IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al., *Plaintiffs*, v. **UNITED STATES, et al.,** *Defendants*, **STATE OF CALIFORNIA, et al.,** *Intervenors-Defendants*.	**No. 4:18-cv-00167-O**

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTEREST OF *AMICUS CURIAE*

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 healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 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 healthcare 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 healthcare 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 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 objectives those changes advance, and the consequences to health insurance providers and consumers of enjoining the ACA. AHIP's perspective will provide the Court with a more comprehensive understanding of the serious and irreparable practical consequences of granting either a preliminary injunction or declaratory judgment in this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

This Court must deny a preliminary injunction unless plaintiffs can clearly demonstrate, among other requirements, that the injunction would not "disserve the public interest." Plaintiffs nevertheless neglect to address the significant disruption and other harms such relief would inflict—not only on health insurance providers and the markets and customers they serve, but on the Nation's entire healthcare sector. AHIP and the federal defendants therefore agree that the relief plaintiffs seek should be denied. AHIP and the federal defendants also agree that the ACA's provisions affecting Medicaid and Medicare should remain intact.

Despite those points of agreement, AHIP disputes the federal defendants' (and plaintiffs') position that zeroing out the individual mandate penalty renders the mandate unconstitutional, and that the provision is inseverable from the ACA's guaranteed-issue and community-rating provisions. The declaratory judgment sought by the federal defendants as a remedy would be just as disruptive as preliminarily enjoining those same provisions. Even assuming the Court has reservations about the constitutionality of the individual mandate and the severability of that provision from the ACA (either in its entirety or in part), the profound harm to the public interest flowing from either a grant of preliminary injunctive relief or a grant of declaratory relief—through detrimental impacts on patients, governments, health insurance providers, medical care providers, and other stakeholders—compels their denial.

Since its passage in 2010, the ACA has transformed the healthcare system. It has restructured the individual and group markets for purchasing health insurance, expanded Medicaid, and reformed Medicare. An estimated 20 million previously uninsured individuals have enrolled in health insurance coverage. In addition, states have rewritten their own healthcare laws, government agencies have remodeled public healthcare programs like Medicaid and Medicare, and health insurance providers (like AHIP's members) have invested significant

resources into building and offering products to comply with the ACA. In short, the ACA has reached virtually every corner of the healthcare industry.

The healthcare system, while constantly evolving, cannot pivot to a new (or, worse yet, non-existent) set of rules without consequences. Abruptly threatening or even cutting off billions of federal dollars that allow individuals to purchase insurance and that fund benefits offered through Medicaid or Medicare would have devastating effects. Enjoining enforcement of federal laws like the federally-facilitated marketplaces and the products sold on them would be similarly disruptive. As Congress made clear in its recent legislative attempts to repeal the ACA, repeal could not be immediate or without some substitute, but instead had to be accompanied by a period of transition towards some replacement to protect stakeholders and consumers. Plaintiffs may choose to ignore the dramatic and destabilizing consequences of their requested relief, but this Court cannot.

In the short-term, for example, a preliminary injunction would halt payments made in connection with advance premium tax credits, which 8.7 million individuals who purchased coverage on the individual marketplaces rely upon to lower the cost of insurance. The vast majority of those individuals may be unable to afford their monthly premiums and thus risk losing coverage. The elimination of ACA-specific programs, such as the Risk Adjustment Program that transfers billions in funds from Exchange health plans with healthier enrollees to plans with higher-risk enrollees, would leave the latter financially exposed. In addition, the broader landscape of interlocking federal and state laws would be left in flux—creating complicated questions regarding the applicability and enforcement of state laws and regulations, including those that are expressly tied to the ACA.

The Medicaid program would likewise experience significant disruptions. Stopping the funding for individuals made newly eligible for Medicaid under the ACA would harm the 34 states that have chosen to expand their Medicaid programs and potentially disrupt healthcare coverage for the 12 million people added as a result of that expansion. States, many of which already face budget challenges, would need to grapple with the unexpected loss of federal funds. Medicaid managed care plans, operating under contracts negotiated with their state business partners, would face substantial financial exposure and operational uncertainty as states may be unable to make their contracted payments. The coverage of millions of low-income and medically-vulnerable patients—and their ability to receive necessary treatments and prescription drugs—would be cast into doubt. At the same time, state Medicaid programs would see drug costs increase considerably for all enrollees (including children, disabled, and elderly) due to the loss of the ACA's enhanced prescription drug rebates.

Enjoining the ACA would similarly have serious impacts on Medicare beneficiaries. The ACA made fundamental changes to the methodology used to set annual payment rates for Medicare Advantage plans and to the design of the Part D program, including eliminating the "donut hole" gap in prescription drug coverage between initial coverage limits and catastrophic-coverage thresholds. Health insurance providers receiving prospective monthly payments, the 44 million seniors covered by Medicare Part D, and the 20 million beneficiaries enrolled in Medicare Advantage plans would all face substantial uncertainty and other disruptions as the federal government determines how to implement the pre-ACA payment methodology and benefit structure during the pendency of a preliminary injunction. For example, millions of seniors and other Part D enrollees could face unexpectedly high out-of-pocket costs for their prescription drugs if the coverage gap is reinstated. And confusion and uncertainty around

payment levels could cause delays in payments to Medicare Advantage and Part D plans pending the outcome of this litigation—leaving a potential shortfall of more than $25 billion each month.

The effects of either a preliminary injunction or declaratory judgment would not be limited to the near term. Health insurance providers (including AHIP's members) have been developing products for the 2019 calendar year since late 2017 based on the ACA. And the real-world results of those efforts defy the federal government's prediction that the individual marketplace could not function after elimination of the individual mandate if the guaranteed-issue and community-rating provisions remained in place: The 2019 products and rates, which have already been filed in many states per state-law and other guidance, account for the elimination of the individual mandate penalty and indicate the increasing steadiness of individual markets. A preliminary injunction (or declaratory judgment) that issued this summer would *not* provide certainty going into fall open enrollment, as plaintiffs submit. To the contrary, an injunction would leave federally-facilitated marketplaces unable to operate and leave state-based marketplaces in limbo as ACA-related tax credits and other provisions that facilitate participation fall away.

An injunction would also create significant disruption for Medicare Advantage and Part D plan sponsors that have already submitted bids to the Centers for Medicare & Medicaid Services for 2019 based on the ACA's rules, and for Medicare enrollees that are eligible to enroll for 2019 starting October 15, 2018. Further still, it would change assumptions about the pool and mix of enrollees in Medicaid managed care plans used to set rates for 2019, calling into question their actuarial soundness and potentially forcing states to expend considerable resources adjusting rates for a materially-different risk pool.

At bottom, plaintiffs seek to turn off the health insurance system as we know it with the flip of a switch. The ACA's scale and scope make that impossible. Accordingly, this Court should deny a preliminary injunction.

ARGUMENT

In addition to showing a likelihood of success, irreparable harm, and that the balance of hardships favors them, plaintiffs must show that a preliminary injunction "will not disserve the public interest." *Voting for Am., Inc. v. Steen*, 732 F.3d 382, 386 (5th Cir. 2013). The Fifth Circuit has "repeatedly cautioned that a preliminary injunction is an extraordinary remedy which should not be granted unless the party seeking it has clearly carried the burden of persuasion on all four requirements." *Id.* Because the "[f]ailure to sufficiently establish any one of the four factors requires this Court to deny the movant's request for a preliminary injunction," *City of Dallas v. Delta Air Lines, Inc.*, 847 F.3d 279, 285 (5th Cir. 2017), the "satisf[action] [of] one requirement does not necessarily affect the analysis of the other requirements," *Defense Distributed v. United States Dep't of State*, 838 F.3d 451, 457 (5th Cir. 2016). And "[m]andatory preliminary relief, which goes well beyond simply maintaining the status quo *pendente lite*, is particularly disfavored." *Martinez v. Mathews*, 544 F.2d 1233, 1243 (5th Cir. 1976).

Under these standards, plaintiffs' bid for a preliminary injunction must fail. At a minimum, plaintiffs cannot demonstrate that such relief "will not disserve the public interest"—a factor that captures "judicial concern about the impact of legal decisions on society as a whole as opposed to the more limited interests of private litigants." *Mississippi Power & Light Co. v. United Gas Pipe Line Co.*, 760 F.2d 618, 626 (5th Cir. 1985) (discussing "vital public interest involved in protecting consumers"); *see* 11A CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 2948.4 (3d ed. 2018) ("Focusing on this factor is another way of inquiring whether there are policy considerations that bear on whether the order should

issue."). Even the federal government, which agrees in part with plaintiffs on the merits, believes that a preliminary injunction is "unwarranted." Br. 20 (ECF No. 92).

Citing out of circuit precedent, plaintiffs assert that they have satisfied the public interest factor because "'it is always in the public interest to prevent the violation of a party's constitutional rights.'" Pls. Br. 49-50 (ECF No. 40) (quoting *Awad v. Ziriax*, 670 F.3d 1111, 1132 (10th Cir. 2012)). But that is not the law of the Fifth Circuit, which holds that countervailing public interests can outweigh any need to enjoin a likely unconstitutional law. *See Defense Distributed*, 838 F.3d at 458-459 (affirming that plaintiffs' "interest in protecting their constitutional rights" was insufficient to satisfy the public interest factor because "the public interest in national defense and national security [wa]s stronger"). In any event, because the predicate for plaintiffs' argument that the ACA's individual mandate is unconstitutional—elimination of the individual penalty—does not occur until 2019, there is presently no constitutional violation to remedy. And any public interest in enjoining the individual mandate cannot be bootstrapped to the many other ACA provisions that plaintiffs have not challenged as unconstitutional. At bottom, a preliminary injunction that will threaten or cut off billions of dollars in federal funds, upend a complex federal law that has transformed the Nation's healthcare system, and leave states, health insurance providers, patients, and others unequipped and unable to support the market—all of which is likely to result in the loss of coverage for tens of millions of Americans—does not satisfy the high bar for the extraordinary relief plaintiffs seek.

I. PLAINTIFFS' EXTRAORDINARY REQUEST FAILS TO ACCOUNT FOR THE IMPACT AND REACH OF THE ACA

A. The Disruption Caused By Enjoining The ACA Would Be Commensurate With Its Unique Complexity, Scale, And Scope

It is widely acknowledged that the ACA represents the most significant health legislation enacted since the Social Security Act amendments that created the Medicare and Medicaid programs in 1965. The ACA adopted several major reforms, including (i) restructuring the individual and small group markets, providing financial assistance for individuals and families earning under 400% of the federal poverty level (FPL), and offering tax credits to certain small employers who offer coverage; (ii) expanding Medicaid to cover low-income adults ages 19-64 earning up to 138% of the FPL; and (iii) reforming numerous provisions of Medicare including phasing out a longstanding coverage gap in prescription drug coverage. *See* Decl. of Matthew David Eyles ¶ 2 (ECF No. 15-1) ("Eyles Decl.").

Since the ACA's enactment, the number of people without health insurance has dropped by 20 million. *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).[1] In the first quarter of 2017, millions of individuals enrolled in fully insured coverage in both the individual market (18.4 million) and the small group market (13.6 million), with AHIP's member plans actively participating in both and providing coverage to 13.5 million individuals. Eyles Decl. ¶ 5. The expansion of Medicaid—currently in 34 states, Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (last visited June 13,

[1] https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

2018)[2]—led to a 13% increase in the number of covered non-elderly people between 2013 and 2016.

The ACA's reach, however, goes much further than those statistics. In the wake of the ACA, many states passed conforming legislation—including new laws pegged to the ACA's provisions. *See* National Conference of State Legislatures, *2011-2014 Health Insurance Reform Enacted State Laws Related to the Affordable Care Act* (updated June 17, 2014).[3] And the ACA has had broader economic effects, including providing budget savings to states through increased federal Medicaid support and delivering an important source of funding in Medicaid expansion states to allow rural hospitals to remain open. Adam Searing, *Study Documents How Medicaid Expansion Helps Keep Rural Hospitals Open*, GEORGETOWN UNIV. HEALTH POLICY INST. (Jan. 12, 2018).[4]

The ACA provides billions of dollars of federal payments through advance premium tax credits, small business tax credits, and Medicaid payments in the form of federal financial participation. An abrupt cessation of such funding would materially impact health insurance providers and other stakeholders across the healthcare sector. *See* Part II, *infra* (discussing individual market, Medicaid, and Medicare impacts). And it would jeopardize healthcare coverage for millions of Americans, Eyles Decl. ¶ 12 (noting elimination of Medicaid coverage for 12 million people), not to mention the provision of critical services that are now tied to the ACA, *e.g.*, Decl. of Henry J. Aaron ¶ 42 (ECF No. 15-1) (ACA's prevention and public health

[2] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-9

[3] http://www.ncsl.org/research/health/health-insurance-reform-state-laws-2013.aspx#2014_laws

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

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.").

The consequences would reverberate across the economy as well. Partial repeals of the ACA have been calculated to increase the number of uninsured individuals by over 30 million and would significantly increase the cost of uncompensated care. *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)[5]; H.R. 1628, Obamacare Repeal Reconciliation Act of 2017, CONG. BUDGET OFFICE (July 19, 2017) (hereinafter "CBO Report").[6] That would put considerable budget stress on state and local governments, health insurance providers, and the health system more generally.

B. Congress Recognized The Risks Of An ACA Repeal (Even If Replaced) And Provided For A Years-Long Stable Transition Period

Distilled to its most basic premise, the preliminary relief sought in this case would operate no differently than the repeal of the ACA (either in whole or in part) without the benefit of either a transition period or any manner of replacement. Before undertaking such an extraordinary step, it is instructive to consider Congress's most recent deliberations concerning the different efforts to repeal and replace the ACA. The legislative proposals that the 115th Congress considered reflected one area of clear consensus: that repeal itself could not be

[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

[6] https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf

immediate or without substitute, but rather must be accompanied by a transition period towards some replacement, which would be subject to its own implementation period.

Given the scale, scope, and complexity of the ACA, and the extensive impacts any repeal-and-replace effort would engender, Members of Congress—including those leading the effort to repeal the ACA—widely acknowledged the need for and wisdom of a stabilizing transition period. In May 2017, the House approved the American Health Care Act (AHCA)—among the most noteworthy repeal-and-replace proposals—which maintained existing advance premium tax credits (APTCs) for two years (2018-2019) before transitioning to a different tax credit structure starting in 2020. H.R. 1628, 115th Cong. § 132 (2017). The Senate's responsive legislative proposal, the Better Care Reconciliation Act (BCRA), similarly sought to avoid coverage disruptions to consumers by: (i) funding APTCs for two years before major changes would take effect in 2020; and (ii) creating a "State Stability and Innovation Program" that would use $50 billion during 2018-2021 to "address[] coverage and access disruption" and provide support for states, BCRA § 106. These bills also included transition periods for changes in Medicaid expansion coverage. For example, the AHCA reduced (and did not eliminate) federal funding for the expansion population starting in 2020, and the BCRA phased down federal funding over a four-year period beginning in 2021. AHCA § 111(2); BCRA § 125(a).

Both the House and Senate bills also would have delayed the implementation of new replacement measures. A "per capita-based cap on payments for medical assistance," for instance, would not have taken effect in the Medicaid program until fiscal year 2020. AHCA § 121; BCRA § 132. Likewise, the Medicaid flexible block grant option for states would not have taken effect until fiscal year 2020. AHCA § 121; BCRA § 133. And in both instances, even

the proposed transition timeframes were deemed inadequate.[7] Similarly, neither the AHCA nor the BCRA included provisions that would have repealed the ACA's reforms to the Medicare program, and those bills altered only some of the many changes the ACA made to Medicaid. Taken together, the inclusion of such transitional relief provisions and Congress's repeated approach of not repealing the entirety of the ACA's modifications to Medicare and Medicaid reflect that any repeal-and-replace effort must include an orderly and measured transition, rather than the abrupt halt sought by plaintiffs here.

II. GRANTING PRELIMINARY RELIEF WOULD RESULT IN MASSIVE DISRUPTION, MARKET CHAOS, AND IMMEDIATE SHORT-TERM HARMS TO PATIENTS, HEALTH INSURANCE PROVIDERS, AND OTHER STAKEHOLDERS

Notably, plaintiffs do not dispute the need for "all States and individuals *** [to] prepare to operate and live without the ACA" or that "they should be afforded sufficient time to prepare." Pls. Br. 41, 49. In plaintiffs' words, which are equally applicable to other ACA participants, "[t]ime to prepare is key" in view of the reality that "States cannot turn their employee insurance plans and Medicaid operations on a dime." *Id.* at 49. That much plaintiffs have right. But it does not follow that a preliminary injunction should issue "sooner rather than later." *Id.* Because an injunction will not provide any protections against disruption and confusion, or otherwise ensure a stable transition period, such relief will not be in the public interest—regardless of when it issues. The immediate impacts of a preliminary injunction on the

[7] *See, e.g.*, Statement for the Record of American's Health Insurance Plans & Blue Cross Blue Shield Association on the Graham-Cassidy-Heller-Johnson (CGHJ Proposal), Submitted to the Senate Finance Committee 4 (Sept. 25, 2017), https://www.ahip.org/wp-content/uploads/2017/09/AHIP-BCBSA-statement-for-Senate-Finance-hearing.pdf (noting that an 18-month period for states to establish state-specific comprehensive health coverage programs in order to receive federal block grant funding and prepare to transfer to a per capita cap Medicaid financing system was an extremely short timeframe for implementation, and would likely lead to chaos in both the individual market and Medicaid programs in all states)

individual market, Medicaid, and Medicare leave no doubt why, even if the Court were to have reservations about the constitutionality of the individual mandate, the public interest on balance would still be disserved by granting plaintiffs' request.

A. Individual Market

Those participating in or connected to the individual market would face tremendous coverage disruption, financial losses, and uncertainty if the Court grants preliminary relief.

A preliminary injunction would halt payments made in connection with the ACA's APTCs, which allow lower-income enrollees to apply for the federal government to subsidize (on a prospective basis) a sizeable portion of their monthly insurance premiums for the upcoming year if their household income meets certain criteria. *See* 26 C.F.R. § 1.36B-2. Eliminating payment of APTCs—resulting in a sudden spike in monthly premiums—would have the effect of making coverage unaffordable for many of the 8.7 million Americans who rely on those subsidies. *See* Centers for Medicare & Medicaid Services, *2017 Effectuated Enrollment Snapshot* 2 (June 12, 2017).[8] The approximately 9 million people who pay the whole cost of their individual market coverage without any APTCs, in turn, would be affected by deterioration of the market 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 Congressional Budget Office's (CBO) review of the proposed Obamacare Repeal Reconciliation Act of 2017 is instructive. Unlike the AHCA and the BCRA discussed above, that measure would have repealed the ACA *without any replacement*—tantamount to the preliminary injunction sought in this case. The CBO concluded that such legislation would have two

[8] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

principal effects on insurance 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*, 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. As a result, "about half of the nation's population would live in areas having no insurer participating in the nongroup market in 2020 because of downward pressure on enrollment and upward pressure on premiums," with that proportion reaching "about three-quarters of the population by 2026." *Id.* Although the figures would be smaller for a preliminary injunction period, they leave no doubt regarding the scale of disruption if the ACA is enjoined without an orderly transition.

Preliminary relief would further destabilize the individual market by eliminating the ACA's Risk Adjustment Program, which encourages health insurance providers to compete based on the value and efficiency of their plans, rather than by attracting healthier enrollees. *See* Centers for Medicare & Medicaid Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* 3-4 (June 30, 2017).[9] The program accomplishes this objective by transferring funds from plans with healthier enrollees to plans with higher-risk enrollees (such as those with chronic or other pre-existing conditions). *Id.* If this Court enjoined the continuation of the Risk Adjustment Program, health insurance providers that disproportionately enrolled higher-cost and higher-risk individuals would not receive adjustment payments. The cessation of such payments would have a

[9] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

meaningful impact: in 2016, risk adjustment payments accounted for 11% of premiums in the individual ACA market. *Id.* at 9, tbl. 3. That impact would extend into 2019, as health insurance providers have already submitted individual rates in many states that assume the continued operation of the Risk Adjustment Program. *See* pp. 22-23, *infra*.

In a similar vein, many state laws (including certain plaintiffs' laws) also require health insurance providers to lock in rates prospectively for a full plan year and to provide coverage for a fixed period of time. *See, e.g.*, CAL. INS. CODE § 10901.9(c)(2) & CAL. HEALTH & SAFETY CODE § 1399.811(c)(2); LA. REV. STAT. ANN. § 22:1098; OR. REV. STAT. § 743.022(3); WASH. REV. CODE §§ 48.44.021(1)(c)(vi), 48.44.022(1)(f), 48.46.063(1)(c)(vi), 48.46.064(1)(f). Those state laws assume that health insurance providers and the state receive reimbursement or subsidies from the federal government for bearing certain costs imposed by the ACA in the form of coverage mandates and other requirements. Health insurance providers have similarly made actuarial assumptions about risk pool mix and anticipated enrollment numbers based on the continued existence and enforcement of the ACA (including the continued operation of the risk adjustment program and payment of APTCs).

In the event that this Court enjoins enforcement of the ACA, it would be unclear whether health insurance providers could permissibly recalculate rates or design new products based on the new actuarial realities created by such a grant of relief. As noted above, many states have passed laws and enacted regulations that assume and rely upon the continued enforcement and viability of the ACA, which include (among others) provisions related to guaranteed issue regardless of pre-existing conditions, three-to-one age band rating requirements, and dependent child coverage until the age of 26. Injunctive relief would raise complicated questions as to the continued applicability and enforcement of these state laws and regulations.

B. Medicaid

Granting preliminary relief would significantly disrupt Medicaid. Currently, 34 states have expanded Medicaid. Millions of low-income Americans depend on Medicaid and health plans offered through Medicaid managed care organizations for affordable access to medical care. Eyles Decl. ¶ 7. The elimination of the ACA's expansion of Medicaid eligibility would cause states to lose federal funding that covers most of the expenses for 12 million expansion enrollees. *Id.* ¶ 12. Based on 2016 data, the amount needed to cover the expansion population is estimated at $66 billion annually. Robin Rudowitz, *Understanding How States Access the ACA Enhanced Medicaid Match Rates*, KAISER FAMILY FOUND. (Sept. 29, 2014)[10]; *see also* CBO Report, *supra*, at 6 (estimating that Obamacare Repeal Reconciliation Act of 2017's 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 this revenue (even temporarily) and may have no choice but to eliminate coverage for millions of people.

At the same time, millions of expansion enrollees could face the prospect of losing their coverage and their ability to receive necessary treatments and prescription drugs. CBO Report, *supra*, 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 individuals, including those in the middle of critical and potentially lifesaving treatments. Without coverage, many expansion enrollees would forgo preventative care and seek much more expensive healthcare as a last resort from emergency rooms and public hospitals. Recent studies document that increased

[10] https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

coverage through the Medicaid expansion resulted in a $6.2 billion reduction in uncompensated healthcare costs for hospitals from 2013-2015. *See* Antonisse, *supra*.

A preliminary injunction 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). Enjoining 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 beneficiaries.

Furthermore, an injunction would have the effect of reducing targeted ("pass-through") payments to healthcare entities that states deem critical to their healthcare 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 those providers—which are 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 lost Medicaid coverage.

Ultimately, the impact of losing federal Medicaid funds would be felt in all states, including the 26 states that chose to expand Medicaid through contracts with Medicaid managed care plans. Data from 2016 indicate that approximately 11.9 million expansion enrollees are served through such managed care arrangements. *See* Centers for Medicare & Medicaid

Services, Medicaid Budget and Expenditure System (MBES) Enrollment Report (Dec. 2016).[11] While each state's contracts with their respective managed care plans may differ, they would all face the same fundamental question regarding whether the state could afford to keep making contractually obligated payments. In some states, depending on state law and the agreed-to contract terms, legal uncertainty may arise as to whether plans would be required to continue providing coverage without receiving payment pending the resolution of this case. Yet clearly plans did not enter into their contracts with the expectation that they would be forced to assume significant liability for amounts that were otherwise contractually agreed to be paid by their state business partners. Such a scenario would severely impair many plans.

A preliminary injunction that immediately 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 healthcare providers, implementing state operations, and expanding information systems to accommodate their projected expansion membership and healthcare utilization. An injunction could force plans to eliminate jobs in operational areas where staffing levels vary with enrollment and subject plans to losses in administrative areas with fixed staffing costs.

Finally, the preliminary relief requested could result in Medicaid programs incurring higher prices for prescription drugs because it would roll back the ACA's increase in prescription drug rebates and reverse the ACA's extension of 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%. *See* Medicaid and CHIP Payment Access Commission/MACPAC,

[11] https://data.medicaid.gov/Enrollment/2016-4Q-Medicaid-MBES-Enrollment/capi-ym43

Issue Brief, Medicaid Spending for Prescription Drugs 3, fig. 1 (Jan. 2016).[12] 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%. *Id.* While 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 changes reduced drug costs. A mid-2018 change would cut back the drug rebates without giving managed care plans or states the opportunity to negotiate offsetting rebates.

C. Medicare

A preliminary injunction of the ACA would also significantly disrupt the Medicare Advantage and Medicare Part D programs. Under those programs, health insurance providers receive prospective monthly payments that are set on an annual basis by the Centers for Medicare & Medicaid Services (CMS). The ACA made a number of major changes in the methodology used to calculate those payments, the status of which would be immediately called into question by a preliminary injunction. That, in turn, could disrupt coverage for more than 44 million seniors and individuals with disabilities currently covered by Medicare Part D and for the 20 million beneficiaries enrolled in Medicare Advantage plans.[13]

With respect to Medicare Part D, the ACA created the Coverage Gap Discount Program and phased in increased plan coverage to reduce beneficiary out-of-pocket spending in what is colloquially known as the "donut hole." *See* Health Care and Education Reconciliation Act, Pub.

[12] https://www.macpac.gov/wp-content/uploads/2016/01/Medicaid-Spending-for-Prescription-Drugs.pdf

[13] *See* Centers for Medicare & Medicaid Services, MEDICARE ADVANTAGE, COST, PACE, DEMO, AND PRESCRIPTION DRUG PLAN CONTRACT REPORT—MONTHLY SUMMARY REPORT (May 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html. As of May 2018, 20 million enrollees are in Medicare Advantage plans, and 18 million of these receive drug coverage through these plans. A total of 44 million enrollees are in plans that offer drug coverage (18 million in Medicare Advantage and 26 million in stand-alone prescription drug plans or other plan types).

L. No. 111-152 § 1101, 124 Stat. 1029, 1036-1037 ("HCERA"); Medicare.gov, *Costs in the Coverage Gap* (last visited June 13, 2018) (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).[14]

An injunction 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." This would cause substantial financial hardship for many seniors and individuals with disabilities, especially those who live on a fixed income. *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 422, fig. 14-6 (Mar. 15, 2018).[15] And there would be downstream effects as well given that affordability is a primary driver of people not taking recommended prescriptions, which in turn can lead to clinical complications and adverse health outcomes.

With respect to Medicare Advantage, the ACA implemented a number of reforms to the benchmarks used to calculate federal payments to health insurance providers, created a quality bonus payment based on plan performance, 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.

Preliminarily enjoining the ACA could destabilize Medicare Advantage. Congress requires that CMS prospectively set payment rates for Medicare Advantage plans on an annual basis, by the first Monday in April, so that health insurance providers can determine the financial risk of providing a defined set of benefits. *See* 42 U.S.C. § 1395w-23(b). And by statute,

[14] https://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html

[15] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

Medicare Advantage plans must submit bids to CMS by the first Monday in June of each year to determine the benefits and establish the premiums based on those rates. *See id.* § 1395w-24(a). Enrollees choose plans based on the benefits and premiums reflected in the bids. Most of these choices are made by enrollees during the open enrollment period that occurs from October 15 to December 7 each year. A preliminary injunction would be inconsistent with these statutory requirements, as 2018 payment rates for Medicare Advantage plans are based on bids and rates calculated in 2017.

More broadly, the injunction could create significant disruption in the Medicare Advantage bidding and payment system. It would create confusion as to how CMS calculates payment rates and the appropriate benefits that apply for the remainder of 2018. It could eliminate performance-based programs that incentivize high quality health plans. The injunction would raise questions about the level of supplemental benefits required for enrollees under different rebate levels. And it could have other impacts, including on provider contracts.

These uncertainties could result in CMS halting all payments to private plans pending the outcome of this litigation. Payments to Medicare Advantage and Part D plans exceed $25 billion each month. *See* 2018 ANNUAL REPORT, BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 11, tbl. II.B1 (June 5, 2018).[16] Delays in these payments could create serious fiscal challenges.

III. A PRELIMINARY INJUNCTION OR DECLARATORY JUDGMENT WOULD IRREPARABLY IMPAIR HEALTH INSURANCE PROVIDERS' ABILITY TO MAKE PLAN OFFERINGS FOR 2019

The grant of a preliminary injunction would cause longer-range disruption to the health insurance industry and harm to the public interest. Despite the challenges that health insurance

[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

providers have faced over the last several years, they have relied upon and expected the government to be a reliable business partner. Congress's prior efforts to enact repeal-and-replace legislation providing for a stable transition period speak to that relationship. A preliminary injunction, however, would upset expectations and undercut "the Government's own long-run interest as a reliable contracting partner," thereby making "willing partners more scarce" in the future. *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-192 (2012).

A preliminary injunction would leave no time for health insurance providers to make necessary adjustments in the individual market for the 2019 calendar year. Health insurance providers began the process of developing and pricing products for 2019 based on current law as far back as November 2017. In addition, because the ACA preserves the historical role of states in conducting and approving health insurance premiums, premiums must be filed with state regulators as early as eight months in advance (*i.e.*, in May 2018) under schedules set by the states. Furthermore, initial applications to participate in the federal Exchanges for the next calendar year are filed starting in May. *See* Attach. A, at 1.

Accordingly, plaintiffs' view—that "an injunction, for example, issued on December 31, 2018 will be far less effective than an injunction issued promptly after briefing is complete *** because individuals will make insurance decisions during fall open-enrollment periods," Pls. Br. 49—reveals a fundamental misunderstanding of the disruption that will ensue if a preliminary injunction is granted. This is not simply a matter of open enrollment. By the time briefing concludes on July 9, 2018, health insurance providers in 39 states will have already filed their premium rates and various product offerings for 2019 with state regulators. *See* Attach. A, at 2.

The sudden suspension of the ACA thereafter would create an environment where many health insurance providers—faced with massive market uncertainty and instability—would find

fewer incentives to participate in federally-facilitated and state-based marketplaces in 2019. It would also jeopardize individuals' ability to purchase affordable and robust coverage throughout much of the country. Indeed, if the ACA's requirements are deemed invalid, states would be forced to reexamine their existing laws and potentially need to enact new laws and implement new regulatory regimes in order to approve any products for sale for 2019. In the 40 states where 7.8 million enrollees rely on a federally-facilitated marketplace, open enrollment simply would not be possible; those ACA-created marketplaces would cease operations on all fronts. State-based marketplaces would also need to make difficult decisions about how to proceed. As ACA-related tax credits and other provisions fall away and enrollment declines because APTCs are not paid, state-based marketplaces would lack expected revenues (which are typically based on user fees) and likely would need to curtail their operations sharply.

The federal government argues that (Br. 13-16) in the absence of the individual mandate, "retention of the guaranteed-issue and community-rating requirements would expose health insurers (and their customers) to unfettered adverse selection by individuals who can game the system by waiting until they are sick to purchase insurance," thereby impeding operation of the individual marketplaces. That theoretical "death spiral" argument, however, misses the real-world fact that the 2019 plans and rates filed by health insurance providers (pursuant to the process explained above) already account for the operation of those provisions with the individual mandate penalty zeroed out for 2019, *i.e.*, effectively *without* the individual mandate. *See*, *e.g.*, Press Release, Department of Financial Services, New York State, Proposed 2019 Health Insurance Premium Rates for Individual and Small Group Markets (June 1, 2018)[17]; Press Release, Office of the Health Insurance Commissioner, State of Rhode Island, 2019 Requested

[17] https://www.dfs.ny.gov/about/press/pr1806011.htm

Commercial Health Insurance Rates Have Been Submitted to OHIC for Review (May 30, 2018).[18] Despite the resulting increases in some premiums, the individual markets have demonstrated a continued resiliency—and, in many instances, have shown signs of increasing steadiness as states and health insurance providers respond to a shifting market composition. *See* Repealing the Individual Health Insurance Mandate: An Updated Estimate, CONG. BUDGET OFFICE 1 (Nov. 2017) (concluding that "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade" if Congress "repeal[ed] th[e] [individual] mandate starting in 2019—and ma[de] no other changes to current law").[19]

But if, as the federal government requests, this Court were to issue a declaratory judgment invalidating the ACA's guaranteed-issue and community-rating requirements (effective 2019), the harmful effects would be no less for 2019 than if the Court were to grant plaintiffs' request for preliminary injunctive relief now. As discussed, health insurance providers have already designed and submitted products based on the ACA's requirements, including offering them on a guaranteed-issue basis and using actuarial standards based on community-rating requirements. Shifting to a marketplace that eschews guaranteed-issue and community-rating would only upend a steadying market, not save it.

And finally looking beyond the individual market, the Medicare and Medicaid programs would also be impacted long-term. Health insurance providers participating in Medicare Advantage submitted their bids for 2019 on or before June 4, 2018. *See* Memorandum from Kathryn A. Coleman, Dir., Centers for Medicare and Medicaid Services to Medicare Advantage

[18] http://www.ohic.ri.gov/documents/2018%20Rate%20Review%20Documents/2018%20Rate%20Review%20Process%20Press%20Release%20-%20Requested%20Rates.pdf

[19] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

Organizations, Section 1876 Cost Plans 1 (Apr. 12, 2018).[20] As noted above, the bids covered a specific set of benefits and premiums, based on rates determined under the ACA methodology. A change in rates for 2019 in the latter half of 2018 would place this entire Medicare Advantage benefit structure at risk. Further, it would be inconsistent with existing statutory requirements that rates be set *in advance of* bid submissions.

A preliminary injunction would also raise a number of issues around rates for Medicaid managed care plans. Medicaid rate setting is 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. By drastically altering the covered population, a preliminary injunction would negate the actuarial basis for current Medicaid plan rates, and could compel states to undertake a lengthy and expensive process of rebuilding and recalculating rates to reflect the removal of expansion enrollees from the risk pool. Those impacts could well materialize in 2019. States and plans may have already devoted significant resources toward setting rates based on current law, and it may be difficult following a preliminary injunction to obtain CMS approval of new final rates prior to the start of the year.

CONCLUSION

The Court should: (1) deny plaintiffs' motion for a preliminary injunction; and (2) reject the federal defendants' request that the Court enter declaratory judgment invalidating the individual mandate, guaranteed-issue, and community rating provisions as of January 1, 2019.

[20] https://mabenefitsmailbox.lmi.org/MABenefitsMailbox/Documents/CY%202019%20MA%20Bid%20Review%20and%20Operations%20Guidance%20(002).pdf

Respectfully submitted,

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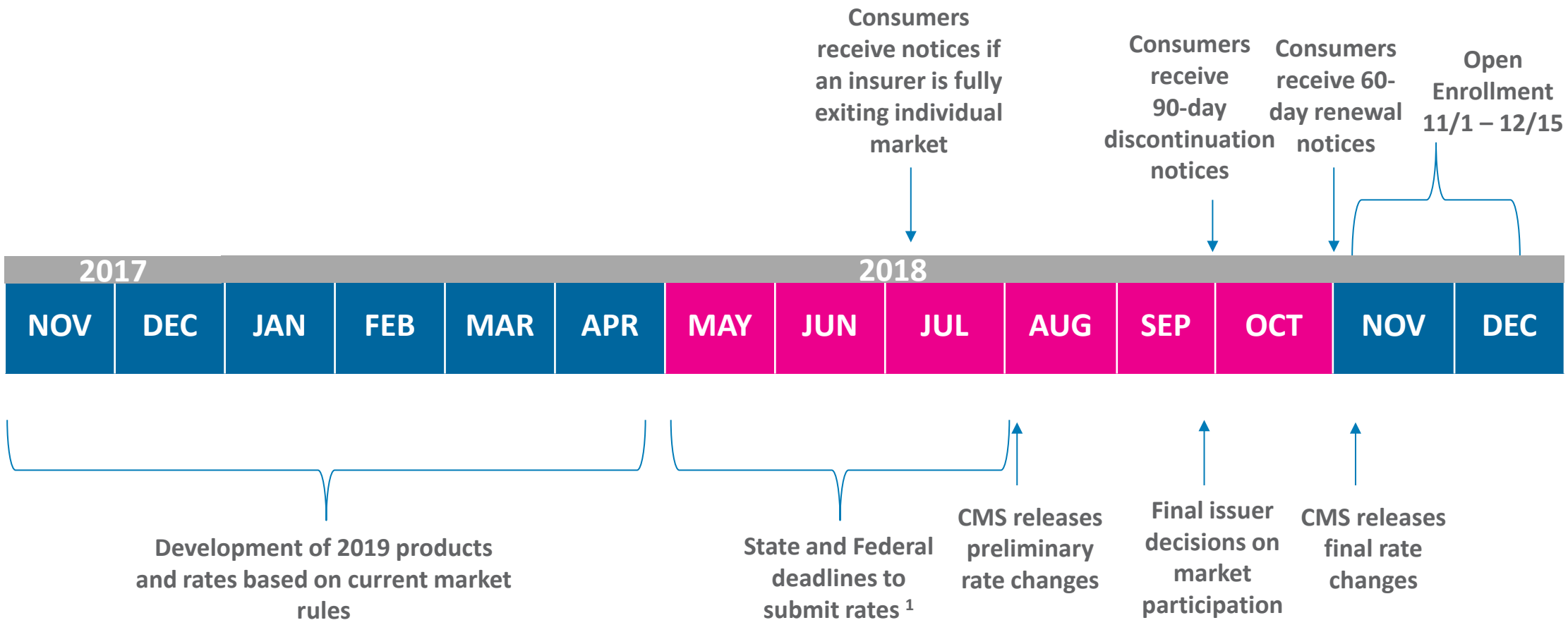
June 14, 2018

ATTACHMENT A

2019 Individual Market Rates: Key Dates



[1] Federal deadline for rates is July 25. State deadlines can be found on the following slide.

2019 QHP State Rate Filing Deadlines

Updated May 30, 2018

May		June		July	
1st	Maryland*, California* ***Fed Rate Deadline for States w/o Effective Rate Review*** *(OK, TX, WY)*	1st	Arizona, Hawaii, Idaho*, Illinois, S. Dakota, D.C.*, Minnesota*	2nd	Wisconsin
				6th	Utah
				11th	Mississippi, New Jersey, Tennessee
4th	Virginia	4th	Maine	13th	Alaska, Kansas
9th	New Hampshire	8th	Nevada**	16th	Connecticut*
11th	Vermont*	10th	New Mexico	23rd	Arkansas
14th	New York*,Oregon**	11th	Colorado*	25th	Alabama, Georgia, Iowa, Missouri ***Federal Rate Deadline for States w/Effective Rate Review***
15th	Rhode Island*	12th	Michigan		
21st	Pennsylvania, N. Carolina	13th	Kentucky		
24th	Washington*	14th	Montana		<u>Fed 5/1 Date Applies</u> Texas Oklahoma Wyoming
25th	N. Dakota	20th	Indiana, Delaware, Louisiana ***FFM QHP application***		
		22nd	Florida		
		25th	S. Carolina		
		27th	W. Virginia		
		29th	Massachusetts*		
		30th	W. Virginia		

* Indicates State-Based Marketplace (SBM) state; ** Indicates State-Based Marketplace-Federal Platform state (SBM-FP)

CERTIFICATE OF SERVICE

I certify that on June 14, 2018, the foregoing *amicus curiae* brief was electronically submitted to the Clerk of Court for the U.S. District Court for the Northern District of Texas using the Court's electronic case filing system. Accordingly, notice of this filing will be sent to all counsel of record.

/s/Jayant Kartik Tatachar