IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

BRIEF *AMICI CURIAE* FOR ECONOMIC AND HEALTH POLICY SCHOLARS IN SUPPORT OF DEFENDANTS

MATTHEW S. HELLMAN
D.C. Bar No. 484132
MATTHEW E. PRICE
D.C. Bar No. 996158
JENNER & BLOCK LLP
1099 New York Avenue, NW
Suite 900
Washington DC 20001
(202) 639-6000
mhellman@jenner.com

Counsel for Amici Curiae

December 8, 2015

TABLE OF CONTENTS

TABLE OF AUTHORITIES*

Cases

STATUTES

* Authorities upon which we chiefly rely are marked with an asterisk.

OTHER AUTHORITIES

INTEREST OF *AMICI CURIAE*[*]

Amici curiae are a group of 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 and are intimately familiar with its purpose and structure. They are:

- **Henry J. Aaron, Ph.D.**,[†‡] Senior Fellow, Brookings Institution; Assistant Secretary for Planning and Evaluation, U.S. Department of Health, Education & Welfare (1977-78);
- **Linda Blumberg**, Ph.D., Senior Fellow, The Urban Institute; Health Policy Advisor, Office of Management & Budget, The White House (1993-94);
- **David Cutler**, Ph.D.,[†‡] Otto Eckstein Professor of Applied Economics, Department of Economics and Kennedy School of Government, Harvard University; Senior Economist, Council of Economic Advisors (1993); Director, National Economic Council (1993);
- **Douglas Elmendorf**, Ph.D., Visiting Fellow, Brookings Institution; Director, Congressional Budget Office (2009-15); Chief of the Macroeconomic Analysis Section, Federal Reserve Board (2002-06); Deputy Assistant Secretary for Economic Policy, U.S. Department of the Treasury (1999-2001);
- **Judith Feder**, Ph.D.,[‡] Institute Fellow, Urban Institute; Professor, Georgetown University McCourt School of Public Policy; Principal Deputy Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (1993-95);
- **Sherry Glied**, Ph.D.,[‡] Dean and Professor of Public Service, Robert F. Wagner Graduate School of Public Service, New York University; Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2010-12); Senior Economist, Council of Economic Advisors (1992-93);

[*] No person or entity other than *amici* and their counsel assisted in or made a monetary contribution to the preparation or submission of this brief.
[†] Signifies Fellow, American Academy of Arts and Sciences.
[‡] Signifies Member, National Academy of Medicine.

- **Mark Hall**, J.D.,‡ Fred D. & Elizabeth L. Turnage Professor of Law, Wake Forest University School of Law and School of Medicine; Founding Director, Center for Bioethics, Health & Society;
- **John Holahan**, Ph.D., Institute Fellow, Health Policy Center, The Urban Institute;
- **Timothy Jost**, J.D.,‡ Emeritus Professor, Washington and Lee University School of Law;
- **John McDonough**, DrPH, Professor of Public Health Practice and Director of Executive & Continuing Professional Education, Harvard T.H. Chan School of Public Health; Senior Advisor on National Health Reform, U.S. Senate Committee on Health, Education, Labor and Pensions (2008-10);
- **Marilyn Moon**, Ph.D.,‡ Institute Fellow, American Institutes for Research;
- **Harold Pollack**, Ph.D., Helen Ross Professor of Social Service Administration and Public Health Sciences at the University of Chicago;
- **Sara Rosenbaum**, J.D.,‡ Harold and Jane Hirsh Professor of Health Law and Policy, Milken Institute School of Public Health, The George Washington University;
- **William Sage**, M.D., J.D.,‡ James R. Dougherty Chair for Faculty Excellence, School of Law, and Professor, Dell Medical School, University of Texas at Austin; Cluster Leader, Health Care Working Group (President's Task Force on Health Care Reform) (1993); and
- **Stephen Zuckerman**, Ph.D., Senior Fellow and Co-Director, Health Policy Center, The Urban Institute.

Amici believe that health care reform is essential to constraining the growth of health care spending and to extending health insurance coverage, and that such reform cannot succeed without cost-sharing subsidies for people with low or moderate incomes. *Amici* submit this brief to explain the economic and health policy reasons why cost-sharing subsidies are necessary for the Affordable Care Act's reforms to function as intended by Congress.

INTRODUCTION

Congress debated health care reform in 2009 against the backdrop of an enduring health care crisis. By 2009, the ranks of the uninsured had swelled to 50.7 million Americans. *See* Carmen DeNavas-Walt et al., U.S. Census Bureau, *Income, Poverty, and Health Insurance*

Coverage in the United States: 2009, at 24, 71 (2010), http://www.census.gov/prod/2010pubs/p60-238.pdf. Health care costs and spending were rising rapidly, having nearly doubled in the previous decade. *See* David I. Auerbach & Arthur L. Kellerman, *A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average U.S. Family*, 30 Health Aff. 1630, 1630, 1632 (2011). Bankruptcies due to medical bills or debts were likewise increasing dramatically. *See* David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. Med. 741 (2009). Congress sought to address this growing crisis by transforming particular components of the existing health care system to provide coverage for substantial populations of uninsured individuals on an affordable and stable basis.

Rather than drawing on a blank canvas, Congress drew on the experience of the States, and in particular the one State in which health insurance reform had succeeded: Massachusetts. Massachusetts had adopted successful health care reform where others had failed by linking three sets of reforms: a requirement that health insurance companies accept everyone seeking insurance coverage and charge them reasonable premiums, a mandate requiring that nearly everyone obtain coverage, and subsidies designed to make coverage affordable for those required to obtain it. In the Affordable Care Act ("ACA"), Congress "adopt[ed] a version of the three key reforms that made the Massachusetts system successful." *King v. Burwell*, 135 S. Ct. 2480, 2486 (2015). As the Court explained in *King*, those three reforms "are closely intertwined," *id.* at 2487, and it is "implausible" that Congress intended any one to apply without the others, *id.* at 2494.

The ACA offered two interrelated subsidies for low-income individuals. *King* dealt with the first of these: premium tax credits that reduce the *premiums* that individuals pay to obtain

health insurance. This case concerns the second kind of subsidy: cost-sharing payments that reduce the *out-of-pocket costs* (such as the plan's deductible) that individuals pay in *using* their insurance.

These two mechanisms must operate in conjunction for the ACA to achieve its aims of making health care affordable and reducing the size of the uninsured population. Even if premiums remain low, high out-of-pocket costs could leave low-income individuals unable to use their insurance to obtain health care. That would in turn ensure that uncompensated care and medical bankruptcies, which the ACA was intended to reduce, would remain common. Recognizing that problem, Congress required that insurers reduce cost-sharing for low-income enrollees and that insurers be reimbursed by the federal government for doing so.

The challenger in this case contends that, even though Congress permanently appropriated premium subsidies, Congress left these cost-sharing subsidies subject to annual appropriations. The consequences of that position are stark. If cost-sharing payments were not appropriated in any given year, and insurers had to absorb the cost of cost-sharing reductions themselves, they would have to charge higher premiums. Insurers could cover some of the cost through increased premiums paid for with increased premium tax credits. But insurers would also have to raise premiums for individuals ineligible for those credits. Those individuals would face the unappealing choice of either paying high premiums without a corresponding benefit or canceling their insurance—which would cause premiums to increase even further. Moreover, if insurers were *not* able to recoup their unreimbursed costs through increased premiums, they might avoid the Exchanges altogether. All in all, the federal government could well end up paying *more* in premium tax credit subsidies—a program the plaintiff concedes is permanently

funded—than is saved by not funding cost-sharing reductions, an absurd result that Congress could not have intended.

Instead, the text and structure of the ACA make clear that Congress understood that premium tax subsidies and cost-sharing subsidies would always go hand-in-hand. Congress mandated that the federal government reimburse insurers for cost-sharing reductions using the same mechanism used to reimburse insurers for premium reductions, with payments made at the same time and based on the same eligibility determinations. No fewer than 44 provisions of the Act tie the two forms of subsidy together, and there are multiple provisions of the legislation that make sense only if cost-sharing reduction payments are reliably paid in combination with the tax credits. Yet there is no evidence that Congress thought that insurers would be fully paid for reducing premiums while left to pay for cost-sharing reductions on their own. The Supreme Court recently cautioned that a "fair reading" of the Affordable Care Act "demands a fair understanding of the legislative plan." *King*, 135 S. Ct. at 2496. The ACA's design demonstrates that Congress intended that cost-sharing reductions and premium subsidies be inextricably linked. *Amici* respectfully urge this Court to reject an interpretation of the Act that would sever that crucial connection.

ARGUMENT

I. The Premium Subsidies and Cost-Sharing Reductions Are Inextricably Linked.

A. The ACA Rests on Three Interrelated Reforms.

As the Supreme Court recently described in *King*, the ACA's expansion of health care coverage is premised on three "intertwined" health care reforms. 135 S. Ct. at 2487. Each is necessary to foster stable, functioning insurance markets consistent with Congress's goal of broad, affordable coverage for all Americans.

The Act first adopts two non-discrimination rules, the "guaranteed issue" and "community rating" requirements. *Id.* at 2486. These ensure that health insurers do not refuse to sell insurance or charge higher premiums to enrollees based on pre-existing conditions or other individualized characteristics that increase the likelihood that the enrollees will require health care services. *See id.*; 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4. The combined effect of these reforms is to make health insurance widely available. But, standing alone, they would likely generate a new problem. If individuals could obtain insurance after becoming sick, Congress recognized, they were likely to "wait to purchase health insurance until they needed care," a phenomenon known as "adverse selection." 42 U.S.C. § 18091(2)(I); *see King*, 135 S. Ct. at 2485. The pool of insured persons would then be less healthy, and premiums would rise to cover these costly customers. *See King*, 135 S. Ct. at 2485. As premiums rose, more and more customers would "make an economic and financial decision to forego health insurance coverage and attempt to self-insure," 42 U.S.C. § 18091(2)(A), or, at least, would "wai[t] until they became ill to buy it," *see King*, 135 S. Ct. at 2486. That, in turn, could lead insurance providers to leave the market altogether, creating a "death spiral" that debilitates the health care system. *Id.*

To address that problem, Congress added a second reform to ensure that a sufficient number of healthy individuals remained in the insurance market. The Act's individual coverage mandate "requires individuals to maintain health insurance coverage or make a payment to the IRS," and was designed to bring millions of new, primarily healthy adults into insurance pools. *Id.* (citing 26 U.S.C. § 5000A). By broadening the health insurance risk pool to include healthy individuals and countering the adverse selection effect of the Act's non-discrimination rules, the mandate was expected to "lower health insurance premiums" for all. 42 U.S.C. § 18091(2)(I).

Congress thus thought the mandate "essential" to the operation of the Act. *Id.*; *King*, 135 S. Ct. at 2486. But Congress also knew that many currently uninsured individuals would not be able to afford insurance without help. If that were so, the mandate would fail to broaden the insurance risk pool as required for the Act to succeed.

Thus, Congress enacted the ACA's third key reform, subsidies for low-income individuals to help them pay for the two types of costs associated with health care. To be eligible for health insurance coverage, individuals must first pay monthly premiums. But as every user of the health care system knows, the costs do not end there. Instead, individuals seeking care must also pay a variety of out-of-pocket costs, including deductibles, copayments for medical visits and prescription drugs, and coinsurance payments for certain procedures and for hospitalization. Because insurance companies use these charges to share the cost of care with the patient, they are referred to as "cost-sharing" charges.

Congress designed the ACA's subsidies to address both types of costs. To offset the cost of monthly premiums, the ACA provides a "premium tax credit." *See King*, 135 S. Ct. at 2487; 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. The credit can be paid in advance directly to the individual's insurer, which in turn reduces the individual's premium. *See* 42 U.S.C. § 18082(a), (c)(2). To offset individuals' out-of-pocket costs, the Act provides "cost-sharing reduction" payments. An individual is eligible for these payments if his or her household income falls between 100 and 250 percent of the federal poverty line and if he or she enrolls in a "silver" health care plan on one of the Act's marketplace Exchanges.[1] *See id.* § 18071(b). All such individuals have their out-of-pocket costs capped at a statutory limit lower than would otherwise apply. *See id.* § 18071(c)(1)(A). Insurers must further reduce the out-of-pocket costs of these

[1] The plans available on these Exchanges include "bronze," "silver," "gold," and "platinum" plans. These tiers are defined by the actuarial value of the plan to the consumer. *See* 42 U.S.C. § 18022(d)(1). A silver plan has an actuarial value of 70 percent.

individuals' plans until those plans' "actuarial value"[2] increases to a certain threshold. Insurers must increase the actuarial value to either 94 percent, 87 percent, or 73 percent, depending on the individual's income level. *See id.* § 18071(c)(1)(B)(i), (c)(2). Cost-sharing reduction payments, just like premium tax credits, are paid in advance directly to the individuals' insurer, which in turn reduces the out-of-pocket costs that the insurer leaves to the individual to pay. *See id.* § 18071(a)(2), (c)(3); *id.* § 18082(a), (c)(3).

B. Cost-Sharing Payments and Premium Subsidies Together Are Critical to the Statutory Scheme.

These cost-sharing payments are no less integral than the premium tax credits to making insurance affordable for the poor, thereby ensuring a broad insurance risk pool that will keep insurers viable and costs low. To illustrate, take a single individual with a 2015 income of $20,000. The individual would be eligible for both premium tax credits and cost-sharing reduction payments because his or her income is approximately 170 percent of the federal poverty level. *See* Annual Update of the HHS Poverty Guidelines, 80 Fed. Reg. 3236, 3237 (Jan. 22, 2015). Without cost-sharing reductions, the general statutory out-of-pocket limit would cap the individual's plan's annual out-of-pocket costs at $6,600 in 2015, representing 33 percent of his or her income. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,802 (Mar. 11, 2014). With cost-sharing reductions, however, the limit on out-of-pocket costs would be reduced to $2,250, representing only 11.25 percent of his or her income. *Id.* at 13,804.

[2] Actuarial value is a measure of the value of the benefits provided by a plan. A plan's actuarial value expressed as a percentage is the percentage of the total covered in-network costs for essential health benefits of a standard population that would be paid by the plan. In other words, a higher actuarial value plan has lower deductibles, copayments, coinsurance, and out-of-pocket limits.

The ACA would also require the individual's insurer to further reduce his or her out-of-pocket costs in order to increase the plan's actuarial value. *See* 42 U.S.C. § 18071(c)(2). The resulting savings are significant. According to a recent analysis by the Kaiser Family Foundation, in States with federally run Exchanges, insurers on average reduced the overall out-of-pocket limit for silver plans from $5,826 to just $1,692—a reduction of nearly *71 percent*—for individuals with incomes between 150 and 200 percent of the federal poverty level. *See* Gary Claxton & Nirmita Panchal, *Cost-Sharing Subsidies in Federal Marketplace Plans*, Kaiser Family Found. (Feb. 11, 2015), http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans/. For those same individuals, the average combined medical and prescription drug deductible dropped from $2,556 to just $737—again, a 71 percent reduction. *Id.* The average copayment likewise dropped from $936 to $506 for a day at an inpatient facility, from $318 to $168 for an emergency room visit, from $56 to $35 for a visit to a specialist, and from $28 to $17 for a primary care visit. *Id.* Out-of-pocket costs are reduced even more dramatically for individuals with incomes between 100 and 150 percent of the federal poverty level. *See id.* As these findings demonstrate, when the statutory cap on out-of-pocket costs is combined with insurers' duty to increase the actuarial value of their plans, individuals eligible to receive cost-sharing subsidies can obtain significantly more affordable health care.

Millions of low-income individuals have benefited from these reduced out-of-pocket costs. The most recent data from the Department of Health and Human Services ("HHS") indicates that, of the 9.9 million consumers that have enrolled in health insurance coverage through the ACA's marketplace Exchanges, 5.6 million, or 56 percent, were receiving cost-sharing reductions. *See* June 30, 2015 Effectuated Enrollment Snapshot, CMS.gov (Sept. 9, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-

items/2015-09-08.html. In some States, nearly 80 percent of the enrolled population receives cost-sharing subsidies. *Id.*

Had Congress not provided these cost-sharing subsidies, these low-income individuals—assuming they would have purchased insurance at all[3]—would have had to cut back on needed health care services and use their health insurance only for catastrophic medical emergencies.[4] Although the Act also requires that insurers cover the full cost of preventive care without cost-sharing, *see* 42 U.S.C. § 300gg-13(a), many individuals already "forgo screenings and physicals because they[are] unaware of this or know they can[not] afford follow-ups if illnesses are found." Laura Ungar & Jayne O'Donnell, *Dilemma over Deductibles: Costs crippling middle class*, USA Today (Jan. 1, 2015), http://www.usatoday.com/story/news/nation/2015/01/01/middle-class-workers-struggle-to-pay-for-care-despite-insurance/19841235/. That would happen even more frequently if cost-sharing payments were not available.

But delaying care because of high out-of-pocket costs can be "dangerous" and "exponentially more costly" to both the individual and the health care system. *Id.* "When sickness finally drives" an individual "to seek care, once treatable conditions have escalated into grave health problems, requiring more costly and extensive intervention." *Nat'l Fed'n of Indep.*

---

[3] If out-of-pocket costs are prohibitively high such that health insurance has limited utility, individuals may opt not to pay for it at all. *See* Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All but Useless*, N.Y. Times, Nov. 15, 2015, at A22 (describing individuals who dropped or chose not to enroll in health insurance as a result of high deductibles).

[4] *See* Sara R. Collins et al., The Commonwealth Fund, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse* 9-10 (May 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1817_collins_problem_of_underinsurance_ib.pdf; The RAND Corp., *Analysis of High Deductible Health Plans* (2009), http://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html#patient-experience.

Bus. v. Sebelius ("*NFIB*"), 132 S. Ct. 2566, 2612 (2012) (Ginsburg, J., concurring in part). Individuals with high deductibles are also more likely to have difficulty paying their medical bills, to have substantial medical debt, or to have declared bankruptcy. *See* Sara R. Collins et al., The Commonwealth Fund, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse* 8-9 (May 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1817_collins_problem_of_underinsurance_ib.pdf. Hospitals and other health care providers, of course, necessarily struggle to recover the cost of caring for individuals who cannot afford to pay that cost.

Congress thus required cost-sharing reduction payments as an essential and integral step toward effectuating its stated aim of mitigating the burden to poor individuals from medical bankruptcies and the burden to the health care system from uncompensated care. *See* 42 U.S.C. § 18091(2)(F), (G); *NFIB*, 132 S. Ct. at 2585 (Opinion of Roberts, C.J.); *id.* at 2611 (Ginsburg, J., concurring in part). The ACA's cost-sharing provisions impose an affirmative mandate on both health insurers and HHS. Insurers "shall reduce the cost-sharing" of eligible individuals' plans. 42 U.S.C. § 18071(a)(2).[5] HHS, meanwhile, "shall make periodic and timely payments to the issuer equal to the value of the reductions." *Id.* § 18071(c)(3)(A). The Congressional Budget Office estimates that insurers are projected to receive payments for cost-sharing reductions of $5 billion in 2015, which escalates to $16 billion over the next ten years. *See* Congressional Budget Office, Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015

[5] Similarly, States offering basic health programs under § 18051 (which we describe below) must ensure that "the cost-sharing an eligible individual is required to pay" does not exceed the level necessary for the plans to have an actuarial value of 90 percent (for individuals with incomes under 150 percent of the federal poverty level) or 80 percent (for individuals between 150 and 200 percent of the federal poverty level). 42 U.S.C. § 18051(a)(2)(A)(ii).

Baseline, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

Plaintiff admits that the ACA imposes a mandatory obligation on insurers to reduce cost sharing for eligible individuals, even without reimbursement. Pls.' Mem. in Supp. of Their Mot. for Summ. J. 6 n.4, ECF No. 53. Requiring insurers to reduce cost sharing without reimbursement—even for a single year—could have widespread and destabilizing effects. Faced with billions of dollars of unreimbursed costs, insurers would attempt to recover those costs through higher premiums. But, because insurers generally set their premiums for the next calendar year before Congress appropriates funds, if reimbursement for cost-sharing reductions depended on annual appropriations, insurers might not be able to increase premiums until nearly a full year later if Congress failed to appropriate funds for cost-sharing reduction payments. *See* Defs.' Mem. in Supp. of Their Mot. for Summ. J. 22-23, ECF No. 55-1. Some insurers might not be able to afford to wait that long to recoup these massive unreimbursed costs. Those insurers might simply withdraw from the Exchanges, as they are not legally required to offer cost-sharing reductions outside the Exchanges.

Moreover, even if insurers could stay afloat while waiting to implement premium increases, the consequences of those increases for individuals and the federal government could be severe. As stated earlier, to be eligible for cost-sharing reductions, individuals must enroll in silver plans. As insurers attempted to recoup the cost of reducing cost sharing for their silver plans, they would have to raise the premiums for these plans. Indeed, they may charge higher premiums for silver plans than for gold plans. *See* Defs.' Mem. in Supp. of Their Mot. for Summ. J., Exh. 4, at 2-3, ECF No. 55-6 (ASPE Issue Brief: Potential Fiscal Consequences of Not Providing CSR Reimbursements (Dec. 2015) ("ASPE Report")). Since all of an insurer's

enrollees in the individual market in a State are in a single risk pool, insurers would have to raise premiums for *all* silver plan enrollees. *See* 42 U.S.C. § 18032(c)(1); 45 C.F.R. § 156.80(d).

This would have two consequences. First, many individuals who purchase coverage in the individual market do not receive premium tax credits—*e.g.*, the self-employed, early retirees, individuals in employment transitions, and individuals employed by small businesses that do not offer insurance coverage. These individuals would abandon the now more expensive silver plans and instead either drop coverage altogether or buy cheaper bronze plans, or even gold or platinum plans, which would cost only slightly more—or even less—than silver plans. If they dropped coverage, the intent of Congress to expand coverage through the ACA would be undermined. If they simply abandoned silver plans, however, premiums for silver plans would increase dramatically because there would be many fewer silver insurance policies from which to recoup the cost of the cost-sharing reductions insurers would still be required to make. That in turn would cause even more non-subsidized enrollees to drop silver plan coverage. *See* ASPE Report 2.

A second consequence, paradoxical and clearly not intended by Congress, would be that the amount of the premium tax credits offered to subsidized enrollees would increase *across the board*. As a result, total expenditures of the federal government would increase. Premium tax credits are pegged to the cost of the second-lowest cost silver plan. 26 U.S.C. § 36B(b)(2)(B). As insurers raised the premiums of silver plans, the cost of the second lowest-cost silver plan would go up, and premium tax credits would accordingly increase. Individuals with incomes above 200 percent of the federal poverty level, who do not qualify for significant cost-sharing reductions, might conclude that with the higher tax credits they should purchase a gold or even a platinum plan, which would be priced lower or only slightly higher than a silver plan.

Alternatively, they might decide to use their premium tax credits to cover the entire premium of bronze plans, which would now cost much less than silver plans.

As they did so, however, insurers would have to again raise premiums for the remaining silver plan enrollees, who would consist largely of individuals who qualified for substantial cost-sharing reductions, again raising the premium of the second-lowest cost silver plans, and thus the amount of premium tax credits overall. Thus, the paradoxical result would be that eliminating cost-sharing reduction reimbursements to insurers could *raise* the government's overall expenditures due to an even greater increase in premium tax credits, *see* ASPE Report 1, a program that plaintiff admits is fully covered by a permanent appropriation, *see* Pls.' Mem. in Supp. of Their Mot. for Summ. J. 5, ECF No. 53. Congress could not have intended this result.

II. Congress Understood that Premium Subsidies and Cost-Sharing Reduction Payments Are Inextricably Linked.

The text and structure of the Affordable Care Act show that Congress understood that both premium subsidies *and* cost-sharing reductions are necessary to achieve the Act's purposes. Congress consistently linked these two subsidies throughout the Act, and several provisions of the Act would make little sense if individuals did not receive cost-sharing reductions. Yet, as just described, if the challenger's position in this case is accepted, eligible individuals will only receive cost-sharing reductions because insurers must continue to pay them without reimbursement. The insurers would presumably seek to recoup that cost through increased premiums, leading to increased premium tax credits, to be paid from permanently authorized appropriations. Nothing suggests that Congress anticipated or intended that reimbursement for cost-sharing reductions would operate in such a convoluted way. Instead, the available evidence indicates that Congress expected cost-sharing reductions and premium tax credits to be reimbursed in parallel fashion.

To start, eligibility for both premium subsidies and cost-sharing reduction payments is determined at the same time, through the same process. The Act requires HHS to determine, in advance, the income eligibility of individuals "for the premium tax credit allowable under section 36B of Title 26 *and* the cost-sharing reductions under section 18071." 42 U.S.C. § 18082(a)(1) (emphasis added). The Secretary relies on the same information—and the same verification process—to make both eligibility determinations. *See id.* § 18081(a), (b)(3), (c)(3), (e)(2). Underscoring the connection between the two payments, HHS may not allow a cost-sharing reduction for any month if the individual is not *also* allowed a premium tax credit for that particular month under 26 U.S.C. § 36B. *Id.* § 18071(f)(2).

Advance payments for both the premium subsidies and cost-sharing reductions also occur at the same time, through the same process. Once advance eligibility determinations are made, § 18082(c) of Title 42 directs that the subsidies be paid in tandem: "The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit … to the issuer of a qualified health plan" and "[t]he Secretary shall also notify the Secretary of the Treasury … if an advance payment of the cost-sharing reductions … is to be made … [and] The Secretary of the Treasury shall make such advance payment." *Id.* § 18082(c)(2)-(3). In the case of both the premium tax credit and the cost-sharing reduction payments, HHS also maintains control over the schedule of payments to issuers. *Id.* § 18082(c)(2)(A) (requiring advance premium tax credit payments on a "monthly basis" or on "such other periodic basis as the Secretary [of HHS] may provide"); *id.* § 18082(c)(3) (requiring advance cost-sharing reduction payments "at such time and in such amount as the Secretary [of HHS] specifies"); *see also id.* § 18071(c)(3)(A) (HHS "shall make periodic and timely payments" to the issuers of health insurance plans "equal to the value of" the cost-sharing reductions given to an individual by

those issuers).

All told, there are 44 provisions in the Act that speak of the premium subsidies and cost-sharing reductions in the same statutory breath. For example,

- In a provision requiring HHS to ensure that individuals may easily apply for subsidies, Congress specified that the relevant subsidies included both "the premium tax credits under section 36B of Title 26 and cost-sharing reductions under section [18071]." 42 U.S.C. § 18083(e)(1).

- The IRS is authorized to disclose tax return information for "determining any premium tax credit under section 36B or any cost-sharing reduction under [42 U.S.C. § 18071]." 26 U.S.C. § 6103(*l*)(21)(A).

- Individuals' eligibility for certain other public benefits is unaffected by either "any cost-sharing reduction payment or advance payment of the credit allowed under … section 36B." 42 U.S.C. § 18084(2).

- Issuers may not use either "the advance payment of the credit" or "the advance payment of the reduction" to fund certain abortion-related services. *Id.* § 18023(b)(2)(A)(i)-(ii).

- Exchange internet portals must include information to assist individuals in determining whether they are "eligible for a premium tax credit or cost-sharing reduction." *Id.* § 18031(c)(5)(B).

- Exchanges must establish a calculator that consumers can use "to determine the actual cost of coverage after the application of any premium tax credit under section 36B of Title 26 and any cost-sharing reduction under section 18071." *Id.* § 18031(d)(4)(G).

- Exchanges must create outreach programs to "distribute fair and impartial information concerning … the availability of premium tax credits under section 36B of Title 26 and cost-sharing reductions under section 18071." *Id.* § 18031(i)(3)(B).

- Individuals in multi-state plans are "eligible for credits under section 36B of Title 26 and cost-sharing assistance under section 18071" in the same manner as an individual enrolled on a single-state Exchange. *Id.* § 18054(c)(3)(A).

- Exchanges must report to the Department of Treasury "[t]he total premium for the coverage without regard to the [tax] credit … or cost-sharing reductions under section [18071]" and "[t]he aggregate amount of any advance payment of such credit or reductions." 26 U.S.C. § 36B(f)(3)(B)-(C).

- Insurers must report to the Department of Treasury "the amount (if any) of any

> advance payment under section [18082,] of any cost-sharing reduction under section [18071,] or of any premium tax credit under section 36B." *Id.* § 6055(b)(1)(B)(iii)(II).

- Certain employers must provide employees with written notice that they may be "eligible for a premium tax credit under section 36B of … Title 26 and a cost sharing reduction under section 18071." 29 U.S.C. § 218b(a)(2).

- Employers are subject to penalties if they have at least one full-time employee who is eligible for "an applicable premium tax credit or cost-sharing reduction." 26 U.S.C. § 4980H(a)(2), (b)(1)(B), (c)(3).[6]

If cost-sharing reductions did not always accompany premium subsidies, "these provisions would make little sense." *King*, 135 S. Ct. at 2492. The linkage that appears in all of these varied sections expresses Congress's expectation that premium subsidies and cost-sharing reductions would always go hand-in-hand.

Finally, in designing ACA programs (which we describe below) that give States significant flexibility in meeting the Act's requirements, Congress evinced its intent that the cost-sharing subsidies and premium subsidies would be treated the same way. These programs require significant expenditures on the part of the States that opt into the programs. To create an incentive for the States to opt in, Congress authorized federal funds to help States cover those expenditures. That revenue stream, however, is dependent on both cost-sharing reductions and premium subsidies being constantly available. No rational State would elect to opt into such a program without a predictable level of cost-sharing subsidies—and no rational Congress would have designed such an unattractive option for the States.

The first such program permits States to create "basic health programs," through which States may offer state-run health plans to individuals just above the eligibility cutoff for

[6] Other provisions include: 26 U.S.C. § 4980H(d)(3); 42 U.S.C. § 300gg-4(*l*)(3)(A)(ii); *id.* § 1396w-3(b)(1)(C); *id.* § 1397ee(d)(3)(B); *id.* § 18023(b)(2)(B)(i)(I); *id.* § 18032(e)(2); *id.* § 18033(a)(6)(A); *id.* § 18051(a)(2), (d)(3)(A)(i), (d)(3)(A)(ii); *id.* § 18052(a)(3); *id.* § 18071(f)(2); *id.* § 18081(a)(1), (a)(2), (a)(2)(B), (b)(3), (b)(4), (c)(3), (e)(2)(A), (e)(2)(A)(i), (e)(4)(B)(ii), (e)(4)(B)(iii), (g)(1), (g)(2)(A); *id.* § 18082(a)(1), (a)(2)(B), (a)(3), (c), (d), (e).

Medicaid (in States that have opted to expand Medicaid coverage under the Act). *See* 42 U.S.C. § 18051. To date, two States, Minnesota and New York, have established basic health programs. *See* Basic Health Program, Medicaid.gov, http://www.medicaid.gov/basic-health-program/basic-health-program.html (last visited Dec. 7, 2015). Basic health programs must be approved by HHS, and HHS will only approve programs whose plans reduce cost-sharing. *See* 42 U.S.C. § 18051(a)(2)(A)(ii). To reimburse States for these required cost-sharing reductions, HHS "shall transfer to the State" an amount that HHS determines is "equal to 95 percent of the premium subsidies under section 36B of Title 26, and the cost-sharing reductions under section 18071," that individuals covered by the State's plans would have been provided if they were instead enrolled on the Exchanges. *Id.* § 18051(d)(1), (3)(A)(i).

The second program permits States, starting in 2017, to seek an innovation waiver of many of the Act's requirements by proposing an alternative State plan in their place. *See id.* § 18052(a)(1)-(2). A half-dozen States, ranging from Arkansas to Hawaii, have taken steps to propose a waiver plan. *See* Heather Howard & Galen Benshoof, *Section 1332 Waiver Activity Heating Up In States*, Health Affairs Blog (June 24, 2015), http://healthaffairs.org/blog/2015/06/24/section-1332-waiver-activity-heating-up-in-states/. But to obtain an innovation waiver, a State must adopt legislation authorizing the waiver program and present to HHS a "10-year budget plan … that is budget neutral for the Federal Government." 42 U.S.C. § 18052(a)(1)(B). HHS may grant waivers for up to five years, but may not grant a waiver unless, among other things, the State's plan "provide[s] coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as" those provided by the Act. *Id.* § 18052(b)(1)(B). To ensure that States can afford to create such a plan, HHS "shall provide for an alternative means by which the aggregate amount of

[premium tax] credits or [cost-sharing] reductions that would have been paid on behalf of participants in the Exchanges … shall be paid to the State." *Id.* § 18052(a)(3).

No sensible State would elect to pursue either of these programs if there was a significant risk that cost-sharing reductions would be unavailable. In the absence of those reductions, federal funds for cost-sharing reduction would not be distributed to States creating basic health programs, because "95 percent of … the cost-sharing reductions under section 18071" would be zero. *Id.* § 18051(d)(3)(A)(i). Similarly, federal funds for cost-sharing reduction would be unavailable to States with innovative-waiver plans, because the "aggregate amount of … [cost-sharing] reductions" would be zero. *Id.* § 18052(a)(3). Of course, the level of premium tax credits available could increase to fill the gap left by the absence of cost-sharing reduction payments if Congress failed to appropriate cost-sharing reduction funds, as explained above. *See supra*, at 12-14. But States could not know from year to year whether or not Congress would appropriate these funds, or how its failure to do so would affect premium tax credits. States would not undertake these massive and costly state-wide enterprises if their viability depended on sources of revenue that could fluctuate so much in any given year. Indeed, States would find it impossible even to establish a 10-year budget for an innovation-waiver program, and thus could not even apply for one. Congress did not craft these complex programs while simultaneously ensuring that States would not elect to use them.

* * *

Plaintiff does not dispute that the advance premium tax subsidies paid to insurers under 42 U.S.C. § 18082(a)(3) do not depend on annual appropriations because Congress authorized a permanent appropriation under 31 U.S.C. § 1324. In line with Congress' evident intent to treat premium subsidies and cost-sharing reduction subsidies as components of a single integrated

subsidy program, this Court should conclude that Congress's permanent appropriation for the former covers the latter as well.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge that the Court enter judgment in favor of the Defendants.

Dated: December 8, 2015

Respectfully submitted,

/s/ Matthew E. Price

MATTHEW S. HELLMAN
MATTHEW E. PRICE
JENNER & BLOCK LLP
1099 New York Avenue, NW
Suite 900
Washington, DC 20001
202-639-6000

mhellman@jenner.com

Counsel for Amici Curiae