No. 19-840

In the
Supreme Court of the United States

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

On 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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May 13, 2020

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

LEGISLATIVE MATERIALS

PROFESSIONAL JOURNALS

OTHER AUTHORITIES

INTEREST OF *AMICI CURIAE*[1]

The *amici curiae* Bipartisan Economic Scholars are 53 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" or "Act") 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; five recipients of the Arrow Award for best paper in health economics; and three recipients of the American Society of Health Economists Medal, which is awarded biennially to the economist aged 40 or under who has made the most significant contributions to the field of health economics. A complete list of the Bipartisan Economic Scholars is provided in the Appendix at the back of this brief. Many of the Bipartisan Economic Scholars have submitted

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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.

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 Fifth Circuit's ruling on severability, in which that court concluded that Congress may have wanted the rest of the ACA invalidated in whole or in part in the event the mandate were found unconstitutional.[2]

The Fifth Circuit's severability ruling is incorrect. Economic data demonstrate that the ACA remains fully effective and operational even in the absence of the individual mandate. That is true both with respect to the exchanges as well as the vast array of other health policy provisions contained in the Act. The notion that Congress would have wanted the exchanges in particular (also referred to as marketplaces) or the ACA as a whole to be invalidated in the event the mandate was struck down makes no economic sense. Even in normal times, eliminating the ACA in whole or in part would inflict broad damages on individuals, state governments, and businesses. Those consequences would be even more dramatic during the current pandemic and its aftermath, and would contribute to avoidable loss of life. *Amici* urge the Court to reject the Fifth Circuit's conclusion that the individual mandate cannot be severed from the rest of the ACA.

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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

The court of appeals held that the individual mandate provision of the ACA is unconstitutional because Congress in the Tax Cut and Jobs Act of 2017 set the penalty for individuals failing to obtain insurance at $0. It remanded the case to the district court with instructions to identify which components of the ACA, if any, are severable from the individual mandate.

Amici write to make two points in urging this Court to reverse the decision of the court of appeals.

First, the Fifth Circuit's severability analysis should be rejected because it flies in the face of economic logic and data. When Congress reduced the financial penalty for being uninsured to zero in 2017, it understood that the exchanges and the rest of the ACA could and should continue to function even without a penalty for the uninsured. The data have borne that out. Enrollment and insurer participation in ACA exchanges have remained robust even after the penalty fell to $0, and premiums have been steady. Put simply, Congress expected millions of Americans to continue to obtain insurance on the ACA exchanges after 2017, and they have.

As for the contention that Congress would not have wanted *any* of the ACA to survive in the event that the mandate were struck down, even a cursory review of the Act shows that to be false. The provisions of the ACA are enormously diverse and many are entirely unrelated to the individual mandate. To pick just a few examples, Congress chose to provide in the ACA funding enabling states to expand Medicaid coverage to millions of

additional low-income people, few of whom were subject to the individual mandate due to their low incomes, and improved prescription drug coverage for seniors by closing the Medicare "doughnut hole," a group for whom the individual mandate was irrelevant because they were already universally insured through a public insurance program. What remains of the ACA stands on its own.

Second, and as a correlative point, because the ACA continues to achieve a wide array of critical health policy objectives, invalidating it in whole or in part would have disastrous consequences. Modelling shows that approximately twenty million Americans would lose insurance if the ACA were repealed under normal conditions. With the pandemic and its attendant massive increase in unemployment (and thus widespread loss of employer-provided health insurance), those already-staggering numbers would balloon further. At time of writing, the unemployment data from the pandemic is too preliminary to provide a precise estimate, but it can be easily expected that many millions more would be added to the rolls of the uninsured if the ACA were repealed.

Nor would the harm be limited to swelling the ranks of the uninsured. The ACA touches almost every aspect of the health care economy. Insurers, hospitals, and states would all suffer in the event the Act were invalidated. As federal health care funding shrank and the demand for care by those without insurance grew, physicians and hospitals would see their revenues fall. State government budgets would be strained by the growing unmet need for residents' medical care. And

insurers too would suffer as they faced potentially large financial losses in the near term due to falling enrollment and withdrawn subsidies. Without the ACA, the financial stability of the entire US health care system will be threatened as the largest public health crisis in generations puts unprecedented stress on that system.

ARGUMENT

I. The Fifth Circuit's Severability Analysis Lacks Any Economic Foundation And Would Cause Egregious Harm To Those Currently Enrolled In Medicaid And Private Individual Market Insurance As Well As Health Care Providers.

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 is belied by 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 Establish 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 complying with the individual mandate) was eliminated, but the markets remained stable.

Many assumed that expanding insurance coverage in the individual insurance market[3] depended on two provisions – the individual mandate and the penalty that enforced it. These provisions were seen as essential to create and sustain balanced insurance risk pools in individual insurance markets. Because other provisions of the ACA barred insurers from medical underwriting—that is, varying premiums by medical history—it was feared that insurers might attract an enrollee population with disproportionately high medical costs. The individual mandate penalty was intended to incentivize healthy people to remain covered or obtain new coverage.

By 2017, however, it was clear that the penalty was not necessary to the success of the exchanges, the primary marketplace for individual insurance products. *See* Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* at 1 (Nov. 2017)[4] (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": Hearing Before the S. Comm. On Fin.*, 115th Cong. 105–

[3] The individual insurance market refers to health insurance plans purchased by individuals without a group, such as an employer. This market is also sometimes referred to as the nongroup market.

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

06 (Nov. 15, 2017) (statement of Sen. Orin Hatch, Chairman) (citing CBO study in floor comments).[5]

The performance of the exchanges since 2017 bears out that conclusion. The individual insurance market remains stable despite elimination of the penalty to enforce the individual mandate. Consumers realize that insurance—covering essential health benefits, with caps on out-of-pocket cost exposure, and population-based premiums (as opposed to premiums based on individual health status)—is universally available and that federal subsidies make such coverage affordable. This realization has helped stabilize insurance markets in the absence of the mandate.

Thus, actual evidence from the 2019 and 2020 plan years undercuts the once widely-held view that the ACA's market rules, including guaranteed issue, and modified community rating, would be unsustainable in the absence of an individual mandate. In 2020, on average, 3.9 insurers are selling coverage in each of the 502 ACA individual insurance market rating regions across the country. This number is up from 3.7 in 2017, despite the elimination of the mandate penalties. John Holahan et al., Robert Wood Johnson Foundation & Urban Institute, *Marketplace Premiums and Insurer Participation: 2017 – 2020* at 5–6 (Jan. 2020).[6]

Premium data also indicate that the markets have stabilized even as mandate penalties ended. Exchange

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

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

premiums increased substantially in 2018, in large measure because of the elimination of 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 plan 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 individual insurance market risk pools were functioning well without the mandate in place.

Consumer enrollment in exchange coverage also remained relatively stable in the absence of penalties to enforce the individual mandate.[7] A study conducted by the Urban Institute shows that the number of people enrolled in marketplace coverage in 2019 was 90 percent or more of the number of enrollees in 2018 in 46 of 51 states (including the District of Columbia). In 13 of these states, there were more enrollees in 2019 than in 2018. *See* Linda J. Blumberg et al., Urban Institute, *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA* at 21, tbl.9

[7] Consumer enrollment, as described throughout this paragraph, is measured by consumer plan selections at the end of the annual open enrollment period.

(Mar. 2019) (hereinafter Blumberg, *State-by-State Estimates*)[8]. Nationally, overall enrollment in 2019 was 97% of enrollment in 2018. *Id.* Overall enrollment decreased by less than 3 percent between 2018 and 2019 even though two additional states expanded Medicaid eligibility in 2019, which reduced the number of very low income people eligible to enroll in the marketplaces. *See* Centers for Medicare & Medicaid Services, *2018 Marketplace Open Enrollment Period Public Use Files*[9]*;* Centers for Medicare & Medicaid Services, *2019 Marketplace Open Enrollment Period Public Use Files.*[10] Coverage in 2020 was almost unchanged from 2019 (enrollment fell by less than one-half of one percent) despite the fact that two more states expanded Medicaid eligibility at the beginning of the year. *See* Centers for Medicare & Medicaid Services, *2020 Marketplace Open Enrollment Period Public Use Files.*[11]

These data demonstrate that individual insurance markets remained healthy even after the end of the penalty for failing to enroll in a health insurance plan. It

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

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment (last modified Apr. 1, 2020).

[10] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment (last modified Apr. 1, 2020).

[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files (last modified Apr. 2, 2020). This data set is consistent with the Urban Institute's findings that were published in 2019 and referenced above.

follows that to declare that the ACA's individual 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. The ACA is a textbook example of an enactment that serves a myriad of other policy goals beyond those contained in the provision at issue here. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (observing that the relevant inquiry in severability analysis is "whether the statute will function in a *manner* consistent with the intent of Congress"). Those scores of other provisions can, and do, function independently from the individual mandate. *See Champlin Refining Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932) ("The unconstitutionality of a part of an act does not necessarily defeat or affect the validity of its remaining provisions . . . if what is left is fully operative as a law."). 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 ACA reauthorized the entire Indian Health Service (IHS) which provides care to 2.6 million Native Americans through a network of hospitals and outpatient facilities. It also modernized IHS governance and funding. The individual mandate and penalties are irrelevant to the operation of this health system.
- The ACA authorized the FDA to approve biosimilars, a provision intended to provide consumers with access to lower priced medications. This provision 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 also unrelated to the individual mandate, as nearly all of those affected were exempt from the penalties because of their low income. The individual mandate was intended to ensure that *private* individual market insurance pools would be well balanced between the healthy and the sick; it was not concerned with enrollment in Medicaid.
- The ACA improves Medicare's prescription drug coverage by gradually closing the so-called "doughnut" hole. This increase in prescription drug affordability for people age 65 and over and with disabilities is irrelevant to the individual mandate, as people covered by Medicare, even as it existed before the ACA, were already insured.

- Examples of other ACA provisions that bear no relation whatsoever to the insurance coverage mandate include those:
    - Providing free preventive services in Medicare and employer sponsored insurance coverage;
    - Offering dependent coverage for young adults on their parents' policies;
    - 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 illustrate, but do not fully capture, the breadth and number of ACA provisions unrelated to the insurance mandate. 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 individual insurance market. *See* H.Rep. Br. at 39 (listing examples).

There is no sound reason to invalidate these scores of provisions which serve a crucial role in bettering the health care system. To do so would be not only baseless, but harmful, increasing 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 practices and administrative procedures. Such a move would cause chaos and confusion, a maelstrom no Congress could have intended.

II. Because The ACA Can Operate Effectively Without A Mandate, Invalidating The Act Would Have Dire Consequences For Millions Of Individuals And Other Stakeholders In The Health Care Sector.

Because the ACA works even without a penalty imposed for lack of insurance, eliminating it would have enormous consequences. Even before the COVID-19 pandemic, estimates indicated that invalidating the ACA would cause millions of people to lose health insurance coverage.

The pandemic and its attendant unemployment mean that still millions more would be affected, as many of those who lose employer sponsored insurance coverage when they lose jobs would also lose access to the ACA marketplaces (and associated tax credits) and to Medicaid. Uncompensated care would soar, and hospitals, states, and insurers would all be placed under enormous strain.

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

1. Economic Modelling Shows That Even Before The COVID-19 Pandemic, Invalidating The ACA Would Have Eliminated Or Reduced Access To Health Care For Tens Of Millions Of Americans.

Invalidating the ACA would undermine the concrete gains in insurance coverage achieved under the Act. Overall, between 2010 and September 2018, an estimated 19 million more people obtained health

insurance—equating to a 40 percent drop in the uninsured rate. *See* Emily P. Terlizzi et al., National Center for Health Statistics, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2018* at tbl.2 (Feb. 2019).[12]

The newly insured include an estimated 3.2 million African-Americans, 3.8 million people of Hispanic origin, 11 million white Americans, 5.4 million young adults (19-25), and 2.4 million children (0-18). Urban Institute analysis of the 2010 and 2017 National Health Interview Survey. Those gains were seen across the income spectrum, with the uninsured rate dropping by 43 percent for nonelderly adults with income below 138 percent of poverty, 37 percent for people with income between 138 and 400 percent of poverty, and 34 percent for people with incomes above 400 percent of poverty. *Id.*

Much of this gain in coverage occurred because the ACA ensured that coverage in the individual insurance market was affordable. Between 2013 and 2016, the ACA contributed to a 57 percent increase in the number of people covered in the individual insurance market. Henry J. Kaiser Family Foundation, *Health Insurance Coverage of Nonelderly 0-64*, 2013 and 2016.[13] This gain occurred through the ACA's creation of health insurance Marketplaces and its premium subsidies. As of 2017, 84

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[12] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf.

[13] https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 11, 2020).

percent of the 10.3 million enrollees received premium tax credits averaging approximately $4,458 per enrollee per year. *See* Centers for Medicare & Medicaid Services, *2017 Effectuated Enrollment Snapshot* at 5 (June 12, 2017).[14]

At the same time, that financial assistance allowed 71 percent of Marketplace enrollees to buy health insurance for less than $75 per month. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Research Brief: *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace* at 4, tbl.1 (Oct. 24, 2016).[15] This assistance helps explain why the number of people who reported finding it very difficult or impossible to find affordable health insurance dropped almost by half between 2010 and 2016. *See id.* These (and many other) gains would be reversed if the ACA were invalidated in its entirety.

Invalidating the ACA would undo gains in access to healthcare as well. Study after study has shown that the ACA has improved access to health care, especially among low-income people. *See, e.g.*, Sherry A. Glied et al., *Did the ACA Lower Americans' Financial Barriers to Health Care?*, 39 Health Aff. 379, 382-84 (2020); Jonathan Gruber & Benjamin D. Sommers, *The Affordable Care Act's Effects on Patients, Providers,*

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

[15] https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.

and the Economy: What We've Learned So Far, 38 J. Pol'y Analysis & Mgmt. 1028, 1037-39 tbl.2 (2019).[16]

For example, the share of people without a regular source of care, and the share of people who did not receive a routine checkup, both dropped by approximately six percent from 2013 to 2017. The share of people who reported that they were unable to obtain needed medical care because of cost dropped by one-third. That access has resulted in tangible increases in the use of health care services, including outpatient care, a usual source of care or personal physician, preventive services, prescription drug use and adherence, and surgical care. Because of the ACA's requirements, that access to care also includes critical coverage for prescription drugs, mental health, maternity care, substance abuse, autism, and a range of other medical issues that were often not covered under private plans prior to 2010. Moreover, the ACA's guarantee of access to health insurance ensures that the up to 133 million Americans who have a pre-existing health condition, including parents of 17 million children with such conditions, can obtain coverage regardless of their job situation or eligibility for government programs.

An analysis by the Urban Institute, based on their Health Insurance Policy Simulation Model, quantifies the widespread impact from invalidating the entire ACA prior to the pandemic. After accounting for regulatory changes since January 2017 and setting the penalty for violating the individual mandate to $0, the Urban

[16] https://onlinelibrary.wiley.com/doi/full/10.1002/pam.22158.

Institute's model shows that, if the ACA had been overturned in its entirety in 2019,

- 19.9 million fewer people would have had insurance coverage (a 65 percent increase in the uninsured);
- 15.4 million fewer low-income people would have had coverage under Medicaid; and
- 6.9 million fewer people would have had private individual insurance coverage.

Blumberg, *State-by-State Estimates* at 6, tbl.1.

The vast majority of those retaining private individual coverage would have had coverage that was less comprehensive (due to elimination of benefit and actuarial value standards) and substantially less accessible (due to the elimination of guaranteed issue and modified community rating rules). Invalidating the ACA would also cause federal spending on healthcare to have dropped by $134.7 billion, a decline of 35 percent in 2019. *Id.* at 9, tbl.3. This drop represents a particularly large decrease in funding of health care for low and modest income people and would translate into a substantial decrease in affordability and access to care.

Other studies bear out these findings. For example an analysis by researchers at the RAND Corporation estimated that full repeal of the ACA in 2018 would have increased the number of uninsured by 19.7 million people. Evan Saltzman & Christine Eibner, Commonwealth Fund, *Donald Trump's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit*

at 4, Ex.1 (Sept. 2016).[17] They estimated that spending on marketplace subsidies, Medicaid, and the Children's Health Insurance Program would have fallen by roughly $82 billion that year. *Id.* at 8, Ex.6.

2. These Enormous Harms Would Be Exacerbated In The Context Of The COVID-19 Pandemic.

In the context of the coronavirus pandemic, overturning the ACA would have much larger and far more damaging implications for insurance coverage and health care financing. As unemployment rates spike, with many workers losing jobs, they and their family members will also lose the health insurance they have had through those jobs. Without the ACA's subsidies for marketplace coverage and the Medicaid expansion in 35 states and the District of Columbia, very few of these people would have access to affordable insurance coverage.

According to a recent analysis, approximately half of the unemployed were also uninsured prior to the implementation of the ACA's coverage reforms (49 percent of the unemployed were uninsured over the 2008 to 2010 period; 46 percent of the unemployed were uninsured over the 2011 to 2013 period). Anuj Gangopadhyaya & Bowen Garrett, Robert Wood Johnson Foundation & Urban Institute, *Unemployment, Health Insurance and the COVD-19*

[17] https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_sep_1903_saltzman_trump_hlt_care_reform_proposals_ib_v2.pdf.

Recession at 3, tbl.1 (Apr. 2020).[18] Since the ACA's Medicaid expansion and marketplace subsidies were implemented in 2014, the uninsurance rate among the unemployed dropped approximately 20 percentage points to less than 30 percent, showing the importance of the ACA's coverage programs as a safety net for people losing their employer-based insurance coverage.

Another recent analysis estimates that over 70 percent of the workers in industries most vulnerable to losing their jobs and their employer-based health insurance due to the pandemic would be eligible for Medicaid or Marketplace subsidies if they become unemployed. Linda J. Blumberg et al., Robert Wood Johnson Foundation & Urban Institute, *Potential Eligibility for Medicaid, CHIP, and Marketplace Subsidies among Workers Losing Jobs in Industries Vulnerable to High Levels of COVID-19-Related Unemployment* at 17, App.Tbl.2 (Apr. 2020).[19] Almost all of that eligibility is the result of the ACA; very little is due to the pre-ACA Medicaid programs. For example, only 5 percent of these workers living in non-Medicaid expansion states would be eligible for assistance if not for the ACA. With job losses due to the pandemic currently estimated at 22 million and counting, without the ACA's coverage programs in place, it is clear that millions more people would be uninsured at the moment

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[18] https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf.

[19] https://www.urban.org/sites/default/files/publication/102115/potential-eligibility-for-medicaid-chip-and-marketplace-subsidies-among-workers-losing-jobs-in-industries-vulnerable-to-high-levels-of-covid-19-related-unemployment_0.pdf.

when the US is experiencing its worst health crisis in generations.

In addition to reducing the number of uninsured, the ACA's insurance market rules provide critical protections for the people infected by COVID-19 now and in the future. The ACA requires private insurers to cover treatment needs regardless of prior health experience or current health status, and it prohibits insurers from varying premiums based on enrollees' health. Millions of Americans have been or will be infected with the virus, many of whom may experience long term health consequences. Without the ACA's protections, private insurance companies could deny coverage to enrollees based on COVID-19 exposure, exclude that condition from coverage, or limit benefits for the ongoing health consequences from having had the condition. Before 2014, such practices were commonplace in individually purchased health insurance plans and would undoubtedly be implemented again if the ACA was overturned. Thanks to the protections afforded by the ACA, those pernicious practices are prohibited.

B. Striking Down The ACA Will Also Have Drastic Consequences On Healthcare Markets And The Healthcare Industry.

The ACA profoundly transformed the rules governing the operation of the US health care system, Medicare (including payment and benefit rules), Medicaid (including rules governing the calculation of eligibility for those already eligible for the program), employer-sponsored insurance (including rules governing preventive services and young adults), and

individual insurance (including the aforementioned community rating and pre-existing condition requirements in the law). The ACA's subsidies and Medicaid expansions also increased Federal spending in the health care sector, providing a lifeline to hospitals and state governments. In 2019, the Federal government spent $134.7 billion supporting these increases in coverage and access. *See* Blumberg, *State-by-State Estimates* at 9, tbl.3. Striking down the ACA would mean striking down this entire legal structure, and withdrawing a substantial amount of funding from the system.

The economic impact from striking down the ACA will fall particularly heavily on the healthcare industry. In an analysis of the impact of repealing the ACA in its entirety, the sharp reduction in the number of people with insurance was projected to reduce industry profits by $6 billion between 2012 and 2021, and cost private insurers more than $350 billion in profits resulting from the ACA's Medicaid expansion. Brief for Economists as Amici Curiae at 3, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-393), 2012 WL 78244. The Urban Institute study estimates that total uncompensated care costs would have increased by 82 percent if the ACA was fully repealed in 2019, from $61.3 billion to $111.4 billion. Blumberg, *State-by-State Estimates* at 13, tbl.5. These estimates were based on the pre-pandemic situation, which means the impacts of overturning the ACA would be substantially larger now. As unemployment increases and more people enroll in Medicaid through the ACA's eligibility expansions and in private coverage through the Marketplaces, removing these programs under this lawsuit would lead to larger reductions in

government funding for health care and larger increases in demand for uncompensated care.

Within the healthcare sector, hospitals will bear the brunt of the economic harm. After enactment of the ACA, "[n]ationwide, uncompensated care has fallen by more than a quarter as a share of hospital operating costs from 2013 to 2015, corresponding to a reduction of $10.4 billion." Office of the President Council of Economic Advisors, *2017 Economic Report of the President, Chapter 4: Reforming the Health Care System* 196 (Jan. 2017)[20] (*hereinafter* CEA Report). But if the Act is invalidated, hospitals will again face the heavy cost of uncompensated care as the number of people without insurance skyrockets. An analysis funded by the American Hospital Association estimated that if the ACA were repealed, hospitals' overall net income would decrease by $165.8 billion between 2018 and 2026. Allen Dobson et al., Dobson & DaVanzo & Assocs., LLC, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals: Findings, Assumptions and Methodology* at 9 (Dec. 6, 2016).[21] The pandemic has already wreaked havoc with hospital finances. Many hospitals would find it impossible to cope with additional financial shock resulting from invalidation of the ACA.

The cost would be especially severe for hospitals in the 35 states plus the District of Columbia that took advantage of the ACA's Medicaid expansion. In those

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[20] https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf.

[21] https://www.aha.org/system/files/2018-02/impact-repeal-aca-report_0.pdf.

states, "[m]ean annual Medicaid revenue increased significantly" for hospitals, by approximately $4.6 million per hospital over a two-year period. Fredric Blavin, Robert Wood Johnson Foundation & Urban Institute, *How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data* at 3 (Apr. 2017).[22] At the same time, the ACA has helped reduce the costs of uncompensated care for those hospitals by an average of about $3.2 million per hospital, a roughly 34 percent reduction. *Id.* According to one study, expanding Medicaid "significantly improved" operating and excess margins at hospitals, by 67.3 percent and 41.4 percent, respectively. *Id.* Small and rural hospitals—which serve 72 million people "as an important, and often only, source of care," and which the ACA sought to bolster — have tended to experience the greatest gains. American Hospital Ass'n, Trend Watch: *The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform* at 1 (Apr. 2011).[23] Striking down the ACA now will reverse those gains and undo the benefits that hospitals have accrued as a result of Medicaid's expansion.

Many provisions of the ACA affected the fiscal stability of the Medicare program, a foundation of the US health care system on which 60 million seniors and people with disabilities rely. The ACA "along with other factors, has significantly improved Medicare's financial outlook, boosting [Medicare's] revenues and making the

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[22] https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436310.

[23] https://www.aha.org/system/files/2018-03/11apr-tw-rural.pdf.

program more efficient." Paul N. Van de Water, Center on Budget and Policy Priorities, Policy Futures: *Medicare Is Not "Bankrupt"* (May 1, 2019).[24] Since 2010, average annual growth in total Medicare spending was cut in half, to 4.4 percent from 9 percent, and average annual growth in Medicare spending per beneficiary dropped to 1.7 percent from 7.3 percent. Juliette Cubanski et al., Henry J. Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (Aug. 20, 2019).[25] The Medicare Hospital Insurance Trust Fund, which was projected to become insolvent by 2017, is now scheduled to stay solvent from that year until 2026. *See CEA Report* at 296-97 & n.42; *see also* Center for Medicare and Medicaid Services, *2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* at 7 (June 5, 2018).[26] From 2009 to 2020, that Trust Fund's projected 75-year shortfall dropped by 80 percent (to 0.76 percent of taxable payroll from 3.88 percent before the ACA). *See* Center for Medicare and Medicaid Services, *2020 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* at 7-8 (Apr. 22, 2020).[27] As the 2010 Medicare Trustees Report notes, this large improvement in the

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[24] https://www.cbpp.org/research/health/medicare-is-not-bankrupt.

[25] https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing.

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

[27] https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

financial status of the Trust Fund resulted principally due to "the far-reaching effects of the Affordable Care Act. . . ." Center for Medicare and Medicaid Services, *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* at 6 (Aug. 5, 2010).[28] But the Congressional Budget Office has projected that repealing the ACA would increase Medicare spending by $802 billion over ten years, which would require raising seniors' premiums, unwind efficiencies, and hasten the insolvency of the Medicare Hospital Insurance Trust Fund. Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* at 10 (June 2015).[29] In short, invalidating the ACA would all but nullify the ACA's major advances in putting Medicare on solid footing.

The states would face a similar economic impact if the ACA ceased to exist. In the analysis referenced above, the Urban Institute estimated that, without the ACA, states could spend $28.8 billion more on healthcare between 2019 and 2028, "as reductions in Medicaid spending would be more than offset by increases in uncompensated care." Matthew Buettgens et al., Robert Wood Johnson Foundation & Urban Institute, *The Cost of ACA Repeal* at 1 (June 2016).[30] At the same

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[28] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf.

[29] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf.

[30] http://www.urban.org/sites/default/files/publication/81296/2000806-The-Cost-of-the-ACA-Repeal.pdf.

time, federal healthcare spending—on the insurance marketplace, Medicaid, hospitals, and physicians, to name a few—is estimated to drop by nearly a trillion dollars in the sixteen Intervenor-Defendant states alone. Given the exploding demands on state resources and plummeting revenues resulting from the pandemic, states nationwide are expected to face substantial financial hardship in the coming years. As a result, they will be particularly unable to take on the additional burdens associated with the ACA being overturned. This means that such an action can be expected to leave many more Americans with unmet health care needs.

CONCLUSION

For the foregoing reasons, *amici* Bipartisan Economic Scholars respectfully urge the Court to reverse the judgment of the court of appeals.

Respectfully submitted,

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May 13, 2020

APPENDIX

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