[NOT SCHEDULED FOR ORAL ARGUMENT]
No. 16-5202

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITED STATES HOUSE OF REPRESENTATIVES,

Plaintiff-Appellee,

v.

SYLVIA M. BURWELL, in her official capacity as Secretary of Health & Human Services; JACOB J. LEW, in his official capacity as Secretary of the Treasury,

Defendants-Appellants,

On Appeal from the United States District Court for the District of Columbia (No. 1:14-cv-01967) (Hon. Rosemary M. Collyer)

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

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), *amici* certify that:

Parties and Amici. In addition to the parties and *amici* listed in the Brief for Defendants-Appellants, the following *amici* are appearing before this Court:

- **Henry J. Aaron, Ph.D.,**†‡ Senior Fellow, Brookings Institution; Assistant Secretary for Planning and Evaluation, U.S. Department of Health, Education & Welfare (1977-78);
- **Kenneth J. Arrow, Ph.D.,**† Joan Kenney Professor of Economics and Professor of Operations Research, Emeritus, Stanford University; Stanford Health Policy Fellow; recipient of Nobel Prize in Economic Sciences; recipient of the National Medal of Science; recipient of John Bates Clark Medal; recipient of the John von Neumann Theory Prize;
- **Susan Athey, Ph.D.,**†§ Professor of Economics, Economics, Stanford Graduate School of Business; recipient of John Bates Clark Medal;
- **Jeremy Barofsky, Sc.D**., Visiting Fellow, Government Studies, Brookings Institution;
- **Linda Blumberg, Ph.D.,** Senior Fellow, The Urban Institute; Health Policy Advisor, Office of Management & Budget, The White House (1993-94);
- **Barry Bosworth, Ph.D.,** Senior Fellow, Brookings Institution; Director, Council on Wage & Price Stability, The White House (1977-79); Staff Economist, Council of Economic Advisors, The White House (1968-69);
- **Gary Burtless, Ph.D.,** Senior Fellow & Whitehead Chair in Economic Studies, Brookings Institution; Economist, Office of the U.S. Secretary of Labor (1979-81); Economist, Office of the U.S. Secretary of Health, Education, and Welfare (1977-79);

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§ Signifies Member, National Academy of Sciences.

- **Philip J. Cook, Ph.D.,**‡ ITT/Terry Sanford Professor of Public Policy Studies and Professor of Economics & Sociology, Sanford School of Public Policy, Duke University; recipient of the Arrow Award, for best paper in health economics;

- **Amitabh Chandra, Ph.D.,** Professor & Director of Health Policy Research, Kennedy School of Government, Harvard University; recipient of the American Society of Health Economists Medal; Member, Congressional Budget Office Panel of Health Advisors (2012-present); recipient of the Arrow Award, for best paper in health economics;

- **Janet Currie, Ph.D.,**‡ Henry Putnam Professor of Economics & Public Affairs and Director, Center for Health & Well Being, Princeton University; President-Elect, Society of Labor Economists;

- **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);

- **Karen Davis, Ph.D.,**‡ Eugene and Mildred Lipitz Professor, Department of Health Policy and Management, John Hopkins University; Deputy Assistant Secretary for Health Policy, U.S. Department of Health and Human Services (1977-1980);

- **Peter Diamond, Ph.D.,**†§ Professor Emeritus, Massachusetts Institute of Technology; recipient of Nobel Prize in Economic Sciences; former President, American Economic Association;

- **Mark Duggan, Ph.D.**, Professor of Economics, Stanford University; recipient of the American Society of Health Economists Medal;

- **Douglas Elmendorf, Ph.D.,** Dean and Don K. Price Professor of Public Policy, Harvard Kennedy School; 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);

- **Ezekiel Emanuel, M.D., Ph.D.,**‡ Chair, Department of Medical Ethics & Health Policy, Vice Provost for Global Initiatives, Diane v.S. Levy & Robert M. Levy University Professor, Perelman School of Medicine and The

Wharton School, University of Pennsylvania; Special Advisor for Health Policy to the Director of the Office of Management & Budget, The White House (2009-11); Member, National Bioethics Advisory Committee (1996-98); Member, Health Care Task Force, The White House (1993);

- **Judith Feder, Ph.D.,**[‡] Institute Fellow, Urban Institute; Founding Dean and 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);

- **Austin Frakt, Ph.D.,** Health Economist and Associate Professor, Boston University;

- **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);

- **Claudia Goldin, Ph.D.,**[†§] Henry Lee Professor of Economics, Harvard University; President, American Economic Association (2013-14);

- **Vivian Ho, Ph.D.,** James A. Baker III Institute Chair in Health Economics and Professor of Economics, Rice University; Professor, Department of Medicine, Baylor College of Medicine;

- **John Holahan, Ph.D.,** Institute Fellow, Health Policy Center, The Urban Institute;

- **Jill Horwitz, Ph.D.,** Professor of Law, UCLA School of Law;

- **Timothy Jost, J.D.,**[‡] Emeritus Professor, Washington and Lee University School of Law, Consumer Liaison Representative to the National Association of Insurance Commissioners (2010-2016);

- **Lawrence Katz, Ph.D.,**[†] Elisabeth Allison Professor of Economics, Harvard University; Chief Economist, U.S. Department of Labor (1993-94); President, Society of Labor Economists (2013-14);

- **Genevieve M. Kenney, Ph.D.,** Senior Fellow and Co-Director, Health Policy Center, The Urban Institute;

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- **Peter H. Lindert, Ph.D.,** Distinguished Research Professor of Economics, University of California Davis;

- **Eric S. Maskin, Ph.D.,**† Adams University Professor, Harvard University; recipient of Nobel Prize in Economic Sciences;

- **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;

- **Alan C. Monheit, Ph.D.,** Professor of Health Economics and Chair, Department of Health Systems & Policy, and Associate Dean, School of Public Health, Rutgers University;

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- **Harold Pollack, Ph.D.,** Helen Ross Professor of Social Service Administration and Public Health Sciences at the University of Chicago;

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- **James B. Rebitzer, Ph.D.,** Professor of Management, Economics & Public Policy, School of Management, and Professor of Economics, College of Arts and Sciences, Boston University; recipient of the Arrow Award, for best paper in health economics;

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- **Thomas Rice, Ph.D.,**‡ Distinguished Professor, Department of Health Policy and Management, UCLA Fielding School of Public Health;

- **Robert D. Reischauer, Ph.D.,** Distinguished Institute Fellow and President Emeritus, The Urban Institute; Director, Congressional Budget Office (1989-95); Public Trustee, Social Security & Medicare Trust Fund (2011-2015);

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- **Meredith Rosenthal, Ph.D.,** Professor of Health Economics and Policy and Associate Dean, Harvard T.H. Chan School of Public Health;

- **William Sage, M.D., J.D.,**‡ James R. Dougherty Chair for Faculty Excellence, School of Law, and Professor of Surgery and Perioperative Care, Dell Medical School, University of Texas at Austin; Cluster Leader, Health Care Working Group (President's Task Force on Health Care Reform) (1993);

- **Louise Sheiner, Ph.D.,** Senior Fellow & Policy Director, The Hutchins Center on Fiscal and Monetary Policy, Brookings Institution;

- **Katherine Swartz, Ph.D.,**‡ Professor of Health Economics and Policy, Harvard School of Public Health;

- **Kenneth Thorpe, Ph.D.,** Robert W. Woodruff Professor and Chair of Department of Health Policy and Management, Rollins School of Public Health, Emory University; Executive Director and Director of Center for Entitlement Reform, Institute of Advanced Policy Solutions;

- **Laura Tyson, Ph.D.,** Distinguished Professor of the Graduate School, Director of the Institute for Business and Social Impact, University of California at Berkeley; Chair of the Council of Economic Advisers (1993-1995); Chair of the National Economic Council and National Economic Adviser (1995-1996);

- **Paul N. Van de Water, Ph.D.,** Senior Fellow, Center on Budget and Policy Priorities; Assistant Director, Congressional Budget Office (1994-1999);

Assistant Deputy Commissioner for Policy, Social Security Administration (2001-2005);

- **Justin Wolfers, Ph.D.,** Senior Fellow, The Peterson Institute for International Economics; Professor of Economics and Public Policy, University of Michigan; and

- **Stephen Zuckerman, Ph.D.,** Senior Fellow and Co-Director, Health Policy Center, The Urban Institute.

Rulings Under Review. References to the ruling at issue appears in the Brief for Defendants-Appellants.

Related Cases. This case was not previously before this Court, and *amici* are not aware of any related cases in this Court or any other court.

Dated: October 31, 2016

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STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING

All parties have consented to the filing of this brief. The Economic and Health Policy Scholars filed notice of their intent to participate as *amici curiae* on October 25, 2016.[**]

Pursuant to D.C. Circuit Rule 29(d), *amici curiae* certify that a separate brief is necessary because no other *amicus* brief of which we are aware will address the issue raised in this brief: namely, whether Congress intended the negative economic consequences that would flow from Plaintiff-Appellee's proffered interpretation of the statute. To our knowledge, *amici* are the only group of economic scholars submitting a brief in support of Defendants-Appellants. In light of *amici*'s activities, discussed more fully herein, *amici* are particularly well-suited to discuss the economic underpinnings of the Affordable Care Act as evidenced by the statute's text, structure, and purpose, as well as the economic consequences of Appellee's position.

[**] 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.

STATUTES AND REGULATIONS

All applicable statutes and regulations are contained in the Brief for Defendants-Appellants.

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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* include economists who have served in high-ranking positions in the Johnson, Carter, George H.W. Bush, Clinton, George W. Bush, and Obama administrations; three former Directors of the Congressional Budget Office, including the Director at the time the Affordable Care Act was enacted; three Nobel Laureates in Economics; two recipients of the John Bates Clark medal, which is awarded biennially to the American economist under 40 who has made the most significant contribution to economic thought and knowledge; four recipients of the Arrow award for best paper in health economics and the award's namesake; and a recipient of the American Society of Health Economists Medal for the best American health economist aged 40 and under. A complete list of the *amici* is provided in the Certificate as to Parties, Rulings, and Related Cases at the front of this brief.

Amici have closely followed the development, adoption, and implementation of the Affordable Care Act and are intimately familiar with its purpose and structure. *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.

SUMMARY OF ARGUMENT

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: reductions in the *out-of-pocket costs* (such as the plan's deductible) that individuals pay in using their insurance. These reductions, known as "cost-sharing reductions," must accompany premium tax credits, because even if those tax credits help low-income individuals pay their premiums, high out-of-pocket costs could leave those individuals unable to use their insurance to obtain health care. Congress therefore required that insurers pay for cost-sharing reductions and be reimbursed for doing so.

The House of Representatives contends that, even though Congress permanently appropriated payments for premium tax credits, Congress chose to

subject reimbursement of insurers for cost-sharing reductions to annual appropriations. The consequences of that position are stark.

As an initial matter, a decision in favor of the House may lead insurers to exit the Exchanges. If cost-sharing reduction payments were not reimbursed, insurers would have to cover the expense of cost-sharing reductions themselves by charging higher premiums. But insurance companies set their annual premiums in the spring of each year. Thus, if this Court rules in favor of the House after insurers set their premiums for the year, some insurers will be unable to wait until the next opportunity to set premiums to recoup the massive expenses associated with cost-sharing reductions. These insurers can be expected to leave the Exchanges altogether. Even those insurers that remain in the Exchanges would be forced, on an annual basis, to set their premiums well before Congress's appropriation decisions in the fall. Insurers would be forced, on an annual basis, to either raise premiums (anticipating that Congress will not reimburse them) or not (hoping that Congress will). Few insurers could afford to set premiums in an environment with such uncertainty—and it would have made little sense for Congress to have deliberately designed the reimbursement of cost-sharing reductions in this way.

But that is not all. As just noted, the insurers that do remain in the Exchanges would raise premiums, which would drive many individuals to cheaper

plans, both within and without the Exchanges. But the amount of the premium tax credit paid by the federal government is tied to the premiums paid for certain plans on the Exchange, and thus premium tax credit payments would increase as well. All in all, economic modeling consistently shows that the federal government is likely to end up paying *billions of dollars more* in additional premium tax credit subsidies—a program the House concedes is permanently funded—than would be saved by not funding cost-sharing reductions, an absurd result that Congress could not have intended.

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, potentially cause insurers to leave the market, and cost the federal government far more than it would to provide a permanent appropriation for cost-sharing subsidies. The "legislative plan" cannot be "fairly understood" to mandate those negative consequences.

ARGUMENT

I. The Premium Subsidies and Cost-Sharing Reduction Reimbursements 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 refundable, premium tax credit. *See King*, 135 S. Ct. at 2487; 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. Individuals with household incomes between 100 and 400 percent of the federal poverty line are eligible for premium tax credits. *See* 26 U.S.C. § 36B(c)(1)(A). The government can pay the credit 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 requires that insurers pay for "cost-sharing reductions." An individual is eligible for these reductions if his or her household income falls between 100 and 250 percent of the federal poverty line, he or she is eligible for a premium tax credit, and he or she enrolls in a

"silver" health care plan on one of the Act's marketplace Exchanges.[1] *See id.* § 18071(b). Insurers must reduce the out-of-pocket costs of these individuals' plans until those plans' "actuarial value"[2] increases to a certain threshold—94 percent, 87 percent, or 73 percent, depending on the individual's income level. *See id.* § 18071(c)(1)(B)(i), (c)(2). To reimburse insurers for the cost of these cost-sharing reductions, the Act requires that the government make payments in advance directly to the individuals' insurer. *See id.* § 18071(a)(2), (c)(3); *id.* § 18082(a), (c)(3).

These cost-sharing payments are no less integral than the premium tax credits to making insurance affordable for low-income individuals. For example, according to a recent analysis by the Commonwealth Fund, in States with federally run Exchanges, insurers on average reduced the overall out-of-pocket limit for silver plans from $6,224 to just $2,047—a reduction of over *67 percent*—for individuals with incomes between 150 and 200 percent of the federal poverty level. *See* Jon Gabel et al., *The ACA's Cost-Sharing Reduction Plans: A Key to*

[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.

[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.

Affordable Health Coverage for Millions of U.S. Workers, The Commonwealth Fund, at 6 (Oct. 2016), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/oct/1909_gabel_aca_cost_sharing_reduction_plans_rb.pdf. For those same individuals, the average combined medical and prescription drug deductible dropped from $3,063 to just $716—an almost 77 percent reduction. *See id.* at 3. The average copayment likewise dropped from $639 to $313 for a day at an inpatient facility, from $363 to $209 for an emergency room visit, *see* Matthew Rae et al., *Cost Sharing Subsidies in Federal Marketplace Plans, 2016* (Nov. 13, 2015), http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/, from $58 to $33 for a visit to a specialist, and from $31 to $15 for a primary care visit, Gabel et al., *supra*, at 6. 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.* at 3-8. As these findings demonstrate, when premium tax credits are combined with insurers' duty to reduce cost-sharing, eligible individuals can obtain significantly more affordable health care.

B. Cost-Sharing Reduction Reimbursements Are Critical to the Statutory Scheme.

ACA's cost-sharing provisions state that insurers "shall reduce the cost-sharing" of eligible individuals' plans, regardless of whether those reductions are reimbursed by the federal government. 42 U.S.C. § 18071(a)(2). The House thus

admits that the Act imposes a mandatory obligation on insurers to reduce cost sharing for eligible individuals, even without reimbursement. *See* Pls.' Mem. in Supp. of Their Mot. for Summ. J. 6 n.4, *U.S. House of Representatives v. Burwell*, No. 14-cv-1967 (D.D.C. filed Dec. 2, 2015), ECF No. 53.

Requiring insurers to reduce cost sharing without reimbursement—even for a single year—could have widespread and destabilizing effects. As discussed below, a mid-year decision ending cost-sharing reimbursement, or ongoing uncertainty about appropriations, might cause insurers to leave the market altogether. And even if those insurers stayed in the market, economic modeling shows that they would respond by increasing premiums and thereby requiring the government to pay far *more* in additional premium tax credit subsidies—a program the House concedes is permanently funded—than is saved by not funding cost-sharing reductions. That is an absurd result that Congress could not have intended.

1. Uncertainty about appropriations could cause insurers to leave the market.

The immediate effect of a decision from this Court in favor of the House would depend on its timing. In response to such a decision, insurers could in theory raise premiums to recover the additional expense of providing cost-sharing reductions without reimbursement. But insurers in the Exchanges are required to set their premiums for the next calendar year in the late spring, so that CMS and the states may review them. *See, e.g.*, Key Dates for Calendar Year 2016,

CMS.gov (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-2-29-16.pdf. Thus, if a decision from this Court ending cost-sharing reimbursement comes out after insurers have set their premiums for the year, insurers could not raise premiums again until the subsequent year.

That would leave insurers to pay the cost-sharing bill, and it would be a big one. The Congressional Budget Office estimates that insurers are projected to receive payments for cost-sharing reductions of $7 billion in 2016, which escalates to $16 billion per year over the next ten years. *See* Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline, https://www.cbo.gov/sites/default/files/51298-2016-03-HealthInsurance.pdf.

Some insurers will have insufficient capital to wait to recoup these enormous unreimbursed costs. Those insurers might choose instead to simply withdraw from the Exchanges, which is an option that federal law appears to permit. Insurers are not legally required to offer cost-sharing reductions outside the Exchanges, *see* 42 U.S.C. § 18071(b)(1), and the issuers of qualified health plans "could have cause to terminate" their certification agreements with CMS if cost-sharing reductions cease to be "available to qualifying Enrollees . . . during the term of [the] Agreement," as might occur if Congress failed to appropriate funds, *see* Qualified Health Plan

Certification Agreement and Privacy and Security Agreement Between Qualified Health Plan Issuer and the Centers for Medicare & Medicaid Services, CMS.gov, at 6 (Sept. 1, 2016) https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Plan-Year-2017-QHP-Issuer-Agreement.pdf.[3]

Moreover, insurers that remained in the Exchanges would face a separate but equally serious timing difficulty going forward—a difficulty that is inherent to subjecting cost-sharing reimbursements to annual appropriations. Although, as noted, insurers set their premiums for the year in the spring, the federal fiscal year ends on September 30, and Congress frequently does not complete its appropriations process until the fall (or later). *See* Jessica Tollestrup & James V. Saturno, *The Congressional Appropriations Process: An Introduction*, Cong. Research Serv., 4-5 (Nov. 14, 2014), http://www.senate.gov/CRSReports/crs-publish.cfm?pid=%260BL%2BP%3C%3B3%0A. Thus, if reimbursement for cost-sharing reductions depended on annual appropriations, insurers would have to set their premiums without knowing whether they are going to receive reimbursements for the next fiscal year—and thus without knowing whether they should raise premiums to account for those lost reimbursements, or not. *See* Defs.'

[3] The Certification Agreement refers to "CSRs," or "Cost-sharing Reductions," rather than "Cost-sharing Reduction Payments," ceasing to be available, but this appears to be an error, since all parties agree that cost-sharing reductions are available to eligible enrollees regardless of whether insurers are reimbursed for those reductions. *See infra* at 11-12.

Mem. in Supp. of Their Mot. for Summ. J. 22-23, No. 14-cv-1967 (D.D.C. filed Dec. 2, 2015), ECF No. 55-1.

In theory, insurers could simply assume that Congress will not appropriate funds for cost-sharing reimbursement and raise premiums in the spring to a level sufficient to cover cost-sharing reductions. But price competition in the marketplaces is intense, with most enrollees opting for lower cost plans. *See* John Holahan et al., *Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States*, Robert Wood Johnson Foundation & Urban Institute 2 (Mar. 2016) http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000660-Marketplace-Plan-Choice-How-Important-Is-Price-An-Analysis-Of-Experiences-in-Five-States.pdf (noting that Exchange consumers' plan choices "are heavily determined by price"). Insurers that increased their premiums on the assumption that Congress would not ultimately appropriate funds might price themselves out of the market. Insurers that did not would face the risk of grossly insufficient revenue if Congress opted not to reimburse. Insurers would thus face significant uncertainty in determining whether to take that risk or simply exit the Exchanges altogether.

In short, without a permanent appropriation, there is a real risk that insurers will be unable to operate in the Exchanges because they will not know in advance whether they will be compensated for their substantial cost-sharing expenditures.

It is highly unlikely that Congress deliberately designed the reimbursement of cost-sharing reductions in a way that would subject insurers to this massive risk on an annual basis.

2. Economic modeling shows that insurers who stay in the market will raise premiums, costing the government far more in subsidies for premium tax credits than it would have paid for cost-sharing reimbursements.

Moreover, even if insurers chose to remain in the Exchanges and to raise their premiums, and managed to stay afloat while waiting to implement premium increases, economic modeling shows that the federal government would end up paying billions of dollars more in premium tax credits than it would have paid in cost-sharing reduction reimbursements. The House does not dispute that premium tax credits are permanently funded, and so its position boils down to the paradoxical and implausible assertion that Congress intended to leave cost-sharing reimbursement to the whim of future congresses, even though a decision not to fund cost-sharing reductions would require spending billions *more* in premium tax credits.

As stated earlier, to be eligible for cost-sharing reductions, individuals must enroll in silver plans. To recoup the cost of reducing cost-sharing for their silver plans, insurers would raise the premiums charged for silver plans within the Exchanges. *See* Linda J. Blumberg & Matthew Buettgens, *The Implications of a Finding for the Plaintiffs in* House v. Burwell, Urban Inst., 5 (Jan. 2016),

http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf. Premiums for silver plans are likely to rise to be even higher than those for gold plans. *See id.*; J.A.[4] 469-70 (ASPE Issue Brief: Potential Fiscal Consequences of Not Providing CSR Reimbursements 2-3 (Dec. 2015) ("ASPE Report")).[5]

But as silver-plan premiums started to rise, individuals ineligible for premium tax credits and for higher levels of cost-sharing reductions would abandon silver plans and move to other insurance options, increasing the price of silver plans (and of the premium tax credit to the government). That in turn would cause the federal government to pay *more* in premium tax credits than it previously had paid for cost-sharing reduction reimbursements.

The dynamic would work as follows:

First, as just described, if federal reimbursement for cost-sharing reductions were eliminated, the cost to insurers of providing those reductions would be added

[4] Citations to the Joint Appendix are labeled "J.A. __."

[5] Qualified health plans sold inside and outside Exchanges must be assigned the same premium, so silver-plan premiums for qualified health plans outside the Exchanges would rise as well. *See* 42 U.S.C. § 18021(a)(1)(C)(iii). However, this would place insurers offering non-Exchange silver plans at a disadvantage relative to those insurers that do not offer plans on the Exchanges and thus have no cost-sharing reductions to recoup. It is therefore likely that insurers will offer *non*-qualified health plans at the silver level outside of the Exchanges at a lower rate than the silver plans on the Exchanges.

to the silver marketplace premiums, spreading those costs over all silver marketplace enrollees.

Second, premium tax credits would increase with the higher silver marketplace premiums. Premium tax credits are pegged to the cost of the second-lowest cost silver plan on the Exchanges. 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. *See* Blumberg & Buettgens, *supra*, at 1, 5. For that reason, the amount of the premium tax credit paid to all eligible enrollees would increase.

Third, with the higher silver-plan premiums and tax credits, those previously buying silver plans could enroll in gold coverage, and thus receive a higher actuarial value, for the same or lower price than enrolling in silver coverage. As a result, many marketplace enrollees would begin to make different coverage decisions.

The first group of individuals likely to abandon silver plans are those who purchase coverage from the Exchanges but do not receive premium tax credits. *See* Blumberg & Buettgens, *supra*, at 5. These individuals, who include the self-employed, early retirees, individuals in employment transitions, and individuals employed by small businesses that do not offer insurance coverage, need to purchase coverage in the individual market, but have incomes over 400 percent of the federal poverty line, and thus are ineligible for premium tax credits. *See* 26

U.S.C. § 36B(c)(1)(A). Approximately 1.7 million of these people would be expected to abandon the now more expensive silver plans on the Exchange and instead buy equivalent, but cheaper, plans outside of the Exchange. *See* Blumberg & Buettgens, *supra*, at 5.

The second group of individuals likely to drop silver-plan coverage are those who do receive premium tax credits, but who are eligible for no or only minimal cost-sharing reductions. These individuals have incomes between 200 and 400 percent of the federal poverty line who, under the Act's cost-sharing provisions, are entitled to plans with actuarial values of 70 or 73 percent. See 42 U.S.C. § 18071(c)(1)(B)(i)(III)-(IV). As noted earlier, these individuals' silver-plan premiums are likely to rise to be even greater than the premiums for gold plans. *See* Blumberg & Buettgens, *supra*, at 5-6. Individuals whose silver plans have actuarial values of 70 or 73 percent would therefore likely switch to the now-cheaper gold plans, which have a higher actuarial value of 80 percent and thus provide much lower out-of-pocket costs for enrollees. *See id.* Ultimately, all or nearly all of the individuals purchasing silver plan coverage on the Exchanges are likely to be those who are receiving both premium tax credits and the highest levels of cost-sharing reductions. *See* Blumberg & Buettgens, *supra*, at 5-7.

Fourth, because the only remaining silver-plan enrollees would be those entitled to the most significant costs-sharing reductions—whose plans have

actuarial values of 87 or 94 percent—premiums for silver plans would have to be priced to reflect the substantially higher *average* cost to the insurer of those individuals' plans. *See* J.A. 469-70 (ASPE Report 2-3). For example, the silver-plan premium charged to a 40-year old with single coverage would ultimately rise by an average of *$1,040* (2016 estimate). *See* Blumberg & Buettgens, *supra*, at 1, 5. Similarly, the amount of the premium tax credit paid to all eligible enrollees would increase—for the same single 40-year old individual, again by an average of $1,040. *See id.*

Fifth, the combination of insurers building the costs of providing cost-sharing reductions into silver premiums and the ensuing shifts in enrollment would result in a significant net increase in the amount of money spent by the federal government on advance payments for premium tax credits and cost-sharing reduction reimbursements. Although cost-sharing reimbursements would drop, the federal government would end up paying higher premium tax credits both to individuals who receive cost-sharing reductions *and* to many individuals who do not—because many individuals who receive premium tax credits do not qualify for significant cost-sharing reductions. For example, individuals with incomes above 250 percent of the federal poverty level do not qualify for cost-sharing reductions, and individuals with incomes between 200 and 250 percent of the federal poverty level are only entitled to the cost-sharing reductions required to increase the

actuarial value of their silver plan from 70 to 73 percent. *See* 42 U.S.C. § 18071(c)(1)(B)(i)(III)-(IV). Individuals who enroll in bronze, gold, or platinum plans similarly are ineligible for cost-sharing reductions. *See id.* § 18071(b). Yet these individuals are eligible for premium tax credits.

Meanwhile, the House has always conceded that advance payments to insurers for premium tax credits are fully covered by a permanent appropriation. *See* Pls.' Mem. in Supp. of Their Mot. for Summ. J. 5, No. 14-cv-1967 (D.D.C. filed Dec. 2, 2015), ECF No. 53. Thus, the government would have to pay for these individuals' increased premium tax credits, even though the government would have paid nothing, or only a fraction of that cost, in reimbursing their cost-sharing reductions.

As a result, and paradoxically, the federal government would end up paying *more* in increased premium tax credits than it previously had paid for cost-sharing reduction reimbursements—and so the House's interpretation would result in *more* appropriated funds flowing to insurers under the Act. *See* J.A. 468 (ASPE Report 1). Indeed, one estimate places the likely increase in overall costs to the government at $3.6 billion per year (for 2016) and $47 billion over the next 10 years (2016-2025). *See* Blumberg & Buettgens, *supra*, at 7. In the words of Washington Insurance Commissioner Mike Kreidler, "if [the suit] prevails, it will make health insurance costlier for everyone." Mike Kreidler, *Latest ACA*

Challenge puts Consumers Savings at Risk, The Hill (Oct. 6, 2016), http://thehill.com/blogs/congress-blog/healthcare/299434-latest-aca-challenge-puts-consumers-savings-at-risk. It would have made no sense for Congress to have intentionally designed the ACA to rob Peter to pay Paul in this fashion.

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 certain provisions of the Act would make little sense if individuals did not receive cost-sharing reductions. Yet, as just described, if the House's position in this case is accepted, eligible individuals will only receive cost-sharing reductions because insurers must continue to pay them without reimbursement. Insurers that chose to remain in the marketplaces under these conditions 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.[6]

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

[6] *Amici* focus here on those statutory indicia of congressional intent that the Government has not already highlighted in its brief. *See* Br. for Appellants 45-56; D.C. Circuit Rule 29(a).

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 45 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).
- 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).[7]

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 an ACA program that gives 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. Starting in 2017, States may seek an innovation waiver of many of the Act's requirements by proposing an alternative State plan in their place. *See* 42 U.S.C. § 18052(a)(1)-(2). Nearly a dozen States, ranging from Arkansas to Hawaii, have taken steps to propose or have demonstrated interest in a waiver plan. Richard Cauchi, Nat'l Conference of State Legislatures, *Health Innovation Section 1332 Waivers: State Legislation as of 2015* (Dec. 3, 2015),

[7] Other provisions include: 26 U.S.C. § 4980H(a)(2), (b)(1)(B), (c)(3), (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)(A)(i)-(ii), (b)(2)(B)(i)(I); *id.* § 18031(c)(5)(B), (d)(4)(G), (i)(3)(B); *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).

http://www.ncsl.org/documents/health/1332_Waivers_State_Legislation-12-2015.pdf. But HHS 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. 42 U.S.C. § 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). As HHS has explained, the "amount of Federal pass-through funding" available to States with waivers "equals the Secretaries' annual estimate of the Federal cost (including outlays and forgone revenue) for Exchange financial assistance provided pursuant to the ACA that would be claimed by participants in the Exchange . . . in the absence of the waiver." *Waivers for State Innovation*, 80 Fed. Reg. 78,131, 78,134 (Dec. 16, 2015).

No sensible State would elect to pursue an innovation waiver if there was a significant risk that cost-sharing reduction reimbursements would be unavailable. In the absence of those reimbursements, federal funds for cost-sharing reduction would be unavailable to States with innovative-waiver plans, because the "Federal cost (including outlays and forgone revenue) for" cost-sharing reduction reimbursement would be zero. *Id.* Of course, as described above, eventually the

federal government is likely to pay *more* in premium tax credits than it previously paid in both tax credits and cost-sharing reduction reimbursements; that would fill the revenue gap for States. *See supra* at 16-21. 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. And Congress did not craft this complex program while simultaneously ensuring that States would elect not to use it.

* * * * *

The House 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. As the Government has explained, that authorization is best read as covering payments for cost-sharing reductions as well. *See* Br. for Appellants 46-48, 54-55. 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, the district court's order granting judgment in favor of the House of Representatives should be reversed.

Dated: October 31, 2016

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

In accordance with Federal Rule of Appellate Procedure 32(a)(7) and D.C. Circuit Rule 32(e), I certify that the foregoing brief has been prepared in Microsoft Word 2013 using 14-point Times New Roman typeface and is double-spaced (except for headings, footnotes, and block quotations). I further certify that the brief is proportionally spaced and contains 6,167 words, excluding the parts of the brief exempted by D.C. Circuit Rule 32(a)(7). Microsoft Word 2013 was used to compute the word count.

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CERTIFICATE OF SERVICE

I certify that, on October 31, 2016, a true and correct copy of the foregoing was filed with the Clerk of the United States Court of Appeals for the D.C. Circuit via the Court's CM/ECF system, which will send notice of such filing to all registered CM/ECF users.

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