No. 19-10011

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS, *et al.*

Plaintiffs-Appellees

v.

UNITED STATES OF AMERICA, *et al.*

Defendants-Appellants

STATE OF CALIFORNIA, *et al.*

Intervenor Defendants-Appellants

On Appeal from the United States District Court
for the Northern District of Texas

BRIEF OF *AMICI CURIAE* FOR BIPARTISAN ECONOMIC SCHOLARS IN SUPPORT OF INTERVENOR DEFENDANT-APPELLANTS

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INTEREST OF AMICI CURIAE

The *amici curiae* Bipartisan Economic Scholars are a group of 55 distinguished professors and internationally recognized scholars of economics and health policy and law who have taught and researched the economic and social forces operating in the health care and health insurance markets.[1] *Amici* have closely followed the development, adoption, and implementation of the Affordable Care Act ("ACA") and are intimately familiar with its purpose and structure. The Economic Scholars include economists who have served in high-ranking positions in the Johnson, Nixon, Ford, Carter, George H.W. Bush, Clinton, George W. Bush, and Obama administrations; two Nobel Laureates in Economics; one recipient of the John Bates Clark medal, which is awarded biennially to the American economist under 40 who has made the most significant contribution to economic thought and knowledge; six recipients of the Arrow award for best paper in health economics; and three recipients of the American Society of Health Economists Medal, which is awarded biennially to the economist

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for all parties have consented to the filing of this brief.

aged 40 or under who has made the most significant contributions to the field of health economics. A complete list of the Economic Scholars is provided in the Appendix at the back of this brief.

The Bipartisan Economic Scholars believe that the available evidence demonstrates that the ACA has improved the quality and affordability of health care in many ways, including by increasing the availability of private health insurance, expanding and improving Medicaid, reforming Medicare, and supporting federal, state, and local initiatives to prioritize prevention and improve public health.

The Bipartisan Economic Scholars submit this brief to assist the Court in assessing the district court's conclusion that Congress would not have wanted the rest of the ACA to stand if the individual mandate were struck down. There is no doubt that the individual mandate is an important component of the ACA, but the ACA is far larger than the individual mandate and will continue to improve health care markets in a wide variety of ways even without an enforceable individual mandate. As a result, invalidating the ACA as a whole would have far reaching and pernicious economic consequences. *Amici* urge the Court to reject the district court's holding that the individual mandate is not severable from the rest of the

ACA. *Amici* also urge the Court to reject the argument, made by the Department of Justice below, that the community rating and guaranteed issue provisions of the ACA are not severable from the individual mandate.

INTRODUCTION AND SUMMARY OF ARGUMENT

It is indisputable that the ACA has helped to dramatically reduce the number of people without health insurance in America. Since its enactment, an estimated 20 million previously uninsured people—women and men, children and adults, poor and rich, minority and majority—have availed themselves of the quality and affordable coverage offered as a result of the ACA. The individual mandate, along with other provisions of the ACA, helped to ensure that the insurance risk pool includes both the healthy and the sick, thereby decreasing the magnitude of "adverse selection" into private individually purchased insurance markets and thus avoiding a situation that could "le[a]d to an economic 'death spiral.'" *King v. Burwell*, 135 S. Ct. 2480, 2484-86 (2015).

In the decision below, the district court held that the individual mandate is unconstitutional, and that the mandate "is inseverable from the entire ACA." Opinion at 35. According to the district court, "it is unthinkable and impossible that the Congress" would have wanted the rest

of the ACA to stay in place if the mandate were invalidated. *Id.* at 51 (internal quotation marks omitted).

To be sure, the individual mandate played an important role in the ACA's provisions. It is also the case that the 2017 decision of Congress to zero out the penalty for enforcing the individual mandate has caused the number of uninsured to rise, increased premiums for those who remain insured, and had a serious negative effect on the economy. Invalidating the mandate entirely might marginally increase these effects further.

But the economic modelling and analysis prove that the consequences of invalidating only the individual mandate pale in comparison to the dramatic and far-reaching harm that invalidating the ACA in its entirety would cause.

First, the district court's order would cause a surge in the number of people without insurance and significantly erode access to and use of care. As a recent analysis by the Urban Institute shows, after accounting for recent regulatory changes and reducing the penalty for violating the individual mandate, invalidating the ACA now would cause millions of people to lose insurance coverage and cause deep cuts in federal spending on healthcare.

Second, if implemented, the district court's order also would cause enormous disruption and uncertainty for the US health care industry, which constitutes about 20 percent of the US economy. Billions of dollars of private and public investment—impacting every corner of the American health system—have been made based on the existence of the ACA. The district court's order would upend all of those settled expectations and throw healthcare markets, and 1/5 of the economy, into chaos.

Third, the district court's order covers far more that the individual mandate and would undermine scores of laws and regulations that have nothing at all to do with the individual mandate, including the Medicaid program through which millions of Americans receive health care.

Finally, the Department of Justice contended below that while Congress would not have wanted the entirety of the ACA to be invalidated if the mandate were struck down, it also would not have wanted the community rating and guaranteed issue provisions to survive. Br. of United States at 2, D. Ct. Dkt. 92. While the Department has apparently abandoned this position, the Court should understand that economic modelling and analysis along with clear real-time evidence refute that proposition as well. As has been documented by the Administration's own data, the number of

participating insurers in the ACA's nongroup insurance marketplaces is *higher* and the premium increases are *lower* in 2019 than in 2018, the last year with the mandate penalties in place.

Moreover, eliminating the guaranteed issue and community rating provisions would hamstring other important features of the ACA that would remain. For example, without those provisions, millions of individuals with pre-existing conditions would likely be unable to obtain insurance at any price, and thus would not be eligible for the premium tax credit subsidies the ACA provides

In sum, this Court should reverse the district court's order striking down "the entire ACA," and it should reject the contention that Congress would not have wanted the community rating and guaranteed issue provisions that it enacted to be maintained if the individual mandate were invalidated.

ARGUMENT

I. IF IMPLEMENTED, THE RULING BELOW WOULD CREATE A SURGE IN THE NUMBER OF UNINSURED THAT WILL SPUR NEGATIVE CONSEQUENCES THAT REVERBERATE THROUGH THE ECONOMY.

The most immediate impact of implementing the district court's order would be a surge in the number of people without health insurance. But that is not the only impact. Striking down the ACA would cause uncompensated care to soar and markedly decrease federal spending on health care.

A. Invalidating The ACA Would Undo The ACA's Increased Access To Affordable Health Insurance And Healthcare Services.

Invalidating the ACA would undermine the concrete gains in insurance coverage achieved under the Act. Overall, between 2010 and September 2018, an estimated 19 million more people obtained health insurance—a drop of 43 percent in the uninsured rate.[2] These figures include an estimated 3.2 million African-Americans, 3.8 million people of Hispanic origin, 11 million white Americans, 5.4 million young adults (19-25), and 2.4

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[2] Emily P. Terlizzi et al., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018*, National Center for Health Statistics (Feb. 2019), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf.

million children (0-18) who gained insurance coverage.[3] Those gains were seen across the income spectrum, with the uninsured rate dropping by 43 percent for nonelderly adults with income below 138 percent of poverty, 37 percent for people with income between 138 and 400 percent of poverty, and 34 percent for people with incomes above 400 percent of poverty.[4]

Much of this gain in coverage occurred because the ACA ensured that coverage in the individual insurance market was affordable. Between 2013 and 2016, the ACA contributed to a 57 percent increase in the number of people covered in the individual insurance market.[5] This gain occurred through the ACA's creation of health insurance Marketplaces and its premium subsidies. As of 2017, 84 percent of the 10.3 million enrollees received premium tax credits averaging approximately $4,458 per enrollee per year.[6] At the same time, that financial assistance allowed 71 percent of

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3 Urban Institute analysis of the person file and imputed income files for the 2010 and 2017 National Health Interview Survey, https://www.cdc.gov/nchs/nhis/nhis_2010_data_release.htm; https://www.cdc.gov/nchs/nhis/nhis_2017_data_release.htm.

4 *Id.*

5 Henry J. Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Mar. 27, 2019).

6 Centers for Medicare & Medicaid Services, *2017 Effectuated Enrollment Snapshot* (June 2017), https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

Marketplace enrollees to buy health insurance for less than $75 per month.[7] That provides some explanation for why the number of people who reported finding it very difficult or impossible to find affordable health insurance dropped almost by half between 2010 and 2016.[8] These (and many other) gains would be reversed if the ACA were invalidated in its entirety.

The district court's order would undo gains in *access* to healthcare as well. Study after study has shown that the ACA has improved access to health care, especially among low-income people.[9] For example, the share of people without a regular source of care, and the share of people who did not receive a routine checkup, both dropped by approximately six percent from 2013 to 2017.[10] The share of people who reported that they were unable to

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7 Sara R. Collins et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, The Commonwealth Fund, Issue Brief (Feb. 2017), http://www.commonwealthfund.org/publications/issuebriefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance.

8 *See id.*

9 Gerald F. Kominski et al., *The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations*, 37 Annual Rev. Pub. Health 489 (2017), https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031816-044555.

10 Sharon K. Long et al., *Sustained Gains in Coverage, Access, and Affordability Under the ACA: A 2017 Update*, 36 Health Affairs 1656 (2017), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0798.

obtain needed medical care because of cost dropped by one-third.[11] That access has resulted in tangible increases in the use of health care services, including outpatient care, a usual source of care or personal physician, preventive services, prescription drug use and adherence, and surgical care.[12] Because of the ACA's requirements, that access to care also includes critical coverage for prescription drugs, mental health, maternity care, substance abuse, autism, and a range of other medical issues that were often not covered under private plans prior to 2010.[13] Moreover, the ACA's guarantee of access to health insurance ensures that the up to 133 million Americans who have a pre-existing health condition, including parents of 17 million children with such conditions, can obtain coverage regardless of their job situation or eligibility for government programs.[14]

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11 Executive Office of the President Council of Economic Advisors, *Economic Report of the President, Chapter 4: Reforming the Health Care System* 224-25 (Jan. 2017) ("*CEA Report*").

12 Benjamin D. Sommers et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 New Eng. J. Med. 586 (2017), http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.

13 Office of the Assistant Secretary for Planning and Evaluation, Dep't of Health & Human Servs., *Essential Health Benefits: Individual Market Coverage*, Issue Brief, (Dec. 16, 2011), https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage; Amanda J. Abraham et al., *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, 107 Am. J. Pub. Health 31 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/.

14 Office of the Assistant Secretary for Planning and Evaluation, Dep't of Health & Human Servs., *Health Insurance Coverage for Americans with Pre-Existing Conditions:*

An analysis by the Urban Institute, based on their Health Insurance Policy Simulation Model, quantifies the widespread impact from invalidating the entire ACA now.[15] After accounting for recent regulatory changes and setting the penalty for violating the individual mandate to $0, the Urban Institute's model shows that, if the ACA was repealed in its entirety in 2019, 19.9 million fewer people would have insurance coverage (a 65 percent increase in the uninsured), 15.4 million fewer low-income people would have coverage under Medicaid, and 6.9 million fewer people would have private nongroup insurance coverage.[16] And those retaining private nongroup coverage would have coverage that is less comprehensive (due to elimination of benefit and actuarial value standards) and substantially less accessible (due to the elimination of guaranteed issue and modified community rating

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The Impact of the Affordable Care Act, Issue Brief (Jan. 5, 2017), https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

15 Linda J. Blumberg et al., *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*, The Urban Institute and the Robert Wood Johnson Foundation (Mar. 2019), https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state_0.pdf.

16 The 19.9 million person estimated increase in the uninsured produced through this analysis differs modestly from the 19 million person gain in coverage cited earlier in this brief from a different source. The first analysis is an estimate based on date from the National Health Insurance Survey's early release data for 2018. The second analysis reflects results from the Urban Institute's Health Insurance Policy Simulation Model, which is based on the American Community Survey and is calibrated to account for the 2019 open enrollment period and the most recent Medicaid data.

rules). Invalidating the ACA would also cause federal spending on healthcare to drop by $134.7 billion, a decline of 35 percent in 2019. This drop represents a particularly large decrease in funding of health care for low and modest income people and would translate into a substantial decrease in affordability and access to care.

B. Affirming The Ruling Below Will Have Drastic Consequences On Healthcare Markets And The Healthcare Industry.

The ACA profoundly transformed the rules governing the operation of the US health care system, including those affecting the Medicare program (including payment and benefit rules), the Medicaid program (including rules governing the calculation of eligibility for those already eligible for the program), the employer-sponsored insurance market (including rules governing preventive services and young adults), as well as the individual insurance market, which is the focus of the community rating and pre-existing condition requirements in the law. The ACA's subsidies and Medicaid expansions also increased Federal spending in the health care sector. In 2019, the Federal government will spend $134.7 billion supporting these increases in coverage and access. Striking down the ACA would mean striking down this entire legal structure, and withdrawing a substantial share of funding from the system.

The economic impact from striking down the ACA will fall particularly heavily on the healthcare industry. In an analysis of repeal related to an earlier court challenge, the sharp reduction in the number of people with insurance was projected to reduce industry profits by $6 billion between 2012 and 2021, and cost private insurers more than $350 billion in profits resulting from the ACA's Medicaid expansion.[17] The Urban Institute study estimates that total uncompensated care costs would have increased by 82 percent—from $61.3 billion to $111.4 billion—if the ACA was fully repealed in 2019.[18]

Within the healthcare sector, hospitals will bear the brunt of the economic harm. After enactment of the ACA, "[n]ationwide, uncompensated care has fallen by more than a quarter as a share of hospital operating costs from 2013 to 2015, corresponding to a reduction of $10.4 billion."[19] But if the Act is invalidated, hospitals will again face the heavy cost of uncompensated care as the number of people without insurance skyrockets. An analysis funded by the American Hospital Association estimated that if the ACA

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17 Brief for Economists as *Amici Curiae* at 3, 15, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-393), 2012 WL 78244.

18 Blumberg et al., *supra* note 15, at 13.

19 *CEA Report* at 196.

were repealed, hospitals' overall net income would decrease by $165.8 billion between 2018 and 2026.[20]

The cost would be especially severe for hospitals in the 32 states that took advantage of the ACA's Medicaid expansion prior to 2019 (an additional five states are enrolling new eligibles in 2019 or are expected to submit state plan amendments to begin doing so). In those states, "[m]ean annual Medicaid revenue increased significantly" for hospitals, by approximately $4.6 million per hospital over a two-year period.[21] At the same time, the ACA has helped reduce the costs of uncompensated care for those hospitals by an average of about $3.2 million per hospital, a roughly 34 percent reduction.[22] According to one study, expanding Medicaid "significantly improved" operating and excess margins at hospitals, by 67.3 percent and 41.4 percent, respectively.[23] Small and rural hospitals—which serve 72

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20 Allen Dobson et al., Dobson DaVanzo & Associates, LLC, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals: Findings, Assumptions and Methodology* at 9 (Dec. 6, 2016), https://www.aha.org/system/files/2018-02/impact-repeal-aca-report_0.pdf.

21 Fredric Blavin, Robert Wood Johnson Foundation & Urban Institute, *How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data* at 3 (April 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436310.

22 *Id.*

23 *Id.*

million people "as an important, and often only, source of care," and which the ACA sought to bolster[24]—have tended to experience the greatest gains.[25] Striking down the ACA now will reverse those gains and undo the benefits that hospitals have accrued as a result of Medicaid's expansion.

Many provisions of the ACA affected the fiscal stability of the Medicare program, a foundation of the US health care system on which 60 million seniors and disabled people rely. The ACA "along with other factors, has significantly improved Medicare's financial outlook, boosting [Medicare's] revenues and making the program more efficient."[26] Since 2010, average annual growth in total Medicare spending was cut in half, to 4.4 percent from 9 percent, and average annual growth in Medicare spending per beneficiary dropped to 1.3 percent from 7.4 percent.[27] The Medicare Hospital Insurance Trust Fund, which was projected to become insolvent by

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24 American Hospital Ass'n, *The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform* (Apr. 18, 2011), https://www.aha.org/guidesreports/2011-04-18-trendwatch-opportunities-and-challenges-rural-hospitals.

25 *Id.* at 4.

26 Paul N. Van de Water, Center on Budget and Policy Priorities, *Medicare Is Not "Bankrupt:" Health Reform Has Improved Program's Financing* (July 3, 2018), https://www.cbpp.org/research/health/medicare-is-not-bankrupt.

27 Juliette Cubanski & Tricia Neuman, Henry J. Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (July 18, 2017), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing.

2017, was scheduled to stay solvent from that year until 2026.[28] From 2009 to 2017, that Trust Fund's projected 75-year shortfall dropped six-fold (to 0.64 percent of taxable payroll from 3.88 percent before the ACA).[29] But CBO has projected that repealing the ACA would increase Medicare spending by $802 billion over ten years, which would require raising seniors' premiums, unwind efficiencies, and hasten the insolvency of the Medicare Hospital Insurance Trust Fund.[30] In short, invalidating the ACA would all but nullify the ACA's major advances in putting Medicare on solid footing.

The states would face a similar economic impact if the ACA ceased to exist. In the analysis referenced above, the Urban Institute explains that uncompensated care is currently financed by a combination of federal government, state governments, and health care providers themselves. Without the ACA, states would face increasing pressures to try to at least partially compensate for an 82% increase in demand for uncompensated care

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28 *CEA Report* at 297-98 & n.42; *see also* 2018 Annual Report Of The Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds at 7, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (last visited Mar. 27, 2019).

29 Cubanski and Neuman, *supra* note 27.

30 Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* at 10 (June 2015) ("*CBO on Repeal*").

(approximately $50 billion in 2019 alone).[31] Such an increase would be far more than providers alone could internalize, and there is no evidence that federal government funding would increase to this extent. In other words, there would be substantial new financial pressures on states related to the large increase in uncompensated care, and the increased demand would swamp savings from lower levels of spending on Medicaid due to elimination of the ACA's expansion.

II. THE RULING BELOW WOULD INVALIDATE IMPORTANT FEDERAL INITIATIVES UNRELATED TO THE INDIVIDUAL MANDATE AND CAST A SHADOW OVER MANY OTHERS.

The impact of an invalidation would not be limited to increasing the number of uninsured and the after-effects on the economy. The ACA contains "hundreds of new laws about hundreds of different areas of health insurance and health care,"[32] and has resulted in scores of regulations that are now in force—many of which are unrelated to and wholly independent of the individual mandate. As the CBO acknowledged, it "is a difficult task—and one subject to considerable uncertainty—to predict how repealing a law

31 Blumberg et al., *supra* note 15.

32 Petitioner's Appendix at 21a, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-393), 2011 WL 4479805.

as complex as the ACA would be interpreted and implemented by executive branch agencies without some specific statutory guidance."[33] Nevertheless, *amici* offer below a few examples to demonstrate how invalidating the ACA would devastate important federal programs and initiatives that are serving the public interest, and cause widespread confusion and chaos.

Invalidating the ACA would call into question the hundreds of federal laws and regulations that have been enacted as a result of the ACA.[34] A sampling of those provisions demonstrates the breadth of topics that the ACA addresses, and the magnitude of the collateral damage that will be caused if the entire ACA is invalidated.

- Providing free preventive services in Medicare and employer coverage;
- Offering dependent coverage for young adults;
- Requiring disclosure of payments from drug companies;
- Labeling menus with calorie counts;
- Barring annual and lifetime limits on coverage and imposing a cap on the amount of out-of-pocket costs;
- Encouraging states to cover preventive services in Medicaid;

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33 *CBO on Repeal* at 5.

34 Pinpointing the exact number of regulations is challenging because of the scope and scale of the ACA itself. As of June 6, 2018, Regulations.gov lists 585 "closed" rules related to the "Affordable Care Act", and searching the Code of Federal Regulations for P.L. 111-148 yields 603 results.

- Preventing healthcare providers who receive federal funds from discriminating, at a minimum, against women and people with limited English proficiency;
- Mandating that insurers spend at least 80 or 85 percent (depending on the market) of premium revenues on clinical services and quality improvement;
- Closing the Medicare donut hole that requires seniors to pay out-of-pocket for drugs at a certain point;
- Requiring employers to provide break time and private places for nursing mothers;
- Improving patient safety at hospitals by imposing penalties for unnecessary readmissions and avoidable hospital-acquired conditions; and
- Standardizing the income definition (to Modified Adjusted Gross Income) for Medicaid eligibility for most groups.

States, too, wrote and revised laws and regulations based on the federal law and its regulations. So, the impact of invalidating the ACA—which will leave the healthcare sector in disarray, after the sector has already adjusted to the ACA's existence and to the failure of efforts to repeal it—will be even broader than it appears.

Invalidation would cause more people to lose insurance coverage than have gained it since implementation of the ACA and cause substantial disruption within a number of state Medicaid programs. Beginning in the mid-1990s, some states began to apply for and receive federal section 1115 waivers to expand eligibility for Medicaid coverage; these expansions were

frequently financed with savings from moving enrollees into managed care organizations. The seven states that extended coverage to additional populations under the comprehensive waivers were Arizona, Delaware, Hawaii, Massachusetts, New York, Vermont, and Wisconsin. Some of these waivers were not renewed in Medicaid expansion states after 2014 as they were made obsolete under the ACA's eligibility expansion. Invalidation of the ACA could therefore set Medicaid eligibility in these states back to where it was prior to implementation in states without existing coverage waivers. States could try to renegotiate these waivers with the federal government after an invalidation, yet that would require significant time and state expense and would have an uncertain outcome in terms of what the Administration would be willing to agree to and whether the states would be able to show that the new waivers would be budget neutral to the federal government given changed circumstances. Meanwhile, over one million people across the country who would have been insured through Medicaid waivers prior to implementation of the ACA's coverage components could be uninsured.

Invalidating the ACA would also throw the Medicare payment system into chaos because the ACA replaced many of the prior payment systems.

To advance the goal of moving Medicare away from a fee-for-service model, the ACA established mechanisms for deploying a variety of alternative payment models to reward providers for positive outcomes. For example, CMMI or CMS "are managing . . . accountable care organizations (ACOs), medical home models, and bundled payment models" that "include financial incentives for providers (such as doctors and hospitals) to work together to lower spending and improve care for patients in traditional Medicare."[35] That effort has since been quite successful: as of 2016, nearly 30 percent of payments in Medicare and major private plans were made through new payment models, virtually none of which existed in 2010.[36] The ACA also created new payment mechanisms for Medicare Advantage plans.[37] All of these payment mechanisms have their roots in the ACA. As a result, an invalidation that purports to cover all of the ACA (and the regulations

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35 Henry J. Kaiser Family Foundation, *Medicare Delivery System Reform: The Evidence Link*, https://www.kff.org/medicare-delivery-system-reform-the-evidence-link (last visited Mar. 27, 2019).

36 Health Care Payment Learning & Action Network, *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs* (Oct. 30, 2017), https://hcp-lan.org/groups/apm-fpt-work-products/apm-report.

37 Henry J. Kaiser Family Foundation, *supra* note 35; *see also* Jenny Gold, Kaiser Health News, *Accountable Care Organizations, Explained* (Sept. 14, 2015), https://khn.org/news/aco-accountable-care-organization-faq.

promulgated under the ACA) would raise profound questions about their continuing viability. That would spark tremendous confusion and uncertainty among Medicare's millions of beneficiaries and providers. If the ACA were invalidated, would Medicare be allowed to continue making payments using ACA-created vehicles? Or would the payment be put on hold while the case played out? Something in between? Short of spelling out how exactly it applies in innumerable circumstances—in a manner akin to legislation replacing (rather than just repealing) the ACA—an invalidation may effectively freeze certain payments under Medicare and cause unimaginable harm.

III. THIS COURT SHOULD LEAVE IN PLACE THE GUARANTEED ISSUE AND COMMUNITY RATING PROVISIONS.

Before switching its position last week, the United States argued in the district court that the vast majority of the ACA can and should survive even if the individual mandate is invalidated. Br. of United States at 2, D. Ct. Dkt. 92. Its new position is wrong for the reasons stated in Sections I and II, *supra*, but its prior position—that Congress would not have wanted to maintain the ACA's "guaranteed-issue and community-rating requirements" if the Court finds that the individual mandate is invalid, *id.*

(quotation marks omitted)— is just as wrong. That position misunderstood the economic impact of invalidating the individual mandate and how the ACA operates as an integrated whole.

It does not make sense that, in 2017, Congress wanted to repeal the community rating and guaranteed issue provisions when it zeroed out the individual mandate. Those two provisions bar insurers from refusing to sell insurance or charge higher premiums to enrollees based on pre-existing conditions or other individualized characteristics, such as health status, medical condition, medical history, gender, age, or claims experience.[38] They are major reforms that have had and continue to have real and substantial policy benefits independent of the individual mandate. Accordingly, it is reasonable to think that after Congress repeatedly failed to repeal the full ACA, it chose to zero out the individual mandate but to leave the guaranteed issue and community rating provisions in place. Indeed, that is the current state of the law.

Plus, there is ample evidence in the public media record that a broad array of members of Congress who supported and voted for the elimination of the individual mandate penalties also support protections of coverage for

[38] 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4.

people's pre-existing conditions, and it is simply not possible to protect coverage for people with health problems without guaranteed issue and modified community rating. Without guaranteed issue, insurers could deny coverage outright to people with pre-existing conditions. Plus, without modified community rating, insurers could charge people with pre-existing conditions such high premiums that the coverage would be unaffordable to them. Therefore, it is necessarily inappropriate to assume that members of Congress who voted for elimination of the penalties were implicitly voting to eliminate guaranteed issue and modified community rating.

From a contemporary economic perspective, those provisions can survive and have already survived the repeal of the individual mandate penalty implemented in the current year, 2019. To be sure, when Congress considered the ACA in 2010 and when the Supreme Court considered the constitutionality of the individual mandate in 2012, there was concern about adverse selection if the guaranteed issue and community rating provisions were enacted without also enacting the individual mandate. There was also considerable concern that private insurers would be reluctant to enter the new market without an individual mandate in place, making the reform untenable. But, based upon actual experience, those concerns are no longer

primary, and current evidence does not support the elimination of these rules in order to preserve insurance markets.

Although healthier enrollees are the most likely to drop insurance coverage absent a mandate, analysts now recognize that the financial assistance provided to nongroup insurance enrollees (i.e., premium tax credits and cost-sharing assistance) combined with comprehensive insurance benefits are powerful enough incentives to maintain critical numbers of people in these insurance markets, even without financial penalties for going without coverage. Coverage will be lower and premiums higher without the individual mandate penalties in place, but, even so, the insurance markets remain robust and most people are maintaining their coverage.

Nearly a decade after the ACA's enactment, thanks to the other stabilizing features of the ACA—including the premium subsidies, cost-sharing assistance, essential benefit requirements, and risk adjustment provisions—insurance markets are well-positioned to adapt to the zeroing out of the individual mandate, which served to encourage participation in the marketplaces. When Congress considered eliminating the mandate penalty in 2017, the CBO estimated that the change would cause average premiums in the nongroup market to rise by about 10%, but that "nongroup insurance

markets would continue to be stable in almost all areas of the country throughout the coming decade."[39] CBO recently reconfirmed that finding, concluding that despite zeroing out the mandate penalty the individual insurance market will remain stable in most of the country over the next decade, premiums will rise only an average of about 7% between 2019 and 2028, and 12-13 million people will continue to enroll in the individual insurance market.[40]

Indeed, insurers have already shown their willingness to participate in these markets without individual mandate penalties but with the guaranteed issue and modified community rating rules that were implemented in January 2014 with the ACA's other coverage protections. In fact, insurer participation has increased in 2019 and premium increases have moderated. This is clear evidence that these markets continue to operate and, in fact, appear to be thriving, without the mandate penalties in place. An analysis of data in all private nongroup insurance rating areas in the country finds the

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39 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.

40 Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* at 2-3, 5 (May 23, 2018).

following (see table 1). Out of the 498 ACA nongroup insurance rating areas across the country that were in place in each pair of years:[41]

- Between 2017 and 2018 (the last year with mandate penalties in place), 211 or 42% of rating regions had a decrease in the number of insurers participating in their marketplaces. Only 22 rating regions or 4% saw increases in the number of participating insurers that year.
- However, knowing that the individual mandate penalties would be eliminated in 2019, insurer participation increased in 95 (19%) of rating regions. There were decreases in the number of marketplace insurers in only 17 or 3% of rating regions after the mandate penalties were eliminated. Thus, many more rating regions saw increased insurer participation absent the penalties and many more experienced no change compared to the last year when penalties were in place.
- In 2018, the last year with penalties in place, very large premium increases were the norm. That year, the benchmark premium (that on which premium tax credit levels are based) increased by more than

[41] There were 499 rating regions nationally in 2017 but 498 in 2018 due to Idaho reducing its number of regions from 6 to 7. In 2019, there were 502 rating regions nationally due to Washington increasing its number from 5 to 9. The analysis includes only those rating regions that stayed consistent across each pair of years.

20% in 402 or 81% of rating regions. In 2019, those large premium increases occurred in only 17 or 3% of rating regions. In fact, in 2019, the benchmark premium actually decreased in 214 or 43% of rating regions. That only happened in 25 or 5% of rating regions in 2018.

Table 1. Changes in Insurer Exchange Participation and Benchmark Premiums in the Presence and Absence of Individual Mandate Penalties

2018 was the last plan year with individual mandate penalties in place. 2019 plan year decisions were made with insurer knowledge that there would not be penalties in place.

	Change with Individual Mandate Penalties: 2017 to 2018		**Change without Individual Mandate Penalties: 2018 to 2019**	
	Number of Rating Areas	Percentage of Rating Areas	Number of Rating Areas	Percentage of Rating Areas
Increase in Number of Marketplace Insurers	22	4%	95	19%
Decrease in Number of Marketplace Insurers	211	42%	17	3%
Unchanged Number of Marketplace Insurers	265	53%	386	78%
Total Rating Areas Consistent Across 2 Years(*)	498	100%	498	100%
Decrease in Second Lowest Cost Silver Plan	25	5%	214	43%
Increase of 0 to 5% in Benchmark Plan	6	1%	100	20%
Increase of 5-10% in Benchmark Plan	7	1%	113	23%
Increase of 10-20% in Benchmark Plan	58	12%	54	11%
Increase of >20% in Benchmark Plan	402	81%	17	3%
Total Rating Areas Consistent Across 2 Years (*)	498	100%	498	100%

Source: Urban Institute Analysis of Center for Medicare and Medicaid Services and state-based marketplace data.
Notes: This analysis includes only those rating regions that stayed consistent across each pair of years. Idaho reduced its number of rating regions to 6 from 7 in 2018, so there were 499 rating areas nationally in 2017. In 2019, Washington increased the number of rating regions in that state from 5 to 9, make the 2019 national total 502 rating regions. The benchmark plan is the second lowest premium silver level plan offered in a rating region in a given year.

Table reproduced from: Linda J. Blumberg, Matthew Buettgens, John Holahan, and Clare Pan. "State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA," Urban Institute and Robert Wood Johnson Foundation, 2019.

Table 2 shows the number of marketplace open enrollment period plan selections in 2018 and 2019 by state. Plan selections without mandate penalties (2019) are 90 percent or more of plan selections with mandate penalties in place (2018) in 45 of the 49 states for which data are currently available (92 percent of states). Thirteen of these 49 states have more plan

selections in the no mandate penalty year than in the last year with the penalties in place. Overall, plan selections in 2019 are 97 percent of plan selections in 2018.

Taken together, the increased participation of private nongroup insurers, the far increased frequency of lower benchmark premiums and benchmark premiums with small increases, and high enrollment rates in marketplace plans, all following the elimination of mandate penalties, demonstrates clearly functioning and vigorous insurance markets across the country. The operation of these insurance markets today makes it wholly irrational to state that the ACA's nongroup insurance markets and their regulatory protections for people with health problems cannot be separated from the individual mandate. There is myriad current factual information demonstrating that this is not true.

As a result, whatever the prior concerns about an "adverse selection death spiral," there is no economic reason in 2019 for this Court to invalidate the community rating and guaranteed issue provisions if it decides to invalidate the individual mandate.

Table 2: Marketplace Plan Selections in 2018 and 2019, Levels and Percent Change
Includes plan selections as of end of annual open enrollment period

State	2018 Plan Selections	2019 Plan Selections	2019 Plan Selections Relative to 2018 Plan Selections
Alabama	170,211	166,128	98%
Alaska	18,313	17,805	97%
Arizona	165,758	160,456	97%
Arkansas	68,100	67,413	99%
California	1,521,524	1,513,883	99%
Colorado	165,777	169,672	102%
Connecticut	114,134	111,066	97%
Delaware	24,500	22,562	92%
District of Columbia	19,289	data not available	---
Florida	1,715,227	1,783,304	104%
Georgia	480,912	458,437	95%
Hawaii	19,799	20,193	102%
Idaho	101,793	103,154	101%
Illinois	334,979	312,280	93%
Indiana	166,711	148,404	89%
Iowa	53,217	49,210	92%
Kansas	98,238	89,993	92%
Kentucky	89,569	84,620	94%
Louisiana	109,855	92,948	85%
Maine	75,809	70,987	94%
Maryland	153,571	156,963	102%
Massachusetts	270,688	data not available	---
Michigan	293,940	274,058	93%
Minnesota	116,358	123,731	106%
Mississippi	83,649	88,542	106%
Missouri	243,382	220,461	91%
Montana	47,699	45,374	95%
Nebraska	88,213	87,416	99%
Nevada	91,003	83,449	92%
New Hampshire	49,573	44,581	90%
New Jersey	274,782	255,246	93%
New Mexico	49,792	45,001	90%
New York	253,102	271,873	107%
North Carolina	519,803	501,271	96%
North Dakota	22,486	21,820	97%
Ohio	230,127	206,871	90%
Oklahoma	140,184	150,759	108%
Oregon	156,105	148,180	95%
Pennsylvania	389,081	365,888	94%
Rhode Island	33,021	34,600	105%
South Carolina	215,983	214,956	100%
South Dakota	29,652	29,069	98%
Tennessee	228,646	221,533	97%
Texas	1,126,838	1,087,240	96%
Utah	194,118	194,570	100%
Vermont	34,142	34,396	101%
Virginia	400,015	328,020	82%
Washington	243,227	222,636	92%
West Virginia	27,409	22,599	82%
Wisconsin	225,435	205,118	91%
Wyoming	24,529	24,852	101%
Total*	11,480,291	11,153,588	97%

*Note: Total for 2018 plan selections exclude the District of Columbia and Massachusetts because plan selection totals for the 2019 plan year are not yet available for those states. Including them in the 2018 totals alone would distort the calculation of the national 2018 to 2019 comparison.

Sources: https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period, https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2018-open-enrollment-period, data for state based marketplace enrollment was collected from each state website or from local media reports in each year. Specific sources for each of those states are available upon request.

Table reproduced from: Linda J. Blumberg, Matthew Buettgens, John Holahan, and Clare Pan. "State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA," Urban Institute and Robert Wood Johnson Foundation, 2019.

There is another reason to think that Congress would want to retain the guaranteed issue and community rating provisions even though the mandate has been zeroed out beginning in 2019: key provisions of the ACA make little sense without them. For example, in a world without those provisions, customers with pre-existing conditions would be unlikely to find insurance that they could afford at all. To be sure, the ACA offers tax credit subsidies to make insurance more affordable, but those subsidies are available only to those who actually purchase insurance.[42] The upshot is that those subsidies would only be available as a practical matter to individuals healthy enough to obtain insurance in the first instance.[43] But without guaranteed issue, many people with current or prior health problems would be denied insurance outright, denying them the ability to use premium tax credits for which they are eligible. Others would be offered insurance at such a high price that it would be unaffordable.

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42 *See* Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Questions about Health Insurance Subsidies* 1-2 (Nov. 2017), http://files.kff.org/attachment/Issue-Brief-Explaining-Health-Care-Reform-Questions-about-Health-Insurance-Subsidies ("In order to receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance Marketplace.").

43 *See id.*

Moreover, eliminating the guaranteed issue and community rating provisions would undermine the tax credits that the United States maintains should survive invalidation of the individual mandate. The ACA's tax credits and subsidies are calculated based on the second-lowest Silver plan premium available on the exchanges.[44] But that regime presumes the existence of guaranteed issue and community rating provisions. With those provisions, it is easy to determine the second lowest cost plan for every applicant living in the same relevant geographic area because the premium only differs between people based upon a standard age rating curve that applies to everyone in the same geographic area.[45] Conversely, as noted above, without those provisions there would be some people (those with pre-existing conditions) for whom there would no premium offered at which they could purchase a policy; and for others the premium could vary enormously from person to person depending upon their characteristics.

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44 *Id.* at 3 ("The 'benchmark' for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state's Marketplace.").

45 *See* Dep't of Health & Human Servs., https://www.healthcare.gov/glossary/community-rating (last visited Mar. 27, 2019) (defining "community rating" as "[a] rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors"); *id.* at https://www.healthcare.gov/glossary/guaranteed-issue (last visited Mar. 27, 2019) (defining "guaranteed issue" as "[a] requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services").

As a result, it would be impossible to determine the second-lowest Silver plan for any one person unless they applied for coverage from, and were medically underwritten by, every single insurer offering coverage in the marketplace in their geographic area. That in turn would never happen because it would impose huge underwriting costs and time costs to insurers as well as to applicants, and thus would make the premium tax credits and subsidies—provisions that are at the heart of the ACA—impossible to administer. In short, invalidating the community rating and guaranteed issue provisions will cause more chaos and disruption than merely invalidating the individual mandate. That cannot be a result that Congress desired when it chose to move the mandate penalty to zero.

CONCLUSION

For the foregoing reasons, the *amici* Bipartisan Economic Scholars respectfully urge that the Court reverse the order below and hold that to the extent the individual mandate is unlawful, it is severable from the rest of the ACA.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(g)(1) of the Federal Rules of Appellate Procedure, I certify that this document complies with the word limit of Federal Rule of Appellate Procedure 29(a)(5) because, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f), this document contains 6,494 words, and that this document complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6).

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CERTIFICATE OF SERVICE

I certify that, on April 1, 2019, a true and correct copy of the foregoing was filed via the Court's CM/ECF system, which will send notice of such filing to all registered CM/ECF users.

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