No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

State of Texas; State of Wisconsin; State of Alabama; State of Arizona; State of Florida; State of Georgia; State of Indiana; State of Kansas; State of Louisiana; State of Mississippi, by and through Governor Phil Bryant; State of Missouri; State of Nebraska; State of North Dakota; State of South Carolina; State of South Dakota; State of Tennessee; State of Utah; State of West Virginia; State of Arkansas; Neill Hurley; John Nantz,

Plaintiffs-Appellees,

v.

United States of America; United States Department of Health & Human Services; Alex Azar II, Secretary, U.S. Department of Health and Human Services; United States Department of Internal Revenue; Charles P. Rettig, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

State of California; State of Connecticut; District of Columbia; State of Delaware; State of Hawaii; State of Illinois; State of Kentucky; State of Massachusetts; State of New Jersey; State of New York; State of North Carolina; State of Oregon; State of Rhode Island; State of Vermont; State of Virginia; State of Washington; State of Minnesota,

Intervenor-Defendants-Appellants.

On appeal from the U.S. District Court for the Northern District of Texas

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

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SUPPLEMENTAL STATEMENT OF INTERESTED PERSONS

State of Texas, et al. v. United States of America, et al., No. 19-10011

Pursuant to 5th Cir. R. 29.2, the undersigned counsel for *amicus curiae* provides this supplemental statement of interested parties to fully disclose all with an interest in the *amicus* brief. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Amicus Curiae on This Brief

America's Health Insurance Plans is a trade association whose members have no ownership interests. It is incorporated in Delaware as America's Health Insurance Plans, Inc., and has no parent company or stock.

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INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans ("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 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

[1] In accordance with Federal Rule of Appellate Procedure 29(a)(4)(E), *amicus curiae* certifies that no counsel for any party authored this brief in whole or in part, and that no party or other person other than *amicus*, its members, or its counsel made a monetary contribution to the brief's preparation or submission. All parties have consented to the filing of this brief.

has participated as *amicus curiae* in other cases to 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 district court's decision on health insurance providers and all Americans. AHIP's perspective will provide the Court with a more comprehensive understanding of the seismic consequences of the district court's declaration that the individual mandate cannot be severed from the remainder of the ACA, thereby rendering the entire ACA invalid.

INTRODUCTION AND SUMMARY OF ARGUMENT

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

coverage for the first time, and millions more enjoy better and more flexible coverage.

Invalidation of the ACA—irrespective of the continued operation of the so-called individual mandate—would thus 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 did not intend that result in 2017 (when it zeroed out the tax payment for forgoing health coverage without repealing any other ACA provision).

The district court's decision disregards that manifest congressional intent and ignores the devastating consequences that would ensue. For the reasons discussed by the State Defendants and House Intervenor, AHIP strongly disagrees with the district court's holding that Congress's zeroing out of the tax payment renders the individual mandate unconstitutional. This brief, however, focuses on the issue of severability: 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 the fundamental flaws in the district court's severability analysis.

To start, the district court's wholesale invalidation of the ACA is indefensible. That decision not only contravenes Congress's clear intent, but does so with cavalier indifference to the impacts it would unleash on the health care system—including

for *all* of the 295 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.

The district court's decision, if left to stand, would 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 12 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). Nor, as the district court analogized, is the ACA as conceptually simple as a Jenga tower that will collapse upon removing that single block. 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) agreed below 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] (The government has apparently had another change of heart and now embraces the district court's all-or-nothing approach.) But the (since discarded) compromise position comes with its own practical problems: Eliminating these vital protections

[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."

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.

As a legal matter, the district court erred in conflating 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 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 2019 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. The district court ignored 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 amounts of resources to participate in the relevant markets, comply with the law's myriad reforms, and organize their businesses to operate in a revamped health care system. This Court should reverse the district court's blunderbuss attempt to sweep that all away.

ARGUMENT

Congress did not intend and could not have intended to put at risk the entirety of the ACA—undermining both private and public health care coverage for hundreds of millions of Americans—when it zeroed out the tax payment for forgoing coverage. By that point, the ACA's sprawling reforms, which reach virtually every corner of the health care system and affect virtually every health care recipient, had become firmly entrenched—and are only more so today. Regardless of what Congress had intended in 2010, there can be no doubt that the amending Congress in 2017 lacked any intent to tie the fate of the entire ACA to whatever remained of the individual mandate. Congress's extensive deliberations in the run-up to the exceedingly narrow 2017 amendment underscore that fact: there was no agreement on broader efforts to repeal (and replace) the ACA, even for proposals that would

have left intact many ACA reforms (such as those to Medicare and Medicaid) and that would have provided for an orderly transition for material changes (such as continuing the premium tax credits on which millions now rely to obtain coverage).

AHIP agrees with the State Defendants and House Intervenor that the now-unenforceable individual mandate poses no constitutional problem. At the very least, however, the district court's severability decision cannot stand. Congress's intent is the touchstone of the severability analysis, and, given the present realities of the nation's ACA-based health care system, Congress could not have intended the far-reaching consequences that would follow from invalidating the ACA (in its entirety or in significant part). As Congress's surgical amendment in 2017 confirms, the ACA—including but not limited to its vital preexisting-condition protections—does not rise and fall with the individual mandate.

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 295 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

[3] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2017*, at 1 (Sept. 2018), https://www.census.gov/library/publications/2018/demo/p60-264.html.

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, 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

[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.

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 2013 to 2018, enrollment in Medicaid expansion states increased by 13.6 million (36%).[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

[5] Kaiser Family Found., *Marketplace Effectuated Enrollment and Financial Assistance* (2018), https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance. According to National Association of Insurance Commissioners data for 2017, the most recent year for which statistics are available, over 18 million people purchased insurance in the individual market when considering both on- and off-exchange purchases.

[6] Medicaid & CHIP Payment Access Commission, *Medicaid Enrollment Changes Following the ACA*, https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (last visited Mar. 31, 2019).

[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.

could otherwise go unaddressed[8] and has allowed rural hospitals to remain open (through Medicaid expansion funding) that could otherwise close.[9]

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 pain on individuals, families, states, businesses, and the nation's economy.

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[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), 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) (hereinafter "CBO Report"), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

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

The far-reaching impacts of the district court's ruling that the "individual mandate is inseverable from the entire ACA," Op. 47 (formatting altered), 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 the Court has reservations about the mandate's constitutionality. Congress could not have contemplated anything else in 2010, and 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 nearly 80% of people purchasing coverage in the individual market (on and off the exchanges). If this Court were to affirm, those participating in or connected to the individual market would face tremendous coverage disruption, financial losses, and uncertainty.

An affirmance 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 8.9 million Americans who rely on them.[11] The 9 million people who pay the whole cost of their individual market coverage without any tax credits, in turn, would be affected by deterioration of the risk pool. State regulators would then be faced with coverage lapses for millions of people, the possible withdrawal of health insurance providers from the individual market, as well as potential health plan insolvencies and failures.

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

[11] Centers for Medicare & Medicaid Services, *First Half of 2018 Average Effectuated Enrollment Data* (Sept. 15, 2018), https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf.

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

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

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 prospects of which seem dim, to say the least—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 a premium tax credit program akin to that established under the ACA.

Take another example: Prior to 2014, many states used high-risk pools as the primary mechanism to provide health coverage access to individuals with preexisting conditions. Those high-risk pools, however, had limited enrollment due to both chronic underfunding and costly premiums—150% to 200% higher than the average market premium. In some instances, they excluded benefits for enrollees with preexisting conditions if the enrollee lacked prior coverage. In light of the ACA, states have largely dismantled high-risk pools because individuals with

preexisting conditions can now obtain coverage on the individual market on a guaranteed basis. That leaves yet another troubling gap.

b) Group Plans

AHIP's member plans are responsible for providing nearly 60% of large group health coverage and 54% 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 ("SHOP"). In 2017, 156 million Americans received health insurance through their employer, demonstrating that employer-based group health insurance 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 the district court's decision.[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

[13] Kaiser Family Found., *Coverage at Work: The Share of Nonelderly Americans with Employer-Based Insurance Rose Modestly in Recent Years, but Has Declined Markedly over the Long Term* (Feb. 1, 2019), https://www.kff.org/health-reform/press-release/coverage-at-work-the-share-of-nonelderly-americans-with-employer-based-insurance-rose-modestly-in-recent-years-but-has-declined-markedly-over-the-long-term/.

[14] Kaiser Family Found., *Health Reform Glossary* (last visited Mar. 29, 2019), https://www.kff.org/glossary/health-reform-glossary/#glossary-g.

does not offer an adequate plan option and at least one of its employees has purchased subsidized insurance through an exchange. *See* 26 U.S.C. § 4980H(a). Such provisions ensure that most Americans, consistent with our nation's decades-long approach to providing coverage, will be covered by health insurance through typical employment mechanisms.

In addition, the ACA applied guaranteed-issue and community-rating protections to the small group market in a manner that 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]

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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.

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 delivery of more cost-effective services. The district court's severability holding would significantly disrupt those efforts.

Currently, 37 states have expanded Medicaid (or are in the process of doing so) pursuant to the ACA. Millions of low-income Americans depend on Medicaid and health plans offered through Medicaid managed care organizations for affordable access to medical care. Eliminating the ACA's expansion of Medicaid would cause states to lose federal funding that covers most of the expenses for 12 million expansion enrollees. Decl. of Matthew David Eyles ¶ 12 (ECF No. 15-1); *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 judicial roll-back of the ACA's Medicaid provisions would also 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.

Medicaid rate setting is also determined by historic utilization patterns, assumptions about the pool and mix of enrollees, and projected changes in enrollee health status and the costs of services. Drastically altering the covered population would negate the actuarial basis for current Medicaid plan rates, and could foist upon states the time-intensive and costly process of rebuilding and recalculating rates to reflect the removal of expansion enrollees from the risk pool.

Furthermore, invalidation of the ACA would endanger targeted ("pass-through") payments to entities that states deem critical to their health care infrastructures. The enhanced federal share of funding for ACA Medicaid expansion enrollees allows states to reallocate a portion of state funds to support critical access and safety net providers. Absent Congress immediately allocating additional funds, states would likely have to reduce those payments. And the affected providers—often rural or inner-city hospitals—would face insolvency with the sudden loss of revenue, coupled with a rise in uncompensated care to expansion enrollees who had lost Medicaid coverage.

Ultimately, the impact of losing federal Medicaid funds would be felt in all states, not just the 26 states that have chosen to expand Medicaid through contracts with Medicaid managed care plans. Data from 2016 indicate that approximately 12.6 million expansion enrollees are served through such managed care

arrangements.[18] While each state's contracts with their respective managed care plans may differ, they would all face the challenge of making contractually obligated payments. In some states, depending on state law and the contract terms, it may be unclear whether plans would be required to continue providing coverage without receiving payment (at least pending further judicial review). Yet plans obviously did not enter into state Medicaid contracts with the expectation that they would be forced to assume that sort of huge liability. Such a scenario would severely impair many plans.

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.

[18] Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics, 2016* 11 (Spring 2018), https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf.

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%.[19] 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—and significantly so.

d) Medicare

Over 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.

[19] 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.

Under those programs, health insurance providers receive prospective monthly payments that CMS sets on an annual basis. The ACA made a number of material changes in the methodology used to calculate those payments; their status would be called into question immediately. That, in turn, could disrupt coverage for more than 45 million seniors and individuals with disabilities currently covered by Medicare Part D and for the roughly 20 million people enrolled in Medicare Advantage plans.[20]

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."[21] The ACA's invalidation would likely result in the abrupt end to the Coverage Gap Discount

[20] Centers for Medicare & Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report* (Mar. 2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html. As of March 2019, 21.9 million enrollees are in Medicare Advantage plans, and 19.5 million of these receive drug coverage through these plans. A total of 45.5 million enrollees are in plans that offer drug coverage (19.5 million in Medicare Advantage and 26 million in stand-alone prescription drug plans or other plan types).

[21] 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 Mar. 29, 2019) (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.

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 for many seniors and individuals with disabilities, especially those who live on a fixed income, would be substantial.[22] 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 Medicare Advantage and Part D plans would be paid the $25 billion they are owed *each month*.

[22] 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.

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

The above discussion should make abundantly clear that the severability analysis for the ACA is *not*, as the district court described, "like watching a slow game of Jenga." Op. 47. The district court's fundamentally flawed analogy infected its severability analysis: The tower of reforms that the ACA has instituted would not come tumbling down by removing the individual mandate block; virtually all the reforms are built on foundations separate and apart from the mandate.

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. The district court conflated 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."[23]

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. 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 that premium subsidies continue to incentivize participation. The 2019 plans and rates filed by

[23] 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.

health insurance providers have accounted 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 provisions would only upend a steadying market, not save it.

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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.

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 to borrow a phrase from the district court, "that was then, and this now." Op. 42 n.29. 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 context, all but ignored by the district court, 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. The ACA's sweeping reforms have drastically reduced the number of uninsured people and have touched every American with health care coverage, whether through the individual or group markets, Medicaid, or Medicare. 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*.

The district court's decision wields an axe in responding to Congress's scalpel. 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 reverse that judgment.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 6,401 words, and thus complies with the type-volume limitation set forth in Rules 29(a)(5) and 32(a)(5) of the Federal Rules of Appellate Procedure.

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2019, I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the CM/ECF system.

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