No. 14-114

IN THE

Supreme Court of the United States

DAVID KING, *et al.*,

Petitioners,

v.

SYLVIA MATTHEWS BURWELL, AS U.S. SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

INTEREST OF *AMICUS CURIAE*

The American Federation of Labor and Congress of Industrial Organizations is a federation of 56 national and international labor organizations with a total membership of approximately 12.5 million working men and women.[1] This case will determine whether the federal tax credits provided by the Affordable Care Act are available in the 34 states that have elected to have the federal government establish the state-based insurance exchanges mandated by the Act. The AFL-CIO has an interest in this issue because the collective bargaining agreements negotiated by its affiliated unions almost universally provide for employment-based health insurance for covered employees and their immediate families. The system of employment-related health insurance has come under tremendous pressure from the steadily increasing costs of health insurance coverage. The Affordable Care Act addresses the problem of increasing insurance costs by encouraging universal coverage, and the health benefit exchanges and employer responsibility provisions, which are dependent on the availability of premium assistance for insurance purchased through the exchanges, are essential to the Act's plan for achieving that purpose.

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[1] Counsel for the petitioners and counsel for the respondents have filed letters consenting to the filing of *amicus* briefs on either side. No counsel for a party authored this brief *amicus curiae* in whole or in part, and no person or entity, other than the *amicus*, made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

The Affordable Care Act addresses the previously declining rates of employment-based insurance coverage in two ways. First, the Act reduces the pressure of increased premium costs by providing for universal health insurance coverage. Second, the Act penalizes employers for dropping coverage or shifting excessive costs to covered employees. An interpretation of the Act that makes federal tax credits unavailable in the 34 states served by federally-facilitated insurance exchanges will seriously undermine each of these aspects of the Act. The resulting effect could be to seriously undermine employment-based health insurance coverage in those 34 states.

ARGUMENT

The legal question presented by this case is whether the Internal Revenue Service and the Secretary of Health and Human Services have correctly determined that the tax credits provided by the Affordable Care Act to assist low and moderate income Americans to purchase health insurance through state-based insurance exchanges are available in the states that have elected the option of federally-facilitated exchanges. For the record, we state our agreement with Judge Davis's observation that "making the tax credits available to all consumers of Exchange-purchased health insurance coverage is the correct interpretation of the Act and is required as a matter of law." *King v. Burwell*, 759 F.3d 358, 376 (4th Cir. 2014) (Davis, J., concurring) (internal citations omitted). We do not, however, believe that it would be helpful for us to repeat the analysis of the statutory language that has been adequately set forth in the brief for the United States.

The purpose of this brief is to state our concern over the destabilizing effects on the provision of employment-based health insurance coverage that could flow from a determination that tax credits are unavailable in the 34 states that have elected to rely on federally-facilitated exchanges.

The threat to employment-based health insurance coverage comes from two directions. First, a determination that tax credits are unavailable in those 34 states will completely undermine the market for individual health insurance in each of those states with the result that the economic pressures on the health care industry will be more severe than they were prior to the Affordable Care Act. These pressures are likely to drive up the cost of employment-based health insurance and thus encourage employers to either drop employee health insurance or to shift more of the costs of insurance to the employees. Second, a determination that tax credits are not available will free many employers in these states from the penalty provisions of the Affordable Care Act that are designed to encourage continued provision of employment-based health insurance on terms that the covered employees can afford.

The confluence of increased insurance premiums and lifting the employer penalties presents a danger of reviving the erosion of employment-based health insurance that was stemmed by passage of the Affordable Care Act. This time, however, the erosion is likely to be more steep, because the pressures on the employment-based insurance system will be more severe.

1. Employment-based health insurance coverage is vital to financing the provision of healthcare in the

United States. The majority of individuals in the United States receive health coverage through employment-based health insurance policies that are provided either by the individual's own employer or by the employer of a close family member. In 2014, more than 150 million Americans, were covered by employer-sponsored health insurance. Sara R. Collins, et al., "National Trends in the Cost of Employer Health Insurance Coverage, 2003-2013," *Issue Brief*, at 1 (The Commonwealth Fund, December 2014).

Prior to the Affordable Care Act, employer-based health insurance coverage was in decline. As a result of that decline, during the three decades preceding the Affordable Care Act, "the percentage of individuals without health insurance ha[d] generally been increasing." Paul Fronstin, "Tracking Health Insurance Coverage by Month: Trends in Employment-Based Coverage Among Workers, and Access to Coverage Among Uninsured Workers, 1995-2010," *EBRI Notes*, vol. 32, no. 10, at 16 (Employee Benefit Research Institute, October 2011).

"By 2013, the annual total costs of employer-sponsored…[health insurance] premiums averaged just over $16,000." Cathy Schoen, et al., "State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013," *Issue Brief*, at 2 (The Commonwealth Fund, January 2015). These "annual premium increases have far exceeded wage growth for more than a decade—with premiums rising three times faster than wages." *Id.* at 1. In fact, "the total costs of insurance premiums rose far faster than median household income" over the past decade. *Ibid.* *See also* Keenan Dworak-Fisher, et al., "Trends in employment-

based health insurance coverage: evidence from the National Compensation Survey," *Monthly Labor Review* (United States Department of Labor Bureau of Labor Statistics, October 2014) (the costs of "health insurance paid by employers tripled from 1991 to 2012, while wages…increased by 83 percent").

Where employers chose to continue health coverage, they often relied upon employee premium contributions and employee coinsurance, such as copays and deductibles, to offset increases in the premium costs. *See* Schoen, "State Trends," at 4; *Employer Health Benefits Annual Survey*, at 1 (The Kaiser Family Foundation and Health Research & Educational Trust 2014). Thus, "[t]he annual cost of workers' contributions to premiums has nearly doubled" over the past decade, Schoen, "State Trends," at 1, with "[c]overed workers contribut[ing] on average 18% of the premium for single coverage and 29% of the premium for family coverage," *Employer Health Benefits Annual Survey*, at 1, or on average $4,823 per year, *id.* at Ex. A. Higher costs discourage employees from accepting coverage when their employers do offer it. Fronstin, "Tracking Health Insurance Coverage by Month," at 16. The ultimate effect of increased premiums is lower rates of participation in employment-based insurance plans. As a result, the percentage of Americans receiving employer-sponsored health insurance dropped from 69.3% in 2000 to 57% in 2014. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey," *EBRI Issue Brief*, no. 392, at 5, fig. 1 (Employee Benefits Research Institute, September 2013); Collins, et al., "National Trends in the Cost of Employer Health Insurance," at 1.

A substantial portion of the high premium costs that drove employers to either drop employee insurance coverage or shift costs to covered employees was due to uninsured persons receiving unpaid-for health care. Prior to the Affordable Care Act, over $1,000 of the annual premium for each family health insurance policy was attributable to otherwise uncompensated health care services for the uninsured. Kathleen Stoll, et al., *Hidden Health Tax: Americans Pay a Premium*, at 2 (Families USA, 2009).

Uninsured individuals place a burden on the health care system in two ways. First, individuals without health insurance are less likely to receive preventative health care and are more likely to defer treatment until the stage where more expensive interventions are necessary. Second, those individuals often seek care through hospital emergency rooms. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey," *EBRI Issue Brief*, no. 362, at 18 (Employee Benefits Research Institute, September 2011). The hospitals tend to cover the costs of such expensive – but unpaid-for – emergency services by raising prices generally and thus effectively increasing the amounts charged to insured patients and paid by insurers. *See* Teresa A. Coughlin, et. al., "Uncompensated Care for the Uninsured in 2013: A Detailed Examination," at 22 (The Kaiser Commission on Medicaid and the Uninsured, May 2014).

In sum, the costs of treating the uninsured were borne in large part by the insurance companies, which pass the added costs along to employers in the form of higher premiums and by self-insured employers.

Thus, addressing the problem of uninsured individuals is directly relevant to the strength of employment based-health insurance coverage.

2. The Affordable Care Act was designed to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2590 (2012). The central premise underlying the Act is that a necessary condition for bringing the cost of healthcare under control is universal or near universal health insurance coverage.

The Act increases coverage of those individuals who do not receive employment-based health insurance through three interdependent measures. First, insurance companies are prohibited from denying coverage or charging higher premiums based on an individual's prior medical condition or history. Second, low and moderate income individuals are provided with financial assistance in purchasing coverage. Third, individuals who can afford coverage but do not purchase insurance are required to pay a tax penalty.

The second of these measures – financial assistance – is directly at issue in this case. But if financial assistance is rendered unavailable, coverage will become unaffordable to most individuals with the result that the third measure – the tax penalty for not purchasing affordable coverage – will also be annulled.

The individual mandate requires that all qualifying individuals purchase health insurance or be assessed a penalty. 26 U.S.C. § 5000A. The lack of premium assistance credits on federally-facilitated exchanges would excuse many individuals from the mandate be-

cause the Act contains an exception for those who are unable to purchase affordable coverage. *Ibid.* Affordable is defined as premiums less than or equal to 8% of household income. *See* 26 U.S.C. § 5000A(e)(1)(A). The average annual cost of family coverage is likely to be approximately one-quarter of the median family income. *See Employer Health Benefits*, at 1, Ex. A; Carmen DeNavas-Walt and Bernadette D. Proctor, *Income and Poverty in the United States: 2013* (U.S. Census Bureau, September 2014). Thus, the elimination of subsidies on federally-facilitated exchanges will excuse virtually the entire population of a state with a federally-facilitated exchange from the individual mandate.

This would leave only the first measure – the very popular nondiscrimination requirement – standing alone. The nondiscrimination requirement is not undermined by eliminating individual subsidies and mandates. Nor is it likely that the requirement would be repealed, even if the individual subsidies and mandates are largely eliminated through a construction of the Act.

Requiring that health insurance be offered to all individuals regardless of their medical history at the same price will discourage the purchase of insurance by healthy individuals, who will wait to purchase insurance until they need medical treatment. Restricting the insured population to those who are actually receiving medical treatment will severely increase the cost of individual coverage to the point where it approaches the costs of treating the insured individuals. The resulting exorbitant premiums will further discourage the purchase of individual health insurance.

In short, eliminating tax credits in the 34 states that have chosen to rely on federally-facilitated exchanges will make individual health insurance coverage much more unaffordable than it was prior to the Affordable Care Act. Thus, in these states, the burden on the health care system to care for uninsured individuals will be greater than it was before the Act. The predictable increase in health care costs will be passed on to employers who provide health insurance coverage to their employees, thereby increasing the pressure on these employers to either drop coverage or shift the cost of coverage to their employees.

3. In addition to alleviating the pressure on employment-based insurance caused by sharply rising premiums, the Affordable Care Act seeks to directly stem the decline in employer-based health insurance by penalizing employers for either dropping coverage altogether or shifting an undue portion of the costs to employees. The Act does this through two penalty provisions that are inextricably tied to the availability of tax credits for individual health insurance. *See* 26 U.S.C. § 4980H.

First, the Act penalizes larger employers – beginning in 2016, those employers with fifty or more full-time employees – for failure to offer health coverage of any kind to full-time employees. 26 U.S.C. § 4980H(a). The failure-to-offer penalty is only triggered when a full-time employee of a large employer that does not offer health insurance purchases subsidized healthcare through an exchange. Once a single employee does so, the employer is accessed a penalty

calculated on the basis of every full-time employee in its employ.

Second, the employer shared responsibility provision requires that employers provide affordable coverage that provides minimum value. 26 U.S.C. § 4980H(b). Affordable coverage is coverage with an employee contribution less than or equal to 9.5 % of the employee's household income. 26 U.S.C. § 36B(c)(2)(C)(i). Health coverage provides minimum value if the plan's share of the employee's health costs is equal to or greater than 60% of such costs. 26 U.S.C. § 36B(c)(2)(C)(ii). The penalty for failure to provide affordable coverage is also triggered by an employee purchasing subsidized health insurance through an exchange. 26 U.S.C. § 4980H(b). But, this penalty is calculated on the basis of each individual employee who subsequently purchases subsidized insurance on an exchange, not on the basis of all employees of the employer. *Ibid.*

Since both penalties are triggered by an employee purchasing subsidized health coverage on a state-based exchange, eliminating the subsidies in states that rely on federally-facilitated exchanges would eliminate the employer penalties in those states. Lifting the employer penalties at the same time that the cost of employer-provided insurance is likely to steeply increase could have a reverberating effect that would destabilize the employment-based health insurance system.

* * *

The Affordable Care Act has succeeded in relieving the pressure on employment-based health insurance

due to the effects of uninsured individuals. "The rate of premium and deductible growth slowed markedly in 31 states and the District of Columbia from 2010 to 2013…reflect[ing] a reduction in spending on health care services . . . ." Schoen, et al., "State Trends," at 1. Thus, while insurance premium rates for employer-sponsored health plans grew at an average pace of 5.1% per year during 2003-2009, premium growth thereafter has slowed to an average of 4.1% a year. *Id.* at 2. As we have explained, interpreting the tax credit provision of the Act in a manner that would eliminate credits in the 34 states that have relied upon federally-facilitated exchanges would undermine the benefits to the healthcare and health insurance systems achieved by the Act and would most likely leave those systems in worse condition than they were prior to the Act.

CONCLUSION

The decision of the Fourth Circuit should be affirmed.

Respectfully submitted,

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