medicare Part D, the ACA created the Coverage Gap Discount Program and phased in increased plan coverage to reduce patient out-of-pocket spending in what is colloquially known as the "donut hole."[20] The ACA's invalidation would likely result in the abrupt end to the Coverage Gap Discount Program and other ACA modifications to Part D that would leave beneficiaries again responsible for paying 100% of prescription drug costs in the "donut hole." The resulting financial hardship

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[19] Centers for Medicare & Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report* (Jan. 2020), https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/contract-summary-2020-01. As of January 2020, 23.6 million enrollees are in Medicare Advantage plans, and 21 million of these receive drug coverage through these plans. A total of 46.7 million enrollees are in plans that offer drug coverage (21 million in Medicare Advantage and 25.7 million in stand-alone prescription drug plans or other plan types).

[20] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101, 124 Stat. 1029, 1036-1037 ("HCERA"); Medicare.gov, Costs in the Coverage Gap (last visited Jan. 12, 2020) (explaining that most Medicare Part D prescription drug coverages are structured such that once the beneficiary and drug plan have spent a certain amount on covered drugs for that year, there is a temporary coverage gap until a higher threshold is met, which the ACA addresses through discounts and increases in plan liability), https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap.

for many seniors and individuals with disabilities, especially those who live on a fixed income, would be substantial.[21] And given that affordability is a primary driver of people not taking recommended prescriptions, the return of the "donut hole" would increase clinical complications and adverse health outcomes for that already vulnerable population.

With respect to Medicare Advantage, the ACA altered the benchmarks used to calculate federal payments to health insurance providers; created a quality bonus payment based on plan performance to incentivize high-quality health plans; and tied rebate levels to quality for those plans that submit bids below the benchmarks for their service area. *See* HCERA § 1102, 124 Stat. at 1040.

Doing away with the ACA would do away with all these reforms and existing rules, leaving in flux how Part D and Medicare Advantage plans would be paid the $25 billion they are owed *each month*.

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

1. The above discussion should make abundantly clear that the tower of reforms that the ACA has instituted would not come tumbling down by removing the individual mandate. Virtually all the reforms are built on foundations separate and apart from the

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

mandate. And "[g]iven the breadth of the ACA and the importance of the problems that Congress set out to address, it is simply unfathomable *** that Congress hinged the future of the entire statute on the viability of a single, deliberately unenforceable provision." Cal. Pet. App. 103a (King, J., dissenting).

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

But Congress did not. In 2017, Congress amended the individual mandate provision—zeroing out the tax payment so as to render the mandate unenforceable—without amending the guaranteed-issue and community-rating provisions. For good reason: Albeit a valid concern circa-2010-2012, the risk of an adverse-selection "death spiral" in mandate-less markets—in which healthier individuals wait to purchase coverage until they need it while generally less healthy or older individuals enter the market, thereby causing premiums to skyrocket and plan

providers to exit—has been overtaken by real-world facts. Just prior to the amendment, the CBO itself had predicted that, if Congress "repeal[ed] th[e] [individual] mandate starting in 2019 *** and ma[de] no other changes to current law," then "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade."[22]

Despite the zeroing out of the tax payment (amidst other ACA-related uncertainty), data show that the individual markets have demonstrated a continued resiliency—and, in many instances, have shown signs of increasing steadiness—as states and health insurance providers have responded to a shifting market composition.[23] The data are unsurprising in light of the fact that the individual mandate had already been weakened substantially through a plethora of hardship and other exemptions as well as other non-enforcement mechanisms, and

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

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

that premium subsidies continue to incentivize participation. The 2019 and 2020 individual market plans and rates approved by state regulators account for the operation of the preexisting-condition provisions absent any tax penalty, *i.e.*, *without an enforceable individual mandate*.[24] A survey taken after the Justice Department's decision not to defend the mandate's constitutionality found that "removal of the individual mandate impacted market premiums between 1 to 10 percent, with an average load of 5 percent included in the rates."[25]

The reality is that health insurance providers have designed and submitted actuarially sound products, and are continuing to participate in the individual market, without an enforceable mandate. The same holds true for most individuals. In the face of that empirical proof, there is simply no basis to conclude that the guaranteed-issue and community-rating provisions remain inextricably intertwined with the individual mandate today. To the contrary, shifting to a marketplace that eschews those

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

[25] Beth Fritchen & Kurt Geisa, *Oliver Wyman Survey: The Affordable Care Act's Stabilization* (June 20, 2018), https://health.oliverwyman.com/2018/06/aca_survey.html.

provisions would only upend a steadying market, not save it.

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

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

AHIP is not alone in its reassessment. Those same changed circumstances are reflected in Congress's decision—consistent with the CBO's analysis and against the backdrop of stably

functioning individual health care markets—to eliminate the tax payment for forgoing health coverage *without* altering the preexisting-condition provisions. That "unusual insight into Congress's thinking," Cal. Pet. App. 105a (King, J., dissenting), is crucial to the severability analysis.

CONCLUSION

Over the course of nearly a decade, the ACA has fundamentally reshaped the nation's health care system. Congress in 2017 chose not to disturb that paradigm shift—including the promise of affordable coverage for those with preexisting conditions—when defanging the individual mandate without repealing any other part of the ACA. Invalidation of the entire ACA would flout Congress's manifest intent, with profound consequences for our health care system and the hundreds of millions of people it serves. This Court should grant certiorari now to make clear that even if the individual mandate falls, the balance of the ACA will remain in force.

Respectfully submitted.

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