Nos. 19-840 & 19-1019

IN THE

Supreme Court of the United States

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

v.

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

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

v.

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

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

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

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INTEREST OF *AMICUS CURIAE*[1]

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

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

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

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

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

INTRODUCTION AND SUMMARY OF THE ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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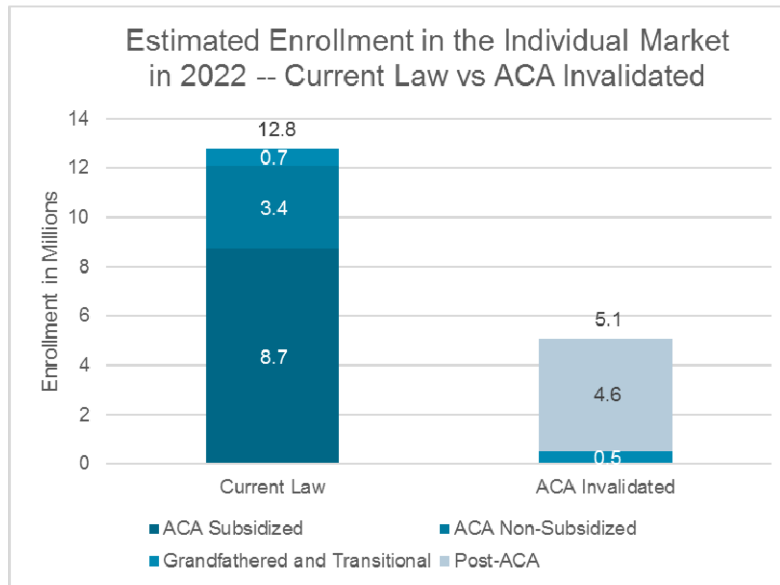
[9] The FPL is $12,760 for an individual or $26,200 for a family of four. *See* Annual Update of the HHS Poverty Guidelines, 85 Fed. Reg. 3060, 3060 (Jan. 17, 2020).

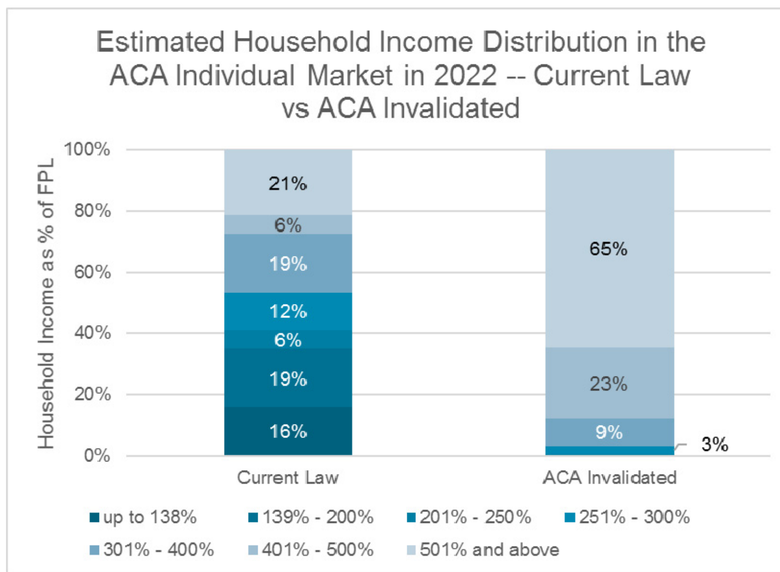
in the short-term, about three-fifths of the 12.8 million Americans currently enrolled in the individual market—that is 7.7 million people—would lose coverage without the ACA. *See* Study at 22a-23a.



Source: OW Study at 22a.

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

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



Source: OW Study at 24a.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

disruptive manner of Respondents' proposed judicial remedy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

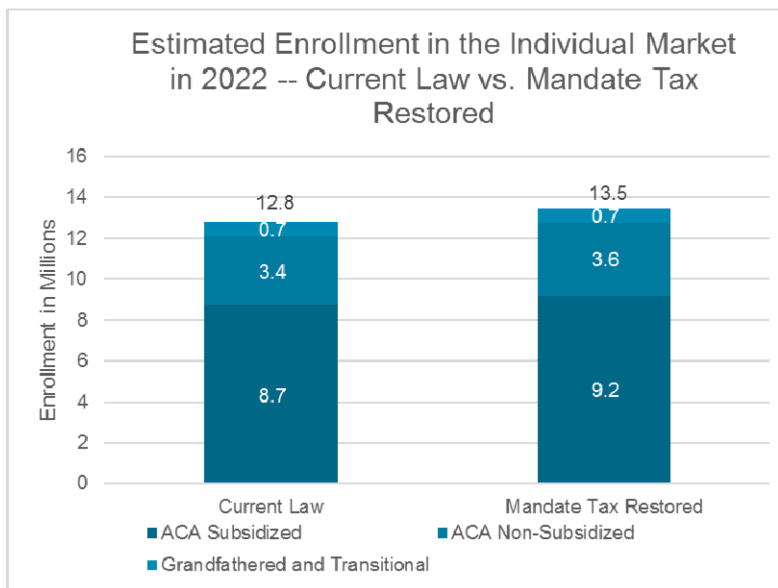
B. Without an Enforceable Mandate, Individual Markets Subject to Community Rating and Guaranteed Issue Requirements Can and Do Function If Married with Subsidies that Incent Participation by Healthy Enrollees

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

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

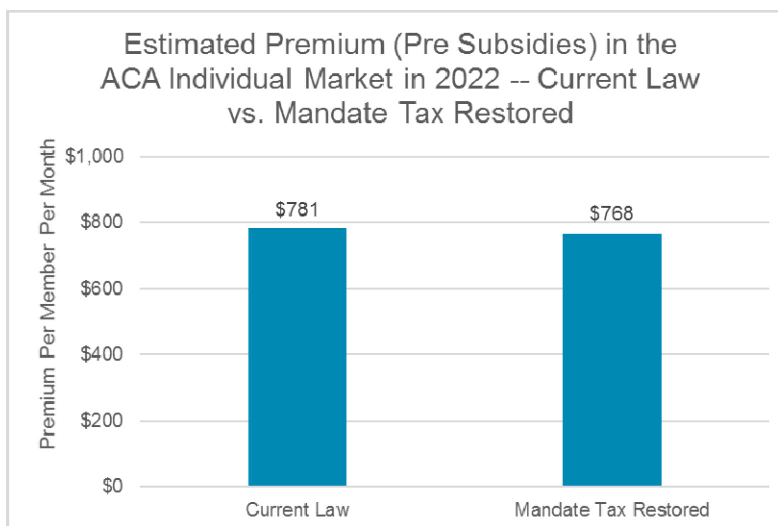
2020 is not yet available, initial enrollment data for this year is roughly similar to last year. *Id.*

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



Source: OW Study at 14a.

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



Source: OW Study at 26a.

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

The decision of the Fifth Circuit should be reversed.

Respectfully submitted,

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