ORAL ARGUMENT SCHEDULED FOR DECEMBER 17, 2014
No. 14-5018

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

JACQUELINE HALBIG, ET AL.,

Appellants,

v.

SYLVIA M. BURWELL,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA (NO. 13-623 (PLF))

BRIEF OF AMICI CURIAE AARP, NATIONAL HEALTH LAW PROGRAM, AND SOUTHERN POVERTY LAW CENTER IN SUPPORT OF APPELLEES URGING AFFIRMANCE

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

All parties, intervenors, and amici appearing before the district court, the original three-judge panel, and in this Court on rehearing en banc are listed in the Briefs for Appellants and/or Appellees.

B. Ruling Under Review

Plaintiffs appealed the final judgment of the district court entered on January 15, 2014, granting defendants' cross-motion for summary judgment. The order (Dkt. #66) and opinion (Dkt. Entry #67) were issued by the Honorable Paul L. Friedman in No. 1:13-cv-00623-PLF (D.D.C.).

C. Related Cases

This case has not previously been before this Court or any other court. We are unaware of any related cases within the meaning of Circuit Rule 28.

Respectfully submitted,

/s/ Iris Y. González
Iris Y. González
Counsel of Record for Amici

CORPORATE DISCLOSURE STATEMENTS

The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) (1993) of the Internal Revenue Code and is exempt from income tax. AARP is also organized and operated as a non-profit corporation pursuant to Title 29 of Chapter 6 of the District of Columbia Code 1951. Other legal entities related to AARP include AARP Foundation, AARP Services, Inc., Legal Counsel for the Elderly, Experience Corps, d/b/a, AARP Experience Corps, AARP Insurance Plan, also known as the AARP Health Trust, and AARP Financial. AARP has no parent corporation, nor has it issued shares or securities.

Date: November 3, 2014.

Respectfully Submitted,

/s/Iris Y. González
Iris Y. González

Pursuant to Fed. R. App. P. 26.1, the undersigned counsel for Amicus Curiae National Health Law Program states that there is no parent corporation, or publicly held company that owns 10% or more of the stock of the National Health Law Program.

Date: November 3, 2014.

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins

The Internal Revenue Service has determined that the Southern Poverty Law Center (SPLC) is organized and operated pursuant to section 501(c)(3) (1993) of the Internal Revenue Code and is exempt from income tax. SPLC is a not-for-profit corporation based and incorporated in Montgomery, Alabama. SPLC has no parent corporation, nor has it issued shares or securities.

Date: November 3, 2014.

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins

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GLOSSARY

ACA or Act	Patient Protection and Affordable Care Act
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program
FPL	Federal Poverty Level
IOM	Institute of Medicine
NHeLP	National Health Law Program
SHOP	Small Business Health Options Program
SPLC	Southern Poverty Law Center

STATUTES AND REGULATIONS

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

STATEMENTS OF IDENTITY, INTERESTS, AND AUTHORITY TO FILE

AARP is a nonprofit, nonpartisan organization with a membership that strengthens communities and fights for the issues that matter most to families such as health care, employment, income security, retirement planning, affordable utilities and protection from financial abuse. Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled health care costs.

In response to the growing number of older people who went without health care services or faced financial burdens due to the unaffordability and unavailability of insurance and other health care costs, AARP sought legislative reforms that would, among other objectives: guarantee access to affordable coverage for people ages 50 to 64 in the individual market who have faced unaffordable insurance due to their age, pre-existing conditions, or health status; and help low- to moderate-income older adults so that people who try to save for retirement may receive assistance with premiums and other health care costs.

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals and families. For over forty years, NHeLP has worked to help individuals and advocates overcome barriers to health care, including lack of affordable services.

The Southern Poverty Law Center (SPLC), based in Montgomery, Alabama, is a non-profit organization founded in 1971 to advance and protect the rights of minorities, the poor, and victims of injustice in significant civil rights and social justice matters. The Economic Justice Project, as part of the SPLC's legal department, seeks to address the unique systematic barriers faced by people living in or on the edge of poverty in the Deep South. Access to health care is an issue of fundamental significance to the populations we seek to serve, and SPLC has worked to ensure meaningful access to state Medicaid programs.

AARP, NHeLP, and SPLC have supported the Patient Protection and Affordable Care Act (ACA or "the Act") and the access to affordable health insurance it provides for millions of individuals. The availability of premium assistance tax credits under the ACA is critical to affordability and thus access to needed health care services. As such, amici are interested in the issues raised by this case, and write to provide the Court additional information about the purpose of the ACA, how its statutory provisions work together to achieve its purpose, and how the Appellants' theory of statutory construction squarely contravenes the Act's purpose and harms the vulnerable people served by our respective organizations, in particular older adults. The effect that the availability of premium tax credits will have on older adults' ability to obtain adequate and affordable health insurance has not been addressed by the parties or other amici.

SUMMARY OF ARGUMENT

The overarching purpose of the ACA is to address the lack of adequate and affordable health care—a complex social and economic problem that affects all, but can be especially challenging to those ages 50 to 64 (hereinafter "pre-Medicare adults"). Pre-Medicare adults faced special difficulties in obtaining adequate and affordable health insurance in the private and employer-based markets and did not qualify for publicly funded insurance.

Prior to the passage of the ACA, uninsured pre-Medicare adults were denied coverage based on preexisting conditions or offered costly policies that excluded coverage for needed care. Even without preexisting conditions, insurance premiums for older adults were up to seven times higher than those for younger adults. Annual and lifetime caps—which were easily exceeded by treatment for a single illness such as cancer, heart disease, or diabetes—meant that many older adults either went without treatment until they became eligible for Medicare or incurred financially ruinous medical debt. The lack of insurance among this pre-Medicare group resulted in worse health outcomes, including death, and negatively impacted personal finances, health care spending, the national economy, and federal programs such as Medicare.

The ACA reflects Congress' chosen policies to address these problems. Reflecting a basic understanding that affordability and accessibility of health

insurance in the private individual market required a larger and more diversified insurance risk pool, key reform provisions of the ACA are designed to encourage people to obtain health insurance and to reduce barriers to coverage. Among these interconnected reforms is the availability of federal tax credits to reduce premiums for individuals who buy insurance on the Exchanges.

Appellants' argument that Congress intended to provide premium tax credits only to individuals in states that established their own Exchanges is inconsistent with the text and structure of the Act[2] and is directly at odds with its purpose, as expressed by Congress and manifested in its interconnected reforms. Appellants' interpretation of a single phrase in one provision of the Act—if accepted—will make insurance unaffordable in the 36 states with federally-facilitated Exchanges, harming low- to moderate-income residents of those states. It would also render meaningless other key provisions of the ACA designed to increase access to affordable health insurance.

ARGUMENT

I. Before the ACA, Health Insurance Was Unavailable or Unaffordable to Millions of Pre-Medicare Adults.

Before the enactment of the ACA, the number of uninsured Americans aged 50 to 64, grew at an alarming rate—increasing from 5.2 million in 2000, to 7.1

[2] Amici adopt and incorporate by reference Appellees' arguments regarding statutory construction of the ACA.

million in 2007, and then to 9.3 million in 2012. *See* Gerry Smolka et al., AARP Pub. Policy Inst., *Health Care Reform: What's at Stake for 50- to 64-Year Olds?* at 1 (2009) [hereinafter *What's at Stake*]; Gerry Smolka et al., AARP Pub. Policy Inst., *Effect of Health Reform for 50-to 64-Year-Olds* 1 (2013) [hereinafter *Effect of Health Reform*]. Most uninsured pre-Medicare adults did not have access to affordable employer-sponsored insurance, could not afford private insurance on the individual market, or did not qualify for publicly funded insurance programs. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population* 2 (2013). The consequences for these individuals, their families, and the nation were and can be devastating.

A. Employer-Sponsored Health Insurance Was Frequently Unavailable or Unaffordable.

For many pre-Medicare adults, employer-sponsored insurance was not available or was unaffordable. In 2012, an estimated 11 million employed pre-Medicare adults did not have employer-sponsored insurance. *Effect of Health Reform*, *supra*, at 2. Of these, less than half were able to obtain coverage from another source. *Id*. The unavailability of employer-sponsored insurance for pre-Medicare adults was driven, in part, by the economic recession, during which this group experienced rising rates of unemployment. *See* Sara R. Collins et al., The Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010* at 2 (2010) [hereinafter *Realizing Health*

Reform's Potential]. Pre-Medicare adults went without employer-sponsored insurance for longer than their younger counterparts because, on average, they remained unemployed for longer periods of time. *Id*. As of December 2013, pre-Medicare adults remained unemployed for an average of 11.6 weeks longer than their younger counterparts. *See* Sara E. Rix, AARP Pub. Policy Inst., *The Employment Situation, December 2013: Disappointing Year-End Numbers for Older Workers* at 4 (2014).

B. Health Insurance on the Individual Private Market Was Unaffordable or Inadequate.

Prior to ACA reforms, many pre-Medicare adults could not afford adequate insurance policies on the private individual market. In 2007, 61% of pre-Medicare adults who tried to purchase health insurance on the private market found it unaffordable. *See Realizing Health Reform's Potential*, *supra*, at 5, ex. 4. Among those who purchased insurance, 60% reported difficulty paying medical bills or accessing services due to cost such that they were effectively underinsured. *Id.* at 6, ex. 5. High health insurance premiums and out-of-pocket medical expenses for older adults were linked to insurance underwriting policies that allowed insurers to deny coverage, charge higher premiums based on age and/or health status, offer very limited policies to people with pre-existing conditions, or offer policies with high cost sharing. *See* Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Lawmakers and*

Regulators at 10 (2012); Lynn Nonnemaker, AARP Pub. Policy Inst., *Beyond Age Rating: Spreading Risk in Health Insurance Markets* at 3, tbl. 1 (2009) [hereinafter *Beyond Age Rating*]. Pre-Medicare adults were disproportionately affected by these underwriting policies because 48 to 86% of people ages 55 to 64 had pre-existing health conditions. U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans* at 3, fig. 1 (2011).

ACA reforms prohibit or limit these practices. *See, e.g.*, 42 U.S.C. § 300gg(a) (2012) (premiums may not be based on health status); 42 U.S.C. § 300gg-1 (2012) (guaranteed issue in individual and group markets); 42 U.S.C. § 300gg-2 (2012) (guaranteed renewal). Yet, challenges remain for pre-Medicare adults shopping for health insurance in the private market because they will still face higher premiums than their younger counterparts. *See* 42 U.S.C. § 300gg(a)(1)(A)(iii) (age rating ratio of 3:1 is still permitted). As a group, however, they are no better able to afford higher premiums than other age groups. Indeed, an analysis of the March 2008 Current Population Survey revealed that the median income for the uninsured ages 50 to 64 was roughly equal to the median income of their younger counterparts. *Beyond Age Rating*, *supra*, at 3, tbl. 1. Federal assistance with premiums and out-of-pocket costs under their plans will be critical to insurance affordability and access for low- to moderate-income pre-Medicare adults.

C. Medicaid or Medicare Was Unavailable.

The majority of those ages 50 to 64 did not qualify for publicly funded insurance until they became eligible for Medicare at age 65. In 2012, only 17% of Medicare beneficiaries qualified due to disability rather than age. Kaiser Family Found., *Medicare at a Glance* (Nov. 14, 2012), http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/. They also did not qualify for other publicly funded insurance. Of the 11 million older workers in 2012 who did not have employer-based health insurance, only 10% had Medicaid coverage and only 8% had some other public coverage. *Effect of Health Reform*, *supra*, at tbl. 2. Even if all states now expanded Medicaid eligibility to include adults who have incomes at or below 138% of poverty, less than one third of the 13.8 million pre-Medicare adults who were on the individual health insurance market or uninsured in 2012 would be eligible for Medicaid. *Id.* at 7-8, fig. 2.

II. The Lack of Adequate and Affordable Health Insurance Among Pre-Medicare Adults Results in Worse Health Outcomes and Death and Negatively Impacts Financial Stability, the Health Care System, Federal Programs, and the National Economy.

A. Uninsured Pre-Medicare Adults Die or Suffer Worse Health Outcomes at Greater Costs to Them and to the Health Care System.

As people age, they are more likely to experience chronic health conditions, resulting in worse health outcomes and increased mortality for the uninsured. The prevalence of multiple chronic conditions is greater in adults ages 45 to 64 than in

younger adults and, for this older population, it increased significantly between 2001 and 2010. Brian W. Ward & Jeannine S. Schiller, *Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey*, 10 Preventing Chronic Disease 1, 5 (2013). For example, adults ages 45 to 64 suffer from heart disease at a rate three times higher than younger adults. Jeannine S. Schiller et al., U.S. Dep't of Health & Human Servs., *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010* at 19 (2012). The Centers for Disease Control and Prevention estimate that chronic conditions are the leading cause of death and disability and that treating such conditions accounts for 75% of health care spending. U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prev., *Chronic Diseases: The Power to Prevent, the Call to Control: At a Glance 2009* at 2 (2009). This tremendous toll on human life and on health care resources can be reduced, as these conditions are preventable and can be effectively controlled, but people must have access to preventive services for early awareness of risk factors, diagnosis, and treatment. *Id.* As explained below, however, lack of insurance is a barrier to seeking such services.

Uninsured pre-Medicare adults are about three times less likely to be up-to-date with clinical preventive services than those who are insured. *See* Megan Multack, AARP Pub. Policy Inst., *Use of Clinical Preventive Services and*

Prevalence of Health Risk Factors Among Adults Aged 50-64 at 40, 43 (2013) (32.8% of insured women were up-to-date, compared to only 10% of the uninsured; 36.1% of insured men were up-to-date, compared to only 12.4% of the uninsured). Uninsured adults are less likely to be aware of risk factors for chronic conditions and less likely to have these conditions diagnosed, treated, or well-controlled. Inst. of Med. (IOM), *America's Uninsured Crisis: Consequences for Health and Health Care*, 72-83 (2009) (comparing uninsured adults ages 18 to 64 to their insured counterparts). Consequently, uninsured adults have worse health outcomes, including higher mortality rates. *Id.* 75, tbl. 3-4.

B. When Uninsured Older Adults Become Eligible for Medicare, They Become Healthier But Are More Costly to the Medicare System.

The IOM found that when previously uninsured older adults gain Medicare coverage at age 65, they experience improved health outcomes and a decreased risk of dying when hospitalized for serious conditions. *Id.* at 72. These findings suggest that uninsured pre-Medicare adults had significant unmet health needs before they became old enough to qualify for Medicare and gained increased access to prescription drugs and other medical treatments to control their illnesses. *Id.* at 77. As a result, the treatment of the previously uninsured is substantially more costly to the Medicare system than treatment of those who were previously insured. *See* U.S. Gov't Accountability Office, *Medicare: Continuous Insurance*

Before Enrollment Associated With Better Health and Lower Program Spending at 9 (2013) (finding that the previously uninsured had 35% more program spending in the first year of Medicare enrollment than those continuously insured over the previous six years); *see also* J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 347 New Eng. J. Med. 143, 151 (2007).

Obtaining preventive services and medical treatments earlier could reduce the cost of medical and drug treatments for individuals enrolled in Medicare because conditions would be diagnosed at less advanced stages and/or better controlled. *See The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 50 (2008) (statement of Dr. John Z. Ayanian). For example, one study followed adults ages 50 to 64 until they reached the age of 75 and found that, if they received screening for colorectal cancer before enrolling in Medicare, the program could realize between $7.7 and $21.7 billion in savings related to their cancer treatment. *See* Nat'l Colorectal Cancer Roundtable, *Increasing Colorectal Cancer Screening – Saving Lives and Saving Dollars: Screening 50 to 64 Year-Olds Reduces Cancer Costs to Medicare* at 2-3 (2007). Similarly, diabetes screening for people who are ages 55 and older and have at least one risk factor could reduce diabetes-related costs of care by 17.1%. Ranee Chattergee et al., *Screening for Diabetes and*

Prediabetes Should Be Cost-Saving in Patients at High Risk, 36 Diabetes Care 1, 4 tbl. 2 (2013). For uninsured pre-Medicare adults, however, these types of preventive and screening services, and treatment for the underlying conditions, are unaffordable and thus inaccessible.

C. Lack of Adequate, Affordable Health Insurance Among Pre-Medicare Adults Profoundly Affects Their Financial Stability and the National Economy.

The lack of adequate, affordable health insurance has a profound effect on both the financial mobility and stability of pre-Medicare adults and, in turn, on the national economy. Many pre-Medicare workers who rely on employer-sponsored health insurance do not leave their jobs, switch jobs, reduce their hours, or retire for fear that they will lose and be unable to regain affordable health benefits. *See* Richard W. Johnson et al., AARP Pub. Policy Inst., *Older Workers on the Move: Recareering in Later Life* at 10, 18 (2009) ("nearly a quarter of career changers lose health benefits when they change jobs; only about 10 percent gain insurance"); *see also* Sara R. Collins et al., The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* at 3 (2011) [hereinafter *Help on the Horizon*] (three fifths of adults ages 18 to 64 who lost a job with health benefits in 2010 became uninsured). Chronically ill workers, who are more likely to be older workers, are 40% less likely to leave their job if they have employer-

sponsored health insurance compared to those who do not rely on such coverage. Kevin T. Stroupe et al., *Chronic Illness and Health Insurance-Related Job Lock*, 20 J. Policy Analysis & Mgmt. 525, 525 (2000). Older workers who turn 65 and are eligible for Medicare but must maintain health coverage for a younger spouse or dependent child are also deterred from retiring or reducing their work hours. *See* Sid Groememan, AARP, *Staying Ahead of the Curve 2007: The AARP Work and Career Study* at 23 (2008). Consequently, the nation's most experienced and valuable workers are discouraged from redirecting their talents where they are most needed, including to entrepreneurship. *See* Robert W. Fairlie et al., *Is Employer-Based Health Insurance a Barrier to Entrepreneurship?* at 45-47 (Rand. Corp., Working Paper No. WR-637-1-EMKF, 2010) (finding that the threat of losing employer-based coverage prevents people from leaving jobs to start their own businesses). The Congressional Budget Office agrees that the availability of affordable health insurance will increase labor market mobility, as it recently projected a decrease in the number of work hours inversely related to the availability of subsidies on the Exchanges. *See* Cong. Budget Office, *Labor Market Effects of the Affordable Care Act: Updated Estimates, Appendix C* at 122 (2014).

People with inadequate or no health insurance had health care costs that were financially debilitating. *See, e.g.*, Karen Pollitz et al., Kaiser Family Found.,

Medical Debt Among People With Health Insurance at 12 (2014) (profiling a 51-year-old man with household income below 400% of FPL and high insurance premiums that contributed to his bankruptcy). One study estimated that 29 million people had used all of their savings on medical expenses. *Help on the Horizon*, *supra*, at 12. Another 22 million were unable to pay for basic necessities such as rent, food, and utilities due to medical bills. *Id.* More than two-thirds of older adults who participated in the individual insurance market paid more than 10% of their income to medical costs. *What's at Stake*, *supra*, at 2, tbl. 1. The median pre-Medicare household with a newly ill and uninsured member lost between 30 and 50% of its assets. Keziah Cook et al., *Does Major Illness Cause Financial Catastrophe?* 45 Health Servs. Res. 418, 419 (2010). These health-care-related financial burdens severely hampered retirement security. Not only are individuals negatively affected by difficulty paying medical bills, but the national economy is hurt as well. When lower-income pre-Medicare adults retire without savings and find they must turn to government assistance to meet housing, food, and utility needs, this affects national budget deficits.

III. The Central and Overarching Purpose of the ACA is to Make Health Insurance, and Thus Health Care, Affordable to *All*.

The central and overarching purpose of the ACA was to address the complex problems described above by making health insurance, and thus health care, accessible and affordable to all. Congress clearly expressed this purpose in the text

of the Act. Moreover, Congress made policy choices in the Act that were clearly intended to effectuate this purpose and thereby reduce the staggering burdens that the lack of affordable insurance imposes on the uninsured, the health care system, the national economy, and federal spending programs. Congress understood that health insurance affordability could only be achieved by significantly expanding and diversifying the population of insured individuals. Thus, many key provisions of the ACA, including those that authorize premium tax credits, are designed to encourage more Americans of varying health statuses to obtain health insurance. Appellants' interpretation of a single phrase in one provision of the Act, which is only used to calculate the amount of the premium tax credit, by contrast, would have the opposite effect: discouraging participation in the insurance marketplace and raising costs.

A. Congress Clearly Expressed the Purpose of the ACA in Its Text.

The purpose of the ACA, as expressed by Congress in its text, is to achieve "near-universal coverage" and "lower health insurance premiums." 42 U.S.C. § 18091(2)(D)-(H) (2012); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (purpose of the Act is "to increase the number of Americans covered by health insurance and decrease the cost of health care"). The name of the Act—the "Patient Protection and Affordable Care Act"—reflects the purpose of the legislation, as do the names of the Titles of the ACA. 42 U.S.C. § 18001

(2012). As the District Court noted, "Title I of the ACA is titled 'Quality, Affordable Health Care for All Americans.'" *Halbig v. Sebelius*, Civ. No. 13623 (PLF), 2014 U.S. Dist. LEXIS 4853, at *53 (D.D.C. Jan. 15, 2014).

B. Congress' Chosen Policies Were Specifically Designed to Work Together to Achieve the Goal of Making Health Insurance Accessible and Affordable to *All*.

Congress chose to accomplish "near universal coverage" and "lower health insurance premiums" through a series of statutory requirements that, working together, make coverage accessible and affordable to everyone. *See* 42 U.S.C. § 18091(2)(G). The ACA reduces the number of uninsured by establishing incentives for individuals, states, and employers to participate in the insurance markets and provide insurance coverage. The Act also increases access to health insurance in the individual market through guaranteed issue provisions, rating limitations, and the individual mandate. These provisions work together to improve affordability because they keep premiums down by ensuring that the insurance risk pool is larger and more diverse by including individuals of varying health statuses. Finally, the ACA makes insurance more affordable for low- to moderate-income individuals through tax credits to subsidize the cost of premiums and other out-of-pocket costs.

1. The ACA Encourages Employers to Offer Adequate and Affordable Health Insurance.

Employer-based insurance is the traditional backbone of the American health insurance system where most adults purchase coverage. Yet, in 2012, 10.8 million older workers did not have access to employer-based insurance, and 5.9 million of those workers were not able to obtain coverage from another source. *Effect of Health Reform*, *supra*, at 2, tbl. 2. The ACA addresses this problem by encouraging employers to offer health insurance. The Act imposes a shared responsibility requirement on large employers, who now face a tax penalty if they do not offer adequate and affordable insurance to their full-time employees. *See* 26 U.S.C. § 4980H(a) (2012) (penalizing large employers who do not offer affordable minimum coverage to employees); 26 U.S.C. §36B(c)(2)(C)(i)(II) (2012) (employer-sponsored coverage is unaffordable if the employee's share of the premium for self-only coverage is more than 9.5 percent of his or her household income); 26 U.S.C. § 4980H(b)-(d) (employer is penalized after verification that it did not offer insurance that meets the affordability and adequacy standards defined by law). Small employers are also encouraged to provide health benefits to their employees through the Small Business Health Options Program (SHOP), which is designed to increase their buying power on the group market by making tax credits available. 42 U.S.C. § 18031(b)(1)(B), *see also* 26 U.S.C. §

45R (2012) (small businesses may be eligible for tax credits for health insurance expenses if low-wage workers buy health insurance through the SHOP).

2. The ACA Encourages Individual Participation in, and Improves Access to, the Individual Market.

For those without employer-sponsored insurance, the ACA eliminates or significantly reduces the barriers that many pre-Medicare adults previously faced in accessing affordable health insurance in the individual market. *See* Part I.B., *supra*; *What's at Stake*, *supra*, at 5. The Act bans insurers' practice of cancelling the policies of people who became ill, 42 U.S.C. § 300gg–12 (2012), and requires insurers to "accept every employer and individual in the State that applies for . . . coverage," regardless of preexisting conditions. 42 U.S.C. § 300gg-1(a). New rating limitations prohibit insurers from charging differential premiums based on health status. 42 U.S.C. § 300gg(a)(1)(A)-(B). Though insurers may still use age-rating, premiums for older adults may not be more than three times the amount of the premium for a younger adult. 42 U.S.C. § 300gg(a)(1)(A)(iii).

To ensure that the insurance market can cover the risk of insuring more people with health conditions, the individual mandate ensures the participation of healthy people by requiring most people to purchase insurance and maintain

minimum health coverage.[3] 26 U.S.C. § 5000A(a) (2012). Between guaranteed issue provisions, rating limitations, and the individual mandate, the ACA seeks to create "effective health insurance markets in which improved health insurance products . . . can be sold" by broadening the risk pool to include people of varying health statuses. 42 U.S.C. § 18091(2)(G).

3. The ACA Makes Health Insurance in the Individual Market More Affordable.

In addition to reducing barriers to access, the ACA makes health insurance on the individual market more affordable through two principal forms of direct financial assistance to qualified individuals buying coverage offered on the Health Insurance Exchange/Marketplace: tax credits to reduce the cost of premiums for people with incomes between 100 and 400% of the federal poverty level, 26 U.S.C. § 36B(b)(3)(A) (2012), and subsidies to reduce out-of-pocket expenses under their plan for people with incomes under 250% of the federal poverty level, 42 U.S.C. § 18071(c)(2) (2012). About 2 million adults ages 50 to 64 on the individual market and more than 5 million who are uninsured may qualify for premium tax credits for individual market coverage purchased on the Exchange. *Effect of Health Reform*, *supra*, at 7. This assistance was designed to encourage low-income adults to purchase insurance rather than seek the unaffordability exemption or pay the

[3] Adults 30 years of age and under and those who demonstrate they cannot afford coverage have the option to purchase catastrophic coverage, and everyone has the option of paying a tax in lieu of purchasing coverage.

shared responsibility tax.[4] 26 U.S.C. § 5000A(b); *see also* H.R. Rep. No. 111-443, vol. 1, at 250 (2010) (premium tax credits "are key to ensuring people affordable health coverage").

4. The ACA Encourages States to Expand Medicaid Coverage for Low-Income Adults Who May be Exempt From the Individual Mandate.

While individuals who cannot afford coverage even with the aid of premium tax credits are exempt from the individual mandate, 26 U.S.C. § 5000A(e)(1), the Act permits states to expand their Medicaid programs so that lower income people are eligible for public insurance under the ACA. 42 U.S.C. §1396a(a)(10)(A)(i)(VIII) (2012). Prior to the ACA, low-income adults without dependent children were not eligible for Medicaid in most states unless they had a disability. Beginning in 2014, adults in this category whose incomes are at or below 138% of federal poverty will be eligible for Medicaid if their state chose to participate in this expansion. 42 U.S.C. § 1396d(y) (2012); *Nat'l Fed'n of Indep. Bus.,* 132 S. Ct. at 2607 (making Medicaid expansion a state option).

Currently, 27 states and the District of Columbia have chosen to expand Medicaid eligibility under the ACA. Kaiser Family Found., *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion* (Aug. 28, 2014),

[4] In 2014, the tax is the lesser of $95 or 1% of taxable income. 26 U.S.C. § 5000A(c)(2)(B) and § 5000A(c)(3). In 2016, the tax increases to $695 or 2.5% of taxable income. *Id*.

http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/ [hereinafter *State Decisions on Marketplaces and Expansion*]. Those living between 100 and 138% of poverty in states that do not expand may purchase coverage on the Exchanges and qualify for premium tax credits and cost-sharing subsidies. About 1.3 million low-income pre-Medicare adults who did not have employer-sponsored health insurance in 2012 had incomes between 100 and 138% of poverty. *Effect of Health Reform*, *supra*, at 7, fig. 2. These low-income pre-Medicare adults could qualify for Medicaid or, if their state of residency is not expanding Medicaid eligibility, for subsidies on the Exchanges.

Considering the reforms discussed above (and others not discussed here), the Congressional Budget Office (CBO) and Joint Committee on Taxation project that millions more under the age of 64 will have insurance coverage than would have had without the ACA—12 million more in 2014, 19 million more in 2015, 25 million more in 2016, and 26 million more each year from 2017 through 2024. Cong. Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* at 4, tbl. 2 (2014) [hereinafter *Effects of Insurance Coverage Provisions*]. The majority of these gains in coverage will be the result of insurance purchases on the Exchanges. *Id*. (*e.g.*, from 2017 to 2024, each year 25 million will be insured through the Exchange and

13 million through Medicaid and CHIP). As detailed below, the vast majority of insurance purchases on the Exchanges are possible only with the financial assistance of premium tax credits.

IV. Premium Tax Credits are Essential to the Act's Primary Purpose—Achieving Access and Affordability for *All*.

The CBO estimated that, in 2014, 5 million people would purchase insurance on the Exchanges with the assistance of premium tax credits. *Id.* tbl. 3. The actual number surpassed those predictions. Approximately 6.7 million people who purchased insurance on the Exchanges in the 2014 enrollment period qualified for premium tax credits, 4.7 million of whom qualified via federally-facilitated Exchanges. U.S. Dep't of Health & Human Servs., *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period: October 1, 2013 -- March 31, 2014, (Including Additional Special Enrollment Period Activity Reported through 4-19-14* at 19 (2014) [hereinafter *Enrollment Report*]. More than twice as many people qualified for tax credits via the federally-facilitated Exchanges as qualified via the State-facilitated Exchanges. *Id*. at 19 (subsidized enrollment via State Exchanges was 1,987,196 and via federally-facilitated Exchanges was 4,683,262). This data confirm both that premium tax credits are critical to ensuring affordability of health insurance, and that the type of exchange is irrelevant to the uninsureds' financial assistance needs.

A. If Premium Tax Credits Are Eliminated on the Federally-Facilitated Exchanges, Health Insurance Will, Once Again, Become Unaffordable for Millions of Low- to Moderate-Income Americans.

If tax credit availability is eliminated from the federally-facilitated Exchanges, health insurance will once again become unaffordable for 4.7 million low-to moderate-income Americans who gained insurance coverage this year. *Id.*; *see also* Kaiser Family Found., *The Potential Side Effects of Halbig* (Jul. 31, 2014), http://kff.org/health-reform/perspective/the-potential-side-effects-of-halbig/ [hereinafter *Potential Side Effects*]. Health insurance will also remain out of reach for an additional 8.1 million uninsured people who would have qualified for premium tax credits via federally-facilitated Exchanges had they enrolled. *See* Kaiser Family Found., *Marketplace Enrollees Eligible for Financial Assistance as a Share of the Subsidy Eligible Population*, http://kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-the-subsidy-eligible-population/# (last accessed on Oct. 31, 2014) (calculated as the difference between those who enrolled with tax premium assistance via federally-facilitated Exchanges as of April 19, 2014 and the estimated total eligible population). The vast majority of these current and potential recipients of the tax credits (9.1 million) live in states that are also not moving forward with Medicaid expansion. *Id.*; *State Decisions on Marketplaces and Expansion.*

Health insurance would also become unaffordable for millions more in the next 10 years. The CBO projects that the number of people who will purchase insurance on the Exchanges with the assistance of premium tax credits will be 10 million in 2015 and 19 million each year from 2016 to 2024, with the exception of 2018 when the number will reach 20 million. *Effects of Insurance Coverage Provisions*, Table 3. Though the CBO did not break these estimates down by type of exchange, the data thus far suggests that most of these people would purchase health insurance via federally-facilitated Exchanges.

B. Eliminating Premium Tax Credits on the Federally-Facilitated Exchanges Will Disproportionately Impact Low- to Moderate-Income Pre-Medicare Adults.

Almost half of those enrolled in plans offered in the Marketplace are pre-Medicare adults. *Enrollment Report* at 18, tbl. A1 (23% are ages 45 to 54 and 25% are ages 55 to 64). Pre-Medicare adults also comprise almost half the people who enrolled through federally-facilitated Exchanges. *Id*. at 20, tbl. B1 (22% are ages 45 to 54 and 25% are ages 55 to 64). Premium tax credits will be especially important to pre-Medicare adults, given their historic difficulty accessing affordable coverage. For example, one study estimates that subsidies will reduce the cost of premiums for a 60-year-old, living at 250% of poverty in Indianapolis, Indiana (a state with a federally-facilitated Exchange) by $433 for a Silver Plan. *See* Cynthia Cox et al., Kaiser Family Found., *An Early Look at Premiums and*

Insurer Participation in Health Insurance Marketplaces, 2014 at 6 (2013). Without premium assistance, this 60-year-old could pay $626 per month for this plan, representing 26% of monthly income.[5] Given the high cost of insurance relative to income, this 60-year-old may opt to forgo health insurance altogether by paying the tax penalty or seeking an exemption. This example illustrates that, for low- to moderate-income people, assistance with their premiums will be the difference between coverage that is affordable and coverage that is out of reach.

V. Premium Tax Credits Were Meant to Incentivize Individuals, Not States.

The text and structure of the ACA support the conclusion that premium tax credits were provided to incentivize individuals to participate in the individual health insurance market, not to incentivize states to establish Exchanges. Like the individual mandate and the federal tax enforcing it, *see* 26 U.S.C. § 5000A(b)(2), premium tax credits are directed at individuals and enforced through federal mechanisms. The amount of the credit depends on the individual's household income. 26 U.S.C. § 36B(b)(3)(A)(i). Additionally, premium credits are available as an advance payment to the individual or are payable directly to the individual's insurer as a refundable federal income tax credit. 26 U.S.C. § 36B(f); 42 U.S.C. §

[5] Two hundred and fifty percent of the FPL in 2013, when this study was conducted, equates to an annual income of $28,725 and a monthly income of about $2,394. *See* Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5,182 (Jan. 24, 2013).

18082(c). Congress may have established other incentives for states to participate in the ACA, *see*, *e.g.*, 42 U.S.C. § 18031(a) (authorizing federal grants to states), but the individual tax subsidy is not one of those incentives.

Appellants cite no authority for their proposition that premium tax credits were intended to "induce states to act" to establish Exchanges beyond a proposed draft bill that did not pass, and was never considered outside of one Committee. Appellants' Br. 47; *see* 155 Cong. Rec. S. 9553 (Sept. 17, 2009), 2010 Bill Tracking S. 1679 (LEXIS). Instead, they point to Medicaid and CHIP as allegedly analogous examples of the federal government incentivizing states to administer a federal program. *See* Appellants' Br. 47. These two statutory schemes, however, differ fundamentally from the ACA. Under both of these Spending Clause programs, the State itself is responsible for accepting the federal money and providing additional state money, using that money to purchase health services, and then providing the purchased benefits to covered individuals according to the State's own program and regulations. States have no role in administering the premium tax credits or enforcing the individual mandate under the ACA. The ACA encourages individual action, rather than State action, by imposing taxes on

the individual or providing refundable tax credits directly to the individual through the federal income tax return.[6]

VI. Eliminating the Availability of Premium Tax Credits in Thirty Six States Will Cannibalize the Act's Key Reforms.

The availability of premium tax credits in all states is essential to achieving the ACA's central purpose. This is evident not only from the effect that the elimination of premium tax credits has on affordability, both in terms of individual affordability and the overall effect it has on prices due to a smaller and higher risk insurance pool, but also from the effect it has on many other reforms central to the ACA. The function of the individual mandate, to increase the number of insured, would be significantly weakened if premium tax credits were eliminated in states with federally-facilitated Exchanges. One study estimates that 83% of those who

[6] The draft proposal Appellants cite in support of their intent argument cuts against it in two important respects. First, the proposal in S. 1679 explicitly stated the prohibition: "the residents of such state *shall not* be eligible for credits." S. 1679, § 3104(a), (d), 111th Cong. (2009) (emphasis added). Nowhere in the final version of the ACA is there an explicit provision stating that if a state does not establish an Exchange, then "the residents of such state shall not be eligible for credits." Additionally, appellants suggest that this draft proposal was an idea borrowed from Timothy S. Jost. Appellants' Br. 47. They fail to point out that, in the cited article, Professor Jost also made two other suggestions of how Congress could incentivize states to establish exchanges and these suggestions do appear in the text of the ACA. *See* Timothy S. Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Institute, Georgetown Univ. Law Ctr., no. 23 at 7, April 27, 2009 ("Congress could invite state participation in a federal program, and provide a federal fallback program to administer exchanges in states that refused to establish complying exchanges . . . [or offer] explicit payments to states that establish exchanges conforming to federal requirements."); *cf*. 42 U.S.C. § 18041(c) *and* 42 U.S.C.§ 18031(a).

purchased health insurance on the federally-facilitated Exchanges (8.1 million people) would be exempt from the individual mandate under the unaffordability exemption without the premium tax credits. *Potential Side Effects*, *supra*. In contrast, only 3% of those who purchased insurance on State Exchanges will qualify for the unaffordability exemption. *Id*. Without the ability to attract more healthy people to the insurance risk pool in states with federally-facilitated Exchanges—as tax credits currently do by reducing premiums by an average of 76%—the number of insurance providers in the individual market would decrease thus reducing competition and increasing premiums. *See* U.S. Dep't of Health & Human Servs., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014* at 2, 17-18 (2014).

All other ACA reforms designed to make coverage more accessible, such as the guaranteed issue provisions and limitations on age rating, will be meaningless to those who cannot afford the premiums. *See* Parts III.B.1-3, *supra*. Moreover, eliminating premium assistance in the 22 states with federally-facilitated Exchanges that are not expanding Medicaid eligibility means that low-income residents in these states will not have new options for affordable coverage. *See* Parts III.B.4 and IV.A., *supra*. Additionally, according to Appellants' interpretative theory, employers in 36 states would be able to evade the employer mandate simply because their state chose not to establish an Exchange—thus

eliminating another important reform designed to increase access to affordable care. *See* Part III.B.1, *supra*. It is implausible, to say the least, that Congress intended to allow the entire Act to be cannibalized by a state's choice not to establish its own Exchange.

CONCLUSION

The ACA was designed to increase the number of insured while making individual market insurance more affordable to all. Premium tax credits for individual purchasers accomplish both goals by encouraging individuals to purchase insurance and by making insurance available to low- to moderate-income purchasers by reducing its costs for them. These tax credits are critical to ensuring that all Americans, and in particular pre-Medicare adults, have access to adequate and affordable health care. Reading the ACA to limit premium tax credits only to people who live in states that established their own Exchanges will make insurance unaffordable and inaccessible to millions of low-to moderate-income Americans in the 36 states with Exchanges that are not exclusively facilitated by the state—a result that is plainly contrary to the purpose the ACA and all of its key reform provisions. Because Appellants' limitation on the availability of premium tax credits would "bring about an end completely at variance with the purpose of the statute," it must be rejected. *United Steelworkers v. Weber*, 443 U.S. 193, 202 (1979) (statutory prohibition on discrimination "because of race" did not prohibit

voluntary race-based affirmative action). For these reasons, and for those detailed in Appellees' Brief, the ruling of the district court should be affirmed.

Date: November 3, 2014.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 3, 2104, I electronically filed the original of the foregoing document with the clerk of this Court by using the CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system. I will also file thirty copies of the foregoing document, by hand delivery, with the clerk of this court on November 4, 2014.

Date: November 3, 2014.

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CERTIFICATE OF COMPLIANCE

1. Amici curiae certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because: this brief contains 6,765 words, excluding the parts of the brief exempted by Fed. R. Ap. P. 32(a)(7)(B)(iii).

2. Amici curiae certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because: this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word 2007 in Times New Roman 14-point font.

3. Pursuant to Fed. R. App. P. 29, amici curiae certify that all parties have consented to the filing of this brief. Amici further certify that no party or party's counsel authored this brief in whole or in part; and no person other than amici contributed money intended to fund the brief's preparation or submission.

Dated: November 3, 2014.

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