IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES HOUSE OF REPRESENTATIVES,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 1:14-cv-01967-RMC
	)	
SYLVIA MATHEWS BURWELL, in her official capacity as Secretary of Health and Human Services, *et al.*,	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS NO GENUINE ISSUE

Pursuant to Local Rule 7(h)(1), the defendants respectfully submit the following statement of material facts as to which there is no genuine issue:

1. For insured individuals and families, the cost of health care covered by a plan consists of a combination of payments to insurers and payments to health care providers. The payments to insurers take the form of monthly premiums that the insurers charge in return for providing coverage. *See* 42 U.S.C. § 18032(b). The payments to health care providers, known as "cost-sharing" payments, reflect the fact that insurance plans typically do not pay for all covered health care costs. *See* 42 U.S.C. § 18022(c)(3)(A)(ii). Rather, plans typically require the insured to pay an amount either as a "co-payment" or "co-insurance" for visits to health care providers. Further, some plans require an individual to pay a certain amount out of pocket, known as a deductible, before certain benefits are fully covered by the insurer.

2. For both economic and legal reasons, premiums and cost sharing are inversely correlated: assuming coverage of the same set of health care services, premiums are higher

when cost sharing is lower, and vice versa. Less cost sharing means that the insurer is paying a greater share of covered individuals' medical expenses, which increases the price of insurance as reflected in the premiums. *See, e.g.*, Statement of Douglas W. Elmendorf, Director, Cong. Budget Office, *Expanding Health Insurance Coverage and Controlling Costs for Health Care* at 13-14, S. Comm. on Budget, 111th Cong., 1st Sess. (2009), reprinted in Cong. Budget Office, *Selected CBO Publications Related to Health Care, 2009-2010* at 298-99 (Dec. 2010).

3. In addition, health insurers are required by state laws to calculate their rates in an "actuarially sound" manner, meaning that they must set premiums at a rate that is calculated to ensure that expected health care costs will be covered. *E.g.*, Cal. Ins. Code § 10181.6. And the Affordable Care Act requires insurers to provide rebates if their medical loss ratios—*i.e.*, the percentage of premium revenues spent on clinical services and activities that improve health care quality, as opposed to profits or administrative costs—are below specified levels (80% in the individual market). *See* 42 U.S.C. § 300gg-18(b).

4. Under the structure of the ACA, Treasury's payments of cost-sharing reductions decrease the amounts that Treasury otherwise would pay out of the federal fisc as premium tax credits. Premiums and cost-sharing are inversely related. If insurers were not reimbursed by the government for complying with the ACA's directive to reduce the cost-sharing requirements imposed on eligible individuals enrolled in silver plans, they would raise silver plan premiums to cover the additional health care costs the insurers themselves would incur as a result. Such premium increases, in turn, would increase the amount that Treasury would be required to pay in tax credits. As the Congressional Budget Office explained while the Act was under consideration, if premiums for silver plans in a particular market go up, federal payments for tax credits "have to rise" as well. Cong. Budget Office, *An Analysis of Health Insurance Premiums*

Under the Patient Protection and Affordable Care Act 20 (Nov. 30, 2009), reprinted in Cong. Budget Office, *Selected CBO Publications Related to Health Care, 2009-2010* at 213 (Dec. 2010).

5. The amount of the tax credit is designed to ensure that eligible enrollees are not required to pay more than a set percentage of their household income out of pocket in order to purchase the second-lowest-cost silver plan available in their rating area. 26 U.S.C. § 36B(b). As a result, an increase in the amount of the premiums for those plans would trigger a dollar-for-dollar increase in the amount of the tax credit available. And that increase would apply to *all* individuals who are eligible for premium tax credits—not just the subset that receives cost-sharing reductions.

6. The ACA's system of health insurance Exchanges and subsidies became effective on January 1, 2014. *See* 42 U.S.C. § 18031(b)(1); Pub. L. No. 111-148, § 1401(e), 124 Stat. 119, 220 (2010).

7. In October 2013, in the first piece of appropriations legislation it enacted for fiscal year 2014, Congress included a provision directing HHS to certify that a program was in place to verify that applicants are in fact eligible for both premium tax credits and "reductions in cost-sharing" before "making such credits and reductions available." Continuing Appropriations Act, 2014, Pub. L. No. 113-46, Div. B, § 1001(a), 127 Stat. 558, 566 (Oct. 17, 2013). In accordance with that provision, HHS certified to Congress that the Exchanges "verify that applicants for advance payments of the premium tax credit and cost-sharing reductions are eligible for such payments and reductions." Letter from Kathleen Sebelius, Secretary, U.S. Dep't of Health & Human Servs., to the Hon. Joseph R. Biden, Jr. at 1 (Jan. 1, 2014).

8. Since January 2014, Treasury has been making advance payments of premium tax credits and cost-sharing reductions to issuers of qualified health plans as required by Section 1412 of the ACA. 42 U.S.C. § 18082(a)(3), (c); *see also, e.g.*, Centers for Medicare & Medicaid Servs., Payment Policy and Financial Management Group, *Marketplace Payment Processing*, at 6-7 (Dec. 6, 2013) (discussing plans "to make estimated payments to issuers beginning in January 2014 based on data provided by the December deadline").

Dated: December 2, 2015

Respectfully submitted,

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