IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al.,	:	
Plaintiffs,	:	
		Civil Action No. 4:18-cv-00167-O
- against -	:	
UNITED STATES OF AMERICA,	:	
Defendants.	:	
	:	
-and-		
	:	
CALIFORNIA, et al.,		
	:	
Intervenor-Defendants.		

BRIEF *AMICI CURIAE* FOR
ECONOMIC SCHOLARS IN SUPPORT OF THE INTERVENOR-DEFENDANTS

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INTEREST OF *AMICI CURIAE*[1]

The *amici curiae* Economic Scholars 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* have closely followed the development, adoption, and implementation of the Affordable Care Act ("ACA") and are intimately familiar with its purpose and structure. They are:

- **Linda Blumberg, Ph.D.**, Institute Fellow, The Urban Institute; Health Policy Advisor, Office of Management & Budget, The White House (1993-94);
- **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); recipient of the Arrow Award, for best paper in health economics; recipient of the American Society of Health Economists Medal; Fellow, American Academy of Arts and Sciences; Member, Institute of Medicine;
- **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);
- **Judith Feder**, 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);
- **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); Member, National Academy of Medicine;
- **John Holahan, Ph.D.**, Institute Fellow, Health Policy Center, The Urban Institute;
- **John E. McDonough, DrPH**, Professor of Practice, Harvard T.H. Chan School of public health; Senior Advisor on National Health Reform, U.S. Senate Committee on Health, Education, Labor and Pensions, United States Senate (2008-2010);

[1] No person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for the parties have consented to the filing of this brief.

- **Marilyn Moon, Ph.D.**, Institute Fellow, American Institutes for Research; Member, National Academy of Sciences;
- **Harold Pollack, Ph.D.**, Helen Ross Professor of Social Service Administration and Public Health Sciences at the University of Chicago;
- **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); Member, National Academy of Sciences;
- **Stephen Zuckerman, Ph.D.**, Senior Fellow and Co-Director, Health Policy Center, The Urban Institute.

The Economic Scholars believe that the available evidence demonstrates that the ACA has improved the quality and affordability of health care in many ways, including by increasing the availability of private health insurance, expanding and improving Medicaid, reforming Medicare, and supporting federal, state, and local initiatives to prioritize prevention and improve public health.

The Economic Scholars submit this brief to assist the Court in assessing the claim of the Plaintiffs that it should invalidate the ACA in its entirety if the Court finds that the individual mandate is unlawful. There is no doubt that the individual mandate is an important component of the ACA, but the ACA is far larger than the individual mandate and will continue to improve health care markets in a wide variety of ways even without the mandate. As a result, invalidating the ACA as a whole, even as part of preliminary injunctive relief, would have far reaching and pernicious economic consequences. *Amici* urge the Court to reject Plaintiffs' argument that the individual mandate is not severable from the rest of the ACA, as well as the position of the federal government that the community rating and guaranteed issue provisions of the ACA are not severable from the individual mandate.

INTRODUCTION AND SUMMARY OF ARGUMENT

It is indisputable that the ACA has helped to dramatically reduce the number of people without health insurance in America. Since its enactment, an estimated 20 million previously uninsured people—women and men, children and adults, poor and rich, minority and majority—have availed themselves of the quality and affordable coverage offered as a result of the ACA. The individual mandate helped to ensure that the insurance risk pool includes both the healthy and the sick, thereby decreasing the magnitude of "adverse selection" into private individually purchased insurance markets and thus avoiding a situation that could "le[a]d to an economic 'death spiral.'" *King v. Burwell*, 135 S. Ct. 2480, 2484-86 (2015). Plaintiffs now seek a preliminary injunction to bar Defendants from "enforcing the mandate itself … and, ultimately, the entire ACA." Br. of Pls. at 1-2, Dkt. 40.

To be sure, the 2017 decision of Congress to zero out the penalty for enforcing the individual mandate will cause the number of uninsured to rise, increase premiums for those who remain insured, and have a serious negative effect on the economy. Invalidating the mandate entirely might marginally increase these effects. But the consequences of invalidating only the individual mandate pale in comparison to the dramatic and far-reaching harm from invalidating the ACA in its entirety. The ACA's "10 titles stretch over 900 pages and contain hundreds of provisions," *NFIB v. Sebelius*, 567 U.S. 519, 538-39 (2012), including "more than 40 provisions … that require, permit, or contemplate rulemaking by federal agencies to implement the legislation."[2] Thus far, federal agencies have issued hundreds of regulations under the ACA,

[2] Curtis W. Copeland, Cong. Research Serv., R41180, *Rulemaking Requirements and Authorities in the Patient Protection and Affordable Care Act (PPACA)* i (2011), https://healthcarereform.procon.org/sourcefiles/CRS_Rulemaking_Requirements_HR3590.pdf.

covering every aspect of the health care system. A breathtakingly broad injunction covering all of those statutory and regulatory provisions will cause tremendous harm.

First, an injunction would cause a surge in the number of people without insurance and erode significant improvements in access to and use of care. Many studies have documented the gains in access to affordable health insurance and healthcare that have resulted from the ACA. But those gains would disappear if the ACA were invalidated. As an analysis by the Urban Institute shows, after accounting for recent regulatory changes and reducing the penalty for violating the individual mandate, invalidating the ACA now would cause millions of people to lose insurance coverage and cause deep cuts in federal investments in healthcare. As a result, an injunction would relegate millions to facing the prospect of shorter, sicker, less productive lives.

An injunction also would cause enormous disruption and uncertainty for the US health care industry, which constitutes about 20 percent of the US economy. Billions of dollars of private and public investment—impacting every corner of the American health system—have been made based on the existence of the ACA. After Congress repeatedly rejected efforts to repeal the ACA, those investments were made anticipating that most aspects of the ACA would continue. And even after Congress reduced the penalty for not carrying insurance, those investments were made presuming that at least the remainder of the ACA would remain. The injunction that plaintiffs propose would upend all of those settled expectations and throw healthcare markets into chaos.

An expansive injunction covering the entirety of the ACA would also cause deep economic damage. It would undo efforts to slow the rising cost of healthcare, which in turn would undermine the country's long-term fiscal position. Those consequences will be felt acutely in the healthcare sector and in the states, which depend on the federal government for critical funding. The short- and long-term business and life decisions that have already been made based on the ACA would

probably need to be reconsidered; decisions about the future would probably need to be put on hold. Indeed, the impact of invalidating the ACA is so uncertain that the CBO admits that it cannot even estimate the long-term ramifications it would have on spending, budgets, and growth. Avoiding these negative consequences and the potentially enormous disruption full repeal would cause is reason enough to keep the ACA in place, at least while this complex case is being litigated.

Second, the expansive injunction that Plaintiffs seek would cover far more that the individual mandate and undermine scores of laws and regulations that have nothing at all to do with the individual mandate. The ACA is a comprehensive law that not only expanded the availability of health insurance, but also created new federal programs and reformed old ones in ways wholly unrelated to the individual mandate. For example, the ACA has facilitated billions of dollars in payments from the federal government to states and localities to better serve their populations. The ACA has also spurred innovation in Medicare by revamping that program's outmoded payment system. These are but a few examples, but they illustrate a larger, important point: a broad injunction covering all of the ACA will do far more than limit enforcement of the individual mandate (which Congress has neutered in any event). And it will cause far more harm to the public than good.

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Finally, in papers filed last week, the United States contended that while Congress would not have wanted the *entirety* of the ACA to be invalidated if the mandate were struck down, it also would not have wanted the community rating and guaranteed issue provisions to survive. Br. of United States at 2, Dkt. 92. Economic modelling and analysis as well as straightforward real time evidence do not support that proposition. The community rating and guaranteed issue provisions prevent insurers from charging higher premiums for customers with pre-existing conditions.

Those provisions—which operate independently of the individual mandate—have done much to expand coverage, make it affordable, and ensure that individuals with pre-existing conditions are able to obtain care. And now that insurance markets have adjusted to the ACA and millions more have affordable care, those provisions can survive even in a world without the individual mandate. Indeed, in 2017 the CBO predicted that markets would remain stable and premiums would rise by modest amounts if the individual mandate were invalidated but those provisions remained intact. Congress then opted to zero-out the individual mandate but not to repeal those provisions. In 2018, CBO and the Urban Institute separately concluded that markets would likely remain stable if the individual mandate were invalidated but the guaranteed issue and community rating provisions remained in force. As of today, insurers in nine states have already filed rates for coverage in every county of each state for 2019, assuming continued enforcement of guaranteed issue and community rating, and notwithstanding the elimination of the mandate penalties.[3] No reports to date suggest either insurer exits or areas of the country that may lack an insurer offering qualified health plans next year. Moreover, eliminating the guaranteed issue and community rating provisions would hamstring other important features of the ACA that would remain. For example, without those provisions, individuals with pre-existing conditions would likely be unable to obtain insurance at any price, and thus would not be eligible for the premium tax credit subsidies the ACA provides. It makes little economic sense to assume that Congress intended to provide subsidies but to limit their availability effectively only to the healthiest customers. Additionally, the variability of prices for those receiving an offer would make setting the premium tax credit difficult and potentially impossible, certainly for 2019 and probably for subsequent years.

[3] Rabah Kamal, Cynthia Cox, Michelle Long, Ashley Semanskee, & Larry Levitt, Henry J. Kaiser Family Foundation, *Tracking 2019 Premium Changes on ACA Exchanges* (June 6, 2018), https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/.

In sum, this Court should deny Plaintiffs' motion for a preliminary injunction covering "the entire ACA," and it should reject the contention by the United States that Congress would not have wanted the community rating and guaranteed issue provisions that it enacted to be eliminated if the individual mandate were invalidated.

ARGUMENT

I. STRIKING DOWN THE ACA WOULD CREATE A SURGE IN THE NUMBER OF UNINSURED THAT WILL SPUR NEGATIVE CONSEQUENCES THAT REVERBERATE THROUGH THE ECONOMY.

The most immediate impact of an injunction will be to create a surge in the number of people without health insurance. But that is not the only impact. Striking down the ACA would cause uncompensated care to soar and markedly decrease the federal investment in health care.

A. An Injunction Would Undo The ACA's Increased Access To Affordable Health Insurance And Healthcare Services.

Invalidating the ACA would undermine the concrete gains in insurance coverage. From 2010 to 2016, an estimated 3 million African-Americans, 4 million people of Hispanic origin, nearly 9 million white non-elderly adults, 6.1 million young adults, and 1.2 million children gained insurance coverage.[4] Those gains were seen across the income spectrum, with the uninsured rate dropping by 36 percent for people with income below 138 percent of poverty, 33 percent for people with income between 138 and 400 percent of poverty, and 31 percent for people within incomes above 400 percent of poverty.[5] Between October 2013 and early 2016 alone, an estimated 20 million more people obtained health insurance—a drop of 43 percent in the uninsured rate.

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[4] Namrata Uberoi, Kenneth Finegold & Emily Gee, Office of the Assistant Secretary for Planning and Evaluation, Dep't of Health & Human Servs., *Health Insurance Coverage and the Affordable Care Act, 2010 – 2016* , Issue Brief (Mar. 3, 2016), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf; Executive Office of the President Council of Economic Advisors, *Economic Report of the President*, Chapter 4: *Reforming the Health Care System* 195 (Jan. 2017), https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf (hereinafter "*CEA Report*").

[5] *CEA Report* at 214.

Meanwhile, millions were able to take advantage of their newfound access to health insurance because the ACA ensured that the coverage remained affordable. Between 2013 and 2016, the ACA contributed to a 57 percent increase in the number of people covered in the individual insurance market.[6] Much of that increase is attributable to the ACA's creation of health insurance Marketplaces, where, as of 2017, 84 percent of the 10.3 million enrollees received premium tax credits averaging approximately $4,458 per enrollee per year.[7] At the same time, that financial assistance allowed 71 percent of Marketplace enrollees to buy health insurance for less than $75 per month.[8] That provides some explanation for why the number of people who reported finding it very difficult or impossible to find affordable health insurance dropped almost by half between 2010 and 2016.[9] But these (and many other) hallmark achievements would be reversed if the ACA were invalidated in its entirety.

Gains in access to healthcare would be undone by an injunction as well. Study after study has shown that the ACA has improved access to health care, especially among low-income people.[10] For example, the share of people without a regular source of care, and the share of people who did not receive a routine checkup, both dropped by approximately six percent from 2013 to

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[6] Henry J. Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 11, 2018).

[7] Centers for Medicare & Medicaid Services, *2017 Effectuated Enrollment Snapshot* (June 2017), https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

[8] Sara R. Collins, Munira Z. Gunja, Michelle M. Doty, & Sophie Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, The Commonwealth Fund, Issue Brief (Feb. 2017), http://www.commonwealthfund.org/publications/issuebriefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance.

[9] *See id.*

[10] Gerald F. Kominski, Narissa J. Nonzee & Andrea Sorensen, *The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations*, 37 Annual Rev. Pub. Health 489 (2017), https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031816-044555.

2017.[11] The share of people who reported that they were unable to obtain needed medical care because of cost dropped by one-third, too.[12] That access has resulted in tangible increases in the use of health care services, including outpatient care, a usual source of care or personal physician, preventive services, prescription drug use and adherence, and surgical care.[13] Because of the ACA's requirements, that access to care also includes critical coverage for prescription drugs, mental health, maternity care, substance abuse, autism, and a range of other medical issues that were often not covered under private plans prior to 2010.[14] Moreover, the ACA's guarantee of access to health insurance ensures that the up to 133 million Americans who have a pre-existing health condition, including parents of 17 million children with such conditions, can obtain coverage regardless of their job situation or eligibility for government programs.[15]

An analysis by the Urban Institute, based on their Health Insurance Policy Simulation Model, quantifies the widespread impact from invalidating the entire ACA now. After accounting for recent regulatory changes and setting the penalty for violating the individual mandate to $0, the Urban Institute's model shows that repealing the ACA in its entirety would cause 17.1 million people to lose insurance coverage (a 50 percent increase), 15.1 million low-income people to lose

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[11] Sharon K. Long, Lea Bart, Michael Karmpan, Adele Shartzer, & Stephen Zuckerman, *Sustained Gains in Coverage, Access, and Affordability Under the ACA: A 2017 Update*, 36 Health Affairs 1656 (2017), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0798.

[12] *CEA Report* at 224-25.

[13] Benjamin D. Sommers, Atul A.Gawande, & Katherine Baicker, *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 New Eng. J. Med. 586 (2017), http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.

[14] Office of the Assistant Secretary for Planning and Evaluation, Dep't of Health & Human Servs., *Essential Health Benefits: Individual Market Coverage*, Issue Brief, (Dec. 16, 2011), https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage; Amanda J. Abraham, Christina M. Andrews, Colleen M. Grogan, Thomas D'Aunno, Keith N. Humphreys, Harold A. Pollack, & Peter D. Friedmann , *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, 107 Am. J. Pub. Health 31 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/.

[15] Office of the Assistant Secretary for Planning and Evaluation, Dep't of Health & Human Servs., *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, Issue Brief (Jan. 5, 2017), https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

coverage under Medicaid, and 3.6 million fewer people to have private nongroup insurance coverage. And those retaining private nongroup coverage would have coverage that is less comprehensive (due to elimination of benefit and actuarial value standards) and substantially less accessible (due to the elimination of guaranteed issue and modified community rating rules). In addition, an injunction covering the entire ACA would cause the federal investment in healthcare to drop $146.6 billion, a decline of 37 percent. There is simply no reason to impose these harms on millions of Americans by invalidating the ACA while this litigation runs its course.[16]

B. Striking Down The ACA Will Have Drastic Consequences On Healthcare Markets And The Healthcare Industry.

If the first impact of striking down the ACA is to increase the number of uninsured and undermine the healthcare gains that the ACA helped achieve, an increase in per capita spending on health care is very likely to follow. The ACA has played a significant role in reducing the rate of growth in per capita healthcare spending. From 2010 to 2016, the prices of health care goods and services grew more slowly than in the 1950s when systematic tracking began. As a result, between 2010 and 2016, projections for national health expenditures for 2010 to 2019 dropped by more than $2.6 trillion.[17] The growth rate of premiums and out-of-pocket costs dropped, too.[18] Invalidating the ACA now will threaten all of these gains and is likely to set the U.S. back on a path of unsustainable growth in healthcare spending.

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[16] John Holahan, Linda J. Blumberg, & Matthew Buettgens, The Urban Institute, *Keeping Parts of the Affordable Care Act Intact is Still Better than Total Repeal* (June 14, 2018), https://www.urban.org/research/publication/aca-remains-critical-insurance-coverage-and-health-funding-even-without-individual-mandate.

[17] Stacey McMorrow & John Holahan, Robert Wood Johnson Foundation & Urban Institute, *The Widespread Slowdown in Health Spending Growth Implications for Future Spending Projections and the Cost of the Affordable Care Act* (June 2016), https://www.urban.org/sites/default/files/publication/81636/2000824-the-widespread-slowdown-in-health-spending-growth-implications-for-future-spending-projections-and-the-cost-of-the-affordable-care-act.pdf.

[18] *CEA Report* at 269.

Relatedly, a world without the ACA presents a much bleaker picture of the country's long-term fiscal outlook. The ACA's success in reducing the rate of growth in healthcare spending is widely acknowledged as also having improved the country's finances. Without the ACA, those improvements would be undone. In 2015, the CBO estimated that repealing the ACA would increase federal deficits by $353 billion over ten years, not taking into account macroeconomic feedback.[19] Beyond ten years, repealing the ACA would cause budget deficits to grow rapidly over time, averaging around $3.5 trillion over the decade that follows.[20] Those estimated deficits are "so large" that they would likely persist "even after considering the great uncertainties involved" in predicting future economic conditions.[21] In other words, CBO cannot imagine any scenario—out of the untold number of scenarios that could possibly occur—where invalidating the ACA does not harm the long-term fiscal outlook of the United States.

That fiscal damage would spill-over into Medicare, raising the risk that a foundation of the US health care system would suffer. The ACA "along with other factors, has significantly improved Medicare's financial outlook, boosting revenues and making the program more efficient."[22] Since 2010, average annual growth in total Medicare spending was cut in half, to 4.4 percent from 9 percent, and average annual growth in Medicare spending per beneficiary dropped to 1.3 percent from 7.4 percent.[23] The Medicare Hospital Insurance Trust Fund, which was

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[19] Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* at 1 (June 2015), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf (hereinafter "*CBO on Repeal*").

[20] *Id.*

[21] *Id.* at 2.

[22] Paul N. Van de Water, Center on Budget and Policy Priorities, *Medicare Is Not "Bankrupt:" Health Reform Has Improved Program's Financing* (July 24, 2017), https://www.cbpp.org/research/health/medicare-is-not-bankrupt.

[23] Juliette Cubanski & Tricia Neuman, Henry J. Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (July 18, 2017), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.

projected to become insolvent by 2017, was scheduled to stay solvent in that year until 2026.[24] From 2009 to 2017, that Trust Fund's projected 75-year shortfall dropped six-fold (to 0.64 percent of taxable payroll from 3.88 percent before the ACA).[25] But CBO has projected that repealing the ACA would increase Medicare spending by $802 billion over ten years, which would require raising seniors' premiums, unwind efficiencies, and hasten the insolvency of the Medicare Hospital Insurance Trust Fund.[26] In short, invalidating the ACA would all but nullify the ACA's major advances in putting Medicare on solid footing.

The states would face a similar economic impact if the ACA ceased to exist. In an earlier analysis, the Urban Institute estimated that, without the ACA, states would spend $68.5 billion more on healthcare between 2017 and 2027, "as reductions in Medicaid spending would be more than offset by increases in uncompensated care."[27] At the same time, federal healthcare spending—on the insurance marketplace, Medicaid, hospitals, and physicians, to name a few—is estimated to drop by nearly a trillion dollars in the sixteen Intervenor-Defendant states alone.[28]

Striking down the ACA now could increase healthcare costs and spending even beyond pre-ACA levels. The healthcare industry has been a hotbed of merger activity in recent years. In the hospital area, there were more than 500 mergers between 2009 and 2015, and 115 transactions

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[24] *CEA Report* at 297-98 & n.42; *see also* 2018 Annual Report Of The Boards Of Trustees Of The Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds at 7, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (last visited June 11, 2018).

[25] Cubanski and Neuman, *supra*.

[26] *CBO on Repeal* at 10.

[27] Matthew Buettgens, Linda J. Blumberg, John Holahan, & Siyabonga Ndwandwe, Robert Wood Johnson Foundation & Urban Institute, *The Cost of ACA Repeal* at 1 (June 2016), https://www.urban.org/sites/default/files/publication/81296/2000806-The-Cost-of-the-ACA-Repeal.pdf.

[28] *See* Appendix in Support of Intervenor-Defendants' Motion to Intervene at 26-58, Dkt. 15-1.

valued at more than $63 billion in 2017 alone.[29] Four of the five major health insurers have recently attempted (unsuccessfully) to join forces, the country's two largest pharmacy benefit managers have joined with insurers, and other major non-healthcare companies are reportedly considering entering the health insurance space.[30] That context is critical. Even assuming an injunction could actually restore the pre-ACA state of health care law (a prospect *amici* and many others consider dubious, *see infra* Part II), an injunction cannot possibly restore the pre-ACA state of the world or unwind the many transactions that have taken place based on the ACA's existence. So, striking down the ACA now—in the midst of market consolidation that could risk reduced competition and lead to higher prices in many areas[31]—may do even more harm to healthcare prices and the long-term health of the economy than if the ACA had never been enacted at all.

Stark as it is, the picture painted above does not fully capture the deleterious effect on the economy that would result from striking down the ACA in its entirety. "[T]he ways in which individuals, employers, states, insurers, doctors, hospitals, and other affected parties will respond to the changes made by the ACA—and the ways in which those same people and organizations would respond to its repeal—are all difficult to predict."[32] But there is no doubt that the ACA's

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[29] *Health Affairs New Issue: Market Concentration*, Health Affairs Blog (Sept. 5, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170905.061818/full/; KaufmanHall, *2017 in Review: The Year M&A Shook the Healthcare Landscape* (2018), https://www.kaufmanhall.com/sites/default/files/2017-in-Review_The-Year-that-Shook-Healthcare.pdf.

[30] *See*, *e.g.*, Max Nisen, *Amazon Is Already Reshaping Health Care*, Bloomberg News (Mar. 26, 2018), https://www.bloomberg.com/gadfly/articles/2018-03-26/amazon-s-health-care-threat-is-already-reshaping-the-industry.

[31] *See*, *e.g.*, Maria Polyakova, Kate Bundorf, Daniel Kessler, & Laurence C. Baker, *ACA Marketplace Premiums and Competition Among Hospitals and Physician Practices*, 24 Am. J. Managed Care 85 (2018), http://www.ajmc.com/journals/issue/2018/2018-vol24-n2/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices; Testimony of Paul B. Ginsburg Before the California Senate Committee on Health: Health Care Market Consolidations: Impacts on Costs, Quality and Access, Brookings (Mar. 16, 2016), https://www.brookings.edu/testimonies/health-care-market-consolidations-impacts-on-costs-quality-and-access/.

[32] *CBO on Repeal* at 5.

improvements in the long-term fiscal outlook will reverberate through the economy in countless ways—raising savings, increasing investment, spurring entrepreneurship, and generally improving the financial circumstances for those involved in the American economy. Those gains will free up funds to be deployed to reap even greater gains—in transportation, infrastructure, education, and scientific research. All the while, the country's workforce will be healthier, less stressed, and more productive. It is hard to imagine a ruling less in the public interest than invalidating the ACA.

The economic impact from striking down the ACA will fall particularly heavily on the healthcare industry. According to one analysis of the potential impact of repealing the ACA in 2017, "[a]s millions lose their insurance, hospitals and other providers would see their uncompensated medical care costs soar by $1.1 trillion from 2019 to 2028, and they would experience major revenue losses as well."[33] In a different analysis of repeal related to an earlier court challenge, the sharp reduction in the number of people with insurance was projected to reduce industry profits by $6 billion between 2012 and 2021, and cost private insurers more than $350 billion in profits resulting from the ACA's Medicaid expansion.[34] In an analysis done in the context of 2016 Congressional repeal bills, the demand for uncompensated care was estimated to more than double in 2021, from $21.3 billion to $44.5 billion.[35]

Within the healthcare sector, hospitals will bear the brunt of the economic harm from an injunction. After enactment of the ACA, "[n]ationwide, uncompensated care has fallen by more than a quarter as a share of hospital operating costs from 2013 to 2015, corresponding to a

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[33] Leighton C. Ku, Erika Steinmetz, Erin Brantley, & Brian K. Bruen, Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States* at 1 (Jan. 5, 2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform.

[34] Brief for Economists as Amici Curiae at 3, 15, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-393), 2012 WL 78244.

[35] Buettgens et al., *supra* at 8. These figures assume "that governments would be willing to fund uncompensated care at pre-ACA levels. If governments did not return to pre-ACA levels of uncompensated care funding, the increase in the burden on providers would be higher," and "the unmet need for care would also be higher." *Id.*

reduction of $10.4 billion."[36] But if an injunction is issued, hospitals will again face the heavy cost of uncompensated care as the number of people without insurance skyrockets. An analysis funded by the American Hospital Association estimated that if the ACA were repealed, hospitals' overall net income would decrease by $165.8 billion between 2018 and 2026.[37] An injunction that effectively repeals the ACA would have the same disastrous result.

The cost would be especially severe for hospitals in the 33 states that took advantage of the ACA's Medicaid expansion. In those states, "[m]ean annual Medicaid revenue increased significantly" for hospitals, by approximately $4.6 million per hospital over a two-year period.[38] At the same time, the ACA has helped reduce the costs of uncompensated care for those hospitals by an average of about $3.2 million per hospital, a roughly 34 percent reduction.[39] From higher revenue and lower costs: more profit. According to one study, expanding Medicaid "significantly improved" operating and excess margins at hospitals, by 67.3 percent and 41.4 percent, respectively.[40] Small and rural hospitals—which serve 72 million people "as an important, and often only, source of care," and which the ACA sought to bolster[41]—have tended to experience

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[36] *CEA Report* at 196.

[37] Allen Dobson, Joan DaVanzo, Randy Haught, & Phap-Hoa Luu, Dobson DaVanzo & Associates, LLC, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals: Findings, Assumptions and Methodology* at 9 (Dec. 6, 2016), https://www.aha.org/system/files/2018-02/impact-repeal-aca-report_0.pdf. This number assumes that the Medicare payment reductions effectuated through the ACA would rise and fall with the ACA. If instead the reductions were reinstated in a post-ACA world, as a bill in Congress proposed to do, then between 2018 and 2026 "hospitals will suffer additional losses of $289.5 billion" from changed Medicare payment formulas and $102.9 billion from Medicare and Medicaid payment reductions. *Id*. at 11-13.

[38] Fredric Blavin, Robert Wood Johnson Foundation & Urban Institute, *How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data* at 3 (April 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436310.

[39] *Id.*

[40] *Id.*

[41] American Hospital Ass'n, *The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform* (Apr. 18, 2011), https://www.aha.org/guidesreports/2011-04-18-trendwatch-opportunities-and-challenges-rural-hospitals.

the greatest gains.[42] Striking down the ACA now will reverse those gains and undo the benefits that hospitals have accrued as a result of Medicaid's expansion.

The economic harm discussed above may be amplified by the timing of any preliminary injunction. At present, the health insurance market is in a stable if precarious position. As the CBO recently explained, "[s]ubstantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers' decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country."[43] But striking down the ACA—especially in the middle of a plan year (which may not match the calendar year), or without sufficient lead time for consumers, companies, and markets to adjust—would bring on those very withdrawals. That is because premiums are "locked-in" annually, based on the coverage offered and complex assumptions about the risk pool and other considerations, but an injunction "would change the rules of the insurance market after the year's premiums have been set."[44] Insurers could not retroactively adjust premiums to account for the new (old) reality of having fewer and sicker people comprising greater proportions of the risk pool. Nor could insurers retroactively revisit the terms of coverage, or rescind coverage entirely, if the

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[42] *Id.* at 4.

[43] Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, at 7 (May 23, 2018), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf (hereinafter "*CBO 2018*"); *see also* Matthew Fiedler, USC-Brookings Schaeffer Initiative for Health Policy, *Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017* at 1 (Oct. 2017), https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf ("It is clear that individual market premiums will increase by substantially more than this in 2018. These larger increases likely primarily reflect the unsettled federal policy environment.").

[44] Linda J. Blumberg, Matthew Buettgens, & John Holahan, Urban Institute, *Implications of Partial Repeal of the ACA through Reconciliation* at 15 (Dec. 6, 2016), https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf (hereinafter "*Partial Repeal*").

ACA's requirements were lifted. As Plaintiffs admit, insurers are similarly ill-suited to quickly revise their plans for future years to account for an injunction (especially a temporary one that, by its nature, could be lifted or changed). As a result, markets would face significant uncertainty, "at least some insurers would leave the nongroup market midyear" and "significant market disruption would occur."[45]

II. STRIKING DOWN THE ACA WOULD INVALIDATE IMPORTANT FEDERAL INITIATIVES UNRELATED TO THE INDIVIDUAL MANDATE AND CAST A SHADOW OVER MANY OTHERS.

The impact of an injunction would not be limited to increasing the number of uninsured and the after-effects on the economy. The ACA contains "hundreds of new laws about hundreds of different areas of health insurance and health care,"[46] and has resulted in scores of regulations that are now in force—many of which are unrelated to and wholly independent of the individual mandate. As the CBO acknowledged, it "is a difficult task—and one subject to considerable uncertainty—to predict how repealing a law as complex as the ACA would be interpreted and implemented by executive branch agencies without some specific statutory guidance."[47] Nevertheless, *amici* offer below a few examples to demonstrate how invalidating the whole of the ACA would devastate important federal programs and initiatives that are serving the public interest, and cause widespread confusion and chaos.

An injunction covering all of the ACA would call into question the hundreds of federal laws and regulations that have been enacted as a result of the ACA.[48] A sampling of those

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[45] *Id.* at 2.

[46] Petitioner's Appendix at 21a, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (No. 11-393), 2011 WL 4479805.

[47] *CBO on Repeal* at 5.

[48] Pinpointing the exact number of regulations is challenging because of the scope and scale of the ACA itself. As of June 6, 2018, Regulations.gov lists 585 "closed" rules related to the "Affordable Care Act", and searching the Code of Federal Regulations for P.L. 111-148 yields 603 results.

provisions demonstrates the breadth of topics that the ACA addresses, and the magnitude of the collateral damage that will be caused if the entire ACA is invalidated.

- Providing free preventive services in Medicare and employer coverage;
- Offering dependent coverage for young adults;
- Requiring disclosure of payments from drug companies;
- Labeling menus with calorie counts;
- Barring annual and lifetime limits on coverage and imposing a cap on the amount of out-of-pocking costs;
- Encouraging states to cover preventive services in Medicaid;
- Preventing healthcare providers who receive federal funds from discriminating, at a minimum, against women and people with limited English proficiency;
- Mandating that insurers spend at least 80 or 85 percent (depending on the market) of premium revenues on clinical services and quality improvement;
- Closing the Medicare donut hole that requires seniors to pay out-of-pocket for drugs at a certain point;
- Requiring employers to provide break time and private places for nursing mothers;
- Improving patient safety at hospitals by imposing penalties for unnecessary readmissions and avoidable hospital-acquired conditions; and
- Standardizing ing the income definition (to Modified Adjusted Gross Income) for Medicaid eligibility for most groups.

States, too, wrote and revised laws and regulations based on the federal law and its regulations. So the impact of invalidating the ACA—which will leave the healthcare sector in disarray, after the sector has already adjusted to the ACA's existence and to the failure of efforts to repeal it—will be even broader than it appears.

The Prevention and Public Health Fund (PPHF) is another example of the damage an injunction will cause, by cutting off a key funding stream flowing to the Centers for Disease Control and Prevention (CDC), states, and communities as a result of the ACA. The ACA created

PPHF as "the nation's first mandatory funding stream dedicated to improving our nation's public health system" through "investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs."[49] PPHF has funneled over $3.9 billion to states since 2010, and sent $650 million to states in fiscal year 2017 alone.[50] PPHF funds have been put to a wide variety of beneficial uses, including immunizations, smoking cessation programs, expanding state and local health departments, and epidemiology and laboratory grants.

The Community Health Center Fund (CHCF), "a mandatory multi-billion dollar fund" created by the ACA, is another example of a quality program that would be at risk if the ACA were wholly invalidated.[51] That fund has supported grants to build new health centers, renovate and improve existing ones, and expand services when need is immediate, such as when lead was discovered in the water supply in Flint, Michigan, and when the Zika virus hit Puerto Rico.[52] Since 2010, states have received nearly $13 billion from the federal government through CHCF.[53] That funding has its genesis in the ACA, and would presumably be impacted by an injunction covering all of the ACA.

The Center for Medicare and Medicaid Innovation (CMMI) further illustrates the consequences of invalidating the ACA. The ACA created the center and seeded it with $10 billion over ten years to develop and test innovative new payment models, which could then be deployed

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[49] Center for Disease Control and Prevention, *Prevention and Public Health Fund*, https://www.cdc.gov/funding/pphf/index.html (last visited June 11, 2018).

[50] Trust for America's Health, *Updated Prevention and Public Health Fund (PPHF) State Funding Data (FY10-FY17)* (Mar. 27, 2018), http://healthyamericans.org/health-issues/news/updated-prevention-and-public-health-fund-pphf-state-funding-data-fy10-fy17/.

[51] Cong. Research Serv., R43911, *The Community Health Center Fund: In Brief* at 1 (Jan. 13, 2017), https://www.everycrsreport.com/reports/R43911.html.

[52] *Id*. at 1.

[53] *Id*. at 3-5.

nationwide if successful at reducing costs and maintaining quality.[54] Acting under the dictates of the ACA, CMMI has engaged with thousands of healthcare providers to test different ideas and to implement certain specific payment models that Congress ordered through the ACA.[55] Since its inception, "CMMI has launched over 40 new payment models, involving more than 18 million patients and 200,000 health care providers. Many of these models are in Medicare, including accountable care organizations (ACOs), bundled payment models, and medical homes models. Combined, these three types of models in Medicare are located in all 50 states and the District of Columbia."[56] If the ACA were invalidated in its entirety, however, CMMI and its ongoing initiatives would likely cease.[57]

An injunction covering the entirety of the ACA would also throw the Medicare payment system into chaos because the ACA replaced many of the prior payment systems. To advance the goal of moving Medicare away from a fee-for-service model, the ACA established mechanisms for deploying a variety of alternative payment models to reward providers for positive outcomes.

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[54] Centers for Medicare and Medicaid Services, About the CMS Innovation Center, https://innovation.cms.gov/About/index.html (last visited June 11, 2018); Henry J. Kaiser Family Foundation, *"What is CMMI?" and 11 other FAQs about the CMS Innovation Center* (Feb. 27, 2018), https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/.

[55] Centers for Medicare and Medicaid Services, About the CMS Innovation Center, https://innovation.cms.gov/About/index.html (last visited June 11, 2018); *see also* Centers for Medicare and Medicaid Services, Innovation Models, https://innovation.cms.gov/initiatives/index.html#views=models (last visited June 11, 2018).

[56] Henry J. Kaiser Family Foundation, *"What is CMMI?" and 11 other FAQs about the CMS Innovation Center* (Feb. 27, 2018), https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/ (citing Centers for Medicare and Medicaid Services, *CMS Innovation Center: Report to Congress*, December 2016).

[57] Under a mandate from the ACA, Center for Medicare and Medicaid Services reevaluated 1.6 million Medicare suppliers and providers using new risk-based screening requirements. Press Release, U.S. Dep't of Justice, Fact Sheet; The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud (Feb. 2016), https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-conusmers-and-taxpayers. Applying those requirements, CMS withdrew billing privileges for more than 500,000 suppliers and providers. *Id*. If an injunction were to restore the pre-ACA status quo, these screening measures would be nullified, and the withdrawn suppliers and providers may argue that their privileges should be restored as well.

For example, CMMI or CMS "are managing … accountable care organizations (ACOs), medical home models, and bundled payment models" that "include financial incentives for providers (such as doctors and hospitals) to work together to lower spending and improve care for patients in traditional Medicare."[58] That effort has since been quite successful: as of 2016, nearly 30 percent of payments in Medicare and major private plans were made through new payment models, virtually none of which existed in 2010.[59] The ACA also created new payment mechanisms for Medicare Advantage plans.[60] All of these payment mechanisms have their roots in the ACA. As a result, an injunction that purports to cover all of the ACA (and the regulations promulgated under the ACA) would raise profound questions about their continuing viability. That would spark tremendous confusion and uncertainty among Medicare's millions of beneficiaries and providers. Under an injunction, would Medicare be allowed to continue making payments using ACA-created vehicles? Or would the payment be put on hold while the case played out? Something in between? Short of spelling out how exactly it applies in innumerable circumstances—in a manner akin to legislation replacing (rather than just repealing) the ACA—an injunction may effectively freeze certain payments under Medicare and cause unimaginable harm.

III. THIS COURT SHOULD NOT STRIKE DOWN THE GUARANTEED ISSUE AND COMMUNITY RATING PROVISIONS.

In its brief before this Court, the United States agrees that the vast majority of the ACA can and should survive even if the individual mandate is invalidated. Br. of United States at 2,

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[58] Henry J. Kaiser Family Foundation, *Medicare Delivery System Reform: The Evidence Link*, https://www.kff.org/medicare-delivery-system-reform-the-evidence-link (last visited June 11, 2018).

[59] Health Care Payment Learning & Action Network, *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs* (Oct. 30, 2017), https://hcp-lan.org/groups/apm-fpt-work-products/apm-report.

[60] Henry J. Kaiser Family Foundation, *Medicare Delivery System Reform: The Evidence Link*, https://www.kff.org/medicare-delivery-system-reform-the-evidence-link (last visited June 11, 2018); *see also* Jenny Gold, Kaiser Health News, *Accountable Care Organizations, Explained* (Sept. 14, 2015), https://khn.org/news/aco-accountable-care-organization-faq/.

Dkt. 92. But the United States contends that Congress would not have wanted to maintain the ACA's "guaranteed-issue and community-rating requirements" if the Court finds that the individual mandate is invalid. *Id.* (quotation marks omitted). That position misunderstands the economic impact of invalidating the individual mandate and how the ACA operates as an integrated whole.

It does not make sense that in 2017 Congress wanted to repeal the community rating and guaranteed issue provisions when it zeroed out the individual mandate. Those two provisions bar insurers from refusing to sell insurance or charge higher premiums to enrollees based on pre-existing conditions or other individualized characteristics, such as health status, medical condition, medical history, gender, age, or claims experience.[61] They are major reforms that have had and continue to have real and substantial policy benefits independent of the individual mandate. Accordingly, it is reasonable to think that after Congress repeatedly failed to repeal the full ACA, it chose to invalidate the individual mandate but to leave the guaranteed issue and community rating provisions in place. Indeed, that is the current state of the law.

From a contemporary economic perspective, those provisions can also survive an effective repeal of the individual mandate that is effective in 2019. To be sure, when Congress considered the ACA in 2010 and when the Supreme Court considered the constitutionality of the individual mandate in 2012, there was concern about adverse selection if the guaranteed issue and community rating provisions were enacted without also enacting the individual mandate. But those concerns are no longer well-founded. Nearly a decade after the ACA's enactment, insurance markets are robust and well-positioned to adapt to the invalidation of the individual mandate, which itself is a function of other stabilizing features of the ACA, including the premium subsidies and risk

[61] 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4.

adjustment provisions, which served to encourage participation in the marketplaces. When Congress considered zeroing the mandate penalty in 2017, the CBO estimated that invalidating the individual mandate would cause average premiums in the nongroup market to rise by about 10%, but that "nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade."[62] CBO recently reconfirmed that finding, concluding that despite zeroing out the mandate penalty the individual insurance market will remain stable in most of the country over the next decade, premiums rise only an average of about 7% between 2019 and 2028, and 12-13 million people will continue to enroll in the individual insurance market. [63] The recent analysis by the Urban Institute confirms the CBO's findings.[64] Indeed, insurers have already submitted rate filings for coverage across nine states in 2019, under the assumption that guaranteed issue and community rating provisions remain in effect, but that failure to comply with the individual mandate will no longer carry penalties.[65] To date, there are neither reports of insurer exits from the market nor areas where no insurer will offer an ACA-compliant plan. As a result, whatever prior concerns about an "adverse selection death spiral," there is no economic reason in 2018 for this Court to invalidate the community rating and guaranteed issue provisions if it decides to invalidate the individual mandate.

There is another reason to think that Congress would want to retain the guaranteed issue and community rating provisions even though the mandate has been zeroed out beginning in 2019:

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[62] Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[63] CBO 2018 at 2-3, 5.

[64] John Holahan, Linda J. Blumberg, & Matthew Buettgens, The Urban Institute, *Keeping Parts of the Affordable Care Act Intact is Still Better than Total Repeal* (June 14, 2018), https://www.urban.org/research/publication/aca-remains-critical-insurance-coverage-and-health-funding-even-without-individual-mandate.

[65] Kamal, *supra*.

key provisions of the ACA make little sense without them. For example, in a world without those provisions, customers with pre-existing conditions would be unlikely to find insurance that they could afford at all. To be sure, the ACA offers tax credit subsidies to make insurance more affordable, but those subsidies are available only to those who actually purchase insurance.[66] The upshot is that those subsidies would only be available as a practical matter to individuals healthy enough to obtain insurance in the first instance.[67] But without guaranteed issue, many people with current or prior health problems would be denied insurance outright, denying them the ability to use premium tax credits for which they are eligible. Others would be offered insurance at such a high price that it would be unaffordable.

Moreover, eliminating the guaranteed issue and community rating provisions would undermine the tax credits that the United States maintains should survive invalidation of the individual mandate. The ACA's tax credits and subsidies are calculated based on the second-lowest Silver premium available on the exchanges.[68] But that regime presumes the existence of guaranteed issue and community rating provisions. With those provisions, it is easy to determine the second lowest cost plan for every applicant living in the same relevant geographic area because in general the premium only differs between people based upon a standard age rating curve that applies to everyone in the same geographic area.[69] Conversely, as noted above, without those

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66 *See* Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Questions about Health Insurance Subsidies* 1-2 (Nov. 2017), http://files.kff.org/attachment/Issue-Brief-Explaining-Health-Care-Reform-Questions-about-Health-Insurance-Subsidies ("In order to receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance Marketplace.").

67 *See id.*

68 *Id.* at 3 ("The 'benchmark' for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state's Marketplace.").

69 *See* Dep't of Health & Human Servs., https://www.healthcare.gov/glossary/community-rating/ (last visited June 11, 2018) (defining "community rating" as "A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors."); *Id.* at https://www.healthcare.gov/glossary/guaranteed-issue/ (defining "guaranteed issue" as "A requirement that

provisions there would be some people (those with pre-existing conditions) for whom there would no premium offered at which they could purchase a policy; and for others the premium could vary enormously from person to person depending upon their characteristics.

As a result, it would be impossible to determine the second-lowest Silver plan for any one person unless they applied for coverage from, and were medically underwritten by, every single insurer offering coverage in the marketplace in their geographic area. That in turn would never happen because it would impose huge underwriting costs and time costs to insurers, and thus would make the premium tax credits and subsidies—provisions that are at the heart of the ACA—impossible to administer. In short, invalidating the community rating and guaranteed issue provisions will cause more chaos and disruption than merely invalidating the individual mandate. That cannot be a result that Congress desired when it chose to move the mandate penalty to zero.

CONCLUSION

For the foregoing reasons, the *amici* Economic Scholars respectfully urge that the Court deny Plaintiffs' motion for a preliminary injunction.

health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services.").

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that, on June 14, 2018, a true and correct copy of the foregoing was filed with the Clerk of the United States District Court for the Northern District of Texas via the Court's CM/ECF system, which will send notice of such filing to all registered CM/ECF users.

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