Nos. 19-840 & 19-841

In the
Supreme Court of the United States

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

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

On Petitions for a Writ of Certiorari
to the United States Court of Appeals
for the Fifth Circuit

BRIEF *AMICI CURIAE* FOR BIPARTISAN ECONOMIC SCHOLARS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

The *amici curiae* Bipartisan Economic Scholars are a group of 56 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.

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; three Nobel Laureates in Economics; two recipients of the John Bates Clark medal, which is awarded annually 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; three recipients of the American Society of Health Economists Medal, which is awarded biennially to the economist aged 40 or under who has made the most significant contributions to the field of health economics; and one recipient of the Victor R. Fuchs Lifetime Achievement Award from the American Society of Health Economists. A complete list of the Bipartisan Economic Scholars is provided in the

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[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 received timely notice of, and have consented in writing to, the filing of this brief.

Appendix at the back of this brief. Many of the Bipartisan Economic Scholars have submitted briefs in previous cases concerning the ACA, including cases in this Court. *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2486, 2493, 2494 (2015) (citing Brief for Bipartisan Economic Scholars as *Amicus Curiae*).

Amici submit this brief to assist the Court in assessing the petitions and motions to expedite the Supreme Court's hearing of the case. The Bipartisan Economic Scholars urge the Court to grant the petitions and expedite hearing of this case to avoid the significant harm that delaying review would otherwise occasion. As discussed below, leaving the ACA in limbo for another year or more needlessly threatens injury to every kind of participant in the U.S. health care system, from insurers, to consumers, to providers, to states. Review is also warranted because the notion that Congress would have wanted the exchanges or the ACA as a whole to be invalidated in the event the mandate was struck down makes no economic sense.[2] *Amici* urge the Court to reject the Fifth Circuit's conclusion that the individual mandate may not be severable from the rest of the ACA, including the law's community rating and guaranteed issue provisions.

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[2] Although *amici* maintain that the individual mandate is constitutional even in the absence of a penalty, the analysis in this brief emphasizes the issue of severability as that was the scope of the Fifth Circuit's remand to the district court.

INTRODUCTION AND SUMMARY OF ARGUMENT

In this case, the Court of Appeals held that the individual mandate provision of the ACA is unconstitutional in light of Congress's decision in the Tax Cut and Jobs Act of 2017 to set the penalty for individuals failing to obtain insurance at $0. The Fifth Circuit then remanded the case to the district court for further analysis as to whether any components of the ACA are severable from the individual mandate.

Amici write to make two points in urging this Court to review the decision of the Court of Appeals.

First, certiorari should be granted now, and not after the conclusion of re-review by the district court and the Fifth Circuit. Those lower court proceedings may well take a year or more.

That delay – during which the ACA's validity, in whole or in part, will remain unknown – will inflict substantial and needless harms on private insurers, consumers, health care providers, and states. The markets created and influenced by the ACA can function properly only when insurers can most effectively operate their businesses with the knowledge that the rules underlying their business model are stable and predictable. Put simply, delay is likely to lead to insurers operating in fewer markets and charging higher premiums, with the potential that 100,000 people or more will become uninsured during the pendency of proceedings in the lower courts.

This uncertainty also means that health care providers (especially hospitals and large health systems)

and state governments will be unable to predict and thus make appropriate resource allocations, potentially deterring investments in ways that could compromise population health, create needless stress in state budgets, and frustrate other social priorities. The confusion surrounding a protracted legal process may also deter consumers from enrolling in insurance coverage, thereby damaging public health and increasing mortality. Delaying review undermines that necessary stability and predictability, and will disrupt and harm all of these stakeholders.

Second, on the merits, the Fifth Circuit's severability analysis should be rejected because it lacks any economic foundation. The Fifth Circuit concluded that it was possible that Congress wanted all or part of the ACA to be jettisoned if the individual mandate were found invalid (notwithstanding the fact that Congress left the ACA otherwise intact when it eliminated the financial penalty for being uninsured). Indeed, in several places, the appellate court signaled support for the view that the entirety of the ACA is not severable from the individual mandate. Pet. H.Rep. App. 56a-59a.

That view ignores the economic reality underpinning the Act—an economic reality that Congress was well aware of when it set the penalty to $0 in 2017, and that has been borne out since that time. Economic data show that enrollment and insurer participation in ACA exchanges have remained robust even after the penalty fell to $0. Eliminating those exchanges and the federal financial assistance provided for enrollment in coverage would result in enormous increases in the rolls of the uninsured, as would elimination of the ACA's Medicaid

eligibility expansion. And invalidating the rest of the ACA, an enormous piece of legislation touching almost every aspect of the health sector and of the economy, would cause massive economic harm. Congress could have repealed all or part of the ACA when it eliminated the tax penalty for failing to carry health insurance. It didn't. No further argument is needed about Congressional intent.

ARGUMENT

I. Delaying Review Will Unnecessarily Leave The Entire ACA In Limbo And Harm Insurance Markets, Insurers, Providers, State Governments, And Consumers.

Immediate review of the decision below is warranted to prevent confusion and uncertainty over the future structure of the U.S. health care system. Health care accounts for nearly 1/5 (17.7%) of the nation's entire Gross Domestic Product (GDP). *See* Center for Medicare and Medicaid Services, National Health Expenditure Data (2018).[3]

The ACA touches nearly every aspect of this system, and in highly varied ways. For example, Medicaid expansions and subsidies for coverage increased access to care and spending on many health care services (by an estimated $1.3 trillion over the years 2019-2028), *see* Jessica Banthin et al., The Urban Institute, *Implications of the Fifth Circuit Court Decision in* Texas v. United States 11 (Dec. 2019) (hereinafter

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[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical (last visited Jan. 10, 2020).

Banthin et al., *Implications of the Fifth Circuit Court Decision*);[4] changes in provider payment methods and rates reduced spending on other services. Over the 10 years since the law was passed, all those involved in the system – whether as insurer, provider, state regulator, or consumer – have adjusted and continue to adjust their behavior to the incentives the law created. The Fifth Circuit's decision creates substantial uncertainty for all these actors "and leaves a critical sector of the nation's economy in unacceptable limbo." Pet. H.Rep. Br. at 14.

A. Harm to Insurance Markets and Insurers

The decision below creates considerable uncertainty about the future of the ACA's subsidies for exchange coverage and the ACA's regulatory changes to the individual market and hence, the number and nature of people who will purchase such coverage. Delaying review of the decision below will likely cause insurers to participate in fewer markets, thereby diminishing competition and the pricing discipline that competition produces. The result will be that a substantial number of people would become uninsured during the pendency of lower court proceedings.

Markets. Insurers use their expectations of the numbers and health care cost profile of a market's enrollees when deciding whether to participate in a market and how to set premiums. These decisions are made months prior to the beginning of the annual open enrollment period, which are then fixed for the coming

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[4] https://www.urban.org/sites/default/files/publication/101361/implications_of_the_fifth_circuit_court_decision_in_texas_v_united_states_final_121919_v2.pdf.

year. In fact, insurers begin their planning processes a full year or more ahead of time. For an insurer to enter a new market, it generally must establish or modify hundreds of contracts with hospitals and other health care providers. An ultimate finding that overturned the entire ACA or just the regulations and federal subsidies the law requires in the nongroup insurance market[5] would mean that millions of enrollees could no longer afford the coverage that they hold today. As a result, they would immediately drop their coverage due to an inability to pay the full (unsubsidized) premiums.

Both economic analysis and historical evidence suggest that this uncertainty will reduce insurers' willingness to make the investments necessary to enter new markets. In 2017, some members of Congress, with strong support from the White House, sought to repeal and replace the ACA. This legislative effort, which began in January and extended through the fall, failed, (although Congress did eliminate the individual mandate penalties beginning with plan year 2019) and the administration continued to make policy changes through executive action into the open enrollment period.

This uncertainty caused insurers to delay entry or abort plans to enter some markets and to leave others. The number of marketplace insurers selling coverage

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[5] The private nongroup insurance market, sometimes referred to as the individual market or the direct purchase market, encompasses private insurance purchased outside of employment (group coverage), and is sold through the health care marketplaces or purchased directly from insurers by individual consumers, often with the help of insurance brokers.

decreased in over 40% of rating regions that year, and increased in only 4% of rating regions.[6] *See* Linda J. Blumberg et al., The Urban Institute, *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA* 20, tbl.8 (Mar. 2019) (hereinafter Blumberg et al., *State-by-State Estimates*).[7] The average number of insurers selling nongroup coverage in each of the rating region's marketplaces fell from more than 3.7 in 2017 to 3.0 in 2018. *See* John Holahan et al., The Urban Institute, *Marketplace Premiums and Insurer Participation: 2017-2020* 5 (Jan. 2020) (hereinafter Holahan et al., *Marketplace Premiums and Insurer Participation*).[8]

Premiums. Fewer insurers mean less competitive insurance markets which is strongly correlated with higher premiums, and hence increased federal costs due to larger premium tax credits. *See* Jessica Van Parys, *ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than in Areas With More Competition*, 37 Health Aff. 1243, 1244 (2018); *see also* Linda J. Blumberg et al., The Urban Institute, *Is*

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[6] Rating regions are geographic areas throughout the country in which similar economic factors inform the insurance pricing. In other words, households with similar characteristics within the same rating region will pay roughly the same premium.

[7] https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state_2.pdf.

[8] https://www.urban.org/sites/default/files/publication/101499/moni_premiumchanges_final.pdf.

There Potential for a Public Option to Reduce Premiums of Competing Insurers? 5 (Oct. 2019).[9]

Insurers are likely to respond to the uncertainty generated by the Fifth Circuit's decision in a similar manner, raising premiums to compensate for the possibility that the rules governing insurance markets might change in the middle of an insurance plan year. This too is consistent with the 2017 experience. The national average increase in the lowest priced standard (silver tier) marketplace plan available in the 502 rating areas across the country increased by 30% in 2018. Holahan et al., *Marketplace Premiums and Insurance Participation* 7, tbl.1. That same year the premium of the benchmark (second lowest priced silver plan), which is used for setting premium tax credits, increased by more than 20% in over 80% of the nation's rating regions. *See* Blumberg et al., *State-by-State Estimates* 19. Higher value gold tier plan premiums increased by an average of 19% that same year. In 2016, before the uncertainty was introduced into these markets, industry experts predicted much lower premium increases due to the expectations at that time that the markets would have reached a policy equilibrium. *See* Deep Banerjee, *The U.S. ACA Individual Market Showed Progress in 2016, But Still Needs Time to Mature*, S&P Global (Apr. 7, 2017);[10] *see also* John Holahan et al., The Urban Institute, *What's Behind 2018 and 2019 Marketplace*

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[9] https://www.urban.org/sites/default/files/publication/101221/is_there_potential_for_a_public_option_to_reduce_premiums_of_competing_updated.pdf.

[10] https://www.spglobal.com/en/research-insights/articles/the-us-aca-individual-market-showed-progress-in-2016-but-still-needs-time-to-mature.

Insurer Participation and Pricing Decisions? 5-6 (Jan. 2019).[11]

Increases in premiums make coverage less accessible, particularly for middle-income consumers who are not eligible for premium subsidies. Estimates suggest that every 1% increase in premiums for this population reduces the number of people purchasing coverage by 0.57%. Congressional Budget Office, *The Price Sensitivity of Demand for Nongroup Health Insurance* 10 (Aug. 2005).[12] Even assuming conservatively a 3% increase in premiums, the number of people without coverage could increase by 100,000.

B. Harm to Providers

Health care providers will face adverse consequences as well from the uncertainty generated by delayed review of the decision below.

Investment. Providers proactively invest in staffing, physical capacity, and technology based on the anticipated number of patients and their health care needs. Heightened uncertainty will make such investments riskier and, hence, less attractive. A potential decrease in insurance coverage of approximately 20 million people – the coverage threat at stake if the ACA is overturned – would have enormous disruptive implications for health care providers. *See*

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[11] https://www.urban.org/sites/default/files/publication/99688/whats_behind_2018_and_2019_marketplace_insurer_participation_and_pricing_decisions_0.pdf.

[12] This price elasticity estimate was calculated for single adults and includes people of all incomes. https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/08-24-healthinsurance.pdf.

Banthin et al., *Implications of the Fifth Circuit Court Decision* 1. The risk of such a large coverage change must therefore be taken into account as providers plan future investments, and the uncertainty could decrease investments in the coming year or years as a consequence.

Some planned infrastructure investments and hiring would be delayed or cancelled. Providers making infrastructure decisions must consider whether demand for their services will remain stable if the ACA is upheld, or will fall if the ACA is invalidated. Uninsured people receive substantially less care than similar insured people, and those who receive care are less likely to be able to pay for it, thus boosting the need for providers to set aside reserves for uncompensated care. *See* Jack Hadley, The Urban Institute, *Sicker and Poorer–the Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 Med. Care Res. & Rev. 3S, 61S-63S (2003). Consequently, without a strong expectation that coverage will be sustained, providers, including hospital systems, will likely scale back investments in physical capacity and curtail hiring of staff.

Reimbursements. Providers will also face heightened uncertainty about the level and nature of the reimbursements they receive for their services. The ACA contains many provisions that changed the form and level of payment for medical care. For example, more than one-third of physicians in the U.S. now participate in Accountable Care Organizations (ACOs), authorized under Section 3022 of the Law. *See* Apporva Rama, Am. Med. Ass'n, *Policy Research Perspectives:*

Payment and Delivery in 2018: Participation in Medical Homes and Accountable Care Organizations on the Rise While Fee-for-Service Revenue Remains Stable 2–3 (2019).[13] Payment rates to Medicare Part A providers in 2019 were 14% lower than would have been the case without the ACA, because of Section 3401 of the Law. *Compare* CBO's March 2009 Baseline: Medicare,[14] *with* CBO's August 2010 Baseline: Medicare.[15] Changes in payment incentives and in payment rates all affect provider decisions about investments in staffing and equipment. Therefore, prolonged uncertainty about whether the ACA may be overturned in the near future may change provider investment decisions in ways that are both inefficient and counter-productive for the providers' and consumers' well-being.

Demonstrations. In addition to generally applicable provider payment reform, the ACA included measures targeted to particular provider groups, aimed at addressing cost through innovative payment demonstrations. The ACA authorized demonstrations to test innovative provider reimbursement schemes that hold promise of reducing the growth of health care expenditures while improving the quality of care. *See* Center for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation, *2018 Report to*

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[13] https://www.ama-assn.org/system/files/2019-09/prp-care-delivery-payment-models-2018.pdf.

[14] https://www.cbo.gov/sites/default/files/recurringdata/51302-2009-03-medicare.pdf.

[15] https://www.cbo.gov/sites/default/files/recurringdata/51302-2010-08-medicare.pdf.

Congress.[16] The Center for Medicare and Medicaid Services (CMS) estimates that "more than 967,800 health care providers participat[e]" in an ACA supported demonstration. *Id.* at 4. One demonstration alone, the Pioneer ACO Model, accounted for a two-year savings to Medicare of around $384 million dollars. *Id.* at 2. Government funding for these cost-saving and innovative payment strategies, however, is crucial. *See* Abt Associates, et al., *Evaluation of the Accountable Care Organization Investment Model: AIM Implementation and Impacts Over Two Performance Years* 2 (Sept. 2019)[17] (observing that many new program participants would not have joined without government funding). Thus, faced with prolonged uncertainty as to the future of the program, providers may be unwilling to continue to invest in these cost-saving demonstrations.

Providers adjust their practice patterns and investments to reflect the average characteristics of the patients they serve. *See* Sherry Glied & Joshua Graff Zivin, *How do Doctors Behave When Some (but not all) of Their Patients are in Managed Care?*, 21 J. Health Econ., 337, 346 (2002). Faced with policy uncertainty, providers are likely to delay investments (for example, investing in hospital services, such as psychiatric emergency services, that disproportionately serve low income populations) that might be profitable and desirable if the ACA remains in effect but not if it is terminated. *See* Jill R. Horwitz, *Making Profits and*

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[16] https://innovation.cms.gov/Files/reports/rtc-2018.pdf (accessed on Jan. 3, 2020).

[17] https://innovation.cms.gov/Files/reports/aim-second-annrpt.pdf.

Providing Care: Comparing Nonprofit, for-profit, and government Hospitals, 24 Health Aff. 790, 796 (2005).

Thus, the longer the ACA's validity remains in doubt, the more likely providers are to second guess worthwhile investments and reconsider expansions of health care delivery capacity that might otherwise improve population health and generate health care savings. Even recent business decisions may be reconsidered and altered.

Biosimilars. Uncertainty surrounding the future of the ACA is also likely to affect other health care suppliers in unfortunate ways. Research and development of new biosimilar drugs is illustrative. The ACA authorized the Food and Drug Administration to approve biosimilars (the "generic" version of biologic drugs). If this provision of the ACA is invalidated, new biosimilar medications cannot be brought to market. Since, by at least one estimate, the development of each biosimilar requires dedication of $100 to $250 million in resources over 7 to 8 years, *see* Erwin A. Blackstone & P. Fuhr Joseph, Jr., *The Economics of Biosimilars*, 6 Am. Health & Drug Benefits 469, 470-71 (2013),[18] the uncertainty posed by ongoing litigation that could overturn the authorization may make manufacturers unwilling to invest in producing these products in as timely a fashion as possible.

C. Harm to States

The ongoing uncertainty caused by the case would also have detrimental effects on the ability of state governments to budget effectively. Thirty-five states

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4031732/.

have expanded Medicaid eligibility under the ACA as of January 1, 2020.[19] *See* Kaiser Family Foundation, *Status of State Medicaid Expansion Decisions: Interactive Map* (Jan. 10, 2020).[20] These expansions have significantly increased the federal health care dollars flowing into these states and decreased the demand for uncompensated care sought by their residents. Savings occurred in many areas of their budgets due to Medicaid expansion, including behavioral health programs and criminal justice programs. *See*, *e.g.*, Larisa Antonisse et al., Kaiser Family Foundation, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* 2-3 (Aug. 2019).[21]

State governments, concerned about the future of the ACA, may delay or cancel spending investments in non-health areas because of fears that state dollars will be needed to counteract possible losses of federal funds under an ACA rollback.

Delay is harmful regardless of the ultimate resolution of this case. States may ignore the potential implications of the case in the near-term, and make policy decisions that obligate them to finance programs that put the state in a precarious situation should the ACA be judicially overturned without notice. The greater the uncertainty of the judicial timeframe and the longer the process continues, the greater is the

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[19] Two additional states have passed ballot initiatives to expand Medicaid eligibility, with implementation expected in late 2020.

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

[21] http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review.

likelihood that states will respond by making spending and revenue raising decisions that could be counter to their economic interests and the well-being of their residents.

D. Harm to Consumers

The ACA made comprehensive insurance available to all consumers nationwide regardless of employment status, with prices set without regard to an individual's health status. This change in the operation of nongroup health insurance allowed people to make employment decisions, including entrepreneurship, based on the best fit of their skill levels and ambitions instead of on the basis of access to health insurance for themselves and their family members. Ongoing uncertainty about the continued application of the ACA is likely to lead some workers to make different labor market decisions, due to fears of giving up job-based coverage.

Research has shown that consumers are easily confused about coverage options in the face of uncertainty, and that this confusion leads to worse outcomes. In 2017, news outlets reported that efforts to repeal the ACA caused some consumers to believe that the ACA had already been repealed, and to think they no longer had access to subsidies that made health insurance affordable. *See, e.g.*, Ron Allen & Ezra Kaplan, *Here's a Place Where the Confusion Over Obamacare Really Hurts*, NBC News (Nov. 1, 2017, 8:31 AM);[22] Margot Sanger-Katz, *How Failure of the Obamacare Repeal Affects Consumers*, N.Y. Times

[22] https://www.nbcnews.com/politics/white-house/here-s-place-where-confusion-over-obamacare-really-hurts-n816086.

(Sept. 26, 2017).[23] The number of people uninsured that year increased by approximately 500,000, at least in part because of this confusion. *See* Jennifer Tolbert et al., Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Dec. 13, 2019);[24] *see also* Sara R. Collins et al., *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?* (Sept. 2017)[25] (finding one-third of uninsured people who were aware of the Marketplace but did not visit them reported that it was because they thought the ACA was going to be repealed).

Evidence of the sensitivity of consumer decision making to the availability of information is also apparent in a recent study conducted by the U.S. Treasury Department. *See* Jacob Goldin et al., *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach* (NBER Working Paper No. 26533, 2019).[26] The study found that people can decide to purchase health insurance based on very modest information cues about the availability of subsidies. *See id.* at 2. Those who received additional information in a letter from the IRS were more likely to enroll in coverage and mortality rates in this group decreased appreciably. *See id.* at 2-3. Extended litigation over the future of the ACA is the

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[23] https://www.nytimes.com/2017/09/26/upshot/how-the-failure-of-obamacare-repeal-affects-consumers.html.

[24] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[25] https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand?redirect_source=/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage.

[26] https://www.nber.org/papers/w26533.

type of information cue that is likely to decrease the number of people enrolling in insurance coverage; consequently, it can be expected to cost more lives the longer it takes to play out.

II. Review Is Also Warranted Because The Fifth Circuit's Severability Analysis Lacks Any Economic Foundation.

This Court should also grant review because the severability analysis adopted by the Fifth Circuit is contrary to basic economic principles. The Fifth Circuit hypothesized that Congress may have wanted all or part of the ACA to be invalidated if the individual mandate were struck down. That supposition flies in the face of the economic reality of the ACA—a reality that Congress was aware of when it chose to eliminate the individual mandate penalty, but not to invalidate the rest of the ACA in 2017.

A. Economic Data Establishes That The ACA Markets Can Operate Without The Mandate

The ACA's success does not rise and fall with the individual mandate. Beginning in plan year 2019 (January 1, 2019 through December 31, 2019), the individual penalty for not purchasing health insurance coverage (in other words, the penalty for not abiding with the individual mandate) was eliminated, but the markets remained stable.

As the driving force behind the individual mandate, the penalty was assumed to be integral to the success of the ACA's aim to increase health insurance coverage. Consequently, the individual mandate penalties, which took effect in 2014, were seen by many analysts as

critical to establishing the reformed insurance risk pools in nongroup insurance markets. The insurance plans offered in the nongroup insurance markets faced the most significant modifications to both the regulation and structure of the plans and their pricing. Newly opening these markets to people with serious medical needs and newly prohibiting insurers from setting prices or benefits based on applicants' health status put these markets at risk of attracting a disproportionately high medical cost enrollee population. The individual mandate penalty was intended to increase the incentives for healthier people to remain covered or obtain new coverage.

By 2017, however, it was clear that a substantial penalty was not necessary for the exchanges to work. *See* Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017)[27] (concluding "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade" following repeal of individual mandate); *see also Continuation of Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act"* S. Comm. On Fin., 115th Cong. 105–06 (Nov. 15, 2017) (statement of Sen. Orin Hatch, Chairman) (citing CBO study in floor comments).[28]

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

[28] https://www.finance.senate.gov/imo/media/doc/11-15-17%20--%20The%20Tax%20Cuts%20and%20Jobs%20Act%20--%20Day%203.pdf.

The performance of the exchanges since 2017 supports that conclusion. The critical reforms that the ACA made to the nongroup insurance market remain stable in the absence of a penalty to enforce the individual mandate. Consumers are aware that coverage is available and that federal subsidies are available to people with modest incomes to make coverage affordable. Awareness of subsidized insurance coverage that includes essential health benefits, federal limits on out-of-pocket cost exposure, and population based (as opposed to individual health status based) pricing has helped keep insurance markets stable even without the mandate in place.

Thus, actual evidence from the 2019 and 2020 plan years undermines the once widely-held view that guaranteed issue, modified community rating, or any of the ACA's market rules are unsustainable in the absence of an individual mandate. In 2020, on average, 3.9 insurers are selling coverage in each of the 502 ACA nongroup insurance rating regions across the country, up from 3.7 in 2017, despite the elimination of the mandate penalties. Holahan et al., *Marketplace Premiums and Insurer Participation* 5–6.

Premium data also indicate that the markets have stabilized even as mandate penalties ended. Premiums increased substantially in 2018, in large measure because the Administration eliminated direct reimbursement for cost-sharing subsidies, the policy uncertainty surrounding the individual mandate, and other executive actions. Since then, however, marketplace benchmark premiums have typically decreased or risen modestly.

- In 2019, the first year without penalties, the benchmark premium decreased or increased by less than 5% in 63% of rating regions.
- In 2020, the second year without the penalties in place, benchmark premiums either fell or increased nominally (by less than 5%) in over 80% of rating regions.

Collectively, these data indicate that the nongroup insurance risk pools were not worsening without the mandate in place, as had been feared.

Consumer enrollment also remained relatively stable in the absence of penalties for the individual mandate. A study conducted by the Urban Institute shows the number of plan selections made by individuals in the marketplace during open enrollment in 2018 and 2019 by state. *See* Blumberg et al., *State-by-State Estimates* 21, tbl.9. Plan selections without mandate penalties (2019) were nearly equal (90% or more) to plan selections with mandate penalties in place (2018) in 46 of the 51 states (including the District of Columbia), or 90% of states. *Id.* In point of fact, 13 of these 51 states had more plan selections by individuals in the first year without a penalty than in the last year with the penalties in place. *Id.* Overall, plan selections in 2019 were 97% of plan selections in 2018. *Id.* (Data for 2020 are not yet available since some states are still in the midst of their open enrollment periods into January 2020.).

Taken together, these data demonstrate a good bill of health for nongroup insurance markets even without the penalty for failing to purchase a health insurance plan. It follows that to declare that the ACA's nongroup insurance markets and their regulatory protections for

people with health problems cannot be separated from the individual mandate is wholly irrational.

B. There Is No Economic Reason Why Congress Would Have Wanted The Myriad Other Provisions In The ACA To Be Invalidated.

The Fifth Circuit also suggested that Congress may have wanted the rest of the ACA to fall if the mandate was invalidated. Even putting to one side this Court's presumption of severability as a legal matter, *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018), the ACA is textbook example of an enactment that serves myriad other policy goals beyond those contained in the provision at issue here. Those hundreds of other provisions can, and do, function independent of the individual mandate. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–85 (1987). The notion that Congress would have wanted to eliminate these provisions in a world in which a $0 penalty mandate was invalidated is nonsensical.

In addition to the severability of the marketplaces, the marketplace subsidies, and the insurance market reforms (discussed in *supra* section IIA), a handful of examples further demonstrate the independence of various ACA provisions from the individual mandate:

- The entire Indian Health Service (IHS) was reauthorized by the ACA. This reauthorization included a significant modernization of the governance and funding of IHS which provides care to 2.6 million people through a network of hospitals and outpatient facilities. The individual mandate and penalties are irrelevant to the operation of this health system.

- As noted in the previous section, the ACA authorized the FDA to approve biosimilars. This type of investment, intended to provide consumers with access to lower priced medications, is completely unrelated to the individual mandate.
- The optional expansion of eligibility for the Medicaid program to those with incomes up to 138% of the federal poverty level (at state choice) is unrelated to the individual mandate since the vast majority of those eligible were exempt from the penalties to start with due to their low income. In addition, the balance of risks in the Medicaid insurance pools has never been an issue, since the care of enrollees is almost entirely financed by governments. By contrast, the individual mandate was intended to ensure that *private* nongroup insurance pools would be well balanced between the healthy and the sick.
- The ACA provides for filling the Medicare program's prescription drug "doughnut" hole, thereby improving prescription drug affordability for those age 65 and over. Again, this provision is irrelevant to the individual mandate since virtually all Americans age 65 and over are already insured through the Medicare program.
- Other examples include:
    - Providing free preventive services in Medicare and employer sponsored insurance 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;
- 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;
- Requiring employers to provide new mothers with break time and private places for nursing;
- Improving patient safety at hospitals by penalizing unnecessary readmissions and avoidable hospital-acquired conditions; and
- Standardizing the income definition (to Modified Adjusted Gross Income) for Medicaid eligibility for most groups.

These examples are just the tip of the iceberg. From health care delivery demonstrations authorized under

the Act, to improvements in the training of health care professionals, to the authorization of studies on the adequacy of Medicare payments to rural hospitals, the ACA reaches across the entirety of the U.S. health care system in ways completely unrelated to the health care risk of enrollees in the nongroup market. *See* Pet. H.Rep. Br. at 13 (listing examples).

There is no sound reason to invalidate these hundreds of provisions which serve a crucial role in bettering the health care system. In fact, doing so would only increase costs for insurers, health care providers, state governments, and the federal government, all of whom have made extensive accommodations to incorporate the law into their business and administrative practices. The confusion and chaos that such a move would cause is difficult to imagine, a priori, but is certainly a maelstrom that Congress did not intend.

CONCLUSION

For the foregoing reasons, *amici* Bipartisan Economic Scholars respectfully urge the Court to grant the petitions.

Respectfully submitted,

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