Record No. 14-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

DAVID KING, ET AL.,
Appellants,

v.

KATHLEEN SEBELIUS,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA (NO. 3:13-CV-630 (JRS))

BRIEF OF AMICI CURIAE AARP AND NATIONAL HEALTH LAW PROGRAM IN SUPPORT OF APPELLEES URGING AFFIRMANCE

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STATEMENT OF IDENITY, INTEREST 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. NHeLP and AARP

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, AARP and NHeLP are interested in the issues raised by this case. NHeLP and AARP 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 have faced special difficulties in obtaining adequate and affordable health insurance in the private and employer-based markets and were not eligible 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 and death, and it 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 access. Among these interconnected reforms is the availability of federal tax assistance with premium payments to 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 of the Act[1] and is directly at odds with its purpose, as reflected in its text, structure, and key reform provisions. Appellants' interpretation of just one phrase in the Act—if accepted—will make insurance unaffordable in the 34 states with federally-run 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 enactment of the ACA, the number of uninsured Americans ages 50 to 64, who were not yet eligible for Medicare, was growing at an alarming rate—increasing from 5.2 million in 2000, to 7.1 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?* 1 (2009) [hereinafter *What's at Stake*]; *and* 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

[1] AARP and NHeLP adopt and incorporate by reference Appellees' arguments regarding statutory construction of the ACA.

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 working 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* 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*. For example, 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* 4 (2014).

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

Prior to the 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 costs so that they were effectively underinsured. *Id.* at 6, ex. 5. One 2013 study found that among adults with private insurance, 16% had problems paying or were unable to pay medical bills. John Holahan et al., *Access and Affordability on the Verge of Health Reform*, Urban Inst. tbl. 2 (Jan. 28, 2014), http://hrms.urban.org/briefs/access-and-affordability-on-the-verge.html. 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 or offer very limited policies to people with pre-existing conditions, charge high premiums based on age alone, or offer policies with high cost sharing. Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Lawmakers and Regulators* 10 (2012); Lynn Nonnemaker, AARP Pub. Policy Inst., *Beyond Age Rating: Spreading Risk in Health Insurance Markets* 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* 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. *Medicare at a Glance*, Kaiser Family Found. (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* 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* 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. *Id.* To reduce this toll, people must have access to preventive services for early awareness of risk factors, diagnosis, and treatment. As explained below, however, being uninsured 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, *State Preventive Care Ranking For Midlife Adults*, AARP Pub. Policy Inst., http://www.aarp.org/research/ppi/preventive-services.html#/map/men_preventative_services?cmp=RDRCT-STPRVCRNKG_JUL09_013 (last visited Mar. 25, 2014). Uninsured adults are less likely to be aware of heart disease and

its risk factors and to have these conditions treated or well-controlled, and are more likely to have cancers diagnosed and treated in advanced stages. 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, they have higher mortality rates. *Id.* Additionally, the Institute of Medicine (IOM) found that uninsured individuals with chronic illnesses such as hypertension, diabetes, cancer, and heart disease suffer worse health outcomes due to delayed diagnoses and delayed treatment, and thus would most likely benefit from health insurance. *Id.* at 74-80.

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 pre-Medicare adults have significant unmet health needs before they become old enough to qualify for Medicare, the point at which they 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 9 (2013) (finding that the previously uninsured had 35% more program spending in the first year of Medicare enrollment than those previously insured continuously for 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 reduces the cost of drugs and medical treatments for individuals enrolled in Medicare because conditions are diagnosed, are at less advanced stages, and/or are 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* 2-3 (2007). Similarly, diabetes screenings 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).

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 the financial stability of pre-Medicare adults and, in turn, on the national economy—restricting labor market mobility and causing individuals to incur medical care costs that deplete retirement savings and contribute to debt and bankruptcy. 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 health benefits. *See* Richard W. Johnson et al., AARP Pub. Policy Inst., *Older Workers on the Move: Recareering in Later Life* 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* 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, for example, 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* 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?* 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* 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* 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. Additionally, consumer credit is less available and/or more expensive due to excessive medical debt and bankruptcies, and businesses suffer in turn.

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 increasing and diversifying the insured risk pool. 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). "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. Furthermore, these provisions work to improve affordability because they keep premiums down by ensuring that the insurance risk pool is not only larger, but also diverse, including individuals of varying health statuses. Finally, the ACA makes insurance more affordable for low- to moderate-income individuals by providing tax credits to subsidize the cost of premiums and by providing assistance with 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, under which they 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 care 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. 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 supra* Part I.B; *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 ratings 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.[2] 26 U.S.C. § 5000A(a) (2012). Between guaranteed issue provisions,

[2] Adults 30 years of age and under and those who demonstrate they cannot afford coverage have the option or purchase catastrophic coverage, and everyone has the

ratings limitations, and the individual mandate, the ACA seeks to create "effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions 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 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

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option of seeking an exemption or paying a tax in lieu of purchasing coverage. In 2014, the tax is the lesser of $95 or 1% of taxable income. *See* 26 U.S.C. § 5000A(c)(2)(B) and § 5000A(c)(3). In 2016, the tax grows to $695 or 2.5% of taxable income. *Id*.

purchase insurance rather than choose the other options to fulfill their individual shared responsibility requirement—such as seeking an exemption or paying a tax. 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, in most states low-income adults without dependent children were not eligible for Medicaid, 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, 26 states and the District of Columbia have chosen to expand. Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision, 2014*, http://kff.org/ health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last visited Mar. 25, 2014). 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.

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

The CBO estimates that, in 2014, 5 million people will purchase insurance on the Exchanges with the assistance of premium tax credits. Cong. Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline*, Table 3 (2014). By 2018, that number is expected to reach 20 million. *Id*. Of these, approximately 12.5 million reside in states that have either a federally-facilitated or partnership Exchange. *See* Gary Claxton et al., Kaiser Family Found., *State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act* 1 (2013) at 3, tbl. 1; *State Decisions for Creating Health Insurance Marketplaces, 2014*, Kaiser Family Found., http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (last visited Mar. 25, 2014) [hereinafter *State Decisions*]. The most recent report of enrollment shows that, from October 1, 2013 to March 1, 2014, 4.2

million people selected plans on the Marketplace. U.S. Dep't of Health & Human Servs., *Health Insurance Marketplace: March Enrollment Report for the Period: October 1, 2013 -- March 1, 2014* 1 (2014). Eighty-three percent of all enrollees, on both the state-facilitated and the federally-facilitated Exchanges, have selected plans with premium tax assistance. *Id*. at 6.

The majority of those enrolled in plans offered in the Marketplace are pre-Medicare adults. *Id*. at 7, tbl. 3 (23% are ages 45 to 54 and 30% are ages 55 to 64). Premium tax credits will be especially important to pre-Medicare adults, given their historical difficulty accessing affordable care. 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* 6 (2013). Without premium assistance, this 60 year-old could pay $626 per month for this plan, representing 26% of monthly income.[3] Given the high cost of insurance relative to income, this 60 year-old may opt to pay the tax penalty, which can range from $95 to 1% of taxable income in 2014, 26 U.S.C. § 5000A(c)(2), or seek an exemption and forgo health insurance altogether. This

[3] Two hundred and fifty percent of the federal poverty level 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).

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. *See* 26 U.S.C. § 36B(f); 42 U.S.C. § 18082(c) (2012). Congress may have established other incentives for states to participate in the ACA, *see* Appellees' Br. 41-42, 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. 43-46; *see* 155 Cong. Rec. S 9553 (Sept. 17, 2009), 2010 Bill

Tracking S. 1679 (LEXIS). Moreover, Appellants' analysis of this proposed draft bill and its alleged impact on how the court should interpret the ACA provision at issue is flawed. Appellants argue that because one committee considered—but did not succeed in referring out of committee—a bill that conditioned the availability of tax credits on the implementation of certain insurance reforms, then surely Congress must have intended that a provision in the ACA which calculates the amount of a premium tax credit would condition the availability or the tax credit on whether the individual's state of residence established an Exchange. But this conclusion does not flow from the premise because the provision in the draft bill that Appellants cite to and the ACA provision at issue are not analogous. The proposed draft provision on which Appellants rely explicitly stated the consequences for not complying with the conditions. "If a state failed to take those steps, 'the residents of such state *shall not be eligible for credits*.'" (Appellant's Brief, p. 45) (citing to S. 1679, § 3104(d)(2)) (emphasis in original). The provision at issue in this case does not explicitly state that if an Exchange is not established by the state its residents "shall not be eligible for tax credits."

Lacking support in the legislative history for their state inducement argument, Appellants point to Medicaid and CHIP as allegedly analogous examples of the federal government incentivizing states to administer a federal program. *See* Appellants' Br. 44. These two statutes, however, differ

fundamentally from the premium tax credits provisions in the ACA because under both programs, the State itself is responsible for accepting the federal 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 such role in administering the individual mandate or premium tax credits under the ACA. Instead, the ACA encourages individual action by imposing taxes or providing refundable tax credits directly to the individual through the federal income tax return.

VI. Eliminating the Availability of Premium Tax Credits in Thirty Four 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. All other ACA reforms designed to make coverage more accessible, such as the guaranteed issue provisions and limitations on age rating, will be meaningless if insurance in the individual market remains unaffordable. *See supra* Parts III.B.1-3. 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 supra* Part III.B.4.[4] Additionally, according to Appellants' interpretative theory, employers in 34 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 supra* Part III.B.1. 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. 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 older 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 34 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

[4] It is estimated that about 9.4 million people in these 22 states will qualify for premium tax credits. *See supra*, *State Decisions*; *supra*, Claxton, at tbl. 1.

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.

Dated: March 25, 2014

Respectfully submitted,

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Dated: March 25, 2014

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