No. 19-10011

United States Court of Appeals
for the
Fifth Circuit

STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

– v. –

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

Intervenor Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS (FORT WORTH)
DISTRICT COURT CASE NO. 4:18-CV-167

BRIEF FOR *AMICUS CURIAE* BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF INTERVENOR DEFENDANTS-APPELLANTS

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

Pursuant to Fifth Circuit Rules 28.2.1 and 29.2, the undersigned counsel of record for *amicus curiae* provides this supplemental statement of interested parties to fully disclose all those with an interest in the *amicus* brief. These representations are made to permit the judges of this Court to evaluate possible disqualification or recusal.

Amicus Curiae on this Brief

Amicus Curiae Blue Cross Blue Shield Association has no parent and no corporation owns stock in it.

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INTEREST OF AMICUS CURIAE[1]

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-six independent, community-based and locally-operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide health insurance to nearly 106 million people—nearly one-third of all Americans—in every zip code in all fifty states, the District of Columbia, and Puerto Rico. Blue Plans offer a variety of insurance products to all segments of the population, including federal employees, large employer groups, small businesses and individuals. As leaders in the healthcare community for over eighty years, Blue Plans seek to expand access to quality healthcare for all Americans and have extensive knowledge of and experience with the health insurance marketplace.

Blue Plans are regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA"), and have been the leading providers of health insurance in the individual health insurance markets, including the Exchanges created by the ACA. By the end of 2018, Blue Plans insured over 4.1 million enrollees who obtained their coverage through the Exchanges. BCBSA

[1] BCBSA submits this brief pursuant to Federal Rule of Appellate Procedure 29(a), and all parties have consented to the filing of this brief. Undersigned counsel for *amicus curiae* certify that this brief was not authored in whole or in part by counsel for any of the parties; no party or a party's counsel contributed money for the brief; and no one other than *amicus curiae* has contributed money for this brief.

has an interest in advising the Court about the destabilizing consequences for this country's health insurance markets if the Court affirms the district court's decision striking down the ACA in its entirety, consequences that will be devastating for the millions of Americans that rely on those markets.

Additionally, before the ACA's "individual mandate," "guaranteed issue," and "community rating" provisions entered into effect, BCBSA filed an *amicus* brief sharing its predictions regarding how these provisions might interact. *See Nat'l Fed'n of Indep. Bus.* ("NFIB") *v. Sebelius*, Nos. 11-393, 11-398, 11-400, Br. of Am. Health Ins. Plans & Blue Cross Blue Shield Ass'n As *Amici Curiae* In Support of Reversal of the Court of Appeals' Severability Judgment (S. Ct. Jan. 6, 2012) ("BCBSA Br."). BCBSA has an interest in explaining how its views have evolved based on Blue Plans' subsequent experience participating in the ACA's individual market.

INTRODUCTION AND SUMMARY OF ARGUMENT

When Congress enacted the ACA in 2010, it adopted policies that touch on nearly every aspect of the healthcare system in the United States. *See generally* ACA, Pub. L. No. 111-148. With respect to the health insurance market, in particular, Congress's primary goal was clear: to ensure that all Americans, including the low-income and the sick, have access to healthcare coverage through either a private insurer or the government. *See* 42 U.S.C. § 18091(2)(D).

To improve access to healthcare services for low- and middle-income Americans, Congress created incentives for states to expand Medicaid, *see* 42 U.S.C. § 1396d(y)(1), and established subsidies to assist those at 400% or below the federal poverty level (the "FPL") to purchase insurance, *see, e.g.*, 26 U.S.C. § 36B. The program that Congress devised to ensure that sick Americans have access to affordable health insurance is more complex.

Before the ACA, health insurers could consider preexisting health conditions when setting their premium rates, which often resulted in prohibitively expensive premiums or denial of coverage altogether for those Americans who needed coverage most. Congress remedied this problem by adopting the ACA's "guaranteed issue" provision, which prohibits insurers from denying coverage based on enrollees' preexisting health conditions, and the "community rating" provision, which prohibits insurers from raising premiums based on those conditions. *See* 42 U.S.C. §§ 300gg *et seq.* Congress, however, knew that the health insurance markets in states that had adopted similar provisions in the 1990s had collapsed when healthy people delayed purchasing insurance until they were sick—a phenomenon that is widely known as "adverse selection." If only sick people participate in a health insurance market, insurers must increase prices to cover those higher costs, which drives more healthy people out of the market. This

vicious cycle is often referred to as a "death spiral" and, if allowed to progress, it ultimately causes health insurance markets to collapse.

Mindful of this challenge, Congress modeled the ACA on the approach taken by Massachusetts, which had successfully implemented guaranteed issue and community rating requirements without prompting an exodus of healthy individuals from the market. *See King v. Burwell*, 135 S. Ct. 2480, 2486 (2015) (*citing Examining Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform: Hearing Before the S. Comm. on Health, Educ., Labor, & Pensions*, 111th Cong. (2009)). Like Massachusetts, Congress adopted a "mandate" to deter adverse selection. Congress designed the mandate to discourage healthy Americans for whom the cost of insurance is less than a certain percentage of their income from waiting until they are sick to obtain coverage by giving them a choice between purchasing insurance or paying a tax. *See* 26 U.S.C. § 5000A(e). Additionally, Congress sought to deter individuals from waiting until they are sick to obtain coverage by restricting enrollment to a designated annual period. *See* 42 U.S.C. § 300gg-1(b). Finally, by requiring the cost of coverage to be calculated net of the government subsidies mentioned *supra*, the ACA increases the number of Americans who are subject to the mandate. *King*, 135 S. Ct. at 2487.

Soon after its enactment, the Supreme Court considered whether Congress had the constitutional authority to enact the individual mandate and determined that the mandate was a lawful exercise of Congress's tax power. *NFIB v. Sebelius*, 567 U.S. 519 (2012). In December 2017, however, a different Congress passed the Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054 (Dec. 22, 2017) (the "TCJA"), which reduced to $0 the tax associated with the individual mandate—meaning that failing to purchase insurance no longer triggers an obligation to pay a tax to the government. *See id.* § 11081. As a result, the mandate is now—as a practical matter—unenforceable. Plaintiffs here sued, arguing that an unenforceable mandate is an invalid exercise of Congress's tax power and that the mandate is inseverable from the rest of the ACA. The district court agreed, striking down the ACA in its entirety.

BCBSA agrees with the arguments set forth in the briefs filed by the Defendant States and U.S. House of Representatives but writes separately to explain how the decision below, if affirmed, would upend the health insurance markets in this country. The district court's decision would terminate immediately scores of programs and regulations concerning the administration of healthcare in the United States, many of which have been in effect for nearly a decade and have little, if any, relation to the mandate.

Further, to estimate the effect of the district court's decision on the individual market for health insurance, BCBSA commissioned a study from noted actuarial experts Oliver Wyman. *See* Kurt Giesa & Peter Kaczmarek, Oliver Wyman, Potential Impact of Invalidating the Affordable Care Act on the Individual Market (Apr. 1, 2019) (the "OW Study" or "Study").[2] According to the model developed by OW with input from Blue Plan actuaries who have set premiums and operated plans on the individual market for the past six years, invalidating the ACA would strip health insurance from millions of Americans, especially the low-income and sick Americans that the ACA was designed to protect. Moreover, by eliminating the ACA through court order, the district court's decision would exacerbate the disruption to the health insurance market caused by large-scale changes to the ACA.

Finally, BCBSA addresses the relationship between an enforceable mandate and the ACA's guaranteed issue and community rating provisions, provisions that the 2010 Congress and the entire healthcare industry (including BCBSA) once believed were inextricably linked to the mandate. Over the past six years,

[2] A version of the Study is included as an addendum to this brief. The complete Study, including an appendix, is available at https://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2019/apr/Impact%20of%20Invalidating%20the%20ACA%20on%20the%20Individual%20Market%20--%20w%20Appendix.pdf

however, Blue Plans' experience offering coverage through the Exchanges shows that an individual market subject to guaranteed issue and community rating requirements can function without an enforceable mandate because government subsidies incent enough low-income Americans—particularly those who are healthy—to purchase insurance.

The OW Study shows that Congress's decision to make the mandate unenforceable should only decrease the number of participants in the individual market from 13.3 million to 12.1 million, or 9%, and cause premiums to rise by only $31 per month. Study at 6, 12. In other words, while the market will not function optimally without an enforceable mandate, there is no reason to believe that it will collapse, so long as Congress maintains the subsidies established by the ACA. Accordingly, the 2017 Congress that passed the TCJA could quite rationally conclude that making the mandate unenforceable, while maintaining the ACA's subsidies, did not require repeal of the ACA's community rating and guaranteed issue provisions.

For all of these reasons and others, the district court's severability analysis is deeply flawed.[3] BCBSA therefore urges this Court to reverse the order below.

[3] BCBSA also agrees with U.S. House of Representatives' and Defendant States' arguments that the individual mandate as amended by the TCJA does not violate the Constitution.

ARGUMENT

I. THE DISTRICT COURT'S DECISION WOULD WREAK HAVOC ON THE HEALTHCARE SYSTEM IN THE UNITED STATES

The ACA spans "10 titles[,] over 900 pages[,] and … [contains] hundreds of provisions," *NFIB*, 567 U.S. at 539, that touch on all aspects of the delivery of healthcare in the United States, including many that have nothing to do with the individual mandate, or even health insurance. If affirmed, the district court's decision would invalidate ***all*** of these provisions overnight. The decision would deprive millions of low-income Americans of access to affordable and high quality health insurance. It would also cause a host of other significant disruptions across the healthcare sector generally.

A. The District Court's Decision Would Deprive Millions of Americans of Affordable Health Insurance

The district court's decision would eliminate key provisions of the ACA that have been successful in expanding access to affordable healthcare services to record numbers of low income and sick Americans.

First, as mentioned *supra*, to improve low-income Americans' access to healthcare, Congress encouraged states to expand Medicaid to cover Americans earning up to 138% of the FPL by promising that the federal government would pay for 90% of the additional cost. *See* ACA § 2001 *codified at* 42 U.S.C. § 1396d(y)(1); *see also NFIB*, 567 U.S. at 584. As a result, by 2017, over 17 million *additional* adults across thirty-two states had enrolled in Medicaid. *See*

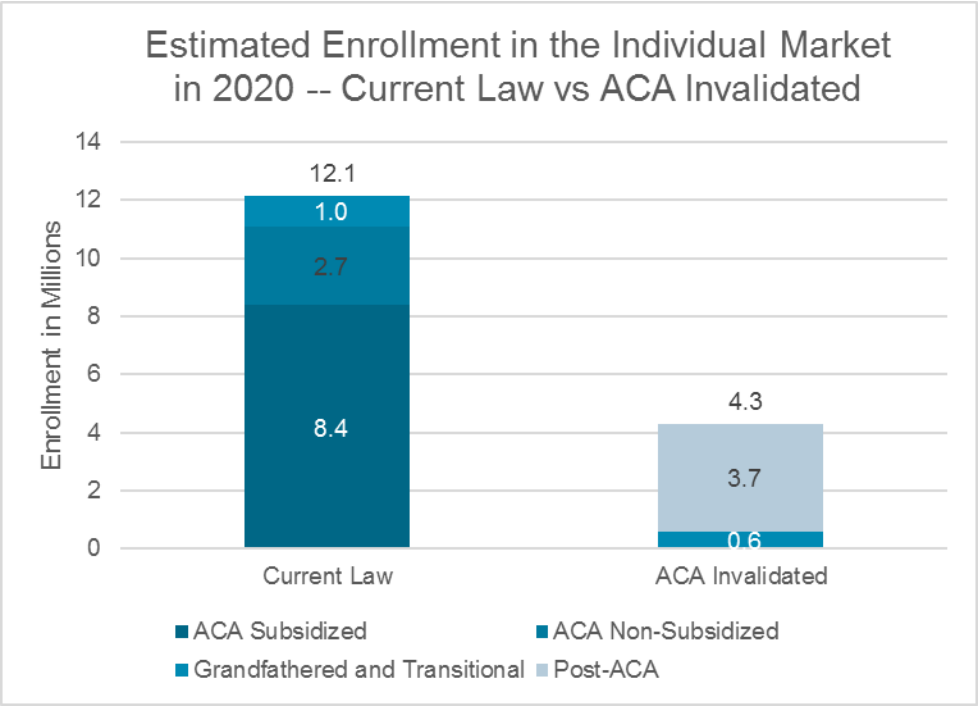
Kaiser Family Found., Medicaid Expansion Enrollment.[4] The district court's decision would force states to pick up the entire cost of providing healthcare services to these beneficiaries or remove millions of people from the program with little notice. This shock wave would have ancillary effects across the healthcare sector; for instance, hospitals and other healthcare providers could expect to see a significant uptick in uninsured visits and other uncompensated care—one study estimated that Medicaid expansion decreased uncompensated care by as much as 41%. *See* Larissa Antonisse et al., Kaiser Family Found., The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review (Mar. 28, 2018).[5]

Second, eliminating the ACA wholesale would disrupt the individual market that Congress reformed to ensure that Americans who are ineligible for Medicaid and do not receive insurance through their employer can nevertheless obtain health insurance, *even if they are sick or have limited means*. Using commercially available data, the OW Study predicts that, in the short-term, nearly two-thirds of the 12.1 million Americans currently enrolled in the individual market—that is 7.8

[4] https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last accessed Apr. 1, 2019).

[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/.

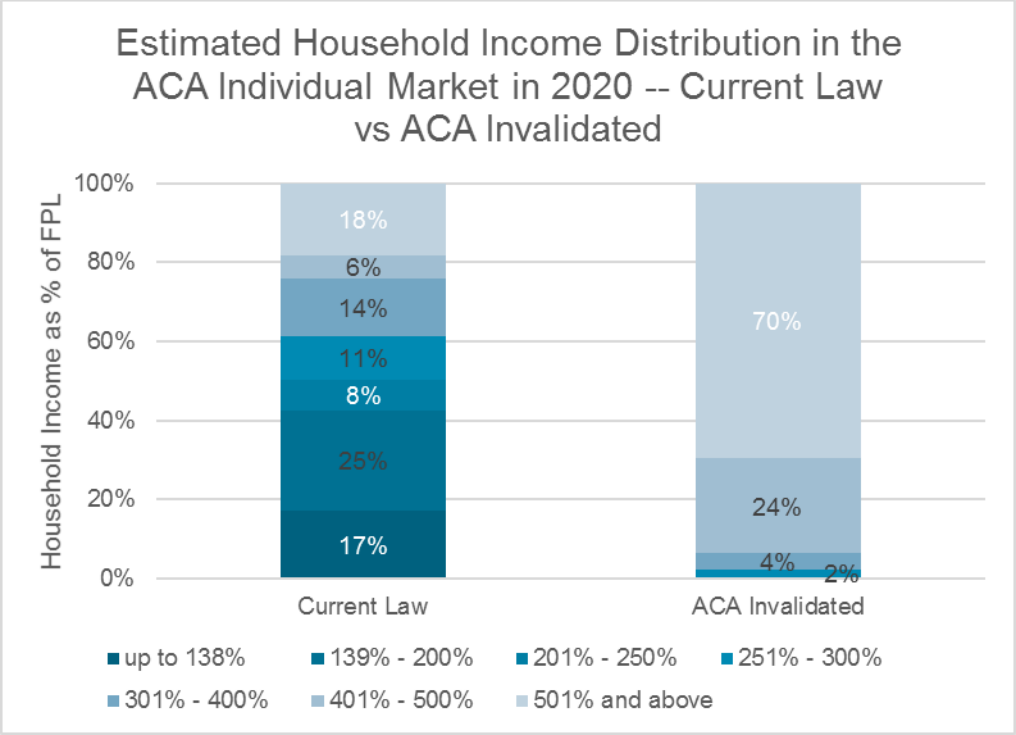
million people—would lose coverage without the ACA. *See* Study at 10. This precipitous drop in coverage would result primarily from the loss of the ACA's subsidies as well as the statute's guaranteed issue and community rating protections. *See id.* at 3.



Source: OW Study at 10.

Eliminating the ACA would not only decrease enrollment in the individual market, but would also change the composition of that market. The ACA's subsidies have made health insurance affordable for Americans earning 400% or less of the FPL, or $49,960 for an individual and $103,000 for a household of four in 2019. *See* Annual Update of the HHS Poverty Guidelines, 84 Fed. Reg. 1167, 1168 (Feb. 1, 2019). The OW Study predicts that in 2020, under current law, the

individual market will provide health insurance to 8.4 million Americans at or below 400% of the FPL, meaning that low- and middle-income Americans will represent roughly 69% of all individual market enrollees. *See* Study at 4-5. If the district court's decision is affirmed, however, the OW Study predicts that only 222,000 low- and middle-income Americans will remain in the individual ACA market, comprising merely 6% of all enrollees. *Id.* at 10, 11. The OW Study confirms that affirming the district court's decision would result in the individual market no longer serving the vulnerable Americans that Congress intended for the ACA to protect.



Source: OW Study at 11.

Without the ACA, health insurance coverage would also shift from sicker and older Americans to healthier and younger enrollees who are less likely to need healthcare services. *Id.* at 11, 12. The OW Study indicates that the proportion of enrollees under the age of twenty would increase from 10% of those currently covered to 23% of those covered (at least in states without separate guaranteed issue requirements). *Id.* at 12. Enrollees over the age of fifty would plummet from nearly 40% of the individual market to just 26%. *Ibid.* And the percentage of enrollees with fair or poor health would be cut in half. *Id.* at 11. In short, the OW Study confirms that the district court's decision would profoundly alter the risk pool that health insurers must cover in the individual market. The market would become largely inaccessible to the population that Congress sought to help when it passed the ACA, the sick, the aged and those of limited means. It would instead serve a healthier, younger and more affluent risk pool.

B. The District Court's Decision Would Eliminate Numerous Provisions Aimed at Ensuring that Americans Can Access High-Quality Health Insurance

Apart from threatening to reverse the ACA's success in providing more Americans with access to healthcare, the district court's decision would also eliminate numerous ACA provisions that have improved the value of insurance coverage for millions of Americans. These other provisions have little, if any, relationship to the individual mandate. It is unreasonable to infer from Congress's

decision in 2017 to render the mandate unenforceable that this same Congress also intended these independent provisions to fall if the mandate was later deemed unconstitutional.

1. For instance, under the district court's order, insurers could remove many of the benefit enhancements that the ACA required individual insurance plans to provide, including:

- *Essential Health Benefits*: The ACA requires small-group and individual plans to provide coverage in ten key categories including emergency services, pediatric services, and preventative care, *see* 42 U.S.C. § 18022(b); *see also* 45 C.F.R. 156.100 *et seq.*

- *Minimum Coverage Value*: The ACA requires small-group and individual plans to cover at least 60% of the value of the health benefits provided under the plan. *See* 42 U.S.C. § 18022(d)-(e).

- *Cost Sharing Limits*: The ACA requires qualifying small-group and individual plans to limit cost-sharing. *See* 42 U.S.C. § 18022(c).

Congress enacted these provisions to enhance the quality of coverage available in the individual market. For instance, the essential health benefits requirement and the minimum coverage value provision prevent some Americans from mistakenly purchasing policies that provide limited outpatient benefits or otherwise leave them underinsured. *See* Proposed Rule, Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70,643, 70,645 (Nov. 26, 2012) ("Taken

together, EHB and AV will significantly increase consumers' ability to compare and make an informed choice about health plans.").[6]

2. Additionally, the district court's order would eliminate other ACA provisions, also unrelated to the individual mandate, which Congress intended to give more value to insureds participating in individual and group plans, such as:

- *Out-of-Pocket and Lifetime Spending Limits*: Limits on annual out-of-pocket spending ($7,900 for an individual, and $15,800 for family, in 2019), *see* 42 U.S.C. § 18022, and a prohibition on lifetime spending limits, *see* 42 U.S.C. § 300gg-11.

- *Clinical Trial Participants*: Plans cannot refuse to provide coverage for participation in a qualifying trial. *See* 42 U.S.C. § 300gg-8.

- *Preventative Health Services*: Plans must cover certain preventative care procedures without co-payments or other cost-sharing. *See* 42 U.S.C. § 300gg-13.

- *Extension of Dependent Coverage*: Plans that offer dependent coverage must make this coverage available until a child is 26 years old. *See* 42 U.S.C. § 300gg-14.

- *Medical Loss Ratio*: To encourage efficiency, plans must submit to the government the percentage of premium revenue spent on medical claims, adjusted by quality expenditures. Plans are required to reimburse their members if they allocate too much money towards profits or other unqualified costs. *See* 42 U.S.C. § 300gg-18. The OW Study predicts that,

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[6] *See also The Health of the Private Insurance Market: Hearing Before the Subcomm. on Health of H. Comm. on Ways & Means*, 110th Cong. (2008) (statement of Am. Academy of Actuaries) (describing limited benefit plans in the individual market, which provided only limited outpatient benefits); *id.* (statement of Karen Davis, Ph.D., President, The Commonwealth Fund, New York, New York) ("As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003.").

without the ACA, insurers will spend up to 10% less of their premium revenues on medical claims. *See* Study at 8-9.

- *Simple Benefit Summaries for Consumers*: Responding to concerns that consumers often did not understand the scope of the coverage they were purchasing, the ACA required health insurers to provide potential enrollees with a summary of benefits and coverage both at the time of application or re-enrollment, and when issuing the policy. *See* 42 U.S.C. § 300gg-15.

- *Rate Review*: The ACA required health insurers to justify to regulators rate increases above a certain percentage. *See* 42 U.S.C. § 300gg-94.

Notably, all of these provisions became effective *before* the individual mandate, which strongly indicates that Congress did not believe that the mandate was necessary for them to operate as intended. *Compare* ACA § 1004 (providing for effective dates for reforms across 2010) *with id.* § 1501 (individual mandate phased in between 2014 and 2016). Moreover, all of these ACA provisions were designed to address problems that *insured* Americans faced prior to the ACA; they had nothing to do with the adverse selection problem that was typically associated with the guaranteed issue and community rating provisions and that Congress feared might trigger a death spiral in the individual market.

For instance, Congress imposed the prohibition on annual coverage caps in response to stories from Americans like a forty-year-old father in Michigan with a heart condition for which his doctors prescribed drugs that cost $4,800 per month. Due to the cost of medication, this man exceeded his $10,000 annual cap on coverage within months and had to pay the remaining $47,600 out-of-pocket each

year. *See* 155 Cong. Rec. S12745-02, S12756 (daily ed. Dec. 9, 2009) (Sen. Stabenow). To take another example, Congress enacted the dependent coverage provision to protect young people like Sarah Posekany, who *lost* her insurance when she had to drop several college classes due to complications from Crohn's disease and therefore no longer qualified for her student health plan. Without coverage through her school or her parents, Ms. Posekany could not afford medication and, as a result, ultimately had to undergo two additional surgeries. 155 Cong. Rec. S12524-03, S12529 (daily ed. Dec. 6, 2009) (Sen. Harkin).

3. Finally, the district court's decision would also reverse Congress's effort to address a gap in the pre-ACA Medicare Part D program, which affords Medicare beneficiaries access to prescription drug coverage through private insurers. As originally enacted in 2003, Part D beneficiaries that exceeded an initial coverage limit were required to pay 100% of their drug costs until their out-of-pocket spending rendered them eligible for "catastrophic coverage." *See* Juliette Cubanski et al., Kaiser Family Found., Closing the Medicare Part D Coverage Gap: Trends, Recent Changes, and What's Ahead (Aug. 21, 2018).[7] By 2010, 3.8 million Part D enrollees paid an average of $1,858 per year due to this

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

coverage gap. *Ibid.* By 2016, the number of beneficiaries who fell into the Part D "donut hole," as it is called, reached 5.2 million. *Ibid.*

When the 2010 Congress enacted the ACA it planned to phase out the Part D coverage gap by 2020. *See* ACA § 3301(b) *codified at* 42 U.S.C. § 1860D-14A. But the *same* Congress that passed the TCJA compressed the timeline to close the gap so that it would be eliminated this year. *See* Bipartisan Budget Act of 2018, Pub. L. 115-123 § 53116, 132 Stat. 64, 306-07 (2018). Invalidating the ACA would impede this legislative effort—which Congress itself clearly did not understand to be linked to an enforceable mandate—and re-establish the coverage gap for millions of Medicare enrollees in Part D.

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

Congressional efforts to modify the ACA would have been substantially less disruptive to health insurance markets and the delivery of healthcare in this country than a court order invalidating the ACA in its entirety.

The Congressional plan to roll back the ACA that received the most support provided for a graduated partial repeal of the law over the course of several years. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. (June 7, 2017) ("AHCA"). While the individual mandate would have been rendered unenforceable retroactive to 2016, *see id.* § 204, other modifications would have phased in for the 2018 benefit year, *see id.* § 134 (allowing greater premium

variation based on age), *id.* § 202(c)(2) (restricting advance premium tax credits to Exchange plans), and still others for the 2019 benefit year, *see id.* § 133 (permitting insurers to penalize enrollees who fail to maintain continuous coverage); *id.* § 202(c)(4) (reducing advance premium tax credits beginning in 2019). The most impactful ACA provisions, however, would have remained in effect until the 2020 benefit year. *See, e.g.*, *id.* § 112 (Medicaid expansion); *id.* § 131 (cost sharing subsidies); *id.* § 112(b) (essential health benefits in Medicaid plans); *see also id.* § 214 (replacing premium tax credits). Moreover, the AHCA would have created a $100 billion fund to help stabilize the health insurance market through 2026, *see id.* § 132, and replaced the existing tax subsidies with new subsidies, *id.* § 214. The AHCA's implementation delays and other market stabilization measures would have afforded health insurers, healthcare providers and insureds the time needed to prepare for dramatically different market conditions.

Judicial repeal, by contrast, would inject even more chaos into health insurance markets and the delivery of healthcare in America. For instance, if this Court were to uphold the district court's decision and effectively repeal the ACA overnight, health insurers may still have contractual obligations to continue covering their current enrollees for the remainder of the benefit year. For many plans, providing this coverage will no longer make economic sense because the

Court will have eliminated the ACA's government subsidies, which affect premium rates. *See infra* at 24-27; *see also King*, 135 S. Ct. at 2489 (recognizing the importance of the ACA's subsidies and their impact on pricing).

Even if the Court delayed its mandate until the next coverage year, health insurers would still not be able to plan properly. Before this appeal is fully briefed, many Blue Plans will have already submitted for review by relevant insurance regulators their proposed rates and benefit plans for the 2020 benefit year. *See* CMS, 2020 Draft Letter to Issuers in the Federally-Facilitated Exchanges, at 6 (Jan. 17, 2019) (setting application window from April 25, 2019 through June 19, 2019). To mitigate these types of concerns, the ACA created a phased implementation period. While some of its provisions entered were effective in 2010, *see supra* at 15, Congress gave states, health insurers and other stakeholders a four-year period to prepare for Medicaid expansion and the launch of the individual Exchanges—and even then, the Exchanges had a famously troubled roll-out. *See* U.S. Gov't Accountability Off., GAO-15-238, CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices, at 13-14 (Mar. 2015) (CMS rushed to meet statutory deadline causing widespread enrollment problems).[8]

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

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In sum, if affirmed, the district court's decision would deprive over 8 million Americans of health insurance in the individual market alone. And this group of newly uninsured Americans would disproportionately consist of the sick, the aged and low-income individuals—the very people for whom a loss of insurance coverage is especially disastrous. Indeed, these are the very people that Congress, both in 2010 and again in 2017, sought to protect by passing and then reaffirming the ACA. The district court's order would also destabilize the health insurance market. There is no evidence whatsoever that Congress even considered—let alone—intended these destabilizing consequences when it reduced to zero the tax for failing to comply with the individual mandate.

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

When it enacted the ACA in 2010, Congress and the health insurance industry believed that an enforceable individual mandate was essential to preventing the adverse selection problem that caused massive market failures in some states that had previously adopted guaranteed issue and community rating requirements. *See* BCBSA Br. at 23-35; *see supra* at 3-4.[9] In the intervening

[9] While the United States recently announced that it intends to ask this Court to

years, however, actual experience has demonstrated that without an enforceable mandate, the individual market will function effectively, albeit suboptimally, so long as the government maintains the tax credits and other subsidies that the ACA established to increase low-income Americans' access to coverage. In other words, while the individual market would function better with an enforceable mandate, experience and the OW Study show that Congress could have rationally decided in 2017 to render the mandate unenforceable while still maintaining the guaranteed issue and community rating provisions at the heart of the ACA.

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

In 2010, BCBSA predicted that, if guaranteed issue and community rating provisions were in effect, an enforceable mandate was necessary for the ACA's individual market to function properly. *See generally* BCBSA Br. BCBSA and Congress were aware of various state-level healthcare reform efforts that had failed. *See* BCBSA Br. at 26-35; *King v. Burwell*, 135 S. Ct. 2480, 2486-87 (2015)

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affirm the district court's decision, in full, earlier in this litigation, the United States argued that an enforceable mandate is all that stands between health insurers and "unfettered adverse selection" by insureds. *See Texas v. United States*, 4:18-cv-00167, Dkt. 92 at 15 (June 7, 2018). Others have advocated for this position, as well, including at least one Plaintiff State here. *See NFIB v. Sebelius*, Nos. 11-393 & 11-400, Br. of Missouri Att'y Gen'l as *Amicus Curiae* in Support of Respondents and Severability at 5 (S. Ct. Feb. 2012) (only guaranteed issue and community rating are unseverable from individual mandate); *NFIB v. Sebelius*, Nos. 11-393 & 11-400, Br. of *Amici Curiae* AARP et al. In Support of Respondents on Severability at 9 (S. Ct. Feb. 2012) (same).

(discussing ACA's roots in a "long history of failed health insurance reform"). Maine, Washington, Kentucky, New Hampshire, New York, and Vermont, in particular, regulated their individual health insurance markets with guaranteed issue and community rating requirements, but they did not adopt an individual mandate. *See* BCBSA Br. at 26-32, 32-35. As explained *supra,* these state reforms resulted in sky-high premiums, correspondingly low enrollment rates, and ultimately an exodus of insurers from the individual market, the very type of death spiral that Congress sought to avoid. *See id.*

BCBSA and Congress also studied the legislative program enacted by Massachusetts, the only state to adopt guaranteed issue and community rating provisions that did not suffer from significant adverse selection. *See* BCBSA Br. at 32-35; *King*, 135 S. Ct. at 2486. Unlike the other states, Massachusetts penalized residents who failed to purchase health insurance, thereby deterring healthy residents from exiting the markets and offsetting the cost to insurers of covering sick enrollees. Additionally, Massachusetts, unlike the other states, offered subsidies to help low-income residents participate in the individual market. *King*, 135 S. Ct. at 2486.[10]

[10] Congress also considered evidence indicating that it could mitigate adverse selection by establishing annual open-enrollment periods. *See Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. (2009) (statement of Am. Academy of Actuaries) (limiting open-enrollment periods is one way to increase enrollment and combat

When Congress first enacted the ACA, it believed that the first of Massachusetts' two innovations—the penalty for failure to maintain coverage—was the secret to Massachusetts' success. *See* 42 U.S.C. § 18091(2)(D); *see also, e.g.*, *Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Comm. on Fin.*, 110th Cong. (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (testifying that guaranteed issue and community rating "will only be successful if there is an insurance mandate to balance the risk in the insured population"). For the reasons explained below, however, the Blue Plans' experience and the OW Study show that government subsidies are an effective means to create incentives that ensure a functioning individual health insurance market, even when that market is subject to guaranteed issue and community rating requirements.

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

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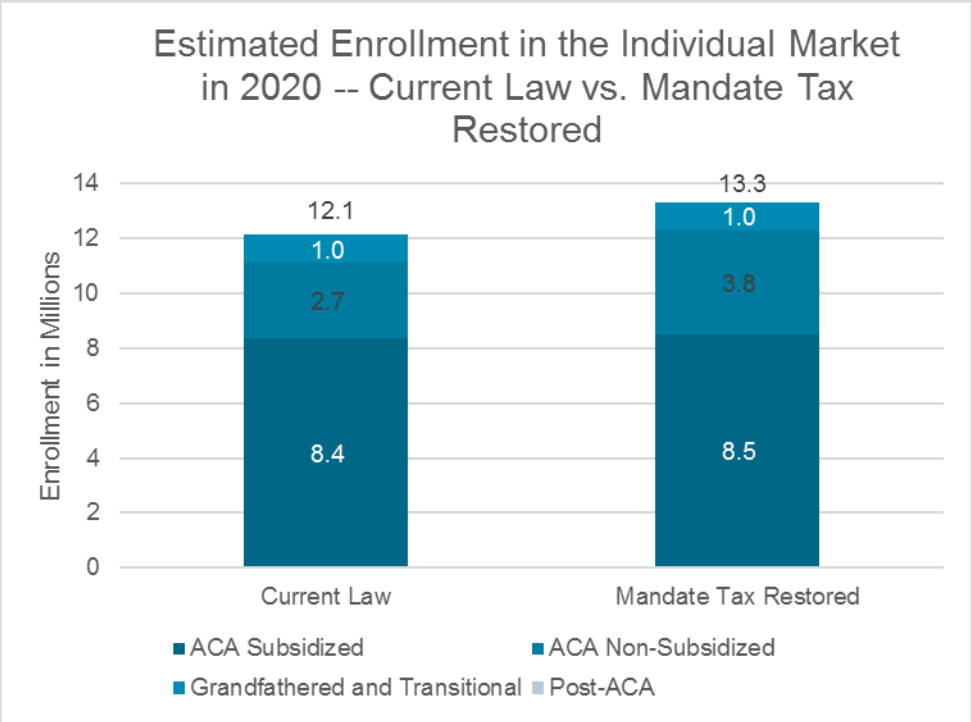
adverse selection); Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (Nov. 30, 2009) (limiting open-enrollment periods discourages healthy individuals from waiting to enroll until illness strikes); *see also* Proposed Rule, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 77 Fed. Reg. 70,583, 70,597 (Nov. 26, 2012) (consistent open enrollment periods for insurance marketplace intended to minimize adverse selection).

by Healthy Enrollees

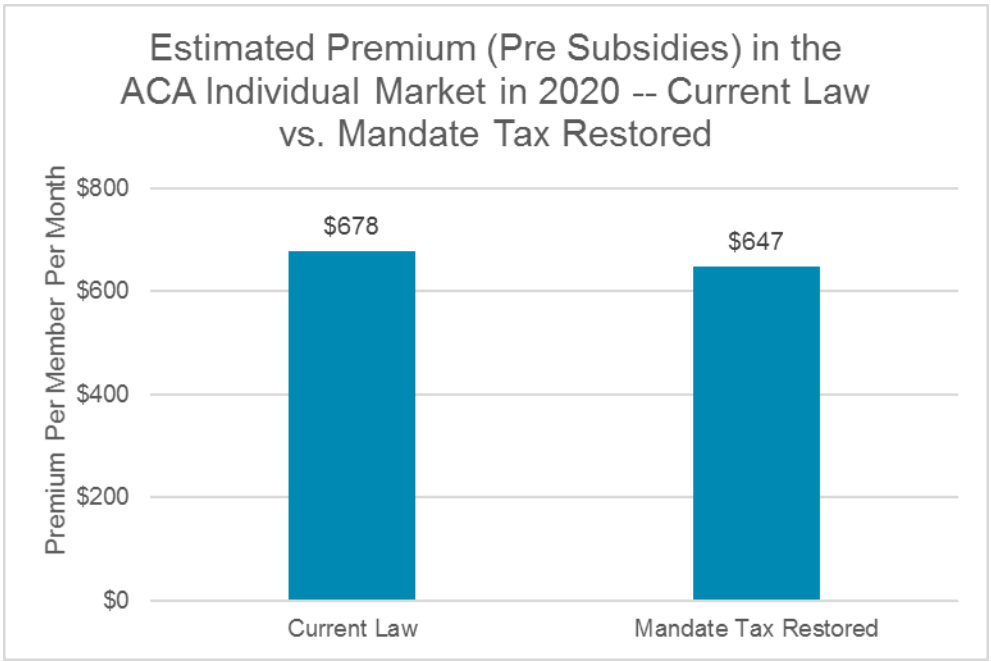
The experience of Blue Plans over the past six years shows that the individual market works best using the model that Massachusetts pioneered and that the ACA copied—which includes *both* an enforceable mandate and subsidies for low-income individuals. But the evidence shows that an enforceable mandate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

The OW Study demonstrates that an individual market with guaranteed issue and community rating provisions but no enforceable mandate will insure 12.1 million enrollees at an average premium of $678 per month, including 8.4 million Americans at or below 400% of the FPL. *See* Study at 4-5. To be sure, this result is suboptimal to the outcome that OW's analysis shows the individual market could achieve with *both* subsidies and an enforceable mandate. As the chart below demonstrates, the OW Study indicates that an individual market with both of these provisions would provide health insurance to 1.2 million *more* Americans (including roughly 100,000 additional Americans at or below 400% of the FPL) than a market with subsidies but no enforceable mandate. *See* Study at 5-6.



Source: OW Study at 6.

This coverage would also cost $31 *less* per month in premiums. *Id.* at 12.



Source: OW Study at 12.

Moreover, these numbers makes sense: The key to averting a death spiral is to ensure that a sufficient number of healthy Americans remain in the individual market. While an enforceable mandate incents some healthy Americans to purchase individual insurance coverage, subsidies for low-income Americans are also a powerful mechanism to ensure that healthy people participate in the individual market. Indeed, the OW Study shows that the switch from an enforceable to an unenforceable mandate causes only 100,000 subsidy-eligible individuals to drop their coverage. *See* Study at 6. Thus, by offering low-income healthy Americans high-quality coverage at an affordable price, the ACA's subsidies effectively incent healthy low-income individuals to remain in the market, preventing the death spiral that Congress sought to avoid when it enacted the ACA and benefitting *all* individual market participants.

Without the subsidies, however, an individual market with guaranteed issue and community rating requirements but no enforceable mandate would collapse. *See King*, 135 S. Ct. at 2493-94 ("The combination of no tax credits and an ineffective coverage requirement could well push a State's individual insurance market into a death spiral."). For instance, assume that health insurers keep plan premiums the same as they would be without any changes to the law: $678 per month or more than $8,000 per year. *See* Study at 7. Without ACA subsidies, many low-income Americans simply cannot afford these premiums, and all but the

wealthiest and sickest Americans would exit the market, causing rates to increase even further. *See id.* at 6-7. Ultimately, in this scenario, the individual market would never reach a stable equilibrium at which insurers could offer coverage and still pay claims, and the only surviving plans would be those that pre-date the ACA and were exempt from its reforms. *See* Study at 6-7, 10.

* * *

Over the last six years, BCBSA has learned that individual markets with guaranteed issue and community rating requirements can function without an enforceable mandate, provided the government offers subsidies to incent healthy individuals to continue purchasing coverage. By the time it enacted the TCJA, Congress also knew that an enforceable mandate was not essential to maintaining the stability of the individual market. *See* Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017). The district court's failure to take any of the ACA's post-enactment history into account when determining whether the mandate is severable from the balance of the ACA was plainly erroneous.

CONCLUSION

For the reasons explained above, the district court's decision should be reversed.

Dated: April 1, 2019

Respectfully submitted,

s/ K. Lee Blalack

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2019, I electronically filed a true and correct copy of the foregoing *Amicus Curiae* Brief with the Clerk of Court by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 5,802 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

s/ K. Lee Blalack, II
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ADDENDUM

OLIVER WYMAN

POTENTIAL IMPACT OF INVALIDATING THE AFFORDABLE CARE ACT ON THE INDIVIDUAL MARKET

April 1, 2019

Kurt Giesa, FSA, MAAA

Peter Kaczmarek, FSA, MAAA

MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

We prepared this report for the Blue Cross and Blue Shield Association ("BCBSA") in support of its *amicus curiae* brief in *Texas v. United States*[1] (the "Litigation"). Our report contains this Executive Summary and an Analysis using our Healthcare Reform Micro-Simulation Model (HRMM)[2] to illustrate the real-world impact of several possible outcomes of the Litigation on the individual market for health insurance.

In short, we find that the individual health insurance market would function better if the Affordable Care Act's (the "ACA") individual mandate to purchase insurance is enforced through an individual mandate payment, as it was before the reforms enacted in 2017. Even without such a payment, however, an individual market that operates pursuant to the ACA's other key provisions will provide affordable health insurance to millions more enrollees than a market without these provisions. More specifically:

- Even without an enforceable individual mandate, we expect that the premium and cost sharing assistance available to lower-income insureds will make it so that the individual market under the current ACA rules (*i.e.*, the ACA without an individual mandate payment) could continue to provide coverage to around 11.1 million enrollees in 2020, including 8.4 million enrollees with income levels that qualify them for the ACA's subsidies.

- Reinstatement of the individual mandate payments to the levels in effect for 2018 with indexing, could increase ACA enrollment in 2020 by 1.2 million and decrease the market-wide average premium rate by 5%.

- The ACA's two principal subsidies—advance premium tax credits ("APTCs") and cost-sharing reduction payments ("CSRs")[3]—are critical to the continued operation of the individual market. If the APTCs and CSRs that are currently available in the individual market were eliminated, but all other ACA requirements remained in place, issuers would not be able to set premium rates in the individual market without taking significant financial losses. This would trigger an exit of issuers from the ACA individual market leaving only those individuals with pre-ACA, transitional and grandfathered plans with comprehensive major medical coverage through the individual market.

[1] Case No. 19-10011 (5th Cir.)

[2] An online version of this report with an appendix describing the HRMM in detail is available here: https://www.oliverwyman.com/our-expertise/insights/2019/apr/potential-impact-on-the-individual-market-of-invalidating-the-af.html

[3] See sections 1401, 1402, 14011-1415 of the Part I of Title I of the ACA: https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

- If all ACA requirements related to the individual market were invalidated, the operation of the individual market would be substantially disrupted. Assuming (i) the return of pre-ACA state regulation regarding guaranteed issue[4] and premium rate restrictions[5] became effective and (ii) APTC and CSR subsidies were no longer available, we estimate that enrollment in the individual market would be just over one third of today's enrollment. Even this assumes that issuers have sufficient time to develop new health insurance products, to have those products approved by the relevant regulators, and to develop the operational capabilities (e.g., medical underwriting) to market those products.

- Compared to the demographic composition of the current individual market, without the ACA, the demographic composition of enrollees in the individual market would be younger, healthier and mostly from households with incomes above 400% of the federal poverty level ("FPL"). We estimate that most of those currently insured under the ACA who qualify for APTCs and CSRs would become uninsured if subsidies were no longer available, as would most individuals with pre-existing health conditions.

[4] https://www.kff.org/other/state-indicator/individual-market-guaranteed-issue-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] https://www.kff.org/other/state-indicator/individual-market-rate-restrictions-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

2

Analysis: Scenarios Modeled and Results

In this section, we discuss the market impact of several potential changes to the ACA. We limit our analysis to the individual market; we do not consider the impact of these scenarios on other sources of coverage, including the employer-sponsored health insurance market or coverage under Medicaid or Medicare. We also focus on the 2020 benefit year.

As background, we estimate that roughly 12.2 million individuals were covered through the ACA individual market in 2018, both on and off the Exchanges.[6] Through the first half of 2018, about 8.9 million total insureds received APTCs to help cover the cost of their premiums, and about 5.4 million also received CSRs to help cover the cost of deductibles and copays.[7] CMS reports that approximately 11.4 million individuals selected or were auto enrolled in an Exchange plan at the end of the 2019 open enrollment period.[8] This excludes individuals enrolling in ACA-compliant coverage off the Exchanges.

We used our HRMM to estimate the baseline market conditions in 2020 without any change, and then modeled the impact of three separate scenarios described below.

Baseline Scenario

Our baseline scenario assumes that all current ACA statutory provisions and regulations remain in effect, without any changes resulting from the Litigation. Premium rates in 2020 are based on the 2019 rates adjusted for increases in the cost and utilization of covered services[9] and assume an additional 2.2% increase due to the reinstatement of the Section 9010 Fee Tax paid by health insurers as required under the ACA.[10]

Under the baseline scenario, we estimate that 12.1 million individuals will have coverage in the individual markets in 2020 at an average rate of $678 per member per month (PMPM), with roughly 1.0 million of those covered under non-ACA-compliant, grandfathered or transitional plans. Of the remaining 11.1 million covered under ACA-compliant plans, 8.4 million enrollees will have incomes less than 400% FPL and so would be eligible for

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[6] Oliver Wyman calculations using the Interim Summary Report on Risk Adjustment for the 2018 Benefit Year. See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Interim-RA-Report-BY2018.pdf

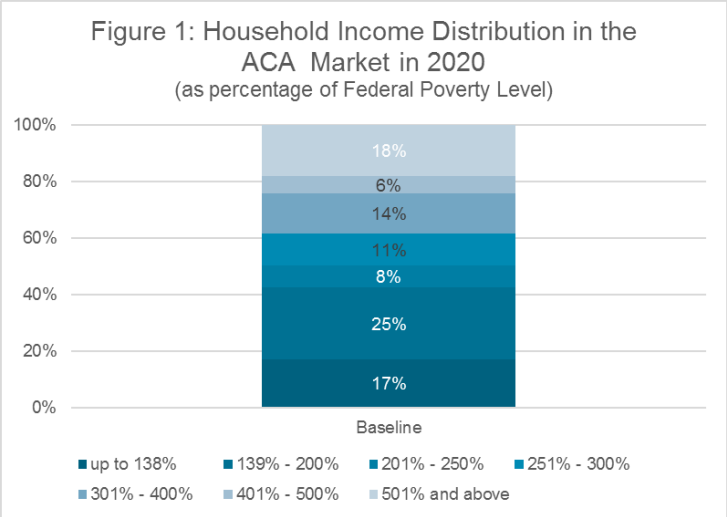
[7] https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018 Effectuated Enrollment Table.pdf

[8] https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report

[9] We used 7% for this analysis. The recent median medical claim cost trends in the group market are between 7% and 10%, see Oliver Wyman's Carrier Trend Survey: https://www.oliverwyman.com/our-expertise/insights/2018/feb/carrier-trend-report---january-2018.html.

[10] https://health.oliverwyman.com/2018/08/new-analysis--how-the-acas-hit-will-impact-2020-premiums.html

APTCs. In Figure 1, we show the distribution of enrollment by income as a percentage of FPL.



Additionally, the market covers those at a variety of health statuses. Thirty percent of those covered rate themselves with “excellent” health, while 33% rate themselves with “very good” health. Twenty-eight percent rate themselves with “good” health, 7% with “fair” health, and 2% with “poor” health.

Finally, the market is skewed to an older demographic. Thirteen percent of those covered are older than 61 years old, 26% are between 51-60 years old, 18% are between 41-50 years old, 16% between 31-40 years old, 18% between 21-30 old, and 10% between 0 and 20 years old.

In summary, we anticipate that without the individual mandate payments, the individual market will continue to cover substantial numbers of low- and middle-income and sick enrollees at rates that are affordable when subsidies are considered. Additionally, the age rating restrictions ensure that Americans retain access to health care as they age.

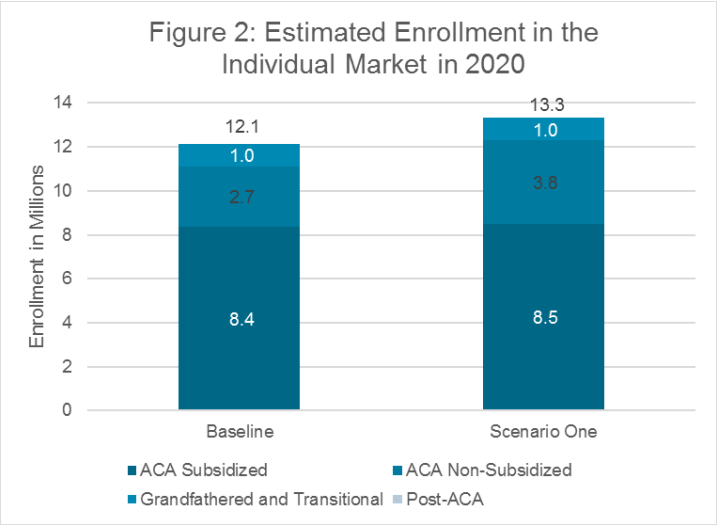
Scenario One: Reinstatement of the Federal Individual Mandate Payments

In Scenario One, we model what happens if the individual mandate payment is reinstated effective January 1, 2020.[11] We assume the required payment will revert to the level that was effective in 2018 (2.5% of income or $695, indexed for inflation), but that all other ACA requirements remain unchanged from the baseline. We include this scenario to explore the impact to the individual market of Congress’s decision to render the mandate unenforceable.

As compared to the baseline, if the individual mandate payments were reinstated for 2020, we estimate that an additional 1.2 million people would be covered, and market wide

[11] The Tax Cuts and Jobs Act set the individual mandate payment amounts to zero percent or $0 for months after December 31, 2018: https://www.congress.gov/115/plaws/publ97/PLAW-115publ97.pdf

average premiums would decline by 5% relative to the baseline, to $647 PMPM, as the morbidity and demographics of the single risk pool improve. In Figure 2, we show that a large majority of the increase in enrollment is among those who are not eligible for subsidies.



Reinstatement of the penalty could improve the market, but again, the baseline shows that the reinstatement of the penalty is not necessary to ensure that the ACA individual market remains viable.

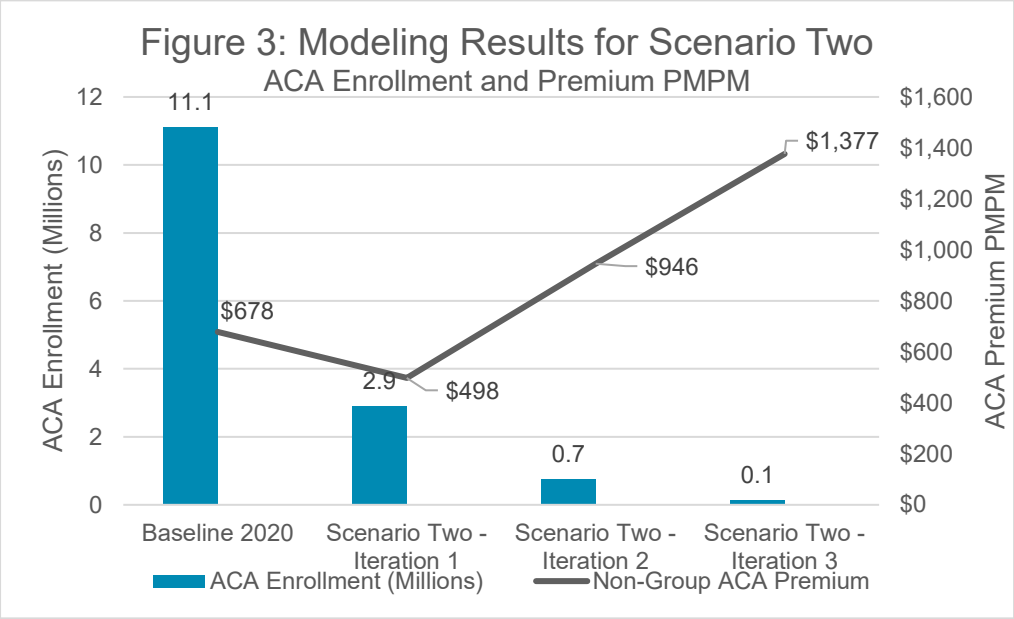
Scenario Two: Ending the Premium Tax Credits and Cost-Sharing Reductions

This scenario considers the impact on the ACA individual market if, beginning in 2020, APTCs and CSRs are no longer available to eligible enrollees. All new or returning enrollees would therefore have to pay the full cost of the premiums charged for ACA coverage without the benefit of subsidized premiums and reduced cost-sharing for qualifying low- and middle-income individuals. All other variables remain consistent with the baseline, including the ACA's guaranteed issue and community ratings requirements, and the absence of a federal individual mandate payment in outcome. Nevertheless, this scenario helps to examine the significance of the subsidies to the stable market outcome in the baseline.

Under this scenario, the model predicts that the individual market would cease to function. We sought to model the premiums that would be necessary for issuers to cover the cost of their administrative expenses and their insureds' claims under these market conditions. Our model, however, fails to reach equilibrium.

Essentially, the model sets a premium that individuals must pay to cover the expected cost of their benefits. Absent APTCs, individuals must pay the full cost of coverage, and so only those individuals with relatively high claims take advantage of the guaranteed issue requirement to gain access to coverage. The model reacts and adjusts premiums upward. The higher premiums cause the healthiest individuals in the risk pool to forgo coverage, so the model sets a higher premium to cover the less healthy members who remain covered. This process continues and the model fails to converge on a premium. In simple terms, the

modeling suggests that issuers would be unable to participate in the market without suffering severe losses. We provide modeling results in Figure 3.



In iteration 1 in Figure 3, the massive loss in enrollment is due to the elimination of the APTCs and the resulting exit from the market of those with incomes less than 400% FPL, even though premiums decline. While premiums decline by about $190 PMPM in the first iteration, individuals qualifying for premium subsidies are losing subsidies worth more than $600 PMPM. In the second iteration, premiums increase by almost $290 PMPM, and because at this stage in the modeling, the market consists almost entirely of individuals who are not eligible for premium subsidies, the market again declines significantly, until at iteration 3, only the oldest and sickest individuals remain, and issuers decline to participate in the market.

This result is not surprising to anyone familiar with health insurance markets. Under the baseline scenario, we estimate that the average non-subsidized premium for silver metal level coverage in 2020 would be $678 PMPM, or roughly $8,100 per year. Obviously, it would be difficult for a large segment of the population to pay this amount on an annual basis without APTCs, and those most likely to enter the market at this premium level would be motivated to do so by an expectation that their claims would be significantly higher than the monthly premium.

The result is that those who currently rely on APTCs for health insurance would likely be unable to find alternative coverage. Alternative options would be limited because the existing ACA rules would limit issuers' ability to offer comparable coverage at affordable premium rates. Ultimately, we project an increase of more than 11 million individuals who would become uninsured or be under-insured.

Scenario Three: Elimination of All ACA Rules from the Individual Market

This scenario models the impact on the ACA individual market should the entire ACA be invalidated starting in 2020. Under this scenario, we assume that all federal regulations

revert to their pre-ACA status. We also assume that issuers would have to apply the state individual market regulations regarding guaranteed issue and rating restrictions that were in effect prior to the full implementation of the ACA in 2010, as summarized by Kaiser Family Foundation.[12] To accomplish this, we modeled two distinct groupings of states:

1) States where guaranteed issue applies to all individuals, where there is a prohibition on rating for health status and gender, and age rating is restricted to 3:1 age bands or is fully prohibited.[13]

2) States without the restrictions discussed above. In these states, we assume there is no guaranteed issue requirement, issuers increase premiums up to twice the standard rate due to the health status of the enrollee and decline those who cannot pass underwriting, and that age rating is allowed for up to 5:1.

This grouping does not reflect all the nuances that were present in the state specific guaranteed issue and rating restrictions in the individual market prior to the enactment of the ACA in 2010, nor does it reflect any potential future regulatory changes. For the purposes of our modeling, however, we believe that this grouping adequately reflects the conditions that would exist under this scenario.

Additionally, we assume that the average benefit level or actuarial value of the plans offered for purchase under this scenario would be 60% in all states, meaning that on average 40% of the allowable claims would be covered by the enrollees as out-of-pocket expenses.[14] We make no adjustment in our modeling to reflect that issuers would not need to offer all essential health benefits currently required under the ACA[15] or other benefit requirements,[16] but again believe that this reasonably represents the conditions that would exist under this scenario for the purposes of our modeling.

Finally, we assume that issuers would price plans to a 75% average loss ratio (claims divided by premiums) in the states without guaranteed issue requirements, and to a 90% loss ratio in the five states with a guaranteed issue requirement. The 75% loss ratio reflects the fact that issuers in the states without guaranteed issue would no longer need to meet the ACA's 80% medical loss ratio standard and would likely sell their products primarily through agent and broker channels and so would incur higher marketing costs. The higher

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[12] https://www.kff.org/other/state-indicator/individual-market-guaranteed-issue-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

and

https://www.kff.org/other/state-indicator/individual-market-rate-restrictions-not-applicable-to-hipaa-eligible-individuals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[13] These states include Maine, Massachusetts, New York, New Jersey, and Vermont.

[14] Oliver Wyman estimate based on the average deductible, coinsurance and out of pocket maximum limits for single PPO coverage in the individual market in 2009 based on AHIP report: https://kaiserhealthnews.files.wordpress.com/2013/02/2009individualmarketsurveyfinalreport.pdf

[15] Sections 1301-1302 of the ACA

[16] Section 1001 of the ACA Amendments to the Public Health Service Act

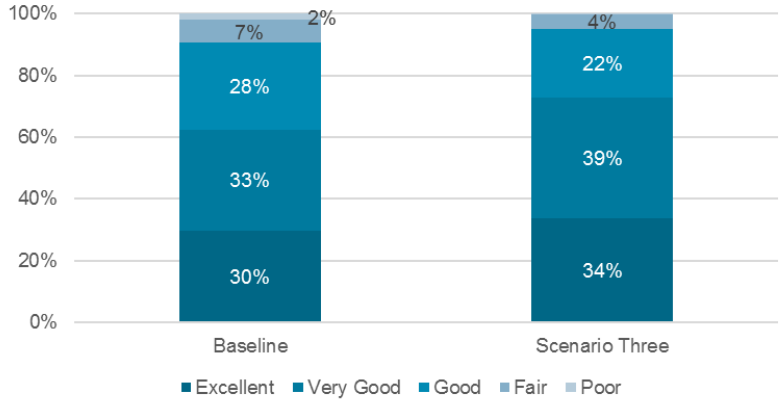
90% loss ratio in the guaranteed issue states assumes that issuers would be able to subsidize the plans sold through gains in other lines of business, or would be required to reduce non-benefit expenses to 10% of premium in developing their premiums.

We believe that the simplified assumptions we make in this scenario would reflect the potential impact on the individual market in broader terms. Substantial regulatory changes such as the invalidation of all the individual market requirements are difficult to predict, and, as such, the impacts to the premiums and enrollment modeled in this scenario should be considered with caution.

These results suggest a worse outcome when compared to the individual market that existed before the ACA was enacted in 2010.[17] Our model suggests that the 2020 individual market would be similar to the pre-ACA market with respect to the distribution by age and income, and that a large majority of those with pre-existing health conditions would lack access to coverage. The market would only cover about half of the number enrollees as were covered in the individual market prior to the ACA. This, however, is likely because 2020 would be the first benefit year of the new market. We would expect the market to slowly grow over time, and to remain smaller than the market under the ACA.

We show the change in health status in Figure 4. Under the baseline, 9% of the 11.1 million insureds, or roughly 1.0 million individuals have self-reported health status of fair or poor, indicating a pre-existing medical condition. Under Scenario Three, where the size of the market declines to 3.7 million (see Figure 5), only 4% of enrollees would have a health status of fair, and essentially none would have a self-reported health status of poor. This presents the loss of access to medical coverage of almost one million individuals in fair and poor health.

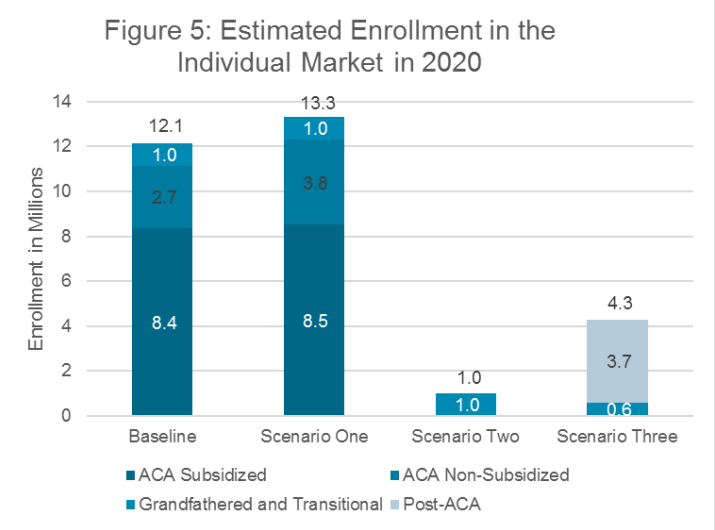
Figure 4: Health Status Distribution in the ACA and Post-ACA Market in 2020



[17] See, for example, https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

Comparing the Scenarios Across Key Metrics

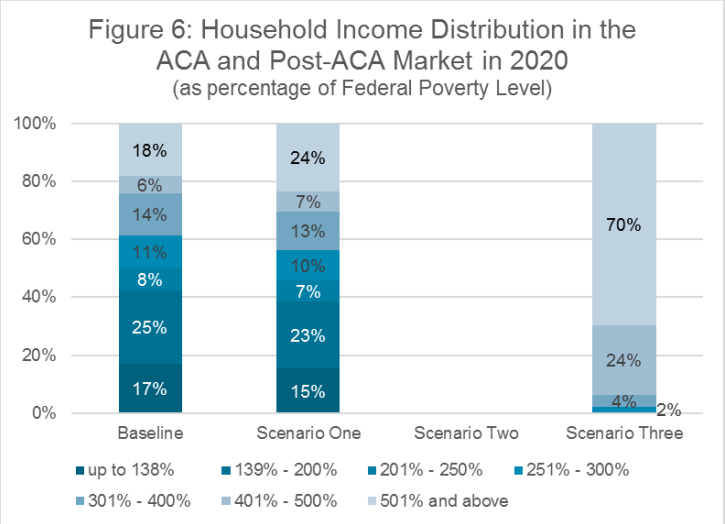
In Figures 5 through 9 we break down the results of each scenario and compare them across key metrics including enrollment, demographic composition, and market average premiums.



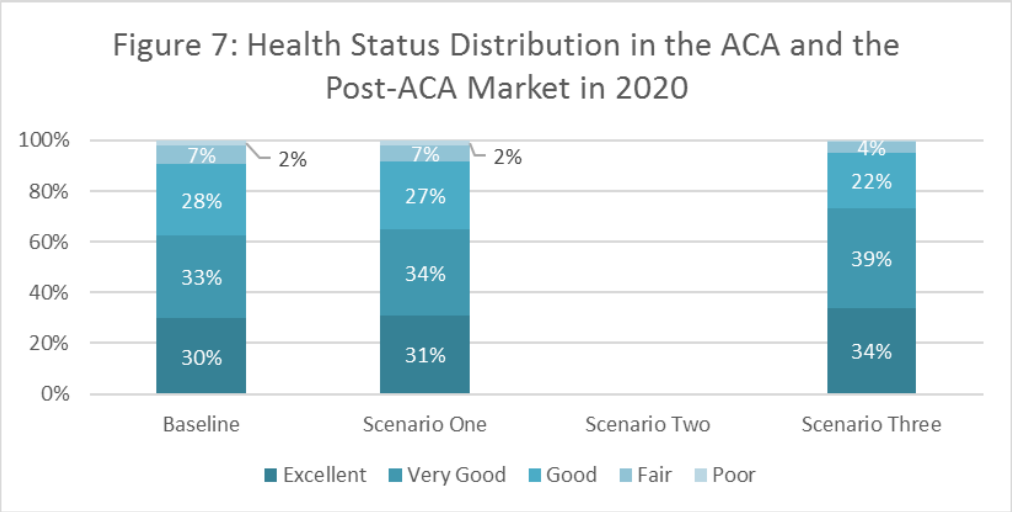
In Figure 5, we show that even without a federal individual mandate, the individual market provides health insurance for a substantial number of enrollees, including millions of low- and middle-income enrollees eligible for subsidies. Specifically, we expect 11.1 million individuals to have ACA coverage in 2020, and that there will be another 1.0 million with grandfathered and transitional policies, for a total of 12.1 million individuals in the individual market.

While functional, the individual market would improve by restoring the individual mandate payment to 2018 levels. Under Scenario One, we project an increase in the ACA individual market enrollment of about 1.2 million enrollees, or roughly 10%. In contrast, however, taking away subsidies would destroy the individual market, and under Scenario Two, only the 1.0 million enrollees covered under transitional and grandfathered plans would maintain their comprehensive medical coverage. Finally, without the ACA, we estimate the post-ACA market enrollment at 4.3 million, just over a third of the baseline enrollment.

Figure 6 further breaks down the individual market under each scenario by income. In the baseline scenario, there is substantial coverage for the lowest-income Americans. Individuals with incomes *greater* than 400% of FPL make up less than one-quarter of the market. Restoring the individual mandate payment causes more, higher-income Americans to participate in the market. This figure, in particular, shows the effect of eliminating the ACA on individual health insurance for poor- and middle-income Americans. Without the ACA, only 222,000 enrollees in the individual market, or 6%, have an income that is less than 400% of the FPL and two-thirds of those individuals have incomes at the upper end of that range, making between 301% and 400% of the FPL.

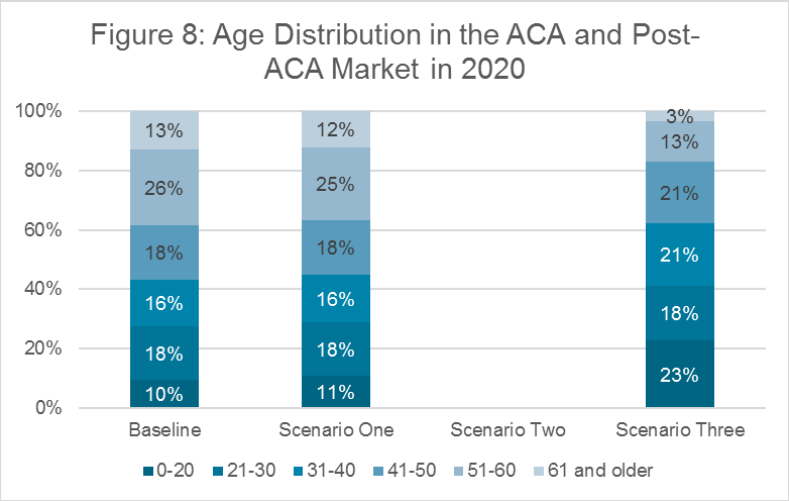


In Figure 7, we show the distribution of ACA individual market enrollees by health status. The model we use to produce these estimates classifies individuals into one of five health status buckets. Under Scenario One, the health status profile of the ACA individual market is slightly healthier than under the baseline, suggesting that an individual shared reponsibility payment will incent more healthy people to participate in the individual market.

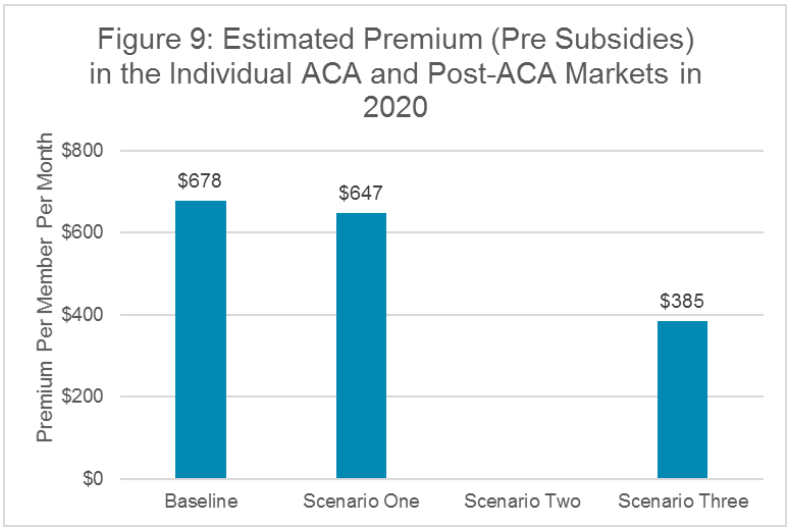


Abolishing the ACA would force many of the sickest enrollees to leave the market. Under Scenario Three, the post-ACA market has the highest share of enrollees in excellent and very good health status. And the percentage of enrollees with fair or poor health is cut in half. This results from the elimination of guaranteed issue and issuers' rating by health status.

In Figure 8, we see the importance of the ACA's reforms on coverage for older Americans. While the relative age of those covered does not change substantially between the baseline and Scenario One, under Scenario Three, the proportion of those over 50 years old in the individual market drops from nearly 40% to just 16%, and the proportion of those over 60 years old is cut in four without the ACA.



In Figure 9, we show that eliminating the individual mandate payment causes market-wide average premiums to rise by $31 PMPM, or about 5%. In the baseline scenario, market wide average premiums are $678 PMPM, while in Scenario One, they are $647 PMPM. We estimate the average premium in Scenario Three at $385 PMPM. The lower premium under Scenario Three results from a combination of a healthier risk pool due to the exclusion of individuals with pre-existing medical conditions, a younger demographic, and lower actuarial value of the health plans.



Report Qualifications, Assumptions and Limiting Conditions

We prepared this report for the Blue Cross and Blue Shield Association for the purposes stated herein. This report is not to be used for any other purpose.

In this work, we have relied on publicly available data and information without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data and information we relied upon are both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

Our conclusions are based on data and information that we believe are appropriate for these purposes, and on the estimation of the outcome of many contingent events. Our estimates make no provision for extraordinary future events not sufficiently represented in historical data on which we have relied, or which are not yet quantifiable.

The sources of uncertainty affecting our estimates are numerous and include items such as changes in policies beyond those modeled here such as changes in outreach and advertising, changes in taxes, and changes in federal and state funding.

While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic and statistical variations from expected values. We have not anticipated any extraordinary changes to the legal, social, or economic environment that might affect the results of our modeling. For these reasons, no assurance can be given that the emergence of actual results will correspond to the projections in this analysis.

The authors of this report are members of the American Academy of Actuaries and meet that body's Qualifications Standards to perform this work and render the opinions expressed in this report.

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