Nos. 19-840 & 19-1019

In the Supreme Court of the United States

THE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON, ANDY BESHEAR, THE GOVERNOR OF KENTUCKY, AND THE DISTRICT OF COLUMBIA,

Petitioners,

v.

THE STATE OF TEXAS, *et al.*,

Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

JOINT APPENDIX

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PETITION FOR A WRIT OF CERTIORARI FILED: JAN. 3, 2020
CROSS-PETITION FOR A WRIT OF CERTIORARI FILED: FEB. 14, 2020
CERTIORARI GRANTED: MAR. 2, 2020

(*Additional counsel and caption listed on inside cover*)

THE STATE OF TEXAS, *et al.*,

Cross-Petitioners,

v.

THE STATE OF CALIFORNIA, *et al.*

Cross-Respondents.

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The following opinions, decisions, orders, and judgments have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the petition for a writ of certiorari in No. 19-840:

[1] The court of appeals initially issued its opinion on December 18, 2019, and then issued a revised opinion on December 20, 2019 that made a series of technical changes. The December 20 version of the opinion appears in the petition appendix in No. 19-840 (at 1a-113a). After that petition was filed on January 3, 2020, the court of appeals issued another revised opinion on January 9, 2020, that made further technical changes. The January 9 version of the opinion is included in this Joint Appendix (at 374-489); and petitioners have cited to that version in their merits briefing.

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-10011

TEXAS, ET AL., *Plaintiffs – Appellees*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants – Appellants,*

CALIFORNIA, ET AL., *Intervenor-Defendants – Appellants.*

DOCKET ENTRIES

DATE	PROCEEDINGS
01/07/2019	US CIVIL CASE docketed. NOA filed by Appellants District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia and State of Washington.
01/07/2019	CASE CAPTION updated. Additional appeal filed. Parties added: Appellants USA, HHS, Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, United States Internal Revenue Service and Charles P.

DATE	PROCEEDINGS
	Rettig. NOA filed by Appellants Mr. Charles P. Rettig, United States Internal Revenue Service, Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, HHS and USA.
	* * * * *
01/07/2019	OPPOSED MOTION to intervene filed by United States House of Representatives.
	* * * * *
01/31/2019	UNOPPOSED MOTION to intervene filed by State of Colorado, State of Iowa, State of Michigan and State of Nevada.
	* * * * *
02/01/2019	OPPOSED MOTION filed by Appellants District of Columbia, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia and State of Washington to expedite the appeal. REVIEWED AND/OR EDITED - The original text prior to review appeared as follows: OPPOSED MOTION filed by Appellant State of California to expedite the appeal
	* * * * *

DATE	PROCEEDINGS
02/11/2019	RESPONSE/OPPOSITION filed by Mr. Paul LePage, State of Alabama, State of Arizona, State of Arkansas, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah, State of West Virginia and State of Wisconsin to the Motion filed by Appellants State of California, District of Columbia, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia and State of Washington.
	* * * * *
02/13/2019	REPLY filed by Not Party United States House of Representatives to the Response/Opposition filed by Appellants USA, HHS, Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, United States Internal Revenue Service and Mr. Charles P. Rettig.
	* * * * *
02/14/2019	REPLY filed by Appellant State of California to the Response/Opposition

DATE	PROCEEDINGS
	filed by Appellees Mr. Paul LePage, State of Alabama, State of Arizona, State of Arkansas, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah, State of West Virginia and State of Wisconsin.
	* * * * *
02/14/2019	COURT ORDER granting motion to intervene by United States House of Representatives.
02/14/2019	COURT ORDER denying Motion to expedite appeal filed by Appellants State of Connecticut, State of Illinois, State of Oregon, State of Delaware, State of Virginia, State of California, State of Hawaii, State of North Carolina, State of Rhode Island, State of Washington, State of New York, State of Massachusetts, District of Columbia, State of Vermont, State of Kentucky, State of Minnesota and State of New Jersey; granting Motion to intervene by State of Colorado, State of Iowa, State of Michigan and State of Nevada.
	* * * * *
03/25/2019	APPELLANT'S BRIEF FILED A/Pet's Brief deadline satisfied. Paper Copies

DATE	PROCEEDINGS
	of Brief due on 04/08/2019 for Appellants District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia and State of Washington.
03/25/2019	INTERVENOR'S BRIEF FILED by Intervenor United States House of Representatives. Paper Copies of Brief due on 04/08/2019 for Intervenor United States House of Representatives.
03/25/2020	LETTER filed by Appellants Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, HHS, Mr. Charles P. Rettig, United States Internal Revenue Service and USA Letter re: United States brief.
	* * * * *
04/08/2019	COURT ORDER granting Motion to extend time to file appellee's brief filed by Appellees State of Tennessee, State of South Carolina, State of Alabama, State of Louisiana, State of Florida, State of Arkansas, State of Wisconsin, State of South Dakota, State of Georgia, State of Missouri, State of Utah,

DATE	PROCEEDINGS
	State of Kansas, State of West Virginia, State of Texas, State of Nebraska, State of Mississippi, State of Arizona, State of Indiana and State of North Dakota E/Res's Brief deadline updated to 05/01/2019 for Appellees Neill Hurley, John Nantz, State of Alabama, State of Arizona, State of Arkansas, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah, State of West Virginia and State of Wisconsin; to extend time to file brief as appellant A/Pet's Brief deadline updated to 05/01/2019 for Appellants Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, Charles P. Rettig, United States Department of Health and Human Services, United States Internal Revenue Service and United States of America.
	* * * * *
04/08/2019	Unopposed Motion filed by Appellants Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Revenue Service and USA for expedited oral argument.
	* * * * *

DATE	PROCEEDINGS
04/10/2019	COURT ORDER expediting the appeal; granting Motion for oral argument filed by Appellants USA, HHS, Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, United States Internal Revenue Service and Mr. Charles P. Rettig.
	* * * * *
05/01/2019	APPELLEE'S BRIEF FILED E/Res's Brief deadline satisfied. Paper copies of Brief due on 05/07/2019 for Appellees State of Alabama, State of Arizona, State of Arkansas, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah and State of West Virginia.
05/01/2019	APPELLANT'S BRIEF FILED by USA, Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, Mr. Charles P. Rettig, HHS and United States Internal Revenue Service. A/Pet's Brief deadline satisfied.
05/01/2019	APPELLEE'S BRIEF FILED E/Res's Brief deadline satisfied. Reply Brief due on 05/22/2019 for Appellants District of Columbia, State of California,

DATE	PROCEEDINGS
	State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia and State of Washington. Paper Copies of Brief due on 05/07/2019 for Appellees Neill Hurley and John Nantz.
	* * * * *
05/22/2019	APPELLANT'S REPLY BRIEF FILED Reply Brief deadline satisfied. Paper Copies of Brief due on 05/28/2019 for Appellants District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New York, State of North Carolina, State of Rhode Island, State of Vermont, State of Virginia and State of Washington.
05/22/2019	INTERVENOR'S REPLY BRIEF FILED Paper Copies of Brief due on 05/28/2019 for Intervenor United States House of Representatives.
	* * * * *
05/23/2019	CASE CALENDARED for oral argument on Tuesday, 07/09/2019 in New Orleans in the West Courtroom -- PM session.

DATE	PROCEEDINGS
	* * * * *
06/26/2019	The ORAL ARGUMENT panel has requested of the parties the following: supplemental letter briefs. Miscellaneous due on 07/03/2019.
	* * * * *
07/03/2019	APPELLANT'S SUPPLEMENTAL BRIEF FILED by Mr. Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services, Mr. Charles P. Rettig, HHS, United States Internal Revenue Service and USA. Miscellaneous deadline satisfied.
	* * * * *
07/05/2019	APPELLANT'S SUPPLEMENTAL BRIEF FILED. Miscellaneous deadline satisfied.
07/05/2019	LETTER filed by Intervenor United States House of Representatives referencing OA Panel Request.
07/05/2019	LETTER filed by Appellees State of Alabama, State of Arizona, State of Arkansas, State of Florida, State of Georgia, State of Indiana, State of Kansas, State of Louisiana, State of Mississippi, State of Missouri, State of Nebraska, State of North Dakota, State of South Carolina, State of South Dakota, State of Tennessee, State of Texas, State of Utah and State of West

DATE	PROCEEDINGS
	Virginia referencing OA Panel Request.
07/05/2019	LETTER filed by Appellees Mr. Neill Hurley and Mr. John Nantz referencing OA Panel Request.
	* * * * *
07/09/2019	ORAL ARGUMENT HEARD before Judges King, Elrod, Engelhardt.
	* * * * *
12/18/2019	PUBLISHED OPINION FILED. [19-10011 Affirmed in Part; Vacated in Part and Remanded] Judge: CDK, Judge: JWE, Judge: KDE. Mandate issue date is 02/10/2020.
12/18/2019	JUDGMENT ENTERED AND FILED. Costs Taxed Against: Each Party to Bear Its Own Costs on Appeal.
	* * * * *
12/20/2019	TECHNICAL REVISION MADE TO OPINION.
	* * * * *
01/09/2020	TECHNICAL REVISION MADE TO OPINION.
	* * * * *
01/29/2020	COURT ORDER denying for rehearing en banc. Mandate issue date is 02/06/2020.
	* * * * *
02/06/2020	MANDATE ISSUED. Mandate issue date satisfied.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants.*

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
02/26/2018	1	COMPLAINT against All Defendants filed by Louisiana, West Virginia, Florida, South Carolina, Texas, South Dakota, North Dakota, Phil Bryant, Arizona, Arkansas, Indiana, Paul LePage, Utah, Missouri, Nebraska, Georgia, Wisconsin, Kansas, Tennessee, Alabama.
	* * * * *	
04/09/2018	14	Answer to Complaint filed by State of California, State of Connecticut, District of Columbia,

DATE	DOCKET NUMBER	PROCEEDINGS
		State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington, State of Minnesota.
04/09/2018	15	MOTION to Intervene filed by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington with Brief/ Memorandum in Support.

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
04/23/2018	27	AMENDED COMPLAINT *FOR DECLARATORY AND INJUNCTIVE RELIEF* against All Defendants filed by West Virginia, Florida, South Carolina, Texas, South Dakota, North Dakota, Arkansas, Utah, Missouri, Kansas, Louisiana, Mississippi, Arizona, Indiana, Paul LePage, Nebraska, Georgia, Wisconsin, Tennessee, Alabama, Neill Hurley, John Nantz.
	* * * * *	
04/26/2018	39	PLAINTIFF-STATES' AND INDIVIDUAL-PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin.

DATE	DOCKET NUMBER	PROCEEDINGS
04/26/2018	40	Brief/Memorandum in Support filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re 39 MOTION for Injunction.
04/26/2018	41	Appendix in Support filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re 39 MOTION for Injunction.
04/27/2018	42	MOTION to Expedite Ruling on Motion to Intervene filed by District of Columbia, State of

DATE	DOCKET NUMBER	PROCEEDINGS
		California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington with Brief/ Memorandum in Support.
		* * * * *
04/30/2018	49	RESPONSE filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re: 15 MOTION to Intervene.
		* * * * *
05/04/2018	67	REPLY filed by District of Columbia, State of

DATE	DOCKET NUMBER	PROCEEDINGS
		California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington re: 15 MOTION to Intervene.
		* * * * *
05/14/2018	73	PROPOSED ANSWER IN INTERVENTION to 27 Amended Complaint, filed by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington.

DATE	DOCKET NUMBER	PROCEEDINGS
05/16/2018	74	ORDER: The Court finds that the Proposed Intervenor States' Motion to Intervene (ECF No. 15) should be and is hereby GRANTED.
	* * * * *	
06/07/2018	91	RESPONSE filed by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington re: 39 MOTION for Injunction.
06/07/2018	92	RESPONSE filed by Alex Azar, Department of Health & Human Services, David Kautter, United States Interval Revenue Services, United States of America

DATE	DOCKET NUMBER	PROCEEDINGS
		re: 39 MOTION for Injunction.
		* * * * *
07/05/2018	175	REPLY filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re: 39 MOTION for Injunction.
07/16/2018	176	ORDER: The Court ORDERS all parties to file any additional information they wish to present in opposition to considering these issues on summary judgment. Any additional information any party wishes to present should be filed on or before July 30, 2018. See FED. R. CIV. P. 56(f)(3).
		* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
07/30/2018	181	RESPONSE filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re: 176 Order Setting Deadline/ Hearing.
07/30/2018	182	RESPONSE filed by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington re: 176 Order Setting Deadline/Hearing.

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
09/05/2018	199	ELECTRONIC Minute Entry for proceedings held before Judge Reed C. O'Connor: Oral Argument held on 9/5/2018.
	* * * * *	
12/14/2018	211	[STAYED per order of Dec 30 2018] ORDER granting Plaintiffs partial summary judgment (Ordered by Judge Reed C. O'Connor on 12/14/2018) (Judge Reed C. O'Connor) Modified on 12/31/2018.
	* * * * *	
12/17/2018	213	MOTION re 211 Order on Motion for Injunction filed by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington with

DATE	DOCKET NUMBER	PROCEEDINGS
		Brief/Memorandum in Support.
		* * * * *
12/21/2018	216	RESPONSE AND OBJECTION filed by Alex Azar, Department of Health & Human Services, David Kautter, United States Interval Revenue Services, United States of America re: 213 MOTION re 211 Order on Motion for Injunction.
12/21/2018	217	RESPONSE filed by Alabama, Arizona, Arkansas, Florida, Georgia, Neill Hurley, Indiana, Kansas, Paul LePage, Louisiana, Mississippi, Missouri, John Nantz, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin re: 213 MOTION re 211 Order on Motion for Injunction.
		* * * * *
12/26/2018	218	REPLY filed by District of Columbia, State of

DATE	DOCKET NUMBER	PROCEEDINGS
		California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington re: 213 MOTION re 211 Order on Motion for Injunction.
		* * * * *
12/30/2018	220	ORDER GRANTING STAY AND PARTIAL FINAL JUDGMENT: On December 17, 2018, the Intervenor Defendants moved the Court to clarify that the December 14, 2018 Order is not binding or to enter a stay if the Order is binding and to enter final judgment or certify the Order for immediate appeal. See ECF No. 213. The Court finds that the December 14, 2018 Order declaring the

DATE	DOCKET NUMBER	PROCEEDINGS
		Individual Mandate unconstitutional and inseverable should be stayed. Accordingly, the Court ORDERS that the December 14, 2018 Order, (ECF No. 211), and the Partial Final Judgment severing Count I and finalizing that Order---which will issue by separate order---be stayed during the pendency of the Order's appeal. (Ordered by Judge Reed C. O'Connor on 12/30/2018).
12/30/2018	221	Final Judgment on Count I: The Court issued its order granting partial summary judgment on Count I of Plaintiffs' Amended Complaint, and has determined that it should be severed from the remaining claims. December 14, 2018 Order, ECF No. 211. In accordance with Federal Rule of Civil Procedure 54(b), the Court therefore DECLARES that 26 U.S.C. § 5000A(a)

DATE	DOCKET NUMBER	PROCEEDINGS
		is UNCONSTITUTIONAL and INSEVERABLE from the remainder of the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119-1045 (2010). (Ordered by Judge Reed C. O'Connor on 12/30/2018).
12/31/2018	223	STAY ORDER AND ADMINISTRATIVE CLOSURE. The Court has entered a partial judgment on Count I in this case (ECF No. 221). The Court determines the remainder of this case should be STAYED pending further orders. The Clerk is therefore instructed to submit a JS-6 form to the Administrative Office, removing this case from the statistical records. Nothing in this Order shall be considered a dismissal or disposition of the remaining clams. The parties are directed to notify the Court upon the conclusion of the ap-

DATE	DOCKET NUMBER	PROCEEDINGS
		peal of the partial judgment within 14 days of any decision. Should further proceedings in the meantime become necessary or desirable, any party may initiate it by filing an appropriate pleading. (Ordered by Judge Reed C. O'Connor on 12/31/2018).
01/03/2019	224	NOTICE OF APPEAL as to 221 Order on Motion for Miscellaneous Relief, 211 Order on Motion for Injunction to the Fifth Circuit by District of Columbia, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Illinois, State of Kentucky, State of Massachusetts, State of Minnesota, State of New Jersey, State of New York, State of North Carolina, State of Oregon, State of Rhode Island, State of Vermont, State of Virginia, State of Washington.

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
01/04/2019	230	NOTICE OF APPEAL as to 221 Order on Motion for Miscellaneous Relief,, 211 Order on Motion for Injunction to the Fifth Circuit by Alex Azar, Department of Health & Human Services, David Kautter, United States Interval Revenue Services, United States of America.
		* * * * *
01/07/2019		USCA Case Number 19-10011 in United States Court of Appeals Fifth Circuit for 224 Notice of Appeal, filed by State of Virginia, State of Hawaii, State of Rhode Island, State of Minnesota, State of Kentucky, State of Vermont, State of New Jersey, State of Connecticut, State of Oregon, State of Illinois, District of Columbia, State of North Carolina, State of Delaware, State of Massachusetts, State of California, State of New York, State of Washington, 230 Notice of Appeal, filed by David Kautter,

DATE	DOCKET NUMBER	PROCEEDINGS
		Department of Health & Human Services, United States of America, Alex Azar, United States Interval Revenue Services.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 23, 2018]

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

TO THE HONORABLE REED O'CONNOR:

The Patient Protection and Affordable Care Act (the "Affordable Care Act," "the ACA" or "the Act"), as recently amended, forces an unconstitutional and irrational regime onto the States and their citizens. Because this recent amendment renders legally impossible the Supreme Court's prior savings construction of the Affordable Care Act's core provision—the individual mandate—the Court should hold that the ACA is unlawful and enjoin its operation.

NFIB v. Sebelius, 567 U.S. 519 (2012), held that in enacting the ACA, Congress sought to do something unconstitutional: impose a mandate to obtain health insurance by requiring that most Americans "shall" insure that they are "covered under minimum essential coverage." 26 U.S.C. § 5000A(a). "Congress [wrongly] thought it could enact such a command under the Commerce Clause[.]" *NFIB*, 567 U.S. at 562

(Roberts, C.J.). The Supreme Court, however, interpreted the mandate to be part-and-parcel of a tax penalty that applies to many (but not all) of those to whom the mandate applies. Thus, even though Congress sought to do something unconstitutional in enacting the mandate under the Commerce Clause, the Supreme Court salvaged its handiwork as a lawful exercise of the taxing power. But things changed on December 22, 2017.

On December 22, 2017, the President signed into law the Tax Cuts and Jobs Act of 2017. This new legislation eliminated the tax penalty of the ACA, without eliminating the mandate itself. What remains, then, is the individual mandate, without any accompanying exercise of Congress's taxing power, which the Supreme Court already held that Congress has no authority to enact. Not only is the individual mandate now unlawful, but this core provision is not severable from the rest of the ACA—as four Justices of the Supreme Court already concluded. In fact, Congress stated in the legislative text that the ACA does not function without the individual mandate.

The ACA's unconstitutionality follows from three holdings in *NFIB* and the aforementioned provision in the Tax Cuts and Jobs Act of 2017. First, a majority of the Supreme Court held that Congress lacks the constitutional authority to compel citizens to purchase health insurance. *NFIB*, 567 U.S. at 558 (Roberts, C.J.); id. at 657 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (hereinafter "Dissenting Op."). Second, the same majority concluded that the ACA included a mandate to buy health insurance that applies to most (but not all) citizens, and a separate tax penalty that applies to most (but not all) of those required to buy insurance under the mandate. *Id*. at 562–63

(Roberts, C.J.); *id*. at 663 (Dissenting Op.). Third, a different majority held that, as a matter of constitutional avoidance, it was "fairly possible" to reinterpret the mandate and tax penalty as a single "tax," which Congress may enact under its taxing authority. *Id*. at 564–74. In reaching this end, the majority concluded that Congress's taxing-power interpretation was only "fairly possible" because the provision at issue raised "at least some revenue for the Government." *Id*. at 564 (citing *United States v. Kahriger*, 345 U.S. 22 (1953)). Indeed, the raising of "at least some revenue" was "*the essential* feature of *any* tax." *Id*. (emphasis added). After all, if a provision raises no revenue, it cannot be said "to *pay* the Debts and *provide* for the common Defence and general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1 (emphasis added).

Pursuant to the Tax Cuts and Jobs Act of 2017, starting in 2019, the tax penalty is eliminated by reducing the tax to zero. Pub. L. No. 115-97, § 11081, 131 Stat. 2054. The individual mandate itself, however, remains. But because the tax penalty provision in the ACA no longer raises *any* revenue, the Supreme Court's avoidance reading is no longer possible. As the Congressional Budget Office explained, the Tax Cuts and Jobs Act of 2017 "eliminate[s]" the "individual mandate penalty . . . *but [not] the mandate itself*." Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1, (November 2017) (emphasis added) (hereinafter "CBO 2017 Report").[1] Because the tax penalty raises $0, it lacks "*the essential feature* of *any* tax," and the avoid-

[1] *See* https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

ance interpretation adopted in *NFIB* to save the individual mandate from its unconstitutionality is no longer "fairly possible."

Following the enactment of the Tax Cuts and Jobs Act of 2017, the country is left with an individual mandate to buy health insurance that lacks any constitutional basis. The invalidity of the ACA's core provision (individual mandate) thus follows from *NFIB*.

Once the heart of the ACA—the individual mandate—is declared unconstitutional, the remainder of the ACA must also fall. *NFIB*, 567 U.S. at 691–708 (Dissenting Op.). As Congress made clear, "[t]he requirement [for individuals to buy health insurance] is *essential* to creating effective health insurance markets." 42 U.S.C. § 18091(2)(I) (emphasis added). "[T]he absence of th[is] requirement would undercut Federal regulation of the health insurance market." *Id*. § 18091(2)(H). In particular, "the guaranteed issue and community rating requirements *would not work* without the coverage requirement [i.e., Section 5000A]." *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (emphasis added). So because the remainder of ACA does not "function in a manner consistent with the intent of Congress," the whole Act must fall with the mandate. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–85 (1987) (describing severability analysis) (emphasis added).

Absent the individual mandate, the ACA is an irrational regulatory regime governing an essential market. The ACA's stated objectives are "achiev[ing] near-universal [health-insurance] coverage," 42 U.S.C. § 18091(2)(D), "lower[ing] health insurance premiums," *id*. § 18091(2)(F), and "creating effective health insurance markets," *id*. § 18091(2)(I). But without the "essential" mandate, coverage will decrease,

premiums will rise, and markets will become irrational. See *id*. Thus, the post-mandate ACA lacks "some footing" in the "realities" of the health-insurance market, *Heller v. Doe*, 509 U.S. 312, 321 (1993), and has no "plausible policy reason" for forcing continued compliance, *Armour v. City of Indianapolis*, 566 U.S. 673, 681 (2012).

In all, the ACA is unlawful and the Court should enjoin its operation. Therefore, Plaintiffs seek declaratory and injunctive relief against the United States of America, United States Department of Health and Human Services, Alex Azar, in his official capacity as Secretary of Health and Human Services, United States Internal Revenue Service, and David J. Kautter, in his official capacity as Acting Commissioner of Internal Revenue, regarding Defendants' actions implementing and enforcing the Patient Protection and Affordable Care Act.

I. PARTIES

1. Plaintiff States are all sovereigns within the United States.

2. Plaintiff Paul LePage is the Governor of Maine and Chief Executive of the Maine Constitution and the laws enacted by the Maine Legislature. Me. Const. art. V, Pt. 1, § 1.

3. Plaintiff Phil Bryant is the Governor of Mississippi and brings this suit on behalf of Mississippi pursuant to Miss. Code Ann. § 7-1-33.

4. Plaintiff Neill Hurley is a citizen and resident of Texas and a citizen of the United States. Mr. Hurley maintains minimum essential health insurance coverage, which he purchased on the ACA-created exchange. Mr. Hurley is subject to the individual

mandate and objects to being required by federal law to comply with it.

5. Plaintiff John Nantz is a citizen and resident of the State of Texas and a citizen of the United States. Mr. Nantz maintains minimum essential health insurance coverage, which he purchased on the ACA-created exchange. Mr. Nantz is subject to the individual mandate and objects to being required by federal law to comply with it.

6. In addition to performing various sovereign functions and prerogatives, all Plaintiff States function as significant employers with tens of millions under their collective charge.[2]

7. Defendants are the United States of America, the United States Department of Health and Human Services ("Department"), Alex Azar, in his official capacity as Secretary of Health and Human Services, the United States Internal Revenue Service ("Service"), and David J. Kautter, in his official capacity as Acting Commissioner of Internal Revenue.

8. The Department is a federal agency and is responsible for administration and enforcement of the laws challenged here. See generally 20 U.S.C. § 3508; 42 U.S.C. §§ 202–03, 3501.

9. The Service is a bureau of the Department of Treasury, under the direction of the Acting Commissioner of Internal Revenue, David J. Kautter, and is responsible for collecting taxes, administering the Internal Revenue Code, and overseeing various aspects

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[2] *See, e.g.*, U.S. Census Bureau, State and Local Government Employment and Payroll Data: March 2015 Annual Survey of Public Employment & Payroll, http://factfinder.census.gov/bkmk/table/1.0/en/ GEP/2015/00A4.

of the Act. *See generally* 26 U.S.C. § 7803 et. seq.; *see* https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions.

10. Any injunctive relief requested herein must be imposed upon the Department, Secretary, Service, and the Acting Commissioner for Plaintiffs to obtain full relief.

II. JURISDICTION AND VENUE

11. The Court has jurisdiction pursuant to 28 U.S.C. § 1331 because this suit concerns the constitutionality of the ACA. The Court also has jurisdiction to compel the Secretary of Health and Human Services and Acting Commissioner of Internal Revenue to perform their duties pursuant to 28 U.S.C. § 1361.

12. The Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, by 5 U.S.C. § 706, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of the Court.

13. Venue is proper under 28 U.S.C. § 1391 because the United States, two of its agencies, and two of its officers in their official capacity are Defendants; and a substantial part of the events giving rise to the Plaintiffs' claims occurred in this District. Further, a plaintiff "resides" in this district, a "substantial part of the events [ ] giving rise to the claim occurred" in this district, and "no real property is involved." *Id*. § 1391(e)(1).

III. FACTUAL BACKGROUND

A. The Individual Mandate and the Affordable Care Act.

14. In 2010, Congress enacted a sweeping new regulatory framework for the nation's healthcare system by passing the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, collectively and commonly referred to as the "Affordable Care Act." *See Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, 124 Stat. 119-1025 (Mar. 23, 2010) (hereinafter, collectively, "the Affordable Care Act," "the ACA" or "the Act"). President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590, 111th Cong.) into law on March 23, 2010, and the Health Care and Education Reconciliation Act (H.R. 4872, 111th Cong.) into law on March 30, 2010.

15. The ACA has the express statutory goals of "achiev[ing] near-universal [health-insurance] coverage," 42 U.S.C. § 18091(2)(D), "lower[ing] health insurance premiums," *id*. § 18091(2)(F), and "creating effective health insurance markets," *id*. § 18091(2)(I).

16. The ACA contains three main features relevant to this lawsuit.

17. First, the ACA contains an "individual mandate" on most Americans to purchase health insurance and, separately, a tax penalty for most who fail to comply. ACA § 1501; 26 U.S.C. § 5000A.

a. The statutory title of the individual mandate is "Requirement To Maintain Minimum Essential Coverage," ACA § 1501; 26 U.S.C. § 5000A(a), and the statutory title

for the tax penalty is "Shared Responsibility Payment," ACA § 1501; 26 U.S.C. § 5000A(b). The individual mandate provides: "An applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage." 26 U.S.C. § 5000A(a).

b. Subsection (b) of Section 5000A—the "Shared Responsibility Payment"—imposed a tax "penalty" on individuals who failed to comply with Subsection (a): "If a taxpayer who is an applicable individual . . . fails to meet the requirement of subsection (a) . . . then . . . there is hereby imposed on the taxpayer a penalty with respect to such failure[ ]." 26 U.S.C. § 5000A(b)(1). Subsection (c) determines the amount of the tax penalty with a multi-step formula. *Id.* § 5000A(c).

c. Some Americans are exempt from the individual mandate, see 26 U.S.C. § 5000A(d)(2)–(4); id. § 1402(g)(1), while others are subject to the mandate but exempt from the tax penalty, see 26 U.S.C. § 5000A(e)(1)–(5). "Many individuals . . . [will] comply with a mandate, even in the absence of penalties, because they believe in abiding by the nation's laws." Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 53 (Dec. 2008).[3]

[3] *See* https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf.

18. Second, the ACA imposes regulations on health-insurance companies.

a. The Act requires health insurance companies to "accept every employer and individual in the State that applies for [ ] coverage," regardless of preexisting conditions (commonly termed "guaranteed issue"). ACA § 1201; 42 U.S.C. § 300gg-1–4.

b. The Act prohibits insurance companies from charging individuals higher premiums because of their health (commonly termed "community rating"). ACA § 1201; 42 U.S.C. § 300gg-4(a)(1).

c. The Act imposes numerous coverage requirements on all health-insurance plans, termed "essential health benefits" in the Act, and limitations on "cost-sharing" on all plans. *See* ACA §§ 1301–02; 42 U.S.C. §§ 18021–22.

d. The Act charges "the Secretary" with the authority to "define the essential health benefits" that plans must include. ACA § 1302; 42 U.S.C. § 18022. Such benefits "shall include" at least "ambulatory patient services," "emergency services," "hospitalization," "maternity and newborn care," "mental health and substance use disorder services, including behavioral health treatment," "prescription drugs," "rehabilitative and habilitative services and devices," "laboratory services," "preventive and wellness services and chronic disease management," and "pediatric services, including oral and vision care." ACA § 1302;

42 U.S.C. § 18022(b)(1)(A)–(J) (capitalization altered).

19. Third, the ACA contains other regulations to promote access to health insurance and the affordability of that insurance.

a. Employers of 50 or more full-time employees (defined as working "on average at least 30 hours [ ] per week," ACA § 1513; 26 U.S.C. § 4980H(c)(4)(A)) must offer affordable health insurance if one employee qualifies for a subsidy to purchase health insurance on the health-insurance exchanges created by the ACA. See ACA § 1513; 26 U.S.C. § 4980H.

b. Covered employers that fail to offer any insurance must pay a penalty of $2,000 per year per employee. ACA § 1513; 26 U.S.C. § 4980H(a), (c)(1). If the employer fails to offer affordable insurance, then it must pay $3,000 per year per employee. ACA § 1513; 26 U.S.C. § 4980H(b); 79 Fed. Reg. 8544, 8544 (Feb. 12, 2014).

c. The Act also authorizes refundable tax credits to make insurance purchased on the exchanges more affordable for individuals between 100% and 400% of the poverty line. See ACA § 1401; 26 U.S.C. § 36B.

d. The Act substantially expanded Medicaid, requiring States to cover—with an expanded benefits package—all individuals under 65 who have income below 133% of the poverty line. 42 U.S.C. § 1396; *see generally NFIB*, 567 U.S. at 574–80 (Roberts, C.J.) (describing expansion and holding

that forcing States to comply is unconstitutional).

e. The Act also imposes additional insurance taxes and regulations, like a tax on high cost employer-sponsored health coverage, 26 U.S.C. § 4980I, a requirement that insurance providers cover dependents up to 26 years of age, 42 U.S.C. § 300gg-14(a), the elimination of coverage limits, *id.* § 300gg-11, and a reduction in federal reimbursement rates to hospitals, *see* 42 U.S.C. § 1395ww.

f. Finally, the Act contains a grab bag of other provisions. For example, the Act imposes a 2.3% tax on certain medical devices, 26 U.S.C. § 4191(a), creates mechanisms for the Secretary to issue compliance waivers to States attempting to reduce costs through otherwise-prohibited means, 42 U.S.C. § 1315, and regulates the display of nutritional content at certain restaurants, 21 U.S.C. § 343(q)(5)(H).

20. According to Congress's own findings, the ACA's provisions do not function rationally without the individual mandate.

a. Congress stressed the importance of Section 5000A's individual mandate with explicit findings in the text of the ACA itself. ACA § 1501; 42 U.S.C. § 18091.

b. Chief among these legislative findings is Section 18091(a)(2)(I), which provides:

> Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C.

> 300gg-3, 300gg-4] (as added by section 1201 of this Act), if there were no requirement [to buy health insurance], many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement [to buy health insurance], together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. *The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.*

42 U.S.C. § 18091(a)(2)(G) (emphasis added). Even after the recent legislative change, the individual mandate remains part of the ACA, permitting the ACA to function exactly as Congress outlined and intended.

c. Other legislative findings from Section 18091 reinforce this point.

   i. "By significantly reducing the number of the uninsured, the requirement, together with the other provisions of th[e] [ACA], will significantly reduce [health care's] economic cost." *Id*. § 18091(2)I. "[B]y significantly reducing the number

of the uninsured, the requirement, together with the other provisions of th[e] [ACA], will lower health insurance premiums." *Id*. § 18091(2)(F).

ii. "The requirement is *an essential* part of [the Government's] regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market." *Id*. § 18091(2)(H) (emphasis added).

iii. "[T]he requirement, together with the other provisions of th[e] [ACA], will significantly reduce administrative costs and lower health insurance premiums. The requirement is *essential* to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." *Id*. § 18091(2)(J) (emphasis added).

d. The Supreme Court explained that the ACA's provisions are "closely intertwined," such that "the guaranteed issue and community rating requirements *would not work* without the coverage requirement [i.e., Section 5000A]." *King*, 135 S. Ct. at 2487 (emphasis added); *NFIB*, 567 U.S. at 547–48 (Roberts, C.J).

e. Upsetting this balance "would destabilize the individual insurance market" in the manner "Congress designed the Act to avoid." *King*, 135 S. Ct. at 2493.

B. The Individual Mandate and the Tax Penalty Are Inextricably Intertwined—One Cannot Exist Without the Other under *NFIB v. Sebelius*.

21. In *NFIB v. Sebelius*, 567 U.S. 519 (2012), the constitutionality of the ACA was challenged by most of the Plaintiff States herein.

22. As relevant here, the States argued that Section 5000A "exceeded Congress's powers under Article I of the Constitution." *Id*. at 540 (Roberts, C.J.). Specifically, the States argued that: (1) the Commerce Clause did not support the individual mandate; (2) Congress's tax power did not support the mandate; and (3) if Section 5000A is unconstitutional, the Court must enjoin the entire ACA because it is non-severable. *See id*. at 538–43 (Roberts, C.J.).

23. A majority of the Supreme Court held (via the opinion of the Chief Justice and the four-Justice dissenting opinion) that the individual mandate exceeded Congress's power under the Commerce Clause and the Necessary and Proper Clause. *Id*. at 558–61 (Roberts, C.J.); *id*. at 657 (Dissenting Op.).

24. A different majority (via the opinion of the Chief Justice and the four-Justice concurring opinion) then held it was "fairly possible" to read the individual mandate plus its tax penalty as a single, unified tax provision, and thus could be supported under Congress's tax power. *Id*. at 563 (Roberts, C.J.).

25. Under this alternate tax interpretation, Section 5000A is no longer "a legal command to buy insurance" backed up by a threat of paying a penalty that is applicable to some, but not all, of those to whom the

mandate applies; "[r]ather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income." Id. (Roberts, C.J.).

26. "The *essential* feature" of the Court's alternative tax holding is that the tax penalty "produces at least some revenue for the Government." *Id*. at 564 (Roberts, C.J.) (citing *Kahriger*, 345 U.S. at 28 n.4) (emphasis added). "Indeed, the payment is expected to raise about $4 billion per year by 2017." *Id*. (Roberts, C.J.). Absent that "essential feature," the Court's alternative interpretation was not "fairly possible" under both the Constitution's text and longstanding Supreme Court precedent.

27. The *NFIB* dissent rejected this alternate reading. The dissent explained that Section 5000A is "a mandate that individuals maintain minimum essential coverage, [which is] *enforced by a penalty*." *Id*. at 662 (Dissenting Op.) (emphasis added). It is "a mandate to which a penalty is attached," not "a simple tax." *Id*. at 665 (Dissenting Op.).

28. The dissent explained that the structure of Section 5000A supported the mandate-attached-to-a-penalty-that-sometimes-applies reading: Section 5000A mandates that individuals buy insurance in Subsection (a), and then in Subsection (b) it imposes the penalty for failure to comply with Subsection (a). *Id*. at 663 (Dissenting Op.). Section 5000A exempts "some" people from the mandate, but not the penalty—"those with religious objections," who "participate in a health care sharing ministry," and "those who are not lawfully present in the United States." *Id*. at 665 (Dissenting Op.) (citations omitted). "If [Section] 5000A were [simply] a tax" and "no[t] [a] requirement" to obtain health insurance, exempting anyone from the

mandate provision, but not the penalty provision, "would make no sense." *Id*. (Dissenting Op.).

29. The Chief Justice agreed with the dissent's primary conclusion (thereby creating a majority) that the "most straightforward reading of" Section 5000A "is that it commands individuals to purchase insurance." *Id*. at 562 (Roberts, C.J.). "Congress thought it could enact such a command under the Commerce Clause, and the Government primarily defended the law on that basis." *Id*. (Roberts, C.J.). The "most natural interpretation of the mandate" is that it is a command backed up by a penalty, not a tax. *Id*. at 563 (Roberts, C.J.).

C. The Tax Cuts and Jobs Act of 2017 Repealed The Tax Penalty, Leaving Only the Unconstitutional Individual Mandate.

30. On December 22, 2017, the President signed into law the Tax Cuts and Jobs Act of 2017. Among many other provisions, the new law amended Section 5000A. Pub. L. No. 115-97, § 11081.

31. This amendment reduces the operative parts of Section 5000A(c)'s tax penalty formula to "Zero percent" and "$0." Pub. L. No. 115-97, § 11081. This change applies after December 31, 2018. *Id*. After the Tax Cuts and Jobs Act of 2017, Section 5000A(a) still contains the individual mandate, requiring "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage," but Section 5000A(b)'s tax "penalty" for an individual who "fails to meet th[is] requirement" is now $0.

32. The House Conference Report of the Tax Cuts and Jobs Act of 2017 agreed. "Under the [ACA], individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a

tax (also referred to as a penalty) for failure to maintain the coverage (commonly referred to as the 'individual mandate')." H.R. Rep. No. 115-466, at 323 (2017).[4] "The Senate amendment reduces the amount of the individual responsibility payment, enacted as part of the Affordable Care Act, to zero." *Id*. at 324. The Conference Report is silent about the individual mandate itself.

33. The CBO's report on the Tax Cuts and Jobs Act of 2017 explains that the bill "eliminate[s]" the "individual mandate penalty . . . *but [not] the mandate itself*." CBO 2017 Report 1. The CBO added that "a small number of people who enroll in insurance because of the mandate under current law would continue to do so [post elimination of the individual mandate's penalty] solely because of a willingness to comply with the law." *Id*.

34. In the Tax Cuts and Jobs Act of 2017, Congress did not amend or repeal the ACA's legislative findings that the individual mandate is essential to the operation of the ACA.

35. As the Supreme Court explained in *NFIB*, "the *essential* feature of any tax" is that it "produces some revenue." 567 U.S. at 564 (emphasis added).

36. Section 5000A, as amended by the Tax Cuts and Jobs Act of 2017, now "produces" no revenue (beginning Jan. 1, 2019). Accordingly, it is not possible to interpret the individual mandate as part of a single unified tax provision.

37. Instead, the "most natural interpretation of the mandate," *id*. at 563 (Roberts, C.J.), is now the

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[4] *See* https://www.gpo.gov/fdsys/pkg/CRPT-115hrpt466/pdf/CRPT-115hrpt466.pdf.

only interpretation possible: an unconstitutional command from the federal government to individuals to purchase a product.

D. The ACA, As Amended, Imposes Serious Injury and Irreparable Harm Upon the States and Their Citizens.

38. As Congress itself found, the ACA's provisions only work rationally with the individual mandate—a mandate now unconstitutional under *NFIB*.

39. The unconstitutional individual mandate, along with the ACA itself, significantly harms and impacts the States, as independent sovereigns, in various ways:

a. Imposing a burdensome and unsustainable panoply of regulations on a market that each State has the sovereign responsibility to regulate and maintain within its own borders, to wit:

i. The ACA imposes a health insurance exchange in each State for consumers to shop for health plans and access subsidies to help pay for coverage. Under the ACA, States can choose between three types of exchanges:

1. State-based exchange (adopted by 16 States, plus the District of Columbia), including five federally-supported exchanges, which rely on the Healthcare.gov technology platform;

2. State-partnership with a federally facilitated exchange (adopted by six States), or

3. Federally-facilitated exchange (adopted by 28 States). Defendant HHS established and imposed the exchange infrastructure on the States and certifies at the federal level that participating health plans meet the federal requirements to sell plans on the exchange. The ACA does not grant States statutory authority to enforce the ACA and HHS maintains the authority to take enforcement action. For States involved in the federally-facilitated exchange, carriers must file plans with both the state regulatory authority and CMS (Centers for Medicare and Medicaid Services), even if they do not plan to participate in the exchange. Whether they are sold on or off the federal Marketplace, all individual and small group health insurance plans must include the essential health benefits package and comply with other federal requirements.

ii. The ACA also imposed myriad market reforms on the States, including guaranteed issue, prohibition on preexisting condition exclusions, and modified community ratings.

b. By forcing state, non-federal governmental officials and citizens to comply with the mandates of the ACA, including the individual mandate, and all of the ACA's associated rules and regulations, instead of

state-based policy regarding health insurance, Plaintiffs are injured. Sovereigns suffer injury when their duly enacted laws or policies are enjoined or impeded. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 601 (1982) (recognizing the interest of a sovereign in its "power to create and enforce a legal code, both civil and criminal"); *Alaska v. U.S. Dep't of Transp.*, 868 F.2d 441, 443 n.1 (D.C. Cir. 1989) (agreeing that the State has standing to seek declaratory and injunctive relief "because DOT claims that its rules preempt state consumer protection statutes, [and therefore] the States have suffered injury to their sovereign power to enforce state law"); *Maryland v. King*, 133 S. Ct. 1, 3 (2012) (citing *New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977) (Rehnquist, J., in chambers) ("It also seems to me that any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.")); *Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013) ("When a statute is enjoined, the State necessarily suffers the irreparable harm of denying the public interest in the enforcement of its laws."); *Coalition for Econ. Equity v. Wilson*, 122 F.3d 718, 719 (9th Cir. 1997); *Illinois Dep't of Transp. v. Hinson*, 122 F.3d 370, 372 (7th Cir. 1997) (State has standing where it "complains that a federal regulation will preempt one of the state's laws.").

c. The unconstitutional individual mandate, along with the ACA itself, significantly harms and impacts the States by compelling them to take corrective action, at great cost, to save their insurance markets, to wit:

i. On January 21, 2018, Governor Scott Walker of Wisconsin called on the Legislature to pass "a state-based reinsurance program" for individuals purchasing insurance on the ACA's exchanges, which will "stabilize[ ]" the market after "insurers exit[ ] [and] shock rate increases." Governor Scott Walker, Press Release, Governor Walker Proposes Health Care Stability Plan to Stabilize Premiums for Wisconsinites on Obamacare (Jan. 21, 2018).[5] This proposal would cost $200 million, split between State and federal funds. Governor Scott Walker, Memo Accompanying Jan. 21, 2018 Press Release.[6] The Wisconsin Legislature passed The Wisconsin Legislature passed a reinsurance program in February 2018.[7] Wisconsin's reinsurance program is necessary be-

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[5] *See* https://walker.wi.gov/press-releases/governor-walker-proposes-health-care-stability-planstabilize-premiums-wisconsinites.

[6] *See* https://jwyjh41vxje2rqecx3efy4kf-wpengine.netdna-ssl.com/wp-content/uploads/2018/01/180120Overview.pdf.

[7] *See* Wisconsin State Legislature, Senate Bill 770, https://docs.legis.wisconsin.gov/2017/proposals/reg/sen/bill/sb770.

cause the ACA's regulations of the individual market causes health-insurance premiums to rise substantially. Without Wisconsin's intervention, plans in the individual market would either not be offered, or would be prohibitively expensive.

ii. Wisconsin's Insurance Commissioner, like the insurance commissioners of all States, will need to take other corrective actions to protect Wisconsin citizens from the ACA's irrational regime.

iii. While the Texas Legislature did not adopt most ACA requirements into Texas law, the Texas Department of Insurance ("TDI") monitors the impact of the ACA on the Texas insurance market and takes action, when warranted, to protect consumers and minimize market disruptions. For example, TDI developed navigator rules to address insufficient federal standards for navigators, 28 TAC §§ 19.4001–19.4017, and the ACA-forced dissolution of the Texas Health Insurance Pool caused insurance coverage disruptions given the difficulties with the federal health exchange rollout, requiring TDI to issue an emergency rule extending existing insurance coverage for Texas Health Insurance Pool enrollees.

iv. Moreover, like other States, many health insurers have withdrawn from Texas due to unsustainable rising costs. Some federally designated regions of

Texas have only one insurance carrier offering healthcare plans. Texas residents and employers, including Texas itself as an employer, suffer as a result of this lack of choice and higher costs.

v. Likewise, the ACA has wrought havoc on the health insurance market in Nebraska. In 2017, two insurers exited Nebraska's individual market, leaving only a single insurer remaining. Aetna announced its withdrawal from Nebraska's individual market in May 2017, citing an expected loss of $200 million for 2017 in the four states Aetna sold individual coverage. In June 2017, Blue Cross and Blue Shield of Nebraska also announced its withdrawal from Nebraska's individual market, citing an expected loss of $12 million for 2017, in addition to the approximately $150 million loss the company experienced in Nebraska from 2014 to 2016. In the wake of these companies' departures, only a single insurer, Medica, is left in Nebraska's individual market. Nebraskans are left to hope Medica—which itself raised premiums in plan year 2017 by an average of nearly 31 percent—remains in the market for 2019.

vi. In Missouri, the Interim Committee on Stabilizing Missouri's Health Insurance Markets, a bi-partisan committee of the Missouri House, was formed to work on solving the rising instability plaguing

the Missouri insurance markets as a result of the ACA. The committee voted unanimously to create the "Missouri Reinsurance Plan," and legislation to establish the Missouri Reinsurance Plan, introduced on February 22, 2018. H.B. 2539, 99th General Assembly (Mo. 2018).[8]

vii. Governor Otter of Idaho recently issued an Executive Order to the Idaho Department of Insurance to "approve [health-insurance plans] that follow all State-based requirements, even if not all [ACA] requirements are met." Office of Governor C.L. "Butch" Otter, Executive Order No. 2018-02 (Jan. 5, 2018).[9] The Idaho Department of Insurance has issued a bulletin implementing this order. Idaho Dep't of Ins., Bulletin No. 18-01 (Jan. 24, 2018).[10]

viii. Maryland began investigating the enactment of its own state-level individual mandate to replace the amended ACA individual mandate.[11]

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[8] *See* https://www.house.mo.gov/billtracking/bills181/hlrbillspdf/5903H.01I.pdf.

[9] *See* https://gov.idaho.gov/mediacenter/execorders/eo2018/EO%202018-02.pdf.

[10] *See* https://doi.idaho.gov/DisplayPDF?Id=4712.

[11] *See* Josh Hicks, *With Obama's Federal Mandate Disappearing, Md. Democrats Push 'Down Payment' Plan*, Wash. Post (Jan. 9, 2018), https://www.washingtonpost.com/local/md-politics/md-democratspush-insurance-down-payment-plan-to-replace-federal-mandate/2018/01/09/bc0afbb0-f4f4-11e7-beb6-c8d48830c54d_story.html?utm_term=.789a454ab8bf.

ix. Other States will need to take similar corrective measures to address the ACA's irrational regime.

40. The unconstitutional individual mandate, along with the ACA itself, significantly harms and impacts the States as Medicaid and CHIP providers:

a. The United States Congress created the Medicaid program in 1965. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965). Medicaid is jointly funded by the United States and the States to provide healthcare to individuals with insufficient income and resources. *See generally* 42 U.S.C. §§ 1396-1396w. To participate in Medicaid, States must provide coverage to a federally-mandated category of individuals and according to a federally-approved State plan. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.10–430.12. All 50 States participate in the Medicaid program.[12]

b. The United States Congress created the Children's Health Insurance Program ("CHIP") in 1997. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, Subtitle J, 111 Stat. 251 (Aug. 5, 1997). The federal government and the States jointly fund CHIP to provide healthcare for uninsured children that do not qualify for Medicaid.

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[12] *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014 through September 30, 2015*, 79 Fed. Reg. 3385 (Jan. 21, 2014).

See 42 U.S.C. § 1397aa. CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance. CHIP provides basic primary health care services to children, as well as other medically necessary services, including dental care. All States now participate in CHIP since its creation in 1997.

c. Because Medicaid and CHIP are entitlement programs, States cannot limit the number of eligible people who can enroll, and Medicaid and CHIP must pay for all services covered under the program. Providing health care to individuals with insufficient income or resources through the Medicaid or CHIP programs is a significant function of state government.

d. One avenue for individuals to comply with Section 5000A's individual mandate is to apply for Medicaid or CHIP. 26 U.S.C. § 5000A(f)(1)(A)(iii). Thus, because of the individual mandate and the ACA, many individuals became eligible for Medicaid, or may have been previously eligible but opted not to enroll. Either way, the individual mandate requires millions more to enroll in Medicaid, imposing additional costs on the States. This reality does not represent "unfettered choices made by independent [state] actors," *ASARCO Inc. v. Kadish*, 490 U.S. 605, 615 (1989), but is rather a direct consequence of the individual mandate and the ACA, leaving Medicaid as the only option through which numerous individuals may comply.

e. As the CBO explained before both the enactment of ACA and the enactment of the Tax Cuts and Jobs Act of 2017, at least some individuals will obtain health insurance because of the mandate, even absent any tax penalty. *See* CBO 2017 Report 1.

f. The mandate forcing more individuals onto Medicaid or CHIP causes significant monetary injuries to the States, because these programs obligate the States to share the expenses of coverage with the federal government.

41. Pursuant to 26 U.S.C. § 4980H, the ACA harms the States as large employers:

a. The ACA requires States, as large employers, to offer their employees health-insurance plans with minimum essential benefits defined solely by the Federal Government.

b. If a State wished to pursue other health-insurance policies for its employees, perhaps by offering insurance with a different assortment of coverage benefits, the Federal Government will tax or penalize the State. 26 U.S.C. § 4980H.

c. The ACA imposes a 40% "[e]xcise tax" on "high cost employer-sponsored health coverage." 26 U.S.C. § 4980I. As an employer, Wisconsin must do "considerable work" restructuring its health-insurance offerings

to avoid this costly measure.[13] This work "may have a significant effect on future plan design and maximum benefit limitations."[14]

d. Because of the costs of the ACA, a major Wisconsin health insurer, Assurant Health, ceased its Wisconsin operations.[15] This cost Wisconsin approximately 1,200 jobs.[16]

e. The ACA resulted in the repeal of Wisconsin's high-risk pool, the Health Insurance Risk-Sharing Plan, which effectively managed the health-insurance needs of high-risk individuals before the full implementation of the ACA. Wis. Stat. §§ 149.10–.53 (2011–12) (statutory framework for Wisconsin Health Insurance Risk-Sharing Plan), repealed by 2013 Wis. Act 20, § 1900n; see generally Wis. Legislative Audit Bureau, Report 14- 7 Health Insurance Risk-Sharing Plan Authority at p. 1 (June 2014) (describing history of Wisconsin's HIRSP, including dissolution and repeal).

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[13] Segal Consulting, Second Report—Observations and Recommendations for 2017 and Beyond, prepared for Wisconsin Group Insurance Board Department of Employee Trust Funds, at p. 141 (Nov. 17, 2015), http://etf.wi.gov/boards/agenda-items-2015/gib1117/item3ar.pdf.

[14] *Id.* at 142.

[15] See Guy Boulton, Milwaukee-Based Assurant Health To Be Sold Of Or Shut Down, Milwaukee Journal Sentinel (Apr. 28, 2015), http://archive.jsonline.com/business/assurant-considering-sale-ofmilwaukee-based-assurant-health-b99490422z1-301614251.html.

[16] *Id.*

f. If state employees obtain subsidized insurance from an exchange instead of from a state plan, the Federal Government will tax or penalize the state.

g. More employees will join state-sponsored plans because of the mandate, imposing additional costs upon the States. See CBO 2017 Report 1. In Texas, for example, from FY13–FY17, the Texas Group Benefits Program, administered by the Employees Retirement System of Texas, spent $487 million on ACA-related costs. *2016 Group Benefits Program Comprehensive Annual Report*, Employees Retirement System of Texas (Feb. 2017).[17]

h. Nebraska, for example, has borne significant new costs at the behest of the ACA. Nebraska, like other States, must offer non-full time employees (i.e., employees working 30–39 hours per week) health insurance plans with premiums identical to those offered to full time employees.

i. In Missouri, revenue is drained by faster-than-projected growth in health care expenditures, driven in part by the impact of the ACA. Accordingly, Governor Greitens's budget for Fiscal Year 2018 includes more than $572 million in cuts across Missouri state government and reduces the State's workforce by 188 positions. Mo. Office of

[17] *See* https://ers.texas.gov/About-ERS/Reports-and-Studies/Reports-and-Studies-on-ERSadministered-Benefit-Programs/FY16-GBP-Comprehensive-Annual-Report.pdf.

Admin., Summary, The Missouri Budget, (2018).[18] For Fiscal Year 2019, the problems continue. "Health care costs paid by the government continue to skyrocket. Obamacare has still not been repealed, and the cost of health care continues to rise. Taxpayers pay more and more for government health care every year with little or no improvement in results." Mo. Office of Admin., Fiscal Year 2019 Budget Priorities, The Missouri Budget.[19]

In South Dakota, the estimated cost impact of the ACA upon the South Dakota State Employee Benefits Program for FY 2015–2018 is as follows: $10,400 for the review of denied appeals; $19,140,252 for the elimination of the lifetime maximum; $4,575,200 for the expanded preventive services paid only by the plan; $3,202,942 for the Transitional Reinsurance Program fee (fee imposed on self-funded plans); $172,141 for the Patient Centered Outcomes Research Institute fee (fee imposed on self-funded plans); $1,514,205 for the expanded health plan eligibility for part-time employees who did not meet the pre-ACA eligibility definition; $100,000 for the Form 1095-C administration. To date, South Dakota is unable to accurately estimate the cost of the pre-existing conditions exclusion or the ex-

[18] *See* https://oa.mo.gov/sites/default/files/FY_2018_Budget_Summary_Abridged.pdf.

[19] *See* https://oa.mo.gov/sites/default/files/FY_2019_Budget_Summary.pdf.

> panded eligibility for adult dependent children to age 26, though upon information and belief, those qualifiers have increased the costs for South Dakota's taxpayers.

42. Under the ACA health insurance plans available to Individual Plaintiffs Hurley and Nantz, Individual Plaintiffs pay dramatically more than prior to the ACA, have lost access to the doctors and health care providers of their choice, and are unable to purchase a health insurance plan that meets their needs and preferences.

43. The ACA injures Individual Plaintiffs Hurley and Nantz by mandating that they purchase minimum essential health insurance coverage despite the Supreme Court's determination that the requirement is unconstitutional. Despite the reduction of the individual mandate penalty to $0.00 under the Tax Cuts and Jobs Act, Individual Plaintiffs have an obligation to comply with the individual mandate under the ACA while it remains federal law, despite the provision's unconstitutionality.

44. The ACA further injures the Individual Plaintiffs by establishing a health-care insurance regulatory system that prevents the Individual Plaintiffs from purchasing health insurance under a free-market system that would allow them to have lower premiums, choice in provider, and options for health insurance plans.

45. The ACA further injures the Individual Plaintiffs by requiring them to divert resources from their businesses in order to obtain qualifying health insurance coverage, regardless of their judgment as to whether maintaining such coverage is a worthwhile

cost of doing business, thereby harming their abilities to maintain their own businesses.

46. In the absence of the ACA, the Individual Plaintiffs would purchase a health-insurance plan different from the ACA-compliant plans that they are currently required to purchase were they afforded the option without the ACA.

47. Each of the injuries to Individual Plaintiffs is caused by the Defendants' continued enforcement of the Affordable Care Act, and each of these injuries will be redressed by a declaratory judgment from this Court pronouncing the Affordable Care Act unconstitutional.

IV. CLAIMS FOR RELIEF

COUNT ONE

Declaratory Judgment That the Individual Mandate of the ACA Exceeds Congress's Article I Constitutional Enumerated Powers

48. Plaintiffs incorporate the allegations contained in paragraphs 1 through 47 as if fully set forth herein.

49. Section 5000A's individual mandate exceeds Congress's enumerated powers by forcing Individual Plaintiffs to maintain ACA-compliant health insurance coverage. Congress lacks the authority under the Commerce Clause and Necessary and Proper Clause to command individuals to purchase health insurance, and the individual mandate cannot be upheld under any other provision of the Constitution.

50. As a majority of the Supreme Court concluded, the "most straightforward reading of" Section 5000A "is that it commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562–63 (Roberts, C.J.); *id*. at

663–65 (Dissenting Op.). Thus, Congress lacks authority under the Commerce Clause and Necessary and Proper Clause to command individuals to purchase health insurance.

51. In *NFIB*, a different majority of the Supreme Court saved Section 5000A from unconstitutionality by interpreting it not as a mandate enforced by a separate tax penalty, but by combining the mandate with the tax penalty and treating those provisions as a single tax on individuals who chose to go without insurance. 567 U.S. at 563 (Roberts, C.J.).

52. The Constitution grants to Congress the "Power to lay and collect Taxes . . . to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1.

53. A provision that raises no revenue is not a tax because it does nothing to "pay the Debts" or "provide for the common Defense and general Welfare of the United States." Indeed, "the essential feature of any tax" is the "produc[tion] [of] at least some revenue for the Government." *NFIB*, 567 U.S. at 564–65, 574.

54. The Tax Cuts and Jobs Act of 2017 reduced Section 5000A's tax penalty to $0. Pub. L. No. 115-97, § 11081. Accordingly, Section 5000A no longer possesses "the essential feature of any tax"; it no longer "produces at least some revenue for the Government."

55. Therefore, after Congress amended Section 5000A, it is no longer possible to interpret this statute as a tax enacted pursuant to a valid exercise of Congress's constitutional power to tax. Rather, the only reading available is the most natural one; Section 5000A contains a stand-alone legal mandate.

56. No other provision of the Constitution supports Congress's claimed authority to enact Section

5000A's individual mandate. Accordingly, Section 5000A's individual mandate is unconstitutional.

57. The remainder of the ACA is non-severable from the individual mandate, meaning that the Act must be invalidated in whole.

58. Alternatively, and at the very minimum, as even the Obama Administration conceded in its briefing in *NFIB*, the guaranteed-issue and community-rating provisions are non-severable from the mandate and must be invalidated along with the individual mandate.

59. Because of Defendants' actions, Plaintiffs have suffered, and continue to suffer, irreparable injury.

60. Plaintiffs are entitled to a declaration that the individual mandate of the ACA exceeds Congress's Article I constitutionally enumerated powers. Plaintiffs also are entitled to a permanent injunction against Defendants from implementing, regulating, or otherwise enforcing any part of the ACA because its requirements are unlawful and not severable from the unconstitutional individual mandate.

COUNT TWO

Declaratory Judgment that the ACA Violates the Due Process Clause of the Fifth Amendment to the Constitution

61. Plaintiffs incorporate the allegations contained in paragraphs 1 through 60 as if fully set forth herein.

62. The Due Process Clause of the Fifth Amendment provides "nor shall any person . . . be deprived of life, liberty, or property, without due process of law." U.S. Const. amend. V.

63. The Fifth Amendment contains an "implicit" "equal protection principle" binding the federal Government. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1686 (2017).

64. Legislation that imposes irrational requirements violates the Due Process Clause.

65. Given that Section 5000A's individual mandate is unconstitutional, the rest of the ACA is irrational under Congress's own findings.

66. The ACA lacks a rational basis now that the individual mandate's tax penalty has been repealed.

67. Section 18091(2)(I), the chief legislative finding in the ACA, explains that "[t]he requirement [to buy health insurance] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I).

68. Given that the ACA's "essential" feature—the individual mandate—is unconstitutional, the law now imposes irrational requirements, in violation of the Due Process Clause.

69. Because of Defendants' actions, Plaintiffs have suffered, and continue to suffer, irreparable injury.

70. Plaintiffs are entitled to a declaration that the ACA violates the Due Process Clause to the Fifth Amendment. Plaintiffs also are entitled to a permanent injunction against Defendants from implementing, regulating, or otherwise enforcing any part of the ACA because its requirements are unlawful and not severable from the unconstitutional individual mandate.

COUNT THREE

Declaratory Judgment That the ACA Violates the Tenth Amendment to the United States Constitution

71. Plaintiffs incorporate the allegations contained in paragraphs 1 through 70 as if fully set forth herein.

72. The Tenth Amendment provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X.

73. Legislation that is irrational is outside the powers delegated to the United States by the Constitution.

74. Under Congress's own findings, the ACA lacks a rational basis now that the individual mandate's tax penalty has been repealed and the individual mandate is unconstitutional. *See supra* ¶¶ 53–62.

75. The ACA is therefore not within the powers delegated to the United States.

76. Because of Defendants' actions, Plaintiffs have suffered, and continue to suffer, irreparable injury.

77. Plaintiffs are entitled to a declaration that the ACA violates the Tenth Amendment to the United States Constitution. Plaintiffs also are entitled to a permanent injunction against Defendants from implementing, regulating, or otherwise enforcing any part of the ACA because its requirements are unlawful and not severable from the unconstitutional individual mandate.

COUNT FOUR

Declaratory Judgment Under 5 U.S.C. § 706 that Agency Rules Promulgated Pursuant to the ACA Are Unlawful

78. Plaintiffs incorporate the allegations contained in paragraphs 1 through 77 as if fully set forth herein.

79. The Administrative Procedure Act requires the Court to hold unlawful and set aside any agency action that is, among other things, (a) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (b) contrary to constitutional right, power, privilege, or immunity; and (c) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right. 5 U.S.C. § 706(2).

80. The Department and Service are both "agenc[ies]" under the Administrative Procedures Act, 5 U.S.C. § 551(1), and the regulations and rules promulgated pursuant to the ACA are "rules" under the Administrative Procedures Act, 5 U.S.C. § 551(4).

81. Because the ACA exceeds Congress's Article I Constitutional enumerated powers and violates the Fifth and Tenth Amendments to the Constitution for the reasons described in prior paragraphs, all regulations promulgated pursuant to, implementing, or enforcing, the ACA are arbitrary and capricious, contrary to law, and in excess of agency authority.

82. Because of Defendants' actions, Plaintiffs have suffered, and continue to suffer, irreparable injury.

83. Plaintiffs are entitled to a declaration that regulations promulgated pursuant to, implementing,

or enforcing the ACA violates the Administrative Procedure Act. Plaintiffs also are entitled to a permanent injunction against Defendants from implementing, regulating, or otherwise enforcing any part of the ACA because its requirements are unlawful and not severable from the unconstitutional individual mandate.

COUNT FIVE

Injunctive Relief Against Federal Officials from Implementing, Regulating, or Otherwise Enforcing the ACA

84. Plaintiffs incorporate the allegations contained in paragraphs 1 through 83 as if fully set forth herein.

85. Plaintiffs are entitled to a permanent injunction against Defendants from implementing, regulating, or otherwise enforcing any part of the ACA because its requirements are unlawful and not severable from the unconstitutional individual mandate.

V. PRAYER FOR RELIEF

Plaintiffs respectfully request that the Court:

A. Declare the ACA, as amended by the Tax Cuts and Jobs Act of 2017, to be unconstitutional either in part or in whole.

B. Declare unlawful any and all rules or regulations promulgated pursuant to, implementing, regulating, or otherwise enforcing the ACA.

C. Enjoin, preliminarily and permanently, Defendants and their employees, agents, successors, or any other person acting in concert with them, from implementing, regulating, enforcing, or otherwise acting under the authority of the ACA.

D. Award Plaintiffs their reasonable costs, including attorneys' fees.

E. Grant Plaintiffs any and all such other and further relief to which they are justly entitled at law and in equity.

Respectfully submitted this the 23rd day of April, 2018,

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JOHN NANTZ

I, John Nantz, do hereby declare:

1. I am a citizen of the United States and a resident of Austin, Texas.

2. I am 31 years old.

3. I am single. I have no dependents.

4. I am self-employed, and the founder of a management consulting business. I advise clients on maximizing growth potential, and develop organizational plans and digital strategic plans.

5. I am ineligible for health insurance coverage through an employer, Medicare, Medicaid, or the Children's Health Insurance Program.

6. I am ineligible to receive a subsidy from the federal government to purchase health insurance coverage.

7. I am currently covered under an individual health insurance plan that meets minimum standards under the Affordable Care Act.

8. For the 2018 calendar year, I purchased health insurance from Oscar Insurance based on a recommendation from Stride Health (an individual insurance advisory company). I am enrolled in the Oscar Saver Bronze Plan, an ACA-compliant individual health insurance plan.

9. My monthly premium is $266.56. I must pay a deductible of $6,500.00 annually before my health insurance company begins to pay for covered health care services. As stated on Oscar Insurance's website, "You pay the full price for covered medical services until you spend $6,500.00. After that, Oscar pays the full amount of your covered medical care (in-network only)". The plan also includes a select set of complimentary services including an annual routine physical examination and Doctor on Demand access. The full list of complimentary services can be found at https://www.hioscar.com/benefits/preventive/.

10. I have been enrolled in an ACA-mandated plan since 2014. Before that, I was enrolled in an employer-sponsored plan offered by McKinsey & Company, which offered access to a much wider network of providers. The cost of my current plan is high given the high deductible, limited network of providers and my age and health status. I enrolled in this plan because I was required by the ACA to do so; I do not believe it provides sufficient value to warrant the cost.

11. My plan is an Exclusive Provider Organization (EPO) Plan. I am limited to using the health care providers within the network. The plan provides no out-of-network benefits.

12. I am young and in good health. I have received minimal professional medical care for years with my use of the healthcare system limited almost exclusively to seeing sports therapists and chiropractors which I have paid out-of-pocket or with my HSA. The money that I have paid for ACA-mandated health insurance premiums would have been much better spent on additional contributions to a Health Savings Account and/or basic catastrophic insurance, which would be my preferred insurance option.

13. The ACA has greatly increased my health insurance costs. My preference would be to purchase reasonably-priced insurance coverage that is consumer-driven in accordance with my actuarial risk. I would maintain health insurance coverage through a plan that offers low premiums and a high deductible priced according to my risks and lifestyle choices. This would be available to me in a consumer-driven, competitive insurance market. In this situation, I would contribute to a Health Savings Account, which I would use to pay for my health expenses.

14. The ACA's individual mandate requires me to divert resources from my business endeavors in order to obtain qualifying health insurance coverage, regardless of my own judgment as to whether maintaining such coverage is a worthwhile cost of doing business. The additional costs imposed upon me by the individual mandate place a burden on my business.

15. I value compliance with my legal obligations, and believe that following the law is the right thing to do. The repeal of the associated health insurance tax penalty did not relieve me of the requirement to purchase health insurance. I continue to maintain minimum essential health insurance coverage because I

am obligated to comply with the Affordable Care Act's individual mandate, even though doing so is a burden to me.

I declare under penalty of perjury under the laws of the State of Texas and the United States that the foregoing is true and correct.

Executed on this 23 day of April, 2018.

/s/ John Nantz
John Nantz

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF NEILL HURLEY

I, Neill Hurley, do hereby declare:

1. I am a citizen of the United States and a resident of Katy, Texas.

2. I am thirty-nine years old.

3. I am married. I have two dependent children.

4. I am self-employed and own a consulting business. I am a technology consultant in the parking industry.

5. I am ineligible for health insurance coverage through an employer, Medicare, Medicaid, or the Children's Health Insurance Program.

6. I am ineligible to receive a subsidy from the federal government to purchase health insurance coverage.

7. I am currently covered under a family health insurance plan that meets minimum standards under the Affordable Care Act. This plan also covers my wife

and our two children. My health insurance company is Community Health Choice, and we are enrolled in the HMO Bronze Plan.

8. I selected and enrolled in my health insurance plan online through www.healthcare.gov – the health insurance marketplace established by the federal government and managed by the U.S. Centers for Medicare and Medicaid Services.

9. My monthly premium is $1,081.70. I must pay a deductible of $6,000.00 annually for myself and for each covered family member or until our combined family deductible expenses meet the overall family deductible of $12,000.00 annually.

10. I first enrolled in an ACA Gold plan in 2016. I paid a monthly premium of $912.60. I renewed that plan in 2017, even though the monthly premium had increased by 17 percent to $1,071.50. In October of 2017, I received a notice from my health insurance that my monthly premium for the same plan would increase by 49 percent to $1,594.84 if I elected to renew coverage for 2018. I had to enroll in the Bronze plan, which provides an inferior level of coverage, because I could no longer afford to pay for the Gold plan.

11. I was enrolled in a health insurance plan through my previous employer before the ACA mandated that I obtain coverage. My previous plan was widely accepted by the health care providers in our local area. I only had to pay a low co-pay for physician visits instead of meeting a high deductible before any benefits are provided. My monthly premiums under my previous plan were only $425.00.

12. I was unable to obtain a plan through the federal marketplace that was accepted by all of my and my family's health care providers. I opted to enroll in

a plan that was accepted by my children's pediatrician. Our family practice physician, ENT specialist, dermatologist, urgent care facility, and urologist do not accept our ACA plan so we had to find new health care providers that we would not otherwise choose. Our new health care providers are not of the same quality as I and my family had before. Some of our new health care providers have limited the number of appointments available to patients with ACA plans, which delays my ability to timely access health care for me and my family.

13. The ACA prevents me from obtaining care from my preferred health care providers and has greatly increased my health insurance costs. I would purchase reasonably-priced insurance coverage that allowed me to access care locally from my preferred service providers, were I not limited to the plans provided through the federal health insurance marketplace.

14. The ACA's individual mandate requires me to divert resources from my business endeavors in order to obtain qualifying health insurance coverage, regardless of my own judgment as to whether maintaining such is a worthwhile cost of doing business. The additional costs imposed upon me by the individual mandate place a burden on my business.

15. I value compliance with my legal obligations, and believe that following the law is the right thing to do. The repeal of the associated tax penalty did not relieve me of the requirement to purchase health insurance. I continue to maintain minimum essential health insurance coverage because I am obligated to comply with the Affordable Care Act's individual mandate.

I declare under penalty of perjury under the laws of the State of Texas and the United States that the foregoing is true and correct.

Executed on this 23rd day of April, 2018.

/s/ Neill Hurley
Neill Hurley

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF BLAISE DURAN

I, Blaise Duran, am a citizen of the United States, am over the age of eighteen, and am competent to testify. The following statements are true and correct based on my personal knowledge:

1. I am the Manager for Underwriting, Data Analysis and Reporting for the Employees Retirement System of Texas ("ERS"), the agency that provides retirement and other benefit programs for Texas employees, retirees, and their dependents. As the Manager for Underwriting, Data Analysis and Reporting for ERS, my responsibilities include analyzing the financial impact to the Texas Employees Group Benefits Program ("GBP") health benefit plans related to the requirements of the Patient Protection and Affordable Care Act (ACA), including certain actions required by state laws amended by the Texas Legislature in 2011 and 2013 related to ACA requirements. I have personal knowledge of the information set forth herein. To the extent that the information

herein is a statement of the financial cost or benefit to the GBP, my personal knowledge is based on information provided by ERS' GBP consulting actuaries and my review of the reasonableness of the assumptions and methodology used by the consulting actuaries to obtain the stated numbers.

2. ERS administers the GBP, which provides coverage for health, life, dental, voluntary accidental death and dismember-ment, vision and short and long-term disability. One objective for offering GBP benefits is to enable the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry.

3. As of August 31, 2017, GBP health insurance plans cover about one of every 53 Texans.

4. As of August 31, 2017, ERS had 534,101 GBP plan participants.

5. For GBP health plan participants, ERS paid about $3.5 billion in medical and pharmacy claims for self-funded plans and premiums for fully insured plans for fiscal year ("FY") 2017, which ran from September 1, 2016 to August 31, 2017.

6. The GBP health plans have instituted plan design changes and taken additional actions, as set forth below, in connection with the ACA, including certain actions required by state laws amended by the Texas Legislature in 2011 and 2013 related to ACA requirements.

7. The ACA contains a prohibition against lifetime and annual dollar limits for essential health benefits, whether in-network or out-of-network. Prior to the ACA, the GBP contained a $l million lifetime limit

on out-of-network coverage; there was no similar limit on in-network coverage. This limit was removed effective September 1, 2010. As a result of this plan design change, the GBP has paid approximately an additional $0.3 million for FY 2011, $0.3 million for FY 2012, $0.3 million for FY 2013, $0.3 million for FY 2014, $0.3 million for FY 2015, $0.4 million for FY 2016, and $0.4 million for FY 2017. Accordingly, for the seven-year period between FY 2011 and FY 2017, the GBP has paid approximately $2.3 million in costs due to this plan design change.

8. The ACA requires provision of coverage for dependent children up to age 26, whether or not they are married. Prior to the ACA, the GBP provided coverage for eligible unmarried dependent children up to age 25. Coverage was expanded to all eligible dependent children up to age 26 effective September l, 2011. As a result of this plan design change, the GBP has paid approximately an additional $7.6 million for FY 2012, $11.1 million for FY 2013, $12.0 million for FY 2014, $13.5 million for FY 2015, $18.3 million for FY 2016, and $19.2 million for FY 2017. Accordingly, for the six-year period between FY 2012 and FY 2017, the GBP has paid approximately $81.7 million in costs due to this plan design change.

9. The ACA requires coverage of certain preventive care services at no cost-share (that is, no co-payment, coinsurance or deductible) to the health plan participant. Effective September 1, 2011, the GBP began providing this coverage at no cost-share. As a result of this plan design change, the GBP has paid approximately an additional $20.3 million for FY 2012, $21.8 million for FY 2013, $23.0 million for FY 2014, $24.6 million for FY 2015, $26.0 million for FY 2016, and $27.2 million for FY 2017. Accordingly, for

the six-year period between FY 2012 and FY 2017, the GBP has paid approximately $142.9 million in costs due to this plan design change.

10. The ACA requires coverage of certain contraceptives for women at no cost share. The GBP began providing this coverage at no cost share on September 1, 2012. As a result of this plan design change, the GBP has paid approximately an additional $8.6 million for FY 2013, $8.3 million for FY 2014, $8.8 million for FY 2015, $9.3 million for FY 2016, and $8 million for FY 2017. Accordingly, for the five-year period between FY 2013 and FY 2017, the GBP has paid approximately $43 million in costs due to this plan design change.

11. The ACA prohibits health plan coverage waiting periods that exceed 90 days. As a result, Section 1551.1055 of the Texas Insurance Code was amended to provide that eligibility under the GBP health plans begins not later than the 90th day after the date of employment. Effective September l, 2014, eligible new employees and their eligible dependents are now enrolled effective the first day of the month following the 60th day of employment. Prior to this ACA requirement and related amendment to the state statute, ERS enrolled employees on the first day of the month after the 90th day of employment. Because administration of the GBP health plans provides for coverage to begin on the first day of the month following an employee's or dependent's first eligibility to participate in the plan, the waiting period was changed to 60 days to ensure compliance with the ACA's 90-day limit. As a result of this plan design change, the GBP has paid approximately an additional $19.3 million for FY 2015, $21.0 million for FY 2016, and $22.8 million for

FY 2017. Accordingly, for the three-year period between FY 2015 and FY 2017, the GBP has paid approximately $63.1 million in costs due to this plan design change.

12. The ACA provides for an out-of-pocket maximum on participant cost share for in-network essential health benefits. The GBP implemented an out-of-pocket maximum on in-network medical coverage effective September l, 2014, and implemented an out-of-pocket maximum on in-network medical and prescription drug coverage effective September l, 2015. As a result of this plan design change, the GBP has paid approximately an additional $0.1 million for FY 2015, $0.4 million for FY 2016, and $0.4 million for FY 2017. Accordingly, for the three-year period between FY 2015 and FY 2017, the GBP has paid approximately $0.9 million in costs due to this plan design change.

13. Under the ACA, employers are required to offer minimum essential health coverage for all full-time employees and this coverage must be affordable and offer minimum value. A "full-time employee" is defined generally as a person working on average 30 hours per week. The GBP definition of an eligible full-time employee was changed from an employee working 40 hours per week to one working 30 hours per week effective September 1, 2013. As a result of this plan design change, the GBP has paid approximately an additional $4.2 million for FY 2014, $4.4 million for FY 2015, $4.7 million for FY 2016, and $5.0 million, for FY 2017. Accordingly, for the four-year period between FY 2014 and FY 2017, the GBP has paid approximately $18.3 million in costs due to this plan design change.

14. The ACA requires payment of PCOR (Patient-Centered Outcomes Research) Fees for seven years.

The PCOR fees apply to plan years ending after October 1, 2012 and before October l, 2019; i.e., in the case of the GBP, FY 2013 - FY 2019. The GBP paid approximately $0.5 million for FY 2013, $0.8 million for FY 2014, $0.9 million for FY 2015, $0.9 million for FY 2016, and $1.0 million for FY 2017. Accordingly, for the five-year period between FY 2013 and FY 2017, the GBP has paid approximately $4.1 million in costs due to this fee.

15. The ACA established the Transitional Reinsurance Program (TRP) to which health insurers and group health plans were required to contribute. The GBP contributed to this program, which was operational for calendar years 2014 - 2016. The TRP impacted GBP cost across four fiscal years: FY 2014 - FY 2017. The GBP paid approximately $18.5 million for FY 2014, $22.1 million for FY 2015, $14.5 million for FY 2016, and $4.0 million for FY 2017. Accordingly, for the four-year period between FY 2014 and FY 2017, the GBP has paid approximately $59.1 million in costs due to this program.

16. Beginning with calendar year (CY) 2014, the ACA requires payment of an annual fee by health insurance providers. The amount payable is the insurer's proportionate share of the aggregate fee for that year as statutorily defined. Certain of the GBP's fully insured health plans are subject to this fee, which can be passed through to the GBP as part of the plans' premiums. There are moratoriums on these fees for CY 2017 and CY 2019. Thus far, these fees have impacted GBP cost across four fiscal years: FY 2014 - FY 2017. The GBP paid fees of approximately $8.9 million for FY 2014, $19.3 million for FY 2015, $22.1 million for FY 2016, and $7.5 million for FY 2017. Accordingly, for the four-year period between FY 2014 and

FY 2017, the GBP has paid approximately $57.8 million due to this fee. Unless the there is a change to the requirement, ERS will continue to comply as required.

17. Although participation was not required, the GBP participated in the ACA's Early Retiree Reinsurance Program (ERRP), receiving reimbursement of certain benefit payments for coverage of its early retirees during FY 2010 and FY 2011. The GBP received reimbursements of approximately $30.2 million in FY 2011 and $40.7 million in FY 2012. Accordingly, in the two-year period FY 2011 and FY 2012, the GBP received approximately $70.9 million due to this program.

18. The ACA established the Coverage Gap Discount Program (CGDP) under Medicare Part D which commenced January l, 2011. The CGDP provides manufacturer discounts to beneficiaries in connection with prescription drug expenditures in the Part D coverage gap. The GBP provided prescription drug coverage to Medicare-eligible participants under HealthSelect until January I, 2013, at which time such coverage was transferred to HealthSelect Medicare Rx, a self-funded Employer Group Waiver Plan under Medicare Part D. Since HealthSelect Medicare Rx participants only pay the plan copay for prescription drugs that would otherwise fall in the coverage gap, the GBP is eligible to receive the manufacturer discounts in order to offset a portion of the cost of HealthSelect Medicare Rx. The GBP received discounts in connection with prescription drugs dispensed of approximately $15.4 million in FY 2013, $39.7 million in FY 2014, $27.7 million in FY 2015, $48.2 million in FY 2016, and $40.0 million in FY 2017. Accordingly, in the five-year period between FY 2013 and FY 2017, the GBP has

received approximately $171.0 million due to this program.

19. Compliance with the ACA has imposed costs on the GBP approximating $0.3 million in FY 2011, $28.2 million for FY 2012, $42.3 million for FY 2013, $76.0 million for FY 2014, $113.3 million for FY 2015, $117.6 million for FY 2016, and $95.5 million for FY 2017. Participation in the ERRP and CGDP by the GBP has resulted for payments to the GBP approximating $30.2 million for FY 2011, $40.7 million for FY 2012, $15.4 million for FY 2013, $39.7 million for FY 2014, $27.7 million for FY 2015, $48.2 million for FY 2016, and $40.0 million for FY 2017. Accordingly, for the seven-year period between FY 2011 and FY 2017, the GBP has incurred approximately $473.2 million in costs and received approximately $241.9 million in connection with its ACA compliance.

20. The GBP has made administrative process changes in connection with its ACA compliance, such as those related to the provision of Form 1095-B's to plan participants and the Internal Revenue Service.

21. The ACA also required ERS to reduce the maximum annual contribution to the GBP flexible spending account from $5,000 to $2,500 effective September 1, 2013; i.e., for FY 2014. While this requirement does not impact GBP cost, it generates additional cost to employers due to the additional social security taxes they will pay as a result of reduced annual pre-tax contributions that employees can make to flexible spending accounts.

22. ERS' process for making a plan design or benefit change to the GBP health plans varies depending on the scope and impact of the change. Plan design

and benefit changes and changes to eligibility requirements require review by ERS staff in order to determine impact to rates, financial status of the GBP, and operations. Additionally changes may require legislative action, approval by the ERS Board of Trustees, action by the third party administrator, system changes by ERS and/or system changes by the third party administrator.

23. So long as the ACA continues to apply to coverages authorized and funded under the GBP, then ERS won't be able to make changes to the plan design that would cause the GBP to discontinue paying claims or costs as addressed in paragraphs 7, 8, 9, 10, 11,12, 13 and 14.

DECLARATION UNDER PENALTY OF PERJURY

24. I, Blaise Duran, a citizen of the United States and a resident of Texas, hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing Declaration is true and correct.

Respectfully submitted this 11th day of April, 2018.

/s/ Blaise Duran
Blaise Duran

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF MICHAEL GHASEMI

My name is Michael Ghasemi and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Forecasting department within Financial Services for the Texas Health and Human Services Commission (HHSC). In my role as Forecasting Director, I oversee the Forecasting team and all data reporting that we provide internally and externally. We provide HHSC client services program caseload and cost projections as well as historical data for continual budget monitoring purposes, client services appropriations requests, and many other related ad hoc or reporting purposes.

2. Effective January 1, 2014. the ACA created two additional "mandatory" populations for Medicaid programs. One of the populations is former foster care children. These are individuals under age 26 who aged out of foster care in the state and who were enrolled in

federally-funded Medicaid when they aged out of foster care. Prior to the ACA, HHSC provided Medicaid to the majority of former foster care children up to age 21. The second population is children ages 6 to 18 up to and including 133 percent of the FPL. These children were eligible for the Children's Health Insurance Program (CHIP) prior to the ACA. Prior to the ACA, Medicaid required states to provide coverage for children through age 5 up to 133% of FPL and 100% of the FPL for children ages 6 to 18.

3. The ACA restricted HHSC to considering only a sole factor to determine eligibility for populations other than those who have a disability or who are elderly: Modified Adjusted Gross Income (MAGI). 42 U.S.C. § 1396a(e)(14). The tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility for those populations. Other income, such as child support and disability payments, cannot be considered. Additionally, HHSC can no longer consider deductions to income, such as dependent care or a work-related expense, when determining eligibility. HHSC also cannot consider assets such as a vehicle when evaluating eligibility for Medicaid.

4. Prior to the ACA, HHSC's policy was to allow children 6 months of continuous Medicaid coverage regardless of family income changes. Pursuant to the ACA, eligibility redeterminations for Medicaid and CHIP are now allowed no more frequently than one per 12 months, unless the enrollee volunteers to HHSC, or HHSC receives a report, that there is a change that affects eligibility. HHSC conducts periodic income checks during the 12-month certification period. For children, the periodic income check cannot

impact the child's eligibility prior to the end of the continuous eligibility period (first six months). The second six months of the child's certification period has non-continuous eligibility, and income information can affect eligibility. For parents and caretaker relatives, the entire certification period for Medicaid has non-continuous eligibility, and changes in income can affect eligibility.

5. Texas's Medicaid caseload (the number of individuals enrolled in the Medicaid eligibility groups) increased from 3.01 million average monthly in State Fiscal Year (SFY) 2009 to 4.07 million average monthly in SFY 2017 (figures are rounded).

6. After the implementation of the ACA, there were increases in the Texas Medicaid caseload due to the 12-month recertification with a periodic income check for children and adults, use of MAGI (rather than income with potential disregards), and former foster care youth population, as well as increases likely due to increased focus and outreach resulting from the ACA. The overall Medicaid caseload rose above 4 million clients by September of 2014, an increase of 9.6 percent over September 2013. The following table provide estimates for ACA-related caseload additions to Medicaid, based on March 2016 forecast data:

7. **ACA-Related Caseload Additions to Medicaid - March 2016 Estimates**[1]

ACA-Related Caseload Additions to Medicaid	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
12-Month recertification	7,349	96,806	97,040	97,928
MAGI Changes/ Eligible, Newly Enrolled	45,796	113,007	116,151	119,298
Foster Care to Age 26	562	1,722	1,816	1,846
CHIP to Medicaid (not "New clients")	46,890	228,002	247,261	253,927
Total	**100,598**	**439,536**	**462,269**	**472,999**

[1] All numbers are Average Monthly Recipient Months by SFY (annualized). These changes are now assumed to be in the Medicaid caseload. As such, distribution of "type" of addition to the caseload is estimated for the step-ups due to MAGI changes, 12-month recertification, and newly-enrolled clients as there is no unique identifier for impacts due to these changes. Underlying caseload data and trends are assumed as a basis for the estimates.

8. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this 13th day of April, 2018.

/s/ Michael Ghasemi
Michael Ghasemi
Director of Forecasting
Texas Health and Human Services Commission

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF STEPHANIE MUTH

My name is Stephanie Muth and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the State Medicaid Director for the Texas Health and Human Services Commission (HHSC). In my role as the State Medicaid Director, I oversee Medicaid and Children's Health Insurance Program (CHIP) services across Texas.

2. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Texas receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. The Federal Fiscal Year 2018 FMAP for Texas is 56.88%, meaning the federal/state share of Medicaid funding is 56.88%/43.12% for most client services.

3. Medicaid cost is determined by the caseload—the volume or number of individuals served in each Medicaid eligibility group—and cost per client—a function of the number, type, and cost of the services a client receives, and how those services are provided.

4. The Affordable Care Act (ACA) mandates certain Medicaid benefits Texas is required to cover. Rather than allowing HHSC to make such determinations based on the needs of Texas's population, the ACA imposed a rule upon Texas that mandated reinstating birthing centers as a Medicaid provider, providing Medicaid reimbursement to providers recognized by states as licensed birth attendants, recognizing licensed midwives as a provider type, and implementing comprehensive tobacco cessation services for pregnant women.

5. The ACA requires all Medicaid providers to revalidate their enrollment information every three to five years. 42 C.F.R. § 455.414. All durable medical equipment providers are required to revalidate enrollment information at least once every three years. All other provider types must revalidate their enrollment information at least once every five years. The ACA also requires states to collect an application fee as a condition for newly enrolling or re-enrolling institutional providers. 42 C.F.R. § 455.460.

6. As part of HHSC's implementation of the ACA's requirements, HHSC contracted with the Texas Medicaid & Healthcare Partnership (TMHP) to implement two initiatives related to the provider revalidation required by the ACA. One initiative was the ACA Provider Re-Enrollment Operations Support initiative, for which HHSC paid TMHP $17,107,072 ($12,632,677 in federal funds and $4,474,395 in state general revenue) for TMHP's work performed on this

initiative from August 1, 2014 through July 31, 2017. This initiative required TMHP to perform various tasks—such as developing an enrollment application, educating the provider community about the need to re-enroll, and answering providers' questions about how to complete the application—in support of the provider revalidation required by the ACA. The second initiative was the ACA Provider Re-enrollment Quick Hits initiative in 2014-2015, for which HHSC paid TMHP $2,084,215 ($1,829,444 in federal funds and $254,771 in state general revenue). This initiative required TMHP to make several enhancements to the then-existing provider enrollment technology to support the ACA provider enrollment regulations.

7. HHSC's Medicaid operations staff spent significant amounts of time working on ACA-related issues, including the ACA provider re-enrollment. Medicaid operations had two staff members (a Project Manager and a Business Analyst) assigned full time to ACA-related work for two years. Medicaid operations also had another Program Manager and the Director working on ACA-related issues. The estimated cost to HHSC for these employees' work on the ACA was $387,082 over a two-year time period.

8. Beginning in January 2014, HHSC was required by the ACA to pay an annual excise tax to the federal government known as the Health Insurer Tax. The tax is based on the amount of health insurance premiums collected. HIT will continue to increase with premium growth. In SFY 2017, HHSC paid $112,044,306.98 in general revenue for Medicaid and $1,078,737.40 in general revenue for CHIP for the Health Insurer Tax, for a total of $113,123,044.38 in general revenue for the Health Insurer Tax.

9. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the __ day of April, 2018.

/s/ Stephanie Muth
Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF WAYNE SALTER

My name is Wayne Salter and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Associate Commissioner for Access and Eligibility Services for the Texas Health and Human Services Commission (HHSC). HHSC Access and Eligibility Services determines eligibility in Texas for Medicaid and the Children's Health Insurance Program (CHIP). As Associate Commissioner for Access and Eligibility Services, I oversee more than 11,000 employees responsible for delivering public assistance programs including Medicaid, Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families, disability determination services and community-based programs and services to millions of Texans every year.

2. HHSC administers Medicaid at the state level to residents of Texas. Texas Medicaid serves: (1) low-income families, (2) children, (3) pregnant women, (4)

elders, and (5) people with disabilities. The Affordable Care Act (ACA) added an additional category: former foster care youth. These are individuals under age 26 who aged out of foster care in the state and who were enrolled in federally-funded Medicaid when they aged out of foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) (West); Affordable Care Act, Pub L 111448, 124 Stat. 865, § 2004. Were the ACA repealed, HHSC would still be required to provide Medicaid to former foster care youth up to age 21.

3. Financial eligibility for Medicaid and many other social programs is based on a family's income level as compared to Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a family would need to meet very basic family needs.

4. Prior to the passage of the ACA, HHSC used these factors to determine eligibility for Medicaid: (1) family income, (2) age, (3) assets, (4) other factors such as being a child, parent, or caretaker relative, a pregnant woman, or an elderly or disabled individual. HHSC reviewed eligibility criteria for Medicaid enrollees every 6 months allowing for a quick determination should anyone become ineligible for Medicaid due to no longer meeting Medicaid eligibility criteria such as household income increasing above the FPL.

5. Effective January 1, 2014, the ACA expanded Medicaid to the following populations:

- As noted above, one of the populations is former foster care children under age 26, and Texas is required to enroll that population in Medicaid without applying a financial test. Pub. L. 111-148, 124 Stat. 271, § 2002.

- The second population is children ages 6 to 18 up to and including 133 percent of the FPL (these children were ineligible for CHIP prior to the ACA).

6. Prior to the ACA, Medicaid required states to provide coverage for children through age 5 up to 133% of FPL and 100% of the FPL for children ages 6 to 18. If the ACA were repealed, HHSC could return to using 100% FPL limit for children ages 6 to 18.

7. The ACA restricted HHSC to considering only a sole factor to determine eligibility for populations other than those who have a disability or who are elderly: Modified Adjusted Gross Income (MAGI). 42 U.S.C. § 1396a(e)(14). The tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility for those populations. Other income, such as child support and disability payments, cannot be considered. Additionally, HHSC can no longer consider deductions to income, such as dependent care or a work-related expense, when determine eligibility. The FPL for each type of Medical assistance program was adjusted to account for the loss of deductions.

8. Under the ACA, HHSC cannot consider assets such as a vehicle or home when evaluating eligibility for Medicaid. HHSC has always exempted the homestead when evaluating eligibility for Medicaid. Were HHSC not subject to operating within the confines of the ACA, it could use pre-ACA income determination methodologies to account for considerations such as assets and alternate income that factor into a household's income status.

9. Prior to the ACA, HHSC's policy was to allow children 6 months of continuous Medicaid coverage regardless of family income changes. Pursuant to the ACA, eligibility redeterminations for Medicaid and CHIP are now allowed no more frequently than one per 12 months, unless the enrollee volunteers to HHSC, or HHSC receives a report, that there is a change that affects eligibility. HHSC conducts periodic income checks during the 12-month certification period in which electronic income data is pulled and compared against the income currently being counted for the Medicaid recipient. For children, the periodic income check is conducted in months five through eight of the certification period and cannot impact the child's eligibility prior to the end of the continuous eligibility period (first six months). The second six months of the child's certification period has non-continuous eligibility, and income information can affect eligibility. For parents and caretaker relatives, the periodic income check is conducted in months three through eight of the certification period. The entire certification period for Medicaid for parents and caretaker relatives has non-continuous eligibility, and changes in income can affect eligibility. If the ACA were repealed, HHSC could revert back to the six month certification period for Children's Medicaid and Medicaid for Parents and Caretaker Relatives without a statutory change.

10. CHIP provides healthcare coverage for children under age 19 whose family income exceeds the Children's Medicaid income limit but is less than or equal to the applicable income limit for CHIP.[1] To

[1] Defined in Texas Works Handbook, C-131.1, Federal Poverty Income Limits (FPIL).

qualify for CHIP, a child must, among other requirements, be uninsured for at least 90 days or claim one of the good cause exemptions to this 90-day waiting period[2] as defined by Texas state statute. The ACA expanded the reasons for good cause beyond what was in the Texas state statute. The ACA also prohibits states from imposing a waiting period of longer than 90 days. 42 C.F.R. § 457.805(b)(l). Additionally, the ACA imposes strict requirements on HHSC regarding how to provide notice to applicants of eligibility determinations, including the language that must be used and the exact content of the notice. 42 C.F.R. § 457.340(e).

11. Federal rules require HHSC to track individuals determined ineligible for Medicaid or CHIP and transfer the information to the Health Insurance Marketplace for coverage. For children subject to the 90-day CHIP waiting period, HHSC sends their information to the Marketplace during the waiting period, contacts the Marketplace once the waiting period has ended, and enrolls the child in CHIP coverage. 42 C.F.R. §457.340(d)(3). HHSC is also required to determine Medicaid or CHIP eligibility for individuals who applied via the Federal Marketplace but were found potentially eligible for Medicaid or CHIP.

12. Subsidies under the ACA are available to adults starting at 100% FPL.

13. The ACA required changes regarding individuals with a Medicaid-qualifying immigration status. Prior to the ACA, a non-citizen had to provide proof

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[2] The waiting period only applies to children who were covered by a third-party health benefits plan (private health insurance) at any time during the 90 days (3 calendar months) before the date of application for CHIP.

that the individual had a Medicaid-qualifying immigration status before the individual could receive Medicaid benefits. The ACA created a new mandate requiring HHSC to allow those individuals to receive Medicaid during a period of "reasonable opportunity" by simply asserting that they are non-citizens with a Medicaid-qualifying immigration status. Pursuant to the ACA, this mere assertion from an individual imposes a duty upon HHSC to provide that individual with Medicaid benefits for 90 days while the individual is given the opportunity to verify his or her immigration status. If the ACA were repealed, HHSC could revert to its pre-ACA policy requiring verification of U.S. citizenship or alien status prior to determining eligibility.

14. The ACA mandates that HHSC initially adopt a Qualified Hospital's preliminary determination of an individual's eligibility for Medicaid. 42 U.S.C. 1396(a)(47). If a Qualified Hospital determines—based upon a household's attestation of income, citizenship or immigration status, and Texas residency—that an individual is Medicaid-eligible, the ACA requires HHSC to provide the individual with Medicaid benefits during a period of "presumptive eligibility" until HHSC determines whether the individual is eligible for Medicaid or for two months, whichever is earlier. This could require HHSC to provide up to two months of Medicaid benefits to individuals that ultimately may not be determined Medicaid-eligible by HHSC. To implement the presumptive eligibility mandate, HHSC built a new website (the Presumptive Eligibility Website) and made updates to the HHSC eligibility determination system (Texas Integrated Eligibility Redesign System, or "TIERS"). Prior to the implementation of the ACA, HHSC already provided presumptive Medicaid eligibility benefits to pregnant

women and women with breast or cervical cancer who were determined presumptively eligible by Qualified Entities. If the ACA were to be repealed, HHSC could stop allowing Qualified Hospitals to determine presumptive eligibility for the following programs without a change in state law: Parent and Caretaker Relative, Pregnant Women, Children under 19, and Former Foster Care.[3]

15. The ACA requires HHSC to send tax form 1095-B out to individuals and the Internal Revenue Service. This requirement that HHSC was not subject to prior to the ACA requires HHSC to incur costs including automation systems, printing, and postage that it would not have otherwise incurred.

16. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 13 day of April, 2018.

/s/ Wayne Salter
Wayne Salter
Assoc. Commissioner for Access and Eligibility Services
Texas Health and Human Services Commission

[3] HHSC would still be required by state law to allow Qualified Entities (such as clinics, physicians, etc.) the ability to determine presumptive eligibility for the following programs: Pregnant Women and Breast and Cervical Cancer.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

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CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JAMIE WALKER, ASSISTANT DEPUTY COMMISSIONER, FINANCIAL REGULATION DIVISION, TEXAS DEPARTMENT OF INSURANCE

Introduction

1. My name is Jamie Walker. I am over eighteen years of age, of sound mind, and am competent to testify to the matters contained in this declaration.

2. I am the Assistant Deputy Commissioner of the Financial Regulation Division at the Texas Department of Insurance (TDI). The Financial Regulation Division is responsible for financial and solvency related issues, including examinations, troubled companies, licensing, withdrawals, managed healthcare networks, and insurance company transactions. As the Assistant Deputy Commissioner, my official duties include managing Financial Regulation staff working on financial and solvency related issues and licensing of insurance market participants.

3. In October 2012, I analyzed the business plans, associated financial information, and merger activity related to entrance into the Texas market. In 2013, I oversaw the development and implementation of the navigator rules authorized under SB 1795, 83rd Legislature, Regular Session (2013).

Market Entrants

4. Insurance companies and health maintenance organizations (HMOs) are required under Insurance Code Chapter 801 to obtain certificates of authority to operate in Texas. The specific requirements for obtaining certificates of authority vary by the type of insurance or plan being offered by a carrier. Insurance code § 841.101 requires the issuance of certificates of authority for certain domestic insurance companies, which includes health insurance companies offering coverage affected by the Affordable Care Act, before engaging in the business of insurance, except for the lending of money. Insurance Code § 843.071 prohibits a person from organizing or operating an HMO in Texas without obtaining a certificate of authority. Insurance Code § 982.051 requires the issuance of certificates of authority for certain foreign insurance companies, which includes health insurance companies offering coverage affected by the Affordable Care Act, before engaging in the business of insurance, except for the lending of money.

5. TDI staff has done an analysis of filings made by carriers wanting to enter the individual health market. No carriers added the accident and health line of authority needed to write individual health coverage between January 1, 2009, and March 22, 2018. However, new carriers were issued certificates of authority with the intent of writing individual health coverage. A summary of the number of carriers issued

accident and health certificates of authority and writing individual health coverage follows:

Calendar Year	No. of New Health Carriers
2009	-
2010	-
2011	2
2012	-
2013	-
2014	2
2015	2
2016	1
2017	-
2018 (thru 3/22)	-

Market Exits

6. An insurer, which includes health insurance companies, must file with the Commissioner a plan for orderly withdrawal under Insurance Code § 827.003 if the company reduces its total annual premium volume by 50% or more, or reduces its annual premium by 75% or more in a line of insurance in Texas. Insurance Code § 843.051 makes an HMO subject to the withdrawal and restriction plan requirements in Insurance Code Chapter 827.

7. Under Insurance Code § 827.005, the Commissioner must approve a withdrawal plan that adequately provides for the meeting the requirements prescribed by Insurance Code § 827.004(3), and the Commissioner may modify restrict, or limit a withdrawal plan as necessary if the Commissioner finds that a line of insurance subject to the withdrawal plan

is not offered in a quantity or manner to adequately cover the risks in Texas or to adequately protect Texans if the withdrawal plan were approved as submitted.

8. Generally, the following actions are involved when TDI receives withdrawal plans. TDI staff reviews the withdrawal plans for completeness and points out deficiencies to the filer when necessary. TDI evaluates whether the plan contents demonstrate that the insurer will be able to meet its contractual obligations, provide service to policyholders and claimants in Texas, and meet any other statutory obligations. Once TDI has concluded that the plan demonstrates those elements, TDI then considers whether, if the plan is approved, the line of insurance being withdrawn from will continue to be offered in a quantity and manner to adequately cover Texas risks.

9. TDI staff has done an analysis of withdrawal plan filings made by carriers between January 1, 2009, and March 22, 2018, affecting participation in the individual health line of business. A summary of the numbers of carriers filing withdrawal plans for the individual health line of business follows:

Calendar Year	No. of Health Withdrawal Filings
2009	-
2010	-
2011	-
2012	-
2013	2
2014	7
2015	2

2016	6
2017	8
2018 (thru 3/22)	-

As of March 22, 2018, there were 10 carriers offering individual health coverage in various Texas regions and one carrier offering coverage statewide.

Activities Involving Navigator Regulation

10. During the 83rd Legislature, Regular Session (2013), the Legislature passed SB 1795, which created Insurance Code Chapter 4154, Navigators for Health Benefit Exchanges. Insurance Code § 4154.001 stated the purpose of the statute as, "[s]ince the State of Texas opted out of implementing a state exchange, pursuant to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, the purpose of this chapter is to provide a state solution to ensure that Texans are able to find and apply for affordable health coverage under any federally run health benefit exchange while helping consumers in this state." Under Insurance Code § 4154.051, the Commissioner was required to determine whether the standards and qualification for navigators provided by 42 U.S.C. § 18031 and any regulations enacted under that section were sufficient to ensure that navigators could perform the required duties. If the Commissioner determined that the federal standards were insufficient, the Commissioner was further required to make a good faith effort to work in cooperation with the United States Department of Health and Human Services (HHS) to propose improvement to those standards. If the Commissioner determined that the insufficiencies in the federal standards had not been

addressed, the Commissioner was required to establish standards and qualifications by rule to ensure navigators could perform the required duties.

11. The federal regulations enacted under 42 U.S.C. § 18031 were adopted in July 2013. TDI staff evaluated the rules. In August 2013, Texas Attorney General Greg Abbot joined 12 other attorneys general in a letter addressing concerns with the federal regulations. In a September 2013, letter to the Commissioner, Governor Perry also addressed concerns with the standards for navigators set out in federal regulations. TDI sought public comment on the sufficiency of the standards in a stakeholder meeting held on September 30, 2013. TDI conducted additional investigation into the federal standards for navigators in follow-up to the stakeholder meeting by meeting or holding teleconferences with navigator entities, consumer advocates, and representatives of health care provider groups. TDI also conducted multiple conference calls with HHS regarding the federal standards. TDI posted an outline of solutions for potential insufficiencies identified during this process and invited additional public comment on the outline. TDI also held a call with HHS on December 2, 2013, to discuss the outline; HHS indicated that it would not consider revising the regulations to address the issues raised in the outline and confirmed that solutions set out in the outline did not present federal preemption concerns. HHS staff suggested that TDI proceed with its proposal of rules. In the adoption of the final TDI rules, which were effective in February 2014, the Commissioner found that insufficiencies existed in the federal standards in the following areas: applicability of federal regulations to individuals and entities providing navigator services; qualifications of individuals who

serve as navigators; education requirements for navigators; privacy requirements; and accountability of navigators. In order to ensure that Texans were protected, TDI required navigators and navigator entities to register with TDI and provide evidence through the registration process that minimum standards were met

12. SB 1795 also included Insurance Code § 4154.006 which contained an automatic expiration date. The chapter was not extended; therefore, the statute and associated rules adopted by TDI expired on September 1, 2017.

Repeal of Texas Health Insurance Pool Statute

13. The Texas Legislature passed SB 1367, 83rd Legislature, Regular Session (2013) abolishing the Texas Health Insurance Pool. The House Research Organization Bill Analysis, dated May 15, 2013, provided in part, "[i]n 1997, the 75th Legislature made operational the Texas Health Insurance Pool to sell health insurance policies to individuals unable to get private coverage due to pre-existing health conditions. The pool, as it is known, began offering coverage in 1998, and enrolled more than 23,000 Texans as of April 2013… Beginning January 1, 2014, the federal Patient Protection and Affordable Care Act (ACA) will require most individuals either obtain health insurance or pay a tax penalty. Individuals purchasing insurance in a health benefit exchange, an online marketplace of private, government regulated health insurance plans, will not be denied coverage or charged more based on their health status." See Exhibit A, which is a true and correct copy of the House Research Organization Bill Analysis for SB 1367, dated May 15, 2013. In the SB 1367 Senate Research Center Bill Analysis, the Author's/Sponsor's Statement of Intent provided in part,

"[c]hanges in federal law have made the Texas Health Insurance Pool (THIP) unnecessary." See Exhibit B, which is a true and correct copy of the Senate Research Center Bill Analysis for SB 1367, dated July 18, 2013.

14. Under Section 2 of the bill, the Commissioner approved the Texas Health Insurance Pool's plan of dissolution under the Commissioner's Order No. 2990, dated February 10, 2014. See Exhibit C attached, which is a true and correct copy of Commissioner's Order No. 2990, dated February 10, 2014. The Commissioner acknowledged the completion of the dissolution effective September 1, 2015, by letter dated August 26, 2015. See Exhibit D attached, which is a true and correct copy of the letter discharging the Texas Health Insurance Pool Board of Directors, dated August 26, 2015.

Activity Involving Complaints

15. TDI regulated fully insured individual and group health plans. TDI's Consumer Protection Section (Consumer Protection) receives and resolves complaints. Insurance Code 521 sets out the requirements for consumer information and complaints at TDI. Insurance Code § 521.002 provides that TDI establish a program to facilitate resolution of policyholder complaints. The program applies to insurers and generally to HMOs. Further, Insurance Code § 521.051 states, in part, that TDI must maintain a toll-free telephone number to receive and aid in resolving complaints against insurers.

16. As part of the process, TDI must provide, through TDI's toll-free telephone number, information related to the number and disposition of justified, verified and documented as valid complaints received; the

rating of an insurer, if any, as published by a nationally recognized rating organization; the kinds of coverage available to a consumer through any insurer writing insurance in this state; an insurer's admitted assets-to-liabilities ratio; and other appropriate information collected and maintained by TDI as found, in part, under Insurance Code § 521.052.

17. TDI regulates the processing and settlement of claims under Insurance Code Chapter 542. Insurance Code § 542.002 provides that Subchapter A of Insurance Code Chapter 542, the Unfair Claim Settlement Practices Act, applies to a life, health, or accident insurance company, in addition to other types of insurers. Insurance Code § 843.051(a) makes HMOs subject to the Act as well. Insurance Code § 542.005 defines a complaint as any written communication primarily expressing a grievance. Under Insurance Code § 542.008, TDI must establish a system for receiving and processing individual complaints alleging a violation of Subchapter A of Insurance Code Chapter 542.

18. In addition, Insurance Code Chapter 843 provides regulatory authority with respect to HMOs, including who a complainant is, what a complaint is, and when to submit a complaint to TDI. A complaint under Insurance Code § 843.002(6), in part, "means any dissatisfaction expressed orally or in writing by a complainant to a[n] [HMO] regarding any aspect of the [HMO's] operation." Insurance Code § 843.002(5) provides that a complainant is "an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who file a complaint."

19. Insurance Coe § 843.282 requires TDI to accept complaints alleging certain violations of Insurance Code Chapter 843 and other laws in the Insurance Code by "[a]ny person, including a person

who has attempted to resolve a complaint through [an HMO's] complaint system process and is dissatisfied with the resolution."

20. The following is based on information conveyed to me from Consumer Protection staff. Consumer Protection receives complaints from consumers and provides, such as physicians and hospitals, involving claims for healthcare services. Consumer Protection maintains a database tracking system for complaints. The system uses codes to track the type of health coverage involved in the complaint. Consumer Protection collected data on healthcare complaints for the calendar years 2010 through 2017, showing the number of complaints involving qualified health plans, under the Affordable Care Act (ACA Complaints) as summarized in the following table:

Calendar Year	No. of ACA Complaints
2010	-
2011	-
2012	-
2013	-
2014	824
2015	1,483
2016	2,117
2017	1,107

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 24 April 2018.

/s/ Jamie Walker
Jamie Walker
Assistant Deputy Commissioner
Texas Department of Insurance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF THEODORE K. NICKEL, COMMISSIONER, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, PURSUANT TO 28 U.S.C. § 1746

1. My name is Ted Nickel, I am the Commissioner of the Wisconsin Office of the Commissioner of Insurance ("OCI").

2. OCI is responsible for regulating the Wisconsin health-insurance market and protecting consumers of this market. Overall, OCI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance environment, including:

a. Reviewing insurance policies that are sold in Wisconsin to make sure they meet the requirements set forth in Wisconsin law;

b. Conducting examinations of domestic and foreign insurers to ensure compliance with Wisconsin laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to the various parties involved in selling and marketing insurance products;

e. Assisting insurance consumers with their insurance problems;

f. Researching special insurance issues to understand and assess their impact on Wisconsin;

g. Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws;

h. Creating and distributing public information and consumer education pieces to educate people about insurance; and

i. Operating a state life insurance fund, a property fund for the property owned by local units of government, and a patients compensation fund insuring health care providers for medical malpractice.

3. As Commissioner, I am the head of OCI and the chief regulator of insurance in Wisconsin. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with OCI include studying the impact of the Affordable Care Act (hereinafter "the ACA," or "the Act") on Wisconsin's insurance market, ensuring Wisconsin's compliance

with the Act, advising the Wisconsin Governor's Office on the ACA, and developing strategies for Wisconsin to mitigate the numerous harms the Act has inflicted on Wisconsin health-insurance markets.

5. A member of my office has testified in front of Congress about the negative effects of the Affordable Care Act on Wisconsin's health-insurance market.[1] Briefly, this testimony explained that Wisconsin had competitive individual and small group health-insurance markets before the ACA, which were significantly harmed by the ACA.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

6. The Affordable Care Act inflicts numerous harms on Wisconsin and its citizens, as detailed below. Specifically, the Act inflicts harms on Wisconsin as a regulator of the health-insurance market.

7. The Act inflicts harms on Wisconsin because, as a result of the Act's individual market reforms many failings, Wisconsin was forced to enact state-level individual market reforms to stabilize this market.

a. Because of the ACA's burdensome regulations, many insurers in Wisconsin have left the individual market, scaled back their offerings in the individual market, or otherwise limited their exposure in the individual market. For those insurers still selling in the individual market, their products have become much more expensive.

[1] This testimony may be found at http://docs.house.gov/meetings/IF/IF14/20170202/105506/HHRG-115-IF14-Wstate-WieskeJ-20170202.pdf.

Premiums have consistently risen since the ACA was enacted. In 2017, average premium rates rose 17%, and in 2018 they increased by 42%.

b. As a result, the Wisconsin Legislature passed a reinsurance program in February 2018 to stabilize the individual market. *See* Wisconsin State Legislature, Senate Bill 770; [2] Governor Scott Walker, Press Release, Governor Walker Proposes Health Care Stability Plan to Stabilize Premiums for Wisconsinites on Obamacare (Jan 21, 2018);[3] Governor Scott Walker, Memo Accompanying Jan. 21, 2018 Press Release;[4]Bob Lang, Legislative Fiscal Bureau Memo Accompanying Assembly Bill 885/Senate Bill 770 (Feb. 12, 2018).[5]

c. Wisconsin's reinsurance program is necessary because the ACA's regulations of the individual market have caused health-insurance premiums to rise substantially. Without Wisconsin's intervention, plans in the individual market would either not be offered, or would be prohibitively expensive.

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[2] https://docs.legis.wisconsin.gov/2017/proposals/reg/sen/bill/sb770.

[3] https://walker.wi.gov/press-releases/governor-walker-proposes-health-care-stability-plan-stabilize-premiums-wisconsinites.

[4] https://jwyjh41vxje2rqecx3efy4kf-wpengine.netdna-ssl.com/wp-content/uploads/2018/01/180120Overview.pdf.

[5] http://docs.legis.wisconsin.gov/misc/lfb/bill_summaries/2017_19/0885_ab_885_wisconsin_healthcare_stability_plan_and_medical_assistance_lapse_2_12_18.pdf

d. This reinsurance program proposal costs an estimated $200 million, split between state and federal funds.

e. The reinsurance plan cannot be implemented without federal approval through a Section 1332 State Innovation Waiver; a process involving drafting of the application, staff travel, and presentation preparation for required public hearings, OCI funds to support actuarial analysis required for inclusion in the application, and administrative expenses necessary to operate the program.

8. As mentioned above, the Act forced Wisconsin insurers out of the individual market and/or all health-insurance markets.

a. For example, a major Wisconsin health insurer, Assurant Health, ceased its Wisconsin operations because of the ACA. *See*, *e.g.*, Guy Boulton, *Milwaukee-based Assurant Health to be sold off or shut down*, Milwaukee Journal Sentinel (Apr. 28, 2015).[6] This cost Wisconsin 1,200 jobs. *Id*.

b. This contributes to the harms to the individual market, as mentioned above. As some health insurers have stopped using agents to sell individual health insurance products and have left the market altogether, therefore no longer needing agents, the ACA has also resulted in OCI collecting less revenue in health insurance-related

[6] http://archive.jsonline.com/business/assurant-considering-sale-of-milwaukee-based-assurant-health-b99490422z1-30161425l.html.

agent licensing fees. Agents licensed to sell insurance in Wisconsin must pay an initial fee of $75.00 along with an application fee of $10.00. *See* Wis. Stat. § 628.04(l)(a); Wis. Admin. Code Ins. § 6.59 ("Licensing of individuals as agents, reinsurance intermediaries, or managing general agents"). A licensing fee of $100 and a biennial license renewal fee of $35.00 also applies to some firms. *See* Wis. Stat. § 628.04(l)(a); Wis. Admin. Code Ins. § 6.58(3), (5).

9. The Act creates an unsustainable insurance market, which will ultimately raise Medicaid reimbursement rates.

a. As the ACA causes insurers to leave the marketplace, more individuals will be unable to obtain insurance coverage.

b. These individuals will ultimately receive uncompensated medical care via hospital emergency rooms. *See generally* 42 U.S.C. § 18091(2)(A), (F), (I) (describing this problem).

c. To compensate for this uncompensated care, health-care providers will raise their rates on compensated services, thus requiring the State to reimburse more money for Medicaid-paid services.

10. The Act harms Wisconsin because it preempted Wisconsin law, preventing Wisconsin from regulating the Wisconsin health-insurance market in the manner it sees fit. Relatedly, Wisconsin repealed statutes and regulations related to its high risk pool, a safety net for individuals with high health care

needs. *See infra*, ¶ 10.a. Without the ACA, Wisconsin could enforce these preempted laws and rules to return stability to the health-insurance market.

a. The ACA resulted in the repeal of Wisconsin's high-risk pool, the Health Insurance Risk-Sharing Plan, which effectively managed the health-insurance needs of high-risk individuals before the full implementation of the ACA. Wis. Stat. §§ 149.10–.53 (2011-12) (statutory framework for Wisconsin Health Insurance Risk-Sharing Plan), *repealed* by 2013 Wis. Act 20, § 1900n; *see generally* Wisconsin Legislative Audit Bureau, Report 14-7 Health Insurance Risk-Sharing Plan Authority at 1 (June 2014) (describing history of Wisconsin's Health Insurance Risk-Sharing Plan, including dissolution and repeal).[7]

b. The ACA preempted Wisconsin law relating to coverage for preventive services. Wisconsin insurance law allows for cost-sharing for preventative services. *See* OCI, Bulletin, September 3, 2010, Patient Protection and Affordable Care Act of 2009 (hereinafter "OCI Bulletin");[8] Wis. Stat. § 632.895 (describing Wisconsin coverage mandates, which Wisconsin had interpreted to permit cost-sharing). The ACA does not allow such cost sharing. *See* 42 U.S.C. § 300gg-13.

c. The ACA preempted Wisconsin law on the treatment of preexisting conditions. Under

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[7] http://legis.wisconsin.gov/lab/reports/14-7full.pdf.

[8] https://oci.wi.gov/Pages/Regulation/Bulletin20100903PPACA.aspx.

Wisconsin insurance law, preexisting condition exclusions were permitted for a 12-month period. *See* OCI Bulletin; Wis. Stat. § 632.76(2)(ac). The ACA's conflicting rules on preexisting conditions increase the cost of health insurance.

d. The ACA preempted Wisconsin fraud rules. Under Wisconsin insurance law, rescission in cases of fraudulent misrepresentation, including negligent misrepresentations, was permitted. *See* OCI Bulletin; Wis. Stat. § 632.76(1). The ACA allows rescission only when fraudulent misrepresentation is intentional. *See* OCI Bulletin; 42 U.S.C. § 300gg-12.

11. The ACA imposes other costs, burdens, and requirements on OCI:

a. The Act forces OCI to expend significant amounts of money on compliance and education costs. For example, in 2013 OCI spent a significant amount of resources on state-wide information-sharing town halls for the public.

b. In preparation to comply with the ACA for the 2018 plan year, OCI held multiple calls with insurers to provide direction on the filing of their rates. With congressional uncertainty and ultimately a decision resulting in the federal government no longer funding cost sharing reduction subsidies (CSRs), OCI had to revise timelines and expectations around rate filings and communicate those expectations verbally and in writing.

12. Finally, without the ACA, OCI could allow insurers to operate under a set of rules that creates certainty and stability for market growth while protecting consumers and offering them affordable access to individual health insurance coverage. Under the ACA, OCI has limited flexibility in regulating the individual market and is forced to react to the implications federal rules have on the Wisconsin market. As mentioned earlier, an example of that reaction is addressing a destabilizing market with between $30–50 million general purpose revenue to support a $200 million state based reinsurance plan.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on 3 April 2018.

Signed,

/s/ Theodore K. Nickel
Theodore K. Nickel
Commissioner,
Wisconsin Office of the Commissioner of Insurance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF ARLENE LARSON, MANAGER OF FEDERAL HEALTH PROGRAMS & POLICY AT WISCONSIN EMPLOYEE TRUST FUNDS, PURSUANT TO 28 U.S.C. § 1746

INTRODUCTION

1. My name is Arlene Larson, I am the Manager of Federal Health Programs and Policy at the Wisconsin Department of Employee Trust Funds ("ETF"). My duties generally include health insurance policy and contract analysis and implementation.

2. ETF is responsible for administering retirement, insurance, and other benefit programs for State and participating Local government employees and retirees of the Wisconsin Retirement System. ETF performs a variety of tasks to satisfy this responsibility. The Group Insurance Board ("Board") enters into contracts to provide the State Group Health Insurance Program.

3. Additionally, my official duties with ETF include ensuring the State's group health insurance program complies with the Patient Protection and Affordable Care Act (hereinafter "the ACA," or "the Act").

WISCONSIN'S STATE-EMPLOYEE HEALTH INSURANCE PLANS AND THE AFFORDABLE CARE ACT'S EFFECTS

4. Below is basic information about the State's employees (and their family members) enrolled in the State's group health insurance program:

a. There are an estimated 167,500 state employees (and their family members) enrolled in the State's group health insurance program. The employee contribution amount appears in the grid, below. It varies between regular State employees and the University of Wisconsin (UW) graduate assistants. It further varies based upon the benefit selected by the employee. Most employees choose a vendor that offers the "It's Your Choice Health Plan." "It's Your Choice Health Plan."

	It's Your Choice Health Plan	It's Your Choice Access Plan	It's Your Choice High Deductible Health Plan (HDHP)	It's Your Choice Access High Deductible Health Plan (HDHP)
Monthly Payment (Premium)				
Individual / Family	$85 / $211	$263 / $656	$30 / $74	$208 / $519
UW Grad Assistant Individual / Family	$42.50 / $105.50	$131.50 / $328	Not eligible	Not eligible

b. For 2017, ETF estimates that the State spent the amounts below on the state-employee group health insurance program.

Employer Estimate	Employee Estimate	Total
$998,003,809.42	$132,613,004.50	$1,130,616,813.92

c. Additionally, there are administrative tasks performed by state employees to enroll each employee in the group health insurance program.

5. The Act required the Board to modify the State's group health insurance program to State employees:

a. The Board enhanced an existing health-care benefit for State employees to comply with the essential-health-benefits requirements. Preventive care is required to be paid at 100% under the ACA.

b. The Act lowered limits on employee flexible health spending accounts. I am aware that every year ETF reviews the limits to be certain we comply with requirements.

6. The ACA's Market Share Fee, ACA § 9010, may have financial impact on the State's group health insurance program in the future.

a. Beginning in 2015, ETF and the Board began an intensive investigation into moving from a fully insured model to a self-insurance model for the State group health insurance program. This investigation included working with the Board's consulting agency, Segal Consulting (Segal), which

issued reports to the board. To date, Segal is the Board's consulting actuary and former benefit consultant.

b. This investigation was motivated in part to find a means to avoid the Act's Market Share fees of approximately 2% of health premiums, per Segal's March 25, 2015 report to the Board. Segal's reports are publicly available on ETF's website. I am aware that in 2015, Congress approved a moratorium on collection insurer taxes for 2017. The moratorium was set to expire in 2018. During annual health plan negotiations regarding 2018 rates, participating health plans were limited in their 2017 administrative fee increases. Per Segal's August 30, 2017 report to the Board, no consideration was given to additional ACA fees currently projected for 2018. The State group health insurance program ultimately did not change to self-insurance, and instead the Board explored cost reductions in other areas.

7. The ACA's 40% excise tax, 26 U.S.C. § 4980I, may have a financial impact on the State's group health insurance program if enacted. This tax is triggered when the cost of plans offered by an employer exceeds a certain value.

a. The Segal reports to the Board, referenced above, also addressed the potential effect of the ACA's excise tax on the State's group health insurance program.

b. The federal government has delayed the enforcement of the excise tax for specific

years, but the State's group health insurance program may be liable to pay the 40% tax if it is imposed as written.

c. If the 40% excise tax is enforced, ETF and the Board will dedicate time and resources during its annual process to review options to avoid or minimize the impact of the excise tax.

d. Segal annually provides benefit alternative calculation estimates to ETF and the Board. If the 40% excise tax is enforced, Segal will provide calculations for options to the State's group health insurance program to minimize or avoid the tax.

8. The ACA imposes other costs and requirements on ETF:

a. The ACA has required ETF to comply with the requirements surrounding IRS Form 1095-C for some retirees in the State's group health insurance program administered by ETF. In 2017, ETF hired a vendor to issue 343 Form 1095-Cs.

b. ETF has had to dedicate some agency resources to studying the ACA and ensuring the State's compliance with the ACA. For example, ETF coordinated with other state agencies and local government municipalities to discuss the potential impact of the employer shared responsibility penalty. These discussions focused primarily on the possibility of employers failing to offer health insurance premium contributions to full-time employees prior to the 91st day after the employee's hire date.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 4-20-18,

Signed,

/s/ Arlene Larson
Arlene Larson, Manager of Federal
Health Programs and Policy
Wisconsin Employee Trust Funds

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JIM L. RIDLING, ALABAMA COMMISSIONER OF INSURANCE

My name is Jim L. Ridling and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am Commissioner of the Alabama Department of Insurance (ALDOI). I have served as Commissioner of ALDOI for over nine (9) years. As Commissioner, I am the head of the ALDOI and the chief insurance regulator for the state of Alabama. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various commissions, councils, and committees in a variety of capacities.

2. ALDOI is responsible for regulating the business of insurance in the state of Alabama. As a part of these responsibilities, ALDOI performs a variety of tasks that are designed to protect insurance consum-

ers while ensuring a competitive insurance environment. Included among the duties and responsibilities are the following:

a. Licensing insurance companies and conducting regular examinations of domestic insurers, and as necessary foreign insurers, to ensure compliance with Alabama laws and rules.

b. Monitoring the financial solvency of licensed insurers to make sure that consumers will be provided the insurance coverage they have paid for when they need it.

c. Reviewing and approving all insurance policies to make sure they meet the requirements of Alabama law.

d. Licensing the insurance producers and various other representatives of the insurers.

e. Assisting insurance consumers with any problems they may experience with their insurance policies.

f. Providing technical assistance on legislation and adopting administrative rules to implement and interpret insurance laws.

3. Included within all the duties and responsibilities is the regulation of the health insurance market, and in particular the impact of the Affordable Care Act (ACA) on Alabama's health insurance market, ensuring compliance of the ACA in Alabama, advising the Alabama Governor's office on the ACA, and to generally develop strategies for the State of Alabama to mitigate the numerous harms the ACA has inflicted on the health insurance markets in the State of Alabama.

4. In particular, the ACA has inflicted numerous harms on Alabama and its citizens, as follows:

a. First, a stated goal of the ACA was to increase competition, as expressed by President Obama in an address to Congress on September 9, 2009, where he said Alabama lacked competition because one carrier had almost 90% of the market.[1] Because of the ACA's burdensome regulations, many insurers in Alabama have left the insurance market or scaled backed their exposure so that there is actually less competition for the individuals within the health insurance market to choose from. Instead of fostering competition, Alabama has seen the exact opposite within its borders when it comes to the ACA's effect on the insurance market. After four years of the ACA, that one company had 100% of the individual health insurance market.

b. Another stated goal of the ACA was to reduce the rates paid for health insurance. The embedded mandates through the essential health benefits requirement in the ACA have added to the health insurer costs in the market, putting upward premium pressure on insurers in the Alabama market for policies in this State. On March 23, 2010 when President Obama signed the ACA into law, an individual aged 52 could purchase a major medical insurance policy for $203 per month. On January 1, 2018, a

[1] http://blog.al.com/live/2009/09/obama_cited_lack_of_competitiv.html

comparable Obama Care policy for a 52 year old was $829, an increase of 308%, or 19% per year.

c. The ACA has had a disastrous effect on the number of insurers within the state regarding the federal risk adjustment within the individual and small group markets. The stated goal again was to increase competition by stabilizing premiums. Here are the results of the risk adjustments for the first three years under ACA:

2014: One insurer collected $2,544,517, four other insurers collected a total of $246,858, and six insurers paid a total of $2,791,376.[2]

2015: One insurer collected $15,326,641, two other insurers collected a total of $104,889, and seven insurers paid a total of $15,431,531.[3]

2016: One insurer collected $27,243,856 and seven insurers paid a total of $27,243,856, (including default payments).[4]

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[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/ Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/ Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

[4] https://www.cms.gov/CCIIO/Programs-and-Initiatives/ Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

2017: The report for 2017 is due this summer. It is anticipated the transfers will be sharply reduced due to the fact that only one insurer remains in the individual market.

d. Finally, the ACA harms Alabama because it preempted Alabama law, thus preventing Alabama from regulating the Alabama health insurance market in the manner it deems most appropriate to the Alabama situation. Without the ACA, Alabama could again enforce preempted laws and rules to return stability to the health insurance market.

5. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this 24th day of April, 2018.

/s/ Jim L. Ridling
Jim L. Ridling
Alabama Commissioner of Insurance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF ALLEN KERR

INTRODUCTION

1. My name is Allen Kerr, I am the Commissioner of the Arkansas Insurance Department ("AID").

2. AID is responsible for regulating the Arkansas health-insurance market and protecting consumers of the market. Overall, AID performs a variety of tasks to protect insurance consumers and ensure a competitive insurance environment, including:

a. Reviewing insurance policies that are sold in Arkansas to make sure they meet the requirements set forth in Arkansas law;

b. Conducting examinations of domestic and foreign insurers to ensure compliance with Arkansas laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to the various parties involved in selling and marketing insurance products;

e. Assisting insurance consumers with their insurance problems;

f. Researching special insurance issues to understand and assess their impact on Arkansas;

g. Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws; and

h. Creating and distributing public information and consumer education pieces to educate people about insurance.

3. As Commissioner, I am the head of AID and the chief regulator of insurance in Arkansas. Generally, my official duties include supervising the entire Department, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with AID include reviewing the impact of the Affordable Care Act (hereinafter "the ACA," or "the Act") on Arkansas' insurance market, ensuring Arkansas' compliance with the Act, advising the Arkansas Governor on the ACA, and developing strategies for Arkansas to mitigate the adverse impact the Act has inflicted on the Arkansas health insurance market.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. The embedded mandates through essential health benefits requirements in the ACA have added to health insurer costs in this market putting upward premium pressure on insurers in the Arkansas market for issuers offering individual and small group policies in this State. We estimate that since the inception of the Arkansas health insurance exchange in 2014, the percentage increase in premium in the individual market from the first year of the Exchange to today is approximately 24%.

6. The Act adds costs to health insurers in benefit requirements, underwriting and in reporting, and this negatively impacts the number of issuers in the health insurance exchange we provide for individual and small group policies. For example, as a result of the ACA costs, several years ago, United Health Care withdrew from participation in the Arkansas exchange, thereby reducing competition and the number of insurers offering individual policies in this State.

7. Finally, the Act harms Arkansas because it has preempted Arkansas law, preventing Arkansas from regulating health insurance in the manner it sees fit.

8. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 19th day of April, 2018.

/s/ Allen Kerr
Allen Kerr, Commissioner
Arkansas Department of Insurance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

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[Filed: April 26, 2018]

DECLARATION OF MIKE MICHAEL

My name is Mike Michael and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Kansas State Employee Health Plan (SEHP). SEHP administers the various insurance plans available to Kansas state employees and participating non-state entities (such as school districts, cities or counties). SEHP is part of the Division of Health Care Finance, a division within the Kansas Department of Health and Environment. I have served with SEHP for over 10 years.

2. I am particularly familiar with the SEHP changes in costs, plans, and policies required to comply with requirements of the Affordable Care Act (ACA).

3. At my direction, SEHP staff have prepared the attached spreadsheet that answers questions posed to SEHP concerning the impact of ACA.

4. As the spreadsheet details, I estimate that the overall impact of ACA on SEHP operations to be additional costs of $44,410,997 spread over the years of 2013 to 2018 inclusive.

5. The three largest categories of ACA costs are:

a. Plan changes to cover out-of-pocket maximums - $14,006,000;

b. Plan changes to cover individual mandate - $10,559,000; and

c. ACA fees for transitional reinsurance - $9,520,452.

6. SEHP is currently in its design stage for the 2019 Plan year. If ACA were to be eliminated, this would affect the 2019 Plan by decreasing costs for compliance. This could potentially affect the insurance rates charged to SEHP participants.

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 24 day of April, 2018.

/s/ Mike Michael
Mike Michael
Director
Kansas State Employee Health Plan

i. What impact does has the ACA had on each agency's budgeting?

- **How does it break down particularly, what costs were "one time" and what costs are ongoing?**

Type of cost	2013	2014	2015	2016	2017	2018	Grand Total
One Time Fees							
Design of Software for 1094/ 1095 Forms			$33,750				$33,750
Ongoing costs by year							
Plan changes							
1. Preventive				$1,031,000	$963,000	$1,017,000	$3,011,000
2. Age 26				$1,391,000	$1,289,000	$1,362,000	$4,042,000
3. Removal of dollar Limit on DME		$290,818	$290,818	$579,000	$521,000	$550,000	$2,231,637
4. Individaul Mandate		$2,110,000	$2,420,000	$2,076,000	$1,922,000	$2,031,000	$10,559,000

Type of cost	2013	2014	2015	2016	2017	2018	Grand Total
5. Out of Pocket Maximum		$4,940,000	$5,280,000	$1,277,000	$1,220,000	$1,289,000	$14,006,000
Total Ongoing Cost		$7,340,818	$7,990,818	$6,354,000	$5,915,000	$6,249,000	$33,849,637
ACA FEES							
Transitional Reinsurance		$4,482,107	$3,089,585	$1,948,760			$9,520,452
Patient-Centered Outcomes Research institut	$90,591	$178,882	$154,456	$156,623	$163,294	$163,294	$907,140
Total ACA Fees							$10,427,592
Form 1094/1095 Report-ing				$18,774	$43,198	$38,048	$100,019
Grand Total							**$44,410,997**

ii. How would a complete repeal of ACA tomorrow affect how policy and other decisions are made for next year?

This would allow the plan to discuss preventative, age 26, DME limits, out of pocket limits and etc. to potentially modify to meet the needs of the state. This would also eliminate additional costs such as PCORI fees and tax reporting of 1094/1095.

- **"In other words: are you currently making plans regarding benefits/policy for next year, and, if so, what impact would repeal of the ACA have on the decision-making that is currently happening?**

  We are currently in discussions about plan design for 2019. If repealed sooner would allow discussions for plan design and potentially lower the plan costs.

- **Would repeal of the ACA now allow your agencies to be more flexible in the decision it makes for next year?**

  This would allow us to discuss options about preventive, age 26 removing DME limits and out of pocket maximums. If repealed sooner would allow discussions for 2019 versus 2020.

- **Would it grant your agencies greater authority in making decisions regarding benefits and health care than it currently has?**

  Yes

- **What benefit would it be to your agencies (especially to its ability to make plans regarding budget, policy, etc.) to have the ACA appealed now as opposed to much later in the year or even next year?**

It would allow discussions of greater options and be able to potentially reduce costs such as PCORI fees and 1094/1095 reporting.

iii. How does your spending/budgeting under ACA compare to prior to the implementation of the ACA?

Because of the increase in cost for ACA, it has required more revenue by the employer and employee to cover the increased costs.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
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CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF DREW L. SNYDER

My name is Drew L. Snyder and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Executive Director for the Mississippi Division of Medicaid (DOM). DOM administers Medicaid at the state level to residents of Mississippi. Mississippi Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Elders; and (5) People with disabilities. As result of the ACA, an additional category was added to this list to include individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) (West); Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004.

2. Financial eligibility for Medicaid and many other social programs is based on a family's income

level as compared to the Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a family would need to meet very basic family needs.

3. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Mississippi receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Generally, Mississippi receives an FMAP of approximately 75%, meaning the federal/state share of Medicaid funding is around 75/25 for most client services.

4. With the passing of the Affordable Care Act ("ACA") in 2010, DOM's ability to manage Medicaid coverage to Mississippi residents has been significantly restricted. The regulations imposed by the ACA result in substantial burden to DOM both administratively and financially.

Administrative & Policy Burdens Under the ACA

5. Prior to the passing of the ACA, DOM used several factors to determine eligibility for Medicaid for families and children including: (1) Family income; (2) age; (3) relationship; (4) other categorical factors, such as being pregnant or disabled.[1] Prior to the ACA DOM had the option to review eligibility criteria for adult enrollees more frequently than 12 months.

6. With the passing of the ACA, DOM was no longer given the flexibility to verify a Mississippi resident's eligibility based on these factors. Instead, the

[1] Individuals receiving SSI cash assistance were and still are automatically eligible for Medicaid.

ACA expanded "mandatory" populations for Medicaid programs, wherein Mississippi was required to provide them Medicaid regardless of actual financial status. *See* Pub. L. 111-148, 124 Stat. 271, § 2002. Specifically, in Mississippi the coverage for former foster children was raised from 21 years old to 26 years old. The ACA also mandated DOM use Modified Adjusted Gross Income (MAGI) to determine eligibility.[2] 42 U.S.C.A. § 1396a(e)(14) (West). In other words, the tax filing rules are now the primary consideration used to determine income and household composition for purposes of Medicaid eligibility. Income that is not taxable cannot be considered.

7. The restrictions placed upon DOM when it evaluates eligibility for Medicaid means that DOM is forced to ignore many factors relevant to an individual's ability to obtain health insurance for himself or herself. As a result, the ACA caused a rise in the number of Mississippi residents enrolled in Medicaid.

8. The ACA also imposed changes to the Medicaid and CHIP renewal process. Pursuant to the ACA, eligibility redeterminations are now allowed no more frequently than once per 12 months, unless the enrollee volunteers to DOM that there is a change that affects eligibility. This change mandated by the ACA restrains the frequency with which DOM can identify persons no longer eligible for Medicaid and remove them from the rolls, thus limiting the ability of the agency to fully review whether an adult continues to be eligible. The ACA's individual mandate contributed

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[2] MAGI applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities.

to the expansion of the Medicaid population in Mississippi as well. As a result of the individual mandate, Mississippi residents were required to seek health care coverage, on penalty of paying a fine to the federal government. Efforts to avoid imposition of the fine likely prompted more individuals to seek Medicaid from DOM.

9. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the individual mandate, I am confident that the individual mandate played a substantial role in the increase in the number of Medicaid recipients since 2011. This assertion is based on my experience with DOM and the research I have participated in to prepare reports to the Mississippi legislature.

10. New requirements pursuant to the ACA regarding non-Mississippi residents and illegal aliens also increased the number of persons receiving Medicaid benefits in Mississippi. While non-residents and illegal aliens are not (and have never been) required to be provided full Medicaid benefits by DOM, the ACA did create a new mandate requiring that DOM allow them to apply for Medicaid by simply asserting that they are in a qualified alien status and qualified to receive benefits. Pursuant to the ACA, this mere assertion from an individual imposes a duty upon DOM to provide him or her benefits for up to 90 days while he or she is given the opportunity to verify their citizenship or alien status. This imposition by the ACA resulted in an increase of persons covered by Medicaid through DOM.

11. The ACA also forced DOM to expand Medicaid coverage by mandating that DOM initially accept a hospital's determination of a person's eligibility for

Medicaid. 42 U.S.C. 1396a(a)(47). If a hospital concludes that an individual is eligible for Medicaid, the ACA requires DOM to provide him or her Medicaid for two months while DOM makes its own eligibility determination. This increased the number of persons receiving Medicaid benefits through DOM at any given time by forcing DOM to provide two months of benefits to many individuals who would not have been approved by DOM as an original matter. In addition to this numerical increase imposed by the ACA, this mandate also required DOM to build new systems to accommodate this requirement. These efforts required the investment of administrative resources, time, and money that could have been spent in other ways that benefitted the state.

12. The ACA also mandates the specific Medicaid services Mississippi is required to cover. Rather than allowing DOM to make such determinations based on the needs of Mississippi's population, the ACA imposed a "one-size-fits-all" rule upon Mississippi governing the provision of inpatient hospital services, outpatient hospital services, family planning services and supplies, federally qualified health centers, nurse midwife services, certified pediatric and family nurse practitioner services, home health care services, medical transportation services, nursing facility services for individuals 21 or over, rural health clinic services, and other significant and complex medical services and systems.

13. The ACA expands Medicaid coverage for adults under age 65 (up to 133% FPL, or rather up to 138% FPL with a 5% income disregard). 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII); (e)(14)(I)(i) (West). However, subsidies are available to adults through the Exchange beginning at 100% FPL.

14. As a cumulative result of these mandates, rules, and restrictions imposed by the ACA, DOM's Medicaid caseload has increased since implementation of the ACA. Since the ACA's implementation in 2014, Mississippi has expanded its Medicaid recipients from 2013 year end enrollment of 715,979 to a current enrollment of 739,082 in March 2018.

Costs Incurred Under the ACA

15. Medicaid Cost is determined by the Caseload - the volume or number of individuals served in each category - and Cost per Client - a function of the number, type, and cost of the services a client receives, and how those services are provided.

16. Given the increase in caseloads as a direct result of the ACA's enactment, state spending on Medicaid has increased dramatically following the ACA's implementation.

17. Beginning in January 2014, DOM was required to pay an annual excise tax to the federal government known as the Heath Insurer Tax. See Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 9010. The tax is based on the amount of health insurance premiums collected. HIT will continue to increase with premium growth. In the FY 2017, DOM paid a total of $43,504,254 in this tax.

18. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 20th day of April, 2018.

/s/ Drew L. Snyder, J.D.
Drew L. Snyder, J.D.
Executive Director
Mississippi Division of Medicaid

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

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UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JENNIFER R. TIDBALL

My name is Jennifer R. Tidball and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Deputy Director for the Missouri Department of Social Services. I have served as Deputy Director since August, 2014. I have served with the Department for 23 years.

2. I am familiar with the business of the Department. As Deputy Director I have been made aware of changes related to the enactment of the ACA by staff that inform the Deputy Director.

3. I have personal knowledge of the matters and information set forth herein.

Missouri Department of Social Services

4. The Missouri Department of Social Services administers Medicaid at the state level to residents of Missouri.

5. Financial eligibility for Medicaid and other social programs is based on a household's income level as compared to the Federal Poverty Level (FPL). Missouri uses multiple FPL percentages for different Medicaid coverage types, dependent upon the program.

6. Medicaid is funded by both the state and federal governments. The federal share of Medicaid funds Missouri receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Generally, Missouri receives an FMAP of 64.61%, meaning the federal/state share of Medicaid funding is around 65/35 for most medical services for FFY 2018.

7. Missouri did not adopt the full Medicaid expansion, the regulations imposed by the ACA result in substantial burden to Missouri Department of Social Services both administratively and financially.

8. Missouri's Medicaid caseload (the number of individuals enrolled in the Medicaid eligibility groups) increased from 881,719 for January 2013 to 969,049 for March 2018.

Administrative Changes to Medicaid Eligibility Under the ACA

9. Missouri Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Elderly; and (5) Persons with disabilities. As a result of the ACA, an additional category was added to this list to include individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX) ; Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004.

10. Before the ACA, Missouri did not offer Medicaid to this full group of former foster care children under age 26.

11. Prior to the ACA, the Missouri Department of Social Services used several factors to determine eligibility for Medicaid including: (1) Family income; (2) age; (3) assets; (4) other factors such as being pregnant or disabled.[1]

12. ACA restricted the Missouri Department of Social Services to consider only a sole financial factor to determine eligibility: Modified Adjusted Gross Income (MAGI).[2] 42 U.S.C.A. § 1396a(e)(14). In other words, IRS tax filing rules are now the only permissible consideration used to determine income and household composition for purposes of Medicaid eligibility. Other income, such as child support and Social Security income for children whose total income falls below an IRS determined threshold, is not considered. Because the ACA left no choice to states but to accept these new criteria, Missouri approved the use of MAGI by SB 127 (2013) beginning in January 2014.

13. The change to MAGI complicated the administration of the program because the eligibility criteria differ from those used for other social service programs. Under the ACA, Missouri built a new eligibility system to process MAGI Medicaid, which was costly and complicated. Under ACA, open enrollment is once

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[1] Individuals receiving SSI cash assistance were and still are automatically eligible for Medicaid.

[2] MAGI applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities.

per year. During the open enrollment period the Department receives an additional 10,000 to 15,000 applications per month.

The ACA's individual mandate increased Missouri's Medicaid enrollment

14. The ACA also included an individual mandate. Missouri residents were required to seek health care coverage or pay a penalty to the federal government.

15. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the ACA, during the time period the ACA was implemented the Medicaid caseload increased, see numbers above.

16. The ACA also mandates the specific Medicaid services Missouri is required to cover.

Costs Incurred Under the ACA

17. Medicaid Cost is determined by the Caseload – the volume or number of individuals served in each category - and Cost per Client - a function of the number, type, and cost of the services a client receives, and how those services are provided.

18. Given the increase in caseloads state spending on Medicaid has increased following the ACA's implementation. With the increase in caseload, the combined state share of Medicaid Administration and Assistance increased from $3,516,957,427 in FFY 2013 to $3,851,597,485 in FFY 2017.

19. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 18th day of April, 2018.

/s/ Jennifer R. Tidball

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

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UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JUDITH MUCK

My name is Judith Muck and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Executive Director of the Missouri Consolidated Health Care Plan (MCHCP). I have served as Executive Director with Missouri Consolidated Health Care Plan for 5 years.

2. As the Executive Director for Missouri Consolidated Health Care Plan, I am responsible for the day-to-day operations of the health plan.

3. I am familiar with the business of MCHCP, with the storage of records in the MCHCP and with changes in costs, plans and policies related to the enactment of the ACA.

4. I have personal knowledge of the matters and information set forth herein except where noted.

The Missouri Consolidated Health Plans

5. The Missouri Consolidated Health Care Plan is a non-federal governmental health plan which provides insurance coverage for most state employees as specified in Chapter 10 of the Revised Statutes of Missouri. Missouri statutes grants to the MCHCP Board of Trustees (the Board) the general administration and the responsibility for the proper operation of the plan. 103.008 RSMo.

6. Under Section 103.014, the Board appoints an Executive Director who has charge of the offices, records and employees of the plan, subject to the discretion of the board.

7. The Board, upon recommendations of the Executive Director of the MCHCP, sets benefits and premiums each year for the next plan year. Taken into consideration when designing the coverage are benefits and limits that are mandated by law, both federal and state.

8. Per 103.100 RSMo, every year MCHCP actuarially estimates the cost based on the plan design chosen by the Board and sends an overall cost to provide benefits to the Office of Administration. The governor makes a recommendation and the legislature passes the funding at the level it approves. MCHCP's budget is contained in the Office of Administration's budget as an employee benefit.

Financial Costs Associated with ACA Regulations

9. With the passing of the ACA Missouri Consolidated Health Care Plan has been affected with new administrative and financial requirements.

10. These requirements are described in the attached chart that was used by the MCHCP which was prepared by our employees shortly after state FY 2017, and updated as needed to summarize the historical and projected impact of the ACA on the MCHCP. This chart was made and kept in the ordinary course of business. This chart was made by assembling the data available to MCHCP in its computerized accounting system, data warehouse, actuarial analysis and contractual terms. This chart was found in the ordinary course of business and it was not prepared for purposes of litigation. The exhibit is a true copy of this chart. All fiscal years reference the state fiscal year. The state fiscal year runs from July 1, through June 30 of the subsequent year.

Lifetime Maximum Benefit

11. At the time of passage and implementation of the ACA, MCHCP did not have a lifetime maximum benefit. "Lifetime maximum benefit" is the maximum dollar amount a health insurance plan will pay in benefits to an insured person during that person's lifetime. The ACA prohibited insurance contracts nationwide from including any lifetime maximum benefit. The ACA thus, eliminated Missouri Consolidated Health Care Plan's ability to choose to impose lifetime maximum benefits for essential health benefits in the future. 42 U.S.C. § 300-gg-11.

Young Adult Dependents

12. Prior to the implementation of the ACA on January 1, 2010, Missouri Consolidated Health Care Plan provided coverage for unemancipated dependents up to age 25 and unemancipated disabled children over age 25 who are permanently and totally disabled when first eligible or covered before age 25..

But the ACA requires that all health insurance coverage nationwide provide continuing coverage for all dependents until the age of 26. 42 U.S.C. § 300-gg-14.

13. Providing continuing health insurance coverage for adult dependents until the age of twenty-six puts costs upon Missouri Consolidated Health Care Plan because each individual insured by the Missouri Consolidated Health Care Plan constitutes expenses for the system.

14. Specifically, Missouri Consolidated Health Care Plan had costs of $316,382 in FY 2011, $1,080.559 in FY 2012, $1,319,790 in FY 2013, $1,574,090 in FY 2014, $1,726,080 in FY 2015, $2,336,735 in FY 2016, $2,333,801 in FY 2017.

15. Accordingly, in the six-year period between 2012 and 2017, compliance with the ACA legal mandate to insure dependents until the age of twenty-six imposed a cost of approximately $10,687,437.

16. Exact additional costs for 2018 are not yet available, but compliance with the ACA will require Missouri Consolidated Health Care Plan to indefinitely continue paying these additional costs because the dependent age requirement mandated by the ACA remains 26, which is higher than the age that Missouri Consolidated Health Care Plan had adopted prior to the implantation of the ACA.

17. MCHCP estimates that these costs will be $2,203,014 in FY 2018, $2,395,552 in FY 2019, $2,553,658 in FY 2020, and $2,722,200 in FY 2021.

Preventive Services

18. Prior to adoption of the ACA on January 1, 2010, Missouri Consolidated Health Care Plan required insured persons to pay deductible, co-insurance

and/or copayments for some preventive care that are now disallowed because the ACA requires that preventive care be covered at 100%. 42 U.S.C. § 300gg-13. Prior to this provision, MCHCP covered almost all recommended preventive services with no cost share. Examples of services not previously covered at 100% include over-the-counter tobacco cessation products with a prescription, vitamin D with a prescription, aspirin with a prescription in certain situations, folic acid with a prescription in certain situations, routine prenatal care, and breast feeding support and services. Because so few services were not already covered, an actuary determined that this requirement did not impact MCHCP premiums. MCHCP lost the flexibility to choose not to offer these services in the future or to offer them subject to cost sharing requirements.

Clinical Trials

19. Effective January 1, 2013, the ACA requires coverage for routine patient care costs incurred as the result of a Phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. Prior to this provision, MCHCP covered routine patient care costs incurred as the result of Phase II, III or IV clinical trials for cancer in accordance with Missouri law. The actuary thus determined that this requirement did not impact MCHCP premiums. MCHCP lost the flexibility to choose not to cover the expanded trial requirements in the future.

Patient-Centered Outcomes Research Institute (PCORI) Fee

20. The ACA requires Missouri Consolidated Health Care Plan to pay a Patient-Centered Outcomes Research Institute (PCORI) fee. 26 U.S.C. § 9511. The

fee applies to issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is based on the average number of lives covered under the plan. The fee applies to plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. MCHCP makes payment in July of each year.

21. Missouri Consolidated Health Care Plan paid the following for its persons enrolled in a health insurance plan: in FY 2014, $87,002; in FY 2015, $173,432; in FY 2016, $181,018; in FY 2017, $187,783. It projects to pay, assuming a 4% trend over current fee of $2.08, $194,640 in FY 2018; $203,106 in FY 2019; $211,230 in FY 2020; and $211,230 in FY 2021.

Transitional Reinsurance Program Fee

22. The ACA requires Missouri Consolidated Health Care Plan to pay the Transitional Reinsurance Program fee. 42 U.S.C. § 18061. Section 1341 of the ACA established a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. If this requirement had not been in place, Missouri Consolidated Health Care Plan would have saved approximately $3,878,420 in FY 2015; $3,185,756 in FY 2016; $2,358,259 in FY 2017; and $388,725 in FY 2018.

Employer Shared Responsibility

23. Prior to the ACA, a full-time employee was defined as an employee who is employed at least 40 hours per week; the ACA altered that number to 30 hours per week. 26 U.S.C.A. § 4980H; Pub. L. 111-148, 124 Stat. 865, § 4980H(d)(4)(A).

24. This change impacted Missouri Consolidated Health Care Plan by increasing the number of persons

the State of Missouri must insure, thus increasing the total cost of providing insurance.

25. Under the ACA, any employer with 100 (decreases to 50 in 2016) or more fulltime equivalents (FTEs) is subject to a penalty if the employer fails to offer access to minimum essential coverage and if any FTE receives a tax credit or if the coverage does not meet minimum value and affordability requirements.

26. MCHCP coverage meets minimum value and affordability requirements. MCHCP offers coverage to all FTEs that are benefit-eligible. Effective January 1, 2015, MCHCP began offering coverage to certain variable hour employees who are not benefit-eligible but who worked on average more than 30 hours per week during the standard measurement period. These individuals are considered an FTE employee for the purpose of the ACA.

27. In FY 2016, this cost $112,833 and in FY 2017, $137,790. Projected costs include $268,242 in FY 2018; $290,897 in FY 2019; $310,096 in FY 2020; and $330,562 in FY 2021. Estimated costs reflect MCHCP's contribution to the premium for variable hour employees.

Excise or Cadillac Tax

28. Under the ACA, a 40 percent excise tax will be assessed, beginning in 2022, on the cost of coverage for health plans that exceed a certain annual limit ($10,200 for individual coverage and $27,500 for self and spouse or family coverage. Limits for retiree coverage are higher.) Estimates are subject to further guidance through regulations not yet available. Issues that can impact the potential amount owed include

rate blending, age and demographic distributions, HSA/FSA contributions as well as other issues.

29. This excise tax was estimated in December 2015, to be $2.0M-$2.5M in FY 2022. The lower amount of the range is estimated based on rate blending with the higher amount reflecting no rate blending. The estimate given also does not include the impact of any future benefit design changes should they occur after the estimate was made.

IRS Reporting Requirements

30. Under the ACA, MCHCP is required to report who has coverage to the Internal Revenue Service (IRS) annually. MCHCP has contracted for the printing and mailing of 1094B and 1095B reporting.

31. Form 1094-B is for the Transmittal of Health Coverage Information Returns. Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment.

32. These costs are $185,061 in FY 2016 and $57,699 in FY 2017. They are projected to be $47,000 in FY 2018; $47,300 in FY 2019; $49,200 in FY 2010; and $51,200 in FY 2021.

Administrative Requirements Associated with ACA Regulations

33. Missouri Consolidated Health Care Plan is currently structuring the benefits and policies for the 2019 plan year and bases its activities on knowledge of whether the ACA is still federal law in order.

34. Without the expenses described above, Missouri Consolidated Health Care Plan would possibly gain back nearly $3 million in funding. This is based

on $2,395,552 for its line item on young adult dependents, $203,106 saved on the PCORI fee, $290,897 on the employer shared responsibility payments, and $47,300 on IRS reporting requirements.

35. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 16 day of April 2018.

/s/ Judith Muck

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP		
Young adult dependents - Covered up to age 26. Effective 01/01/2010. Prior to this provision, MCHCP covered young adult dependents up to age 25 if unmarried and if lived at parent home or attended school. Estimated costs reflect MCHCP's contribution to the	**MCHCP Actual Costs**	
	FY 2011	$316,382
	FY 2012	$1,080,559
	FY 2013	$1,319,790
	FY 2014	$1,574,090
	FY 2015	$1,726,080
	FY 2016	$2,336,735
	FY 2017	$2,333,801
	MCHCP Estimated Costs	
	FY 2018	$2,203,014
	FY 2019	$2,395,552
	FY 2020	$2,553,658
	FY 2021	$2,722,200
Preventive Services - Recommended preventive services must be covered at 100% when delivered in-network. Effective 01/01/2010. Prior to this provision - MCHCP covered almost all recommended preventive services with no cost share. Examples of services not previously covered at 100% include over-the-counter tobacco cessation products with a prescription vitamin D with a prescription, aspirin with a prescription in certain situations, folic acid with a prescription in certain situations. The actuary determined that this requirement did not impact MCHCP	**MCHCP Actual Costs**	
	FY 2011	$0.00
	FY 2012	$0.00
	FY 2013	$0.00
	FY 2014	$0.00
	FY 2015	$0.00
	FY 2016	$0.00
	FY 2017	$0.00
	MCHCP Estimated Costs	
	FY 2018	$0.00
	FY 2019	$0.00
	FY 2020	$0.00
	FY 2021	$0.00

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP	
Women's Preventive Services - Includes additional recommended preventive services specific to women. Effective 01/01/2013 Prior to this provision, MCHCP covered almost all recommended preventive services at 100%. Examples of services not previously covered at 100% included routine prenatal care and breast feeding support and services. The actuary determined that this requirement did not impact MCHCP premiums.	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 $0.00
	FY 2015 $0.00
	FY 2016 $0.00
	FY 2017 $0.00
	MCHCP Estimated Costs
	FY 2018 $0.00
	FY 2019 $0.00
	FY 2020 $0.00
	FY 2021 $0.00
Clinical Trials - Coverage for routine patient care costs incurred as the result of a Phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. Effective 01/01/2013 Prior to this provision, MCHCP covered routine patient care costs incurred as the result of Phase II, III or IV clinical trials for cancer. The actuary determined that this requirement did not impact MCHCP premiums.	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 $0.00
	FY 2015 $0.00
	FY 2016 $0.00
	FY 2017 $0.00
	MCHCP Estimated Costs
	FY 2018 $0.00
	FY 2019 $0.00
	FY 2020 $0.00
	FY 2021 $0.00

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP	
Patient-Centered Outcomes Research Institute (PCORI) Fee - A fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee is based on the average number of lives covered under the policy or plan. The fee applies to plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. Payment made in July of each year. Assumed a 4% trend over current fee of $2.08.	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 $87,002
	FY 2015 $173,432
	FY 2016 $181,018
	FY 2017 $187,783
	MCHCP Estimated Costs
	FY 2018 $194,640
	FY 2019 $203,106
	FY 2020 $211,230
	FY 2021 $211,230
Transitional Reinsurance - Section 1341 of the ACA established a Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 N/A
	FY 2015 $3,878,420
	FY 2016 $3,185,756
	MCHCP Estimated Costs
	FY 2018 $2,358,259
	FY 2019 $388,725
	FY 2020 N/A
	FY 2021 N/A

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP	
Employer Shared Responsibility - Any employer with 100 (decreases to 50 in 2016) or more full-time equivalents (FTEs) is subject to a penalty if the employer fails to offer access to minimum essential coverage and if any FTE receives a tax credit or if the coverage does not meet minimum value and affordability requirements. MCHCP coverage meets minimum value and affordability requirements. MCHCP offers coverage to all FTEs that are benefit-eligible. Effective 01/01/2015, MCHCP began offering coverage to certain variable hour employees who are not benefit-eligible but who worked on average more than 30 hours per week during the standard measurement period. These individuals are considered an FTE employee for the purpose of this law. Estimated costs	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 N/A
	FY 2015 N/A
	FY 2016 $112,833
	FY 2017 $137,790
	MCHCP Estimated Costs
	FY 2018 $268,242
	FY 2019 $290,897
	FY 2020 $310,096
	FY 2021 $330,562
Excise Tax - On January 22, 2018, Congress passed and the President signed into law a two year delay on the Affordable Care Act's 40 percent excise tax on high-value health care plans. The 40 percent excise tax will take effect, beginning in 2022, on the cost of coverage for health plans that	**MCHCP Actual Costs**
	FY 2011 N/A
	FY 2012 N/A
	FY 2013 N/A
	FY 2014 N/A
	FY 2015 N/A
	FY 2016 N/A
	FY 2017 N/A

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP		
exceed a certain annual limit ($10,200 for individual coverage and $27,500 for self and spouse or family coverage. Limits for retiree coverage are higher.) Estimates are subject to further guidance through regulations which are not yet available. Issues that can impact the potential amount owed include rate blending, age and demographic distributions, HSA/FSA contributions as well as others. Although no payments would be due through FY 2021, an actuarial estimate completed in Dec. 2015 estimated the excise tax owed in 2022 to be $2M-$5M. The lower amount of the range is estimated based on rate blending with the higher amount reflecting no rate blending. The estimate given also does not include the impact of any future benefit design changes should they occur after the analysis was completed.	**MCHCP Estimated Costs**	
	FY 2018	N/A
	FY 2019	N/A
	FY 2020	N/A
	FY 2021	N/A
Auto-Enrollment - Employers with >200 employees must auto enroll employees into coverage if a new employee fails to enroll or waive coverage. Implementing regulations	**MCHCP Actual Costs**	
	FY 2011	N/A
	FY 2012	N/A
	FY 2013	N/A
	FY 2014	N/A

Affordable Care Act (ACA) Provisions for Large Groups (101+) with potential cost impact to MCHCP		
have not been issued and this provision will not be effective until such time. Have not estimated costs for this provision.	FY 2015	$0.00
	FY 2016	$0.00
	FY 2017	$0.00
	MCHCP Estimated Costs	
	FY 2018	$0.00
	FY 2019	$0.00
	FY 2020	$0.00
	FY 2021	$0.00
IRS Reporting Requirements - Contracted services for printing and mailing of 1094B and 1095B reporting	**MCHCP Actual Costs**	
	FY 2011	N/A
	FY 2012	N/A
	FY 2013	N/A
	FY 2014	N/A
	FY 2015	N/A
	FY 2016	$185,061
	FY 2017	$57,699
	MCHCP Estimated Costs	
	FY 2018	$47,000
	FY 2019	$47,300
	FY 2020	$49,200
	FY 2021	$51,200

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF BRUCE R. RAMGE

INTRODUCTION

1. My name is Bruce Ramge and I am the Director of the Nebraska Department of Insurance ("NDOI").

2. DOI is responsible for regulating the Nebraska health insurance market and protecting consumers of this market. Overall, NDOI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance market environment, including:

a. Reviewing insurance policies sold in Nebraska to ensure compliance with Nebraska and federal law;

b. Conducting examinations of foreign and domestic insurers doing business in Nebraska to ensure compliance with Nebraska laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to agents, brokers, consultants, and other entities that sell and market insurance products;

e. Researching special insurance issues to understand and assess their impact on Nebraskans;

f. Providing technical assistance on legislation and promulgating rules and regulations to interpret insurance laws;

g. Creating and distributing public information and consumer education about all types of insurance; and

h. When insurance companies are in financially hazardous condition or have become insolvent, working with the guaranty associations made up of insurance companies, which by statute must step in and pay policyholder claims when an insurer, for example CoOportunity, fails.

3. As Director, I am the head of NDOI and the chief regulator of insurance in Nebraska. Generally, my official duties include supervising the entire agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees in a variety of capacities.

4. Additionally, my official duties with NDOI include studying the impact of the Affordable Care Act ("ACA") on Nebraska's insurance market, ensuring Nebraska's compliance with the ACA, advising the

Nebraska Governor on the ACA, and developing strategies for Nebraska to mitigate the numerous harms the ACA has inflicted on Nebraska's health insurance markets.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. The ACA has wrought havoc on the health insurance market in Nebraska and imposed significant burdens on NDOI as regulator of Nebraska's insurance market.

6. Prior to enactment of the ACA, Nebraska's individual major medical market offered more choices for consumers. For example, in 2010, approximately thirty carriers offered coverage in Nebraska's individual market. The ACA's effect on insurers' participation in the market is demonstrated by the numbers: three carriers in 2014, four carriers in 2015 and 2016, two carriers in 2017, and one remaining carrier in 2018.

7. In 2017, two major carriers exited Nebraska's individual market. Aetna announced its withdrawal from Nebraska's individual market in May 2017, citing an expected loss of $200 million for 2017 in the four states Aetna sold individual coverage. In June 2017, Blue Cross and Blue Shield of Nebraska also announced its withdrawal from Nebraska's individual market, citing an expected loss of $12 million for 2017, in addition to the approximately $150 million loss the company experienced selling ACA plans in Nebraska from 2014 to 2016. In the wake of these companies' departures, only a single insurer, Medica, remains in Nebraska's individual market. Nebraskans are left to hope that Medica— which raised premiums 31% for

plan year 2018— remains in the individual market for plan year 2019.

8. Premiums are predicted to keep rising. The Congressional Budget Office's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, federal outlays for health insurance subsidies and related spending will rise by about 60 percent over the projection period, increasing from $58 billion in 2018 to $91 billion by 2028. (cbo.gov/publication/53651). These rising premiums have a significant negative impact on middle-class Nebraskans.

9. The State of Nebraska itself has borne significant new costs as a result of the ACA. For example, the State of Nebraska, like other States, must offer non-full time employees (*i.e.*, employees working 30-39 hours per week) health insurance plans with premiums identical to those offered to full time employees.

10. The Nebraska Department of Insurance, as the primary enforcer of insurance laws, has spent the past six years reading and enforcing thousands of pages of federal regulations, guidance, and other sub-regulatory guidance related to the ACA, completely revised its insurance policy review standards for health insurance products, educated the public on changes in the law, and fielded consumer complaints expressing confusion and frustration about the limited, expensive choices that remain in the Nebraska individual market.

11. Additionally, the ACA harms Nebraska because it has preempted Nebraska law, preventing Nebraska from regulating health insurance in the manner it sees fit.

12. The ACA forced insurers to issue policies to all qualified applicants, regardless of their health condition, and the ACA does not allow insurers to charge higher premiums to people who, because of pre-existing conditions, have higher anticipated medical costs. The ACA forced insurers to pay for pre-existing conditions, which in turn drove up premiums. The ACA forcing insurers to charge the same rate regardless of health condition forced healthy people to pay higher premiums. While sick people's premiums became lower, as discussed below, a mechanism already existed in Nebraska law to provide coverage for high-cost individuals.

13. A recent study confirmed that the top one percent of insureds in Nebraska's individual market are responsible for 40 percent of the medical costs. Nebraska law creates a high-risk pool, which operated as an insurer of last resort for people when private insurers refused to issue coverage to them due to expensive anticipated medical costs. Because the ACA makes private insurance available and "affordable" regardless of a purchaser's health condition, Nebraska's high risk pool cannot operate as it did prior to 2014, to keep high-cost individuals from driving up premiums for insurance purchasers of average or good health.

14. Finally, the ACA harmed the Nebraska health insurance market by creating health insurance co-ops. CoOportunity Health, which operated in Iowa and Nebraska, was the first co-op to go insolvent. Co-ops were conceived in the ACA as an alternative to commercial insurance, to create competition and drive down premiums. The premiums CoOportunity charged were insufficient to cover rising health costs, despite large enrollment numbers (120,000 insureds in Nebraska and Iowa combined) and $147 million in loans from

the federal government, in addition to members' premiums. Under Nebraska law, other health insurers were required to step in with funds to pay the claims of the more than 80,000 Nebraskans insured by CoOportunity. In summary, CoOportunity "created competition" by taking customers from the private market, went insolvent, then looked to its competitors to pay those customers' claims. CoOportunity was put into liquidation in early 2015, and the CoOportunity liquidator filed suit against the federal government, which attempted to put itself, as creditor, ahead of policyholders when the time came to disburse what funds remained in CoOportunity's possession. The ACA's co-op program, nationwide, has cost taxpayers more than $1.8 billion in funds that may never be recovered. Of the original 23 co-ops, only six remain.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 16, 2018

Signed,

/s/ Bruce R. Ramge
Bruce R. Ramge, Director
Nebraska Department of Insurance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

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CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: April 26, 2018]

DECLARATION OF JON GODFREAD

Jon Godfread, being first duly sworn on oath, deposes and states as follows:

1. My name is Jon Godfread and I am the Commissioner of the North Dakota Insurance Department ("NDID").

2. NDID is responsible for regulating the North Dakota health insurance market and protecting the consumers of this market. Overall, NDID performs a variety of tasks to protect insurance consumers and endure a competitive insurance market environment, including:

a. Reviewing all insurance policies offered for sale in North Dakota to ensure compliance with North Dakota law;

b. Conducting examinations of foreign and domestic insurers doing business in North Dakota to ensure compliance with North Dakota laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Issuing licenses to individuals who are qualified to serve as agents or consultants and other entities that sell and market insurance products;

e. Reviewing and approving rates for health insurance plans prior to being offered for sale in North Dakota;

f. Creating and distributing public information and consumer education about all types of insurance; and

g. Providing input and assistance on legislation and rules and regulations affecting insurance.

3. As Commissioner, I am the head of the NDID and the chief regulator of insurance in North Dakota.

4. My official duties include studying the impact of the Affordable Care Act ('ACA") on North Dakota's insurance market and developing strategies for North Dakota to mitigate the negative consequences the ACA has inflicted on North Dakota's health insurance markets.

5. North Dakota's health insurance market was not broken prior to enactment of the ACA. North Dakota had meaningful competition in its marketplace, a highly successful state high risk pool which offered a rich benefit plan, and the state had a low percentage of uninsured individuals. Prior to implementation of the ACA eight to ten percent of North Dakotans had no health insurance. After the implementation of the

ACA eight to ten percent of North Dakotans have no health insurance. The ACA attempted to fix something, which was not broken and has resulted in many negative consequences to North Dakota.

6. In 2017, one major carrier completely exited North Dakota's individual health exchange marketplace due to continued expected financial losses. Another major carrier exited North Dakota's individual exchange marketplace in 48 of the state's 53 counties, citing the same concerns. This left only one insurance company to sell on North Dakota's individual exchange marketplace in 48 of the state's 53 counties for plan year 2018.

7. Premiums are predicted to keep rising. These rising premiums have a significant negative impact on North Dakotans who are self-employed and do not qualify for a subsidy on the federal exchange, as these North Dakotans have been forced to take on the full weight of every rate increase over the years without assistance.

8. The NDID has spent the past eight years reading and enforcing thousands of pages of federal regulations and other regulatory guidance related to the ACA, spent countless hours on calls with federal officials in an attempt to learn how these laws and rules impact North Dakota's health insurance market and our consumers, completely revised its insurance policy review standards for health insurance products, and fielded consumer complaints expressing confusion and frustration about the limited, expensive choice that remain in North Dakota's individual market.

9. The ACA harms North Dakota because it has preempted North Dakota law, preventing North Dakota from regulating health insurance in the manner it sees fit.

10. The ACA forced insurers to issue policies to all qualified applicants, regardless of their health condition, and the ACA does not allow insurers to charge higher premium to people who, because of pre-existing conditions, have higher anticipated medical costs. The ACA forced insures to pay for pre-existing conditions, which in turn drove up premiums. The ACA forcing insurers to charge the same rate regardless of health condition has forced individuals without pre-existing conditions to pay much higher premiums and in many cases, the end result has been that these individuals cannot afford to have health insurance coverage.

11. North Dakota law creates a high risk pool, which prior to the enactment of the ACA operated as an insurer of last resort for people when private insurers declined to issue coverage to them due to expensive anticipated medical costs. Since the ACA makes private insurance available regardless of a purchaser's health condition, North Dakota's high risk pool cannot operate as it did prior to 2014, to keep high-cost individuals from driving up premiums for individuals of average or good health.

Further your affiant sayeth not.

Dated this 19th day of April, 2018

/s/ Jon Godfread
Jon Godfread
North Dakota Insurance Commissioner

Subscribed and sworn to before me this 19th day of April, 2018

/s/ Laura Helbling
Notary Public

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
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[Filed: April 26, 2018]

AFFIDAVIT OF ROBIN TESTER

PERSONALLY APPEARED before me, Robin Tester, who being duly sworn, attests to the following:

1. I am the Insurance Policy Director of the Public Employee Benefit Authority, which administers the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (typically referenced as the "State Health Plan").

2. I am familiar with the Patient Protection and Affordable Care Act, P. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P. L. 111- 152 (ACA).

3. State Health Plan participants include state officers as well as employees of:

- State agencies (pursuant to S.C. Code Ann. § 1-11-710)

- Public school districts (pursuant to § 1-11-710)
- Other participating entities/local subdivisions that elect to participate pursuant to § 1-11-720

Participants also include retirees of these employers as defined in§ 1-11-730 of the Code of Laws and the eligible spouses and eligible children of employees and retirees.

4. Since January 1, 2011, the State Health Plan has complied with the following ACA-prescribed benefits that were not previously provided under the Plan:

- No preexisting condition exclusion for individuals younger than 19
- No preexisting condition exclusion for individuals older than 19 (1/1/2014)
- No lifetime limits on essential benefits
- Restricted annual limits on essential benefits
- Prohibition on rescission of coverage
- Dependent coverage of children younger than 26

5. The net material measureable direct financial impact of the ACA on the State Health Plan totals $29,230,152 during the period from 2011 through 2017:

Reinsurance/PCORI Fees (2013-2017)	-$45,291,815
Early Retirement Reinsurance Fund (2012)	+$27,142,502

Lifetime Medical Claims over $2M	-$11,080,839
Net total	$29,230,252

Notes on calculation: The $2 million lifetime maximum in force prior to January 1, 2011 was only applied to medical expense, not to pharmacy, so pharmacy is not included in the calculation. Furthermore, the mandated addition of adult children up to age 26 and the addition of non-permanent employees was addressed through actuarial adjustment of contributions. The MUSC Health Plan was not included in the calculation because it was created voluntarily as an ACA non-grandfathered plan with the understanding of mandatory ACA coverage requirements.

FURTHER THE AFFIANT SAITH NOT.

/s/ Robin Tester
Robin Tester

SWORN TO before me this 15th day of March, 2018

/s/
NOTARY PUBLIC FOR SOUTH CAROLINA
My Commission Expires: 6/16/27

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
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[Filed: April 26, 2018]

DECLARATION OF THOMAS STECKEL

My name is Thomas Steckel and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Division of Employee Benefits within the South Dakota Bureau of Human Resources ("Bureau"). I have served with the Bureau for 4 years. As the Director of the Division of Employee Benefits ("Division"), I am responsible for developing and implementing the State's health plan for state employees, including flexible benefits such as a vision and dental plan. As a part of these responsibilities, I recommend policy for the State's health plan, administer the health plan, and monitor and balance the health plan's financials. I am particularly familiar with changes in costs, plans, and policies related to the enactment of the ACA because of my role as the Director of the Division. I have personal knowledge of the matters and information set forth herein.

2. The Bureau serves four main roles for the State of South Dakota, each role having its own division within the Bureau. The first role is the Bureau provides human resource services to each agency and bureau under the purview of the Governor of South Dakota. These services include the processing of payroll, maintaining personnel files, and utilizing Human Resource Managers to assist agencies in hiring, developing, and the disciplining of employees. The second role is the Bureau provides employee and organizational development through services such as employee training, leadership development, and 360 and engagement surveys. The third role is the Bureau lies in classification and compensation. The Bureau establishes and administers a compensation structure for executive branch employees and classifies each position based upon the position's job duties. The fourth major role of the Bureau is the establishment and administration of the benefits for state employees, which includes the State's health plan, the flexible benefits available to state employees, and workers' compensation program for state employees.

3. With the passing of the ACA, the Bureau has suffered both administrative and financial burdens that it otherwise would not have. The ACA deprived the Bureau of the flexibility it previously had to provide health insurance plans tailored to the needs of its population.

Financial Costs Associated with ACA Regulations

4. The individual mandate caused the following estimated financial burdens to the Bureau:

a. IRO Review of denied appeals: $10,400.00 ongoing costs;

b. Elimination of lifetime maximum: $19,140,252.00 ongoing costs;

c. Pre-existing conditions exclusion prohibited by ACA: unable to accurately estimate the ongoing costs of this mandate;

d. Expanded eligibility for adult dependent children to age 26: unable to accurately estimate the ongoing costs of this mandate;

e. Expanded preventive services paid only by the plan: $4,575,200.00 ongoing costs;

f. Transitional Reinsurance Program fee: 3,202,942.00 one-time costs;

g. Patient Centered Outcomes Research Institute fee: $172,141.00 ongoing costs;

h. Expanded health plan eligibility for part-time employees who did not meet the State's health plan's pre-ACA eligibility definition: $1,514,205.00 ongoing costs; and

i. Form 1095-C administration: $100,000.00 ongoing costs.

5. "Lifetime maximum benefit" is the maximum dollar amount a health insurance plan will pay in benefits to an insured person during that person's lifetime. The ACA banned insurance contracts nationwide from including any lifetime maximum benefit. The ACA thus eliminated the Bureau's ability to impose lifetime maximum benefits for essential health benefits. 42 U.S.C. § 300-gg-ll (West). Prior to the implementation of the ACA, the Bureau maintained a lifetime annual maximum of $2,000,000. Since the implementation of the ACA, the Bureau has been liable to pay, and has paid, substantial costs that would not have been payable had the pre-ACA lifetime

maximum benefits still been in place. In the seven-year period between 2011 and 2017, the Bureau has paid approximately $19,140,252 in costs that would not have been due had the ACA not eliminated its ability to apply a lifetime maximum benefit. Compliance with the ACA will require the Bureau to indefinitely continue paying these additional costs.

6. Prior to adoption of the ACA, the Bureau required insured persons to pay coinsurance and/or copays for preventative care that are now disallowed because the ACA requires that preventative care be covered at 100%. 42 U.S.C. § 300gg-13 (West). The change to 100% funding of preventative care has cost the Bureau substantial sums. During the six-year period from 2012 to 2017, therefore, the 100% funding for preventative care mandated by the ACA has imposed costs upon the Bureau approximating $4,575,200. 100% funding for preventative care is a permanent requirement pursuant to the ACA, so these costs to the Bureau as a result will continue indefinitely.

7. Prior to implementation of the ACA, the Bureau provided insurance coverage for contraceptive drugs at a rate below 100%. The ACA, however, requires contraceptives to be covered at 100%. 42 U.S.C. § 300gg-13(a)(4) (West); 77 Fed.Reg. 8725 (Feb. 2012). Covering a class of drugs at 100% of cost is more expensive for the Bureau than covering a drug at less than 100% of cost. If the Bureau could have maintained its prior coverage plan for contraceptives, therefore, it would have saved significant monies. Specifically, the Bureau would have saved approximately $672,780 during the five-year period from FY 2013 through 2017. The 100% funding for contraceptives mandate is permanent pursuant to the ACA, so these costs to the Bureau continue.

8. The ACA requires the Bureau to pay a Patient-Centered Outcomes Research Institute (PCORI) fee. 26 U.S.C. § 9511. The fee was started under the ACA for advancements in comparative clinical effectiveness research. The fee increases yearly and is based on per average number of lives that are covered by the plan or policy. In the last fiscal year, the Bureau paid $2.26 per person enrolled in a health insurance plan. If the PCORI fee had not been required under the ACA, the Bureau would have saved approximately $172,141 for FY 2014 to 2018. This fee is imposed currently for plans that end before October 1, 2019 and, therefore, will continue to be paid into 2020 under the ACA.

9. The ACA requires the Agency to pay the Transitional Reinsurance Program fee. 42 U.S.C. § 18061. This fee is collected by the federal government to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. If this requirement had not been in place, the Bureau would have saved approximately $2,622,787 in FY 2015 and FY 2016.

10. Prior to the ACA, a full-time employee was defined as an employee who is employed at least 40 hours per week; the ACA altered that number to 30 hours per week. 26 U.S.C.A. § 4980H (West); Pub. L. 111-148, 124 Stat. 865, § 4980H(d)(4)(A). This change impacted the Bureau by increasing the number of persons the Bureau must insure, thus increasing the total cost of providing insurance. The change required the Bureau to provide insurance coverage to seasonal or temporary employees who meet the ACA definition of

eligible employee. The ACA change in definition of eligible employee would have reduced the cost to the Bureau of providing health insurance coverage to all "full-time" and eligible permanent part-time employees by approximately $1,514,205 for FY 2014 to FY 2018 YTD as of 3/31/18. The 30-hour "full-time employee" rule is a permanent requirement under the ACA and, thus, these costs to the Bureau as a result will continue.

11. Given the facts summarized in ¶¶ 4-10 above, compliance with mandatory provisions of the ACA has imposed costs upon the Bureau approximating $28,715,140.00 dollars in FY 2012-2017 in order to comply with the federal government's requirements under the ACA. These impositions of costs upon the Bureau will continue indefinitely because the mandates imposed by the ACA are generally permanent.

Administrative Burdens Associated with ACA Regulations

12. The individual mandate caused significant administrative burdens and expenses to program our IT system to track and report ACA eligible employees and complete mandatory IRS Form 1095 annual reports.

13. The ACA mandates constrain our flexibility in plan design decisions, and the continued uncertainty as to the potential changes in the law, including partial repeal of certain provisions, make long term strategic planning more complicated than it would be absent the ACA.

14. The Bureau recently made changes to the State employee health plan for the FY 2019 and those changes assumed the ACA is still federal law. Repeal of the ACA is necessary now, as opposed to in future

months or years, because the confines of the law that the Bureau is forced to operate within create a significant obstacle to solving current budgetary concerns. Without the expenses described above in ¶¶ 4-13, the Bureau would gain back approximately $5.1 million in funding. If the ACA is not repealed now, however, this funding would not be available to the Bureau in time to plan for the FY 2019. Thus, the Bureau, its enrollees and the taxpayers of South Dakota would be significantly burdened if the ACA remained law pending this suit.

15. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 24th day of April, 2018.

/s/ Thomas Steckel
Thomas Steckel, Director
Division of Employee Benefits
South Dakota Bureau of Human Resources

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: June 7, 2018]

DECLARATION OF HENRY J. AARON

I, Henry J. Aaron, declare as follows:

1. I am currently the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies Program at the Brookings Institution. From 1990 through 1996, I was the Director of the Economic Studies Program. I am a member of the District of Columbia Health Benefits Exchange Executive Board and a member and former chair of the Social Security Advisory Board. I am a graduate of UCLA and hold a Ph.D. in economics from Harvard University. I taught at the University of Maryland from 1967 through 1989, except for 1977 and 1978 when I served as Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare. I chaired the 1979 Advisory Council on Social Security. During the academic year 1996-97, I was a Guggenheim Fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford University. I have been a member of

the visiting committees for the Department of Economics and the Medical and Dental Schools at Harvard University. I am the author of many books and articles on health insurance and health care policy, including two studies of the impact on health care of limited resources in Great Britain (with William Schwartz), a study of health policy in the United States, and recommendations for modifications in Medicare (a book with Jeanne Lambrew and an article with Robert Reischauer).

2. In creating this declaration, I consulted with fellow national health experts Sara Rosenbaum, the Harold and Jane Hirsh Professor of Health Law and Policy and founding chair, Department of Health Policy, Milken Institute School of Public Health, George Washington University and Jeffrey Levi, Professor of Health Policy and Management at the Milken Institute School of Public Health, George Washington University. While I consulted with these individuals for their expert advice, I can attest to the information in this declaration based on my independent experience and background.

3. I understand that this lawsuit involves a challenge to the Affordable Care Act and seeks to enjoin it. As noted above, I am the author of numerous books and articles on health insurance and health care policy. In my expert opinion, enjoining the Affordable Care Act would completely disrupt the U.S. health care market for patients, providers, insurance carriers, and federal and state governments.

The Affordable Care Act Has Contributed to Improvements in Health Coverage, Access, Financial Security, and Affordability

4. The Affordable Care Act (ACA) is a comprehensive law that has improved the quality and affordability of health care and health insurance. It has done so by: strengthening consumer protections in private insurance; making the individual insurance market accessible and affordable; expanding and improving the Medicaid program; modifying Medicare's payment systems while filling in benefit gaps; increasing funding and prioritization of prevention and public health; supporting infrastructure such as community health centers, the National Health Service Corps, and the Indian Health Service, among other policies. There is widespread agreement that the ACA is the most significant health legislation enacted since the Social Security Act amendments that created Medicare and Medicaid in 1965.

5. The ACA helped lower the number of people without health insurance by an estimated 20.0 million people from October 2013 to early 2016, a drop of 43 percent in the uninsured rate. This increase in coverage included 3 million African-Americans, 4 million people of Hispanic origin, and 8.9 million white nonelderly adults. An estimated 6.1 million young adults and 1.2 million children gained coverage between 2010 and early 2016.[1,2] The reduction in the uninsured rate

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[1] Uberoi N, Finegold K and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016, https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

[2] Executive Office of the President Council of Economic Advisors,

occurred across the income spectrum: the 2013 to 2015 rate reduction was 36 percent, 33 percent, and 31 percent for non-elderly people with income below 138 percent of poverty, between 138 and 400 percent of poverty, and above 400 percent of poverty respectively.[3] The drop in the uninsured rate was larger in states that expanded Medicaid than in states that did not do so.[4]

6. Many studies have found that access to health care has improved since the ACA was enacted, especially among low-income people.[5] For example, from the fall of 2013 to the spring of 2017, the share of non-elderly adults without a regular source of care fell from 30 percent to 24.7 percent; the share that did not receive a routine checkup in the last 12 months fell from nearly 40 percent to 34 percent.[6] The Council of

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2017 Economic Report of the President, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[3] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[4] Broaddus, M, *Census Data: States Not Expanding Medicaid Lag Further on Health Coverage,* Center on Budget and Policy Priorities*,* 2017, https://www.cbpp.org/blog/census-data-states-not-expanding-medicaid-lag-further-on-health-coverage

[5] Kominski GF, Nonzee NJ and Sorensen A, The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations, *Annual Review of Public Health,* 2017, 38:489-505, https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031816-044555

[6] Long SK, Bart L, Karmpan M, Shartzer A and Zuckerman S,

Economic Advisers (CEA) estimated a one third drop in the share of people who reported that they were unable to obtain needed medical care because of cost, with the 2015 level falling below its pre-recession level. The CEA also found a correlation between increased coverage and an increased share of people having a personal doctor and receiving a checkup in the past 12 months.[7] A review of the literature in 2017 found evidence that significant improvements in access to and use of care were associated with gaining coverage. These gains included increased use of outpatient care; greater rates of having a usual source of care or personal physician; increased use of preventive services; increased prescription drug use and adherence; and improved access to surgical care.[8] Racial and ethnic disparities in access to care fell following the expansion of coverage.[9]

Sustained Gains in Coverage, Access, and Affordability Under the ACA: A 2017 Update. *Health Affairs,* 36(9), 2017, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0798

[7] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017, https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[8] Sommers BD, Gawande AA and Baicker K, Health Insurance Coverage and Health – What the Recent Evidence Tells Us, *The New England Journal of Medicine,* 2017, 377:586-593, http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

[9] Chen J, Vargas-Bustamante A, Mortensen K and Ortega AN. Racial and Ethnic Disparities in Health Care Access and Utilization under the Affordable Care Act. *Med. Care,* 2016, 54:140–146, https://www.ncbi.nlm.nih.gov/pubmed/26595227; Sommers BD, Gunja MZ, Finegold K and Musco T. Changes in Self-Reported

7. The expansion of coverage and other provisions of the ACA will contribute to longer, healthier lives. Research on previous coverage expansions has found that having health insurance coverage improves children's learning ability, adults' productivity, and seniors' qualify of life.[10] A recent review found that coverage improves rates of diagnosing chronic conditions, treatment of such conditions, outcomes for people with depression, and self-reported health.[11] The CEA estimated that, if the ACA experience matches that in Massachusetts, 24,000 deaths are being avoided annually.[12] The Institute of Medicine also found that coverage improves community health by limiting the spread of communicable diseases and reducing the diversion of public health resources for medical care for the uninsured.[13]

Insurance Coverage, Access to Care, and Health Under the Affordable Care Act. *JAMA,* 2015, 314:366–374, https://jamanetwork.com/journals/jama/fullarticle/2411283

[10] Institute of Medicine, Board on Health Care Services, *Coverage Matters: Insurance and Health Care,* National Academies Press, 2001, http://www.nationalacademies.org/hmd/Reports/2001/Coverage-Matters-Insurance-and-Health-Care.aspx

[11] Sommers BD, Gawande AA and Baicker K, Health Insurance Coverage and Health – What the Recent Evidence Tells Us, *The New England Journal of Medicine,* 2017, 377:586-593, http://www.nejm.org/doi/full/10.1056/NEJMsb1706645

[12] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[13] Institute of Medicine, Board on Health Care Services, *A Shared Destiny: Community Effects of Uninsurance*, The National Academies Press, 2003, https://www.nap.edu/catalog/10602/a-shared-

8. The law's contribution to health extends beyond its coverage provisions. In part thanks to the ACA's payment incentives and its *Partnership for Patients* initiative, an estimated 125,000 fewer patients died in the hospital as a result of hospital-acquired conditions in 2015 compared to 2010, saving approximately $28 billion in health care costs over this period.[14] And its *Tips from Former Smokers* initiative resulted in an estimated 500,000 people quitting smoking permanently in the first five years of the campaign.[15]

9. The ACA strengthened financial security as well as physical and mental health. A study found that self-reported concerns about the cost of health care dropped at a greater rate for low income people in two states that expanded Medicaid relative to one that did not.[16] Between September 2013 and March 2015, the number of people having problems paying medical bills dropped by an estimated 9.4 million, a reduction

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destiny-community-effects-of-uninsurance.

[14] Agency for Healthcare Research and Quality, *National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data from National Efforts to Make Health Care Safer*, December 2016, https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

[15] Centers for Disease Control and Prevention, Tips Impact and Results, no date, https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html?s_cid=OSH_tips_D9391

[16] Sommers BD, Blendon RJ, Orav EJ and Epstein AM, Changes in Utilization and Health Among Low-Income Adults after Medicaid Expansion or Expanded Private Insurance, *JAMA Internal Medicine*, 2016, 176:1501–1509, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

from 22.0 to 17.3 percent of non-elderly adults.[17] One study found that the amount of debt sent to collection was reduced by over $1,000 per person residing in ZIP Codes with the highest share of low-income, uninsured individuals in states that expanded Medicaid compared to those that did not expand the program.[18] The law also has reduced income inequality: projected incomes in the bottom tenth of the distribution will increase by 7.2 percent while those in the top tenth will be reduced by 0.3 percent.[19]

10. Most experts agree that the ACA contributed to slower health care cost growth since its enactment, although there is disagreement about the size of the effect. The prices of health care goods and services grew more slowly in the period from 2010 to 2016 than in any comparable period since these data began to be collected in 1959. Adding to this, health care service use growth per enrollee slowed since 2010. National health expenditures and projections for 2010 to 2019,

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[17] Kapman M and Long SK, *9.4 Million Fewer Families Are Having Problems Paying Medical Bills*, Urban Institute Health Policy Center, Health Reform Monitoring Survey, 2015, http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having- Problems-Paying-Medical-Bills.html

[18] Hu L, Kaestner R, Mazumder B, Miller S and Wong A, The Effect Of The Patient Protection And Affordable Care Act Medicaid Expansions On Financial Well-Being, *National Bureau of Economic Research*, 2016, No. 22170, http://www.nber.org/papers/w22170.pdf

[19] Aaron H and Burtless A, Potential Effects of the Affordable Care Act on Income Inequality, *Brookings Report*, 2014, https://www.brookings.edu/research/potential-effects-of-the-affordable-care-act-on-income-inequality/

as of 2016, were over $2.6 trillion lower than the national health expenditure projections for the same period made in 2010. Additionally, employer-based health plan premiums and out-of-pocket costs grew more slowly from 2010 to 2016 than they did from 2000 to 2010. As a result, total spending associated with a family policy was $4,400 less in 2016 than it would have been had costs risen as fast as they did during the previous decade. The coverage expansion under the law also lowered hospitals' cost of providing uncompensated care by $10.4 billion in 2015; in states that expanded Medicaid, the share of hospital operating costs devoted to uncompensated care dropped by around half during this period.[20]

11. The ACA's contribution to lower health care cost growth has broader economic effects. It helped stabilize the share of gross domestic product spent on health. When the ACA was under consideration, the Congressional Budget Office (CBO) estimated that the ACA would reduce the federal budget deficit by an estimated $115 billion from 2010 to 2019 by cutting federal health spending and raising revenue.[21] States have realized budget savings as well because of increased federal Medicaid support and reduced uncompensated care costs. Because the ACA has lowered the

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[20] Executive Office of the President Council of Economic Advisors, 2017 *Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf.

[21] Elmendorf DW, Letter to Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, Congressional Budget Office, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf

cost to employers of health insurance for their employees, workers have received higher wages and other fringe benefits. The ACA also has reduced "job lock," by freeing workers to change jobs without fear of losing health insurance coverage. An estimated 1.5 million people became self-employed because of the ACA's individual market reforms and financial assistance.[22] Contrary to some critics' claims, there is no evidence that the law's benefits have come at the expense of employment, hours of work, or compensation.[23] ACA coverage also improves the U.S. system of automatic stabilizers by protecting families' health coverage during economic downturns. Improvement is greatest in states that expanded Medicaid.

The ACA Expanded Consumer Protections in All Types of Private Insurance

12. The ACA improved the quality, accessibility, and affordability of health insurance coverage both for people who were already insured and for the previously uninsured. Insurers may no longer set higher premiums for people with pre-existing conditions, charge women more than men, and carve out benefits

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[22] Blumberg LJ, Corlette S and Lucia K, The Affordable Care Act: Improving Incentives for Entrepreneurship and Self Employment, *Timely Analysis of Immediate Health Policy Issues*, Urban Institute, May 2013, https://www.urban.org/sites/default/files/publication/23661/412830-The-Affordable-Care-Act-Improving-Incentives-for-Entrepreneurship-and-Self-Employment.PDF

[23] Abraham J and Royalty AB, How Has the Affordable Care Act Affected Work and Wages, Leonard Davis Institute of Health Economics, University of Pennsylvania, *Issue Brief,* January 2017, https://ldi.upenn.edu/brief/how-has-affordable-care-actaffected-work-and-wages

for people who need them. They can no longer set annual or lifetime limits on total benefits or rescind coverage except in cases of fraud. Insurers must cover dependents up to age 26 under their parents' plans, include annual out-of-pocket limits, and provide rebates to the insured if total benefits do not exceed statutory shares of premiums received. All non-grandfathered private plans must cover such evidence-based preventive services as immunizations and cancer screenings, and they must do so with no cost sharing. Individual and small group plans now must include essential health benefits: ten categories of health services with a scope that is the same as a typical employer plan. The ACA also filled in the gaps in the Mental Health Parity and Addiction Equity Act, which requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care.

13. The ACA's guarantee of access to health insurance offers peace of mind to the up to 133 million Americans who have a pre-existing health condition, including parents of 17 million children with such conditions.[24] Before the ACA, those with pre-existing conditions had to worry about finding affordable coverage if they lost a job that provided health insurance or they stopped being eligible for programs such as Medicaid or the Children's Health Insurance Program (CHIP). Even if they could find insurance, they faced the risk that needed services might be "carved-out" for them or

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[24] Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, *Issue Brief,* January 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

excluded for all enrollees: before 2014, 62 percent of individual market enrollees lacked maternity coverage, 34 percent lacked coverage for substance use disorders, 18 percent lacked coverage for mental health care, and 9 percent lacked prescription drug coverage.[25] Before enactment of the ACA, parents of children with autism typically lacked private health insurance coverage for habilitative services. The ACA bars benefit carve-outs and requires all individual and small group market plans to cover essential health benefits. The ACA's focus on comprehensive benefits has been particularly important in combatting the opioid epidemic: it requires coverage of screening and treatment for substance use disorders, has expanded parity to all plans, and supports integrating prevention and treatment with mental health, primary care, and other related services.[26]

14. The ACA has improved women's coverage as well. From 2010 to early 2016, 9.5 million women gained coverage.[27] Starting in 2014, the ACA banned the common practice of varying insurance rates by sex

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[25] Office of the Assistant Secretary for Planning and Evaluation, Essential Health Benefits: Individual Market Coverage, *Issue Brief*, December 2011, https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage

[26] Abraham AJ, Andrews CM, Grogan CM, D'Aunno T, Humphreys KN, Pollack HA and Friedmann PD, The Affordable Care Act Transformation of Substance Use Disorder Treatment, *American Journal of Public Health,* 2017, 107(1):31-32, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/

[27] Uberoi N, Finegold K and Gee E, Health Insurance Coverage and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

– a practice that had added an estimated $1 billion a year to women's health insurance premiums.[28] Health plans may no longer carve-out maternity care from plans and must allow women to see their obstetrician or gynecologist without a referral. All non-grandfathered plans must cover women's preventive services, which includes contraceptive services, screening for interpersonal and domestic violence, and breast-feeding services and supplies. The ACA's reduction in cost-sharing for contraceptive services increased women's use of these services, including long-term contraception methods.[29] The ACA's bar on sex discrimination makes it an important civil rights, as well as health reform, law.

15. The ACA has improved coverage for young adults. The ACA requires health insurers to extend dependent coverage to children up to age 26. An estimated 2.3 million young adults (ages 19 to 25) gained health insurance between 2010 and the end of 2013. Starting in 2014, millions more gained coverage through the Health Insurance Marketplaces and other reforms.[30] According to one review, "a wealth of evi-

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[28] Garrett D, Greenberger M, Waxman J, Benyo A, Dickerson K, Gallagher-Robbins K, Moore R and Trumble S, Turning To Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act, National Women's Law Center, *Report,* March 2012, https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

[29] Carlin CS, Fertig AR and Dowd BE, Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women With Employer Coverage, *Health Affairs* 35(9), 2016, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1457

[30] Uberoi N, Finegold K and Gee E, Health Insurance Coverage

dence finds that the ACA dependent coverage expansions increased access to care, use of a wide variety of services, and reduced out-of-pocket spending."[31] For example, mental health visits increased by 9.0 percent and inpatient visits by 3.5 percent for young adults gaining coverage on their parents' plans.[32]

16. The ACA newly required all private health plans to end the use of annual and lifetime limits and to include an annual out-of-pocket limit on cost sharing. An estimated 22 million people enrolled in employer coverage are now protected against catastrophic costs.[33] While data collected on personal bankruptcy does not include causes, filings dropped by about 50 percent between 2010 and 2016; experts attribute some of this change to the new financial protections offered by the ACA starting in 2010.[34]

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and the Affordable Care Act, 2010 – 2016, *Office of the Assistant Secretary for Planning and Evaluation Issue Brief,* 2016. https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf

[31] Abraham J and Royalty AB, How Has the Affordable Care Act Affected Work and Wages, Leonard Davis Institute of Health Economics, University of Pennsylvania, *Issue Brief*, January 2017, https://ldi.upenn.edu/brief/how-has-affordable-care-actaffected-work-and-wages

[32] Akosa Antwi Y, Moriya AS and Simon KI, Access to Health Insurance and the Use of Inpatient Medical Care: Evidence from the Affordable Care Act Young Adult Mandate, *J Health Econ* 39:171-187, 2015, https://www.ncbi.nlm.nih.gov/pubmed/25544401

[33] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

[34] St. John A, How the Affordable Care Act Drove Down Personal

The ACA's Health Insurance Marketplaces Have Given Millions Access to Quality Private Insurance, Often with Financial Assistance

17. The ACA created Health Insurance Marketplaces (Marketplaces), a new way for people not eligible for Medicare or Medicaid to get affordable, accessible private insurance independent of their jobs. These Marketplaces offer websites at which people can compare plans that have four different levels of cost sharing (bronze, silver, gold, and platinum).[35] Financial assistance comes through income-related, premium-based tax credits for qualified individuals with income between 100 and 400 percent of the federal poverty level and cost-sharing assistance or "reductions" for qualified individuals with income between 100 and 250 percent of the federal poverty level enrolled in silver plans. The Marketplaces also provide people with support in navigating the system through in-person help and call centers. In 2018, 12 states operate their State-based Marketplaces (SBMs) (operating their own websites rather than using the federally run HealthCare.gov), 28 states rely entirely on the federal government to run their Marketplaces (use HealthCare.gov), and 11 states have hybrid Marketplaces (assuming some but not all functions).[36] The

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Bankruptcy, *Consumer Reports*, May 2017, https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/

[35] People under age 30 also have access to a plan that only covers catastrophic costs.

[36] Kaiser Family Foundation, State Health Insurance Marketplace Types, 2018, https://www.kff.org/health-reform/stateindicator/state-health-insurance-marketplacetypes/?current

Marketplaces also offer small businesses a way to find qualified health plans (called SHOP).

18. Several aspects of the ACA contributed to the 57 percent increase between 2013 and 2016 in the number of people covered in the individual market (on and off Marketplaces).[37] An estimated 40 to 50 percent of the coverage gain explained by the ACA resulted from the Health Insurance Marketplaces' policies.[38] One key reason for this expansion is financial assistance, primarily in the form of premium tax credits. In 2017, 84 percent of the 10.3 million people enrolled in Marketplaces received premium tax credits, whose average annualized amount was $4,458 per enrollee.[39] The premium tax credit is set to limit the percent of income an enrollee pays for the second-lowest silver plan in an area. This method of setting assistance means that aid varies regionally with health insurance costs. Second, individual market insurance reforms contributed to increased individual market enrollment. The number of people with pre-existing

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Timeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[37] Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/stateindicator/nonelderly-0-64/?dataView=1&currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[38] Frean M, Gruber J and Sommers BD, Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act, *National Bureau of Economic Research,* 53:72-86, 2016, http://www.nber.org/papers/w22213

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

conditions covered in the individual market rose by 64 percent between 2010 and 2014.[40] Coverage also increased because of the individual mandate, the requirement that people who can afford coverage have it. How much of this increase in coverage can be traced to financial incentives, changes in insurance requirements, or the coverage mandate remains a matter of academic dispute.

19. The ACA set up the Marketplaces to encourage competition among insurers, both the keep premiums low and improve customer service. To that end, it standardized benefits to facilitate shopping on price, required that the Marketplaces create tools to allow consumer to compare plans, and established a permanent risk-adjustment program to prevent insurers from profiting by disproportionately enrolling people with lower-than-average health care costs. The unsubsidized cost of coverage in the Marketplaces, before the start of the Trump Administration, was 10 percent lower than the average employer-sponsored insurance premium.[41] In the early years after the Marketplaces opened, some insurers set prices so low that they lost money in order to gain market share; others did not

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[40] Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, *Issue Brief,* January 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[41] Blumberg LJ, Holahan J and Wengle E, Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance, Urban Institute*, Brief*, September 2016, https://www.urban.org/research/publication/are-nongroupmarketplace-premiums-really-high-not-comparison-employer-insurance

fully understand the risks of their new customers. In 2017, they raised premiums to correct those mistakes. After the 2017 price corrections, analysis indicated that premiums would have grown in single digits for 2018 but for the policy changes under the Trump Administration.[42] Premiums have been lower in SBMs than in HealthCare.gov states, because SBMs manage their plans more actively than the administration.[43] In 2017, 71 percent of enrollees could buy a health plan with a cost (net of tax-credit assistance) of less than $75 per month.[44] In 2016, most (70 percent) of Marketplace enrollees reported no difficulty paying out-of-pocket costs in the previous year, slightly lower than enrollees in employer plans (75 percent).[45] States benefited fiscally in two ways: Marketplace financial

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[42] Fiedler M, Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017, USC-Brookings Schaeffer Initiative for Health Policy*, Report,* October 2017, https://www.brookings.edu/wpcontent/uploads/2017/10/individualmarketprofitability.pdf

[43] Hall MA and McCue MJ, Health Insurance Markets Perform Better in States That Run Their Own Marketplaces, *To the Point,* The Commonwealth Fund, March 2018, http://www.commonwealthfund.org/publications/blog/2018/mar/health-insurance-markets-states

[44] Office of the Assistant Secretary for Planning and Evaluation, Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, *Research Brief*, October 2017, https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf

[45] Presentation: 2016 Survey of US Health Care Consumers: A Look at Exchange Consumers, Deloitte Development LLC, 2016, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-consumer-survey-hix.pdf

assistance is fully federally financed and expanded insurance reduces state outlays to offset the cost to providers of uncompensated care.

20. Access and satisfaction as well as affordability of individual market coverage have improved. According to one survey, in 2010, 60 percent of people seeking individual market coverage found it very difficult or impossible to find affordable care; by 2016, that proportion fell to 34 percent.[46] A study of people newly enrolled in one plan in California and Colorado found that the proportion of enrollees with a personal health care provider rose from 59 to 73 percent, and the proportion receiving a flu shot in the previous year rose from 41 to 52 percent.[47] Satisfaction was roughly the same among enrollees in Marketplace plans and employer plans in 2016.[48] Satisfaction among adults with Marketplace or Medicaid coverage rose between 2014 (78 percent) and 2017 (89 percent).[49]

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[46] Collins SR, Gunja MZ, Doty MM and Beutel S, How the Affordable Care Act Has Improved Americans; Ability to Buy Health Insurance on Their Own, The Commonwealth Fund, *Issue Brief,* 2016, http://www.commonwealthfund.org/publications/issuebriefs/2017/feb/how-the-aca-has-improved-ability-to-buy-insurance

[47] Schmittdiel JA, Barrow JC, Wiley D, Ma L, Sam D, Chau CV and Shetterly SM, Improvements in Access and Care Through the Affordable Care Act, *American Journal of Managed Care,* 23(3):e95-97, 2017, http://www.ajmc.com/journals/issue/2017/2017-vol23-n3/improvements-in-access-and-care-through-the-affordable-care-act

[48] Presentation: 2016 Survey of US Health Care Consumers: A look at Exchange Consumers, Deloitte Development LLC, 2016, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-consumer-survey-hix.pdf

[49] The Commonwealth Fund, A Majority of Marketplace and

The ACA's Medicaid Provisions Expanded Eligibility, Improved Accessibility and Quality of Care, and Increased Savings

21. The ACA included a number of changes to Medicaid. It expanded Medicaid coverage to adults with income under 138 percent of the federal policy level (which the Supreme Court ruled was unenforceable as a mandate in 2012, but which 32 states have now adopted). It expanded minimum coverage standards for children ages 6 to 18, simplified program eligibility rules as well as the enrollment and renewal process, increased spending on long-term services and supports, added incentives to encourage quality measurement, and promoted care coordination for dual Medicare-Medicaid eligible beneficiaries. It made family planning coverage a state option, extended coverage for young adults aging out of foster care, increased Medicaid drug rebates, and increased efforts to combat fraud. Through the Center for Medicare and Medicaid Innovation (CMMI), the ACA also supported testing and evaluation of payment reforms to improve quality and decrease costs. The ACA also extended funding for CHIP and made policy changes that Congress recently largely incorporated in a ten-year reauthorization of the program.

22. The number of non-elderly people with Medicaid coverage increased by 13 percent between 2013 and 2016,[50] largely because 32 states (including the

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Medicaid Enrollees Are Getting Health Care They Could Not Have Afforded Prior to Having Coverage, *Affordable Care Act Tracking Survey,* no date, http://acatracking.commonwealthfund.org/

[50] Kaiser Family Foundation, Health Insurance Coverage of Nonelderly 0-64, 2013 and 2016, https://www.kff.org/other/

District of Columbia) expanded eligibility to low-income adults under the new category created by the ACA.[51] Eligibility rule streamlining and other simplifications, increased outreach efforts, a "spillover" effect from the opening of the Marketplaces, and the individual mandate appear to have had a coverage effect as well. A recent literature review listed numerous studies documenting reductions in all states of the proportion of people without insurance. Reductions have been larger in states that expanded Medicaid than in those that did not. It also found that the Medicaid expansion improved coverage among young adults, people with HIV, veterans, rural residents, and racial and ethnic minorities.[52] The law's Medicaid expansion's impact on coverage may have exceeded that of other ACA policies.[53]

23. At least 40 studies have found improved access to and use of health care associated with the Medicaid expansion. For example, one study found that,

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stateindicator/nonelderly-0-64/?dataView=1&currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[51] Maine has also scheduled an expansion to begin on July 1, 2018.

[52] Antonisse L, Garfield R, Rudowitz R and Artiga S, The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review, Henry J Kaiser Family Foundation, *Issue Brief,* September 2017, https://www.kff.org/medicaid/issuebrief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/

[53] Frean M, Gruber J and Sommers BD, Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act, *National Bureau of Economic Research,* 53:72-86, 2016, http://www.nber.org/papers/w22213

from November 2013 to December 2015, low-income adults in two expansion states reported a greater increase (12.1 percentage points) in having a personal physician and a greater reduction (18.2 percentage points) in cost related barriers to access to care compared to low-income adults in a non-expansion state.[54] Medicaid coverage also has increased access to treatment for substance use disorder, including opioid addiction.[55] Some critics of the ACA have alleged that Medicaid expansion caused addiction. What researchers have found is that states that expanded eligibility tended to have higher rates of addiction *before* enactment of the ACA but that drug related mortality *fell* compared to states that did not expand Medicaid after enactment.[56] Evidence is also building that Medicaid coverage for low-income adults has helped provide

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[54] Sommers BD, Blendon RJ, Orav EJ and Epstein AM, Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance, *JAMA Intern Med.,* 176(1):1501-1509, 2016, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420

[55] Clemens-Cope L, Epstein M and Kenney G, Rapid Growth in Medicaid Spending on Medications to Treat Opioid UseDisorder and Overdose, The Urban Institute, *Report,* 2017, http://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_3.pdf Wen H, Hockenberry J, Borders T and Druss B, Impact of Medicaid Expansion on Medicaid-Covered Utilization of Buprenorphine for Opioid Use Disorder Treatment, *Medical Care,* 55(4):336-341, 2017, http://journals.lww.com/lwwmedicalcare/Fulltext/2017/04000/Impact_of_Medicaid_Expansion_on_Medicaid_covered.5.aspx

[56] Goodman-Bacon A and Sandoe E, Did Medicaid Expansion Cause The Opioid Epidemic? There's Little Evidence That It Did., *Health Affairs Blog,* August 2017, https://www.healthaffairs.org/do/10.1377/hblog20170823.061640/full/.

continuity of care for people going in and out of prisons and may reduce recidivism.[57]

24. Much of the evidence on improvements to health stemming from the ACA comes from its Medicaid expansion. One analysis found a 6.1 percent relative reduction in adjusted all-cause mortality in states that had expanded Medicaid before the ACA.[58] In addition, studies have documented improved outcomes for such services as cardiac surgery associated with the ACA's Medicaid policies.[59]

25. The ACA's Medicaid expansion has also led to documented savings to people, states, and the health system. For example, self-reported medical debt in Ohio fell by nearly 50 percent after it broadened Medicaid eligibility.[60] An analysis of prescription drug transaction data found that uninsured people gaining

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[57] Regenstein M and Rosenbaum S, What The Affordable Care Act Means For People With Jail Stays, *Health Affairs,* 33(3), 2014, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1119.

[58] Sommers BD, Baicker K and Epstein AM, Mortality and Access to Care among Adults after State Medicaid Expansions, *The New England Journal of Medicine,* 367:(1025-1034), 2012, http://www.nejm.org/doi/full/10.1056/nejmsa1202099.

[59] Charles E, Johnston LE, Herbert MA, Mehaffey JH, Yount KW, Likosky DS, Theurer PF, Fonner CE, Rich JB, Speir AL, Ailawadi G, Prager RL and Kron IL, Impact of Medicaid Expansion on Cardiac Surgery Volume and Outcomes, *The Annals of Thoracic Surgery,* 104:1251-1258, June 2017, http://www.annalsthoracicsurgery.org/article/S0003-4975(17)30552-0/pdf.

[60] The Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly, January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

Medicaid coverage due to the expansion experienced a 79 percent reduction in out-of-pocket spending per prescription.[61] State budgets may have also benefited from receiving federal matching payments for state-funded programs and reductions in payments for uncompensated care; Louisiana, for example, estimated such savings at $199 million in 2017.[62] A recent national study found no significant increase in state Medicaid spending, nor a decrease in education, transportation, or other state spending, as a result of the expansion.[63] States also have not shown regret about their decisions to expand Medicaid, as indicated by reauthorizations of and public statements supporting the Medicaid expansion, even in Republican-led states.[64] The health system, in particular the hospital sector, has also gained financially from the Medicaid expansion. As previously mentioned, not only has uncompensated care decreased to a greater degree in states that expanded Medicaid as compared to those

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[61] Mulcahy AW, Eibner C and Finegold K, Gaining Coverage through Medicaid Or Private Insurance Increased Prescription Use And Lowered Out-Of-Pocket Spending, *Health Affairs,* 35(9), 2016, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0091

[62] Louisiana Department of Health, Medicaid Expansion 2016/17, June 2017, http://dhh.louisiana.gov/assets/HealthyLa/Resources/MdcdExpnAnnlRprt_2017_WEB.pdf.

[63] Sommers B and Gruber J, Federal Funding Insulated State Budgets From Increased Spending Related To Medicaid Expansion, *Health Affairs,* 65(5):938-944, 2017, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1666

[64] Hall M, Do States Regret Expanding Medicaid? *USC-Brookings Schaeffer On Health Policy,* March, 2018, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/

that did not; the hospitals that gained the most tended to be small, rural, for-profit, and non-federal governmental hospitals.[65]

26. The ACA's Medicaid provisions indirectly and directly improved coverage for people with disabilities. Its expansion directly helped those who did not qualify under pre-ACA rules, including those awaiting a disability determination. It also authorized a new eligibility pathway for full Medicaid benefits for people who were previously only eligible for partial Medicaid benefits under home- and community-based care waivers. The law created new programs such as the Community First Choice Options as well as demonstration programs to integrate care for people eligible for both Medicaid and Medicare. Medicaid covers about 6 million low-income seniors and 10 million non-elderly people with disabilities, with these two groups accounting for nearly two-thirds of overall Medicaid spending. As of 2016, 17 states had adopted the ACA's option for home- and community-based services and 8 were participating in Community First Choice.[66]

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[65] Blavin F, How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data, *The Urban Institute*, April 2017, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf436310.

[66] Musumeci M and Young K, State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities, Henry J Kaiser Family Foundation, *Issue Brief,* May 2017, https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-perenrollee-spending-for-seniors-and-people-with-disabilities/.

The ACA's Medicare Provisions Improved Benefits, Reduced Overpayments, Supported Value-Based Purchasing, and Tackled Fraud and Abuse

27. The ACA modified Medicare to improve its benefits; promote quality, value-based purchasing, and alternative payment models; and lower overpayments and fraud in its traditional program and Medicare Advantage. It created CMMI to develop and test new payment models which, if determined to reduce spending without harming quality of care (or to improve quality without increasing spending), could be adopted by Medicare nationwide. It also included specific payment models as alternatives to paying for volume, such as Accountable Care Organizations (ACOs) and bundled payments that pay per person or episode, respectively. New quality "star rating" programs were expanded to inform choices. The law also raised the Medicare payroll tax for high-income people to support Medicare's Hospital Insurance Trust Fund.

28. The ACA included a major focus on preventive services (described below as well). It created an annual wellness visit in Medicare and eliminated cost sharing for certain evidence based preventive services. In 2016, more than 10.3 million Medicare beneficiaries had an annual wellness visit and 40.1 million used at least one preventive service with no copay (provisions included in the ACA). It also included a provision that would gradually close the coverage gap or "donut hole" in Medicare's Part D drug benefit. Before the ACA, Medicare beneficiaries had no drug coverage after the standard benefit that ends with $2,830 in total spending and its catastrophic benefit that begins with $4,550 in out-of-pocket spending (2010 values). Be-

cause of changes contained in the ACA, nearly 12 million Medicare beneficiaries received cumulative prescription drug savings from 2010 to 2016 that averaged $2,272 per person ($1,149 per beneficiary in 2016 alone).[67] Research suggests the policy both reduced out-of-pocket costs and contributed to greater use of generic drugs.[68] Drug savings for Medicare – and other payers – will also flow from ACA's new pathway for approval of lower-cost "biosimilar" drugs. A RAND analysis estimated that this provision could reduce U.S. health spending by $54 billion from 2017 to 2026.[69]

29. Most of the ACA's savings come from reducing Medicare overpayments. The ACA, for the first time, built permanent productivity adjustments into Medicare payment formulas. The ACA also phased in new benchmark payment rates and reduced upcoding for risk in Medicare Advantage (MA). Despite concerns about an estimated 12 percentage point reduction in

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[67] Centers for Medicare & Medicaid Services, Nearly 12 Million People with Medicare Have Saved over $26 Billion on Prescription Drugs since 2010, Press Release, January 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Pressreleases/2017-Press-releases-items/2017-01-13.html

[68] Bonakdar Tehrani A and Cunningham PJ, Closing the Medicare Doughnut Hole: Changes in Prescription Drug Utilization and Out-of-Pocket Spending Among Medicare Beneficiaries With Part D Coverage After the Affordable Care Act, *Medical Care,* 55(1):43-49, 2017, https://journals.lww.com/lwwmedicalcare/Abstract/2017/01000/Closing_the_Medicare_Doughnut_Hole__Changes_in.7.aspx.

[69] Mulcahy AW, Hlavka JP and Case SR, Biosimilar Cost Savings in in the United States, RAND Corporation, *Perspectives* ,2017, https://www.rand.org/pubs/perspectives/PE264.html.

MA rates, MA program enrollment has grown by over 70 percent and premiums have dropped since 2010.[70] The ACA also included new tools and resources to combat health care fraud; in 2015, the government recovered $2.4 billion, returning $6.10 for each dollar invested, and conducted its largest ever nationwide health care fraud takedown, charging 243 people with false billing.[71]

30. The ACA prioritized delivery system reform to promote more efficient, high-quality care, led by Medicare. 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.[72] In 2017, 21 percent of Medicare beneficiaries received care from an ACO or medical home, with another 33 percent in Medicare Advantage.[73] Because

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[70] Jacobson G, Damico A, Neuman T and Gold M, Medicare Advantage 2017 Spotlight: Enrollment Market Update, Henry J Kaiser Family Foundation, *Issue Brief,* June 2017, https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlightenrollment-market-update/.

[71] Department of Justice, Fact Sheet; The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud, Press Release, February 2016, https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-andabuse-control-program-protects-conusmers-and-taxpayers.

[72] Health Care Payment Learning & Action Network, Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs, *Report,* October 2017, https://hcplan.org/groups/apm-fpt-work-products/apm-report/.

[73] Henry J Kaiser Family Foundation, Medicare Delivery System Reform: The Evidence Link, no date, https://www.kff.org/medicare-delivery-system-reform-the-evidence-link/.

these innovations are new, few evaluations have been done. Some demonstrations seem to have been successful. For example, the pioneer ACOs saved Medicare $24 million in 2016, reduced spending by 1 to 2 percent relative to a comparison group in 2013, and had overall quality composite scores that increased over time.[74] And, research has found that the bundled payments for lower extremity joint replacement reduced readmissions while cutting average Medicare per-episode spending by 21 percent if there were no complications and 14 percent if there were complications.[75]

31. Medicare is on stronger financial footing because of the ACA. In 2010, CBO estimated that the ACA would reduce Medicare spending by over $400 billion from 2010 to 2019.[76] A study by the U.S. Department of Health and Human Services found Medicare spent $473.1 billion less from 2009 to 2014 than it would have had the 2000 to 2008 average growth

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[74] Henry J Kaiser Family Foundation, Medicare Delivery System Reform: The Evidence Link, Side-by-Side Comparison: Medicare Accountable Care Organization (ACO) Model, no date, https://www.kff.org/interactive/side-by-side-comparisonmedicare-accountable-care-organization-aco-models/.

[75] Navathe AS, Troxl AB, Liao JM, Nan N, Zhu J, Zhon W, and Emanuel EJ, Cost of Joint Replacement Using Bundled Payment Models, *JAMA Intern Med.,* 177(2):214-222, 2017, https://jamanetwork.com/journals/jamainternalmedicine/articleabstract/2594805.

[76] Elmendorf DW, Letter to Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, Congressional Budget Office, March 20, 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf

rate continued.[77] Reduced Medicare spending, combined with increased revenue, contributed to extending the life of Medicare's Hospital Insurance Trust Fund by 12 years (to 2029) as compared to its projected insolvency when the ACA was enacted (2017).[78] The benefits of slower Medicare cost growth accrue to beneficiaries and states as well. In 2016, Medicare premiums and cost sharing for traditional Medicare were $700 lower per beneficiary compared to what such spending would have been under 2009 projections.[79] States similarly have saved since they pay Medicare premiums and cost sharing for certain low-income beneficiaries.

The ACA Strengthened the Public Health System and Made Other Capacity Improvements

32. Key coverage and funding provisions of the ACA have protected millions of Americans from infectious and chronic diseases through clinical preventive

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[77] Chappel A, Sheingold S and Nguyen N, Health Care Spending Growth And Federal Policy, Office of the Assistant Secretary for Planning and Evaluation, *Issue Brief,* March 2016, https://aspe.hhs.gov/system/files/pdf/190471/SpendingGrowth.pdf

[78] *Medicare Trustees Report*. Note that 2029 was also the projection in the 2010 report in which the Trustees attributed much of the improvement to the ACA. For Trustees report, see: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

[79] Executive Office of the President Council of Economic Advisors, *2017 Economic Report of the President*, Chapter 4 Reforming the Health Care System, U.S. Government Publishing Office, 2017. https://obamawhitehouse.archives.gov/sites/default/files/docs/chapter_4-reforming_health_care_system_2017.pdf

services, funding for state and local public health services, and investments in healthier communities. It supports improving health system infrastructure through policies such as a new Community Health Center Fund to expand services, a program to build school-based health clinics, a permanent authorization of the Indian Health Care Improvement Act, and a set of workforce policies to promote primary care and increase the number of people trained through the National Health Service Corps. It also encourages integration of behavioral and primary care services through training programs as well its insurance and payment policies.

33. The required coverage of clinical preventive services has resulted in increased use of key preventive services such as blood pressure and cholesterol screenings and flu vaccinations.[80] Insurance coverage of vaccinations and ACA investments in the Section 317 Immunization Program, totaling almost $768 million for fiscal years 2010 to 2017, have increased protection against vaccine-preventable diseases among Americans. For example, women were 3.3 times as likely to have had the HPV vaccine after implementation of the ACA.[81]Increased coverage of smoking cessation services under Medicaid, newly mandated

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[80] Han X, Yabroff KR, Guy GP, Zheng Z and Jemal A, Has Recommended Preventive Service Use Increased after Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States? *Preventive Medicine,* 78:85–91, 2015, http://doi.org/10.1016/j.ypmed.2015.07.012.

[81] Corriero R, Gay JL, Robb SW and Stowe EW, Human Papillomavirus Vaccination Uptake Before and After the Affordable Care Act: Variation According to Insurance Status, Race, and Education (NHANES 2006-2014), *Journal of Pediatric and Adolescent Gynecology,* 31(1):23-27, 2017, https://doi.org/10.1016/j.jpag.

under the ACA, has also been demonstrated both to reduce state health care costs and to improve health outcomes. One analysis in Massachusetts found savings of $3.12 in medical costs for every $1 spent on smoking cessation services.[82]

34. The Prevention and Public Health Fund (PPHF), a new funding stream created by the ACA, has sent over $3.9 billion to states since 2010 ($650 million for fiscal year 2017).[83] This fund has supported key programs, three of which are described below in paragraphs 35-37.

35. The PPHF funded *Tips from Former Smokers*, an advertising campaign to encourage quit attempts. The Centers for Disease Control and Prevention estimated that it led 500,000 people to quit smoking for good in the first five years of the campaign, with an estimated cost of $2,000 for every life saved from a smoking death.[84] In addition, states have received

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2017.07.002.

[82] Richard P, West K and Ku L, The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts, *PLoSONE,* 7(1): e29665, 2012. https://doi.org/10.1371/journal.pone.0029665.https://doi.org/10.1371/journal.pone.0029665

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

[84] Centers for Disease Control and Prevention, Tips Impact and Results, no date, https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html?s_cid=OSH_tips_D9391.

PPHF grants for their smoking cessation programs, totaling over $133 million since 2010.

36. The PPHF investment, including nearly $17 million in fiscal year 2017, permitted expansion of the Diabetes Prevention Program (DPP), a community-based lifestyle change program. This program has been shown to prevent progression to diabetes among many of those with prediabetes, resulting in savings and improved health outcomes. In testing by CMMI, DPP saved Medicare an estimated $2,650 for each person enrolled in DPP over a 15-month period.[85] The Medicare Diabetes Prevention Program (MDPP) is now available to all eligible beneficiaries.

37. PPHF has been critical in expanding and sustaining the capacity of state and local health departments to meet the needs of their communities, in particular through annual funding of the Preventive Health and Health Services Block Grant ($160 million a year) and Epidemiology and Laboratory Grants ($40 million a year). The two grants combined have put over $1.1 billion into communities in fiscal years 2010 through 2017.

38. The ACA invested $1.5 billion in the Maternal, Infant, and Early Childhood Home Visiting Grants to support state-level expansion of the Nurse-Family Partnership. This program has had a dramatic impact on medical care, child welfare, special education, and criminal justice system involvement by the families

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[85] Centers for Medicare & Medicaid Services, Medicare Diabetes Prevention Program (MDPP) Expanded Model, no date, https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/.

served by the program, with a savings to government programs of 1.9 times the cost.[86]

39. There is growing evidence that pediatric asthma, diabetes, heart disease and other chronic conditions are linked with social and economic factors or conditions where people live, grow, and work. [87] Through both the PPHF and CMMI, the ACA has supported investments in the multi-sector partnerships that can address the health-related social needs of people served by our health system. CMMI is supporting a $157 million initiative, Accountable Health Communities (AHC), in 23 states across the country as well as accountable communities for health models through the State Innovation Models grants in 10 states.[88] Through various community prevention programs supported by the PPHF's over $1 billion investment from 2010 to 2017, every state has received support to build stronger partnerships across sectors that will improve the health of communities.

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[86] Miller, TR, Projected Outcomes of Nurse-Family Partnership Home Visitation during 1996-2013, USA., *Prevention Science*, 16(6):765-777, 2015, https://www.ncbi.nlm.nih.gov/pubmed/26076883.

[87] Magnan, S, Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. *National Academy of Medicine*, 2017, https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five.

[88] Centers for Medicare & Medicaid Services, CMS' Accountable Health Communities Model Selects 32 Participants to Serve as Local 'Hubs' Linking Clinical and Community Services, Press Release, April 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-06.html.

40. ACA investments have also expanded the health care workforce in every state. More primary care providers are now working in teams to address complex care needs of populations. The increases are due in large part to the expansion of primary care training programs for physicians, physician assistants, and nurse practitioners funded through the PPHF, which added approximately 4,500 providers.[89] There was also the expansion of residency training programs under the ACA, such as the Teaching Health Centers program, that added approximately 1,555 primary care physicians working in shortage areas. Through a $1.5 billion investment in the National Health Service Corps, the number of people served by Corps clinicians rose from 9 million in 2010 to 15.9 million in 2016. The ACA investment increased its number of health care providers from 7,358 to 15,159, including physicians, nurses, dentists, and behavior health providers serving in over 14,000 shortage area sites. Corps clinicians had an 80 percent retention rate after one year of completed service requirements.

41. The ACA invested in health care facilities as well as workers. Its Community Health Center Fund has been used, among other activities, for facility improvement, expanded access points, and expanded service capacity.[90] This Fund, plus the expansion of Medicaid, contributed to growth in the number of patients served from 19.5 million in 2010 to 25.9 million

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[89] Health Resources and Services Administration, *FY 2016 Annual Performance Report*, 2016, https://www.hrsa.gov/sites/default/files/about/budget/peformancereport2016.pdf.

[90] Congressional Research Service Reports, *The Community Health Center Fund: In Brief*, 2017, https://www.everycrsreport.com/reports/R43911.html.

in 2016.[91] It supported construction and renovation of school-based health clinics, providing about 520 awards.[92] The ACA also authorized new programs within the Indian Health Service, including behavior health programs, and expanded subsidies in Medicaid and the Marketplaces for American Indians and Native Americans.[93]

Enjoining the ACA Would Cause Widespread Harm in All States for the Vast Majority of Americans

42. As this review of the impact of the ACA illustrates, enjoining the ACA would cause grievous immediate and long-term harm to Americans' health and financial security, to the health system, and to federal and state budgets. The law's provisions are so interwoven in the health system that the harms from an injunction would go far beyond negating the benefits directly traceable to the ACA. Some ACA policies could

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[91] Rosenbaum S, Tolbert J, Sharac J, Shin P, Gunsalus R and Zur J, Community Health Centers: Growing Importance in a Changing Health System, Henry J Kaiser Family Foundation, *Issue Brief,* March 2018, http://files.kff.org/attachment/Issue-Brief-Community-Health-Centers-Growing-Importance-in-a-Changing-Health-Care-System

[92] Pilkey D, Skopec L, Gee E, Finegold K, Amaya K and Robinson W, The Affordable Care Act and Adolescents, Office of the Assistant Secretary for Planning and Evaluation, *Research Brief,* August 2013, https://aspe.hhs.gov/system/files/pdf/180281/rb_adolescent.pdf

[93] Ross RW, Garfield LD, Brown DS and Raghavan R, The Affordable Care Act and Implications for Health Care Services for American Indian and Alaska Native Individuals, *J Health Care Poor Underserved,* 26(4):1081-1088, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4824684/.

not simply fall back to what they were almost a decade ago. For example, Medicare probably could not make payments to Medicare Advantage plans pursuant to an injunction since the ACA replaced the previous payment system; 19 million beneficiaries could lose their plans and publicly traded insurers' stocks could plummet. Some programs that pre-dated the ACA would cease to function under an injunction. For example, the ACA's PPHF is now the only source of support for the long-standing Preventive and Public Health Services Block Grant. This grant supports critical services, including lab capacity to test for outbreaks of flu or virus-borne diseases such as Zika, responses to emerging public health threats such as the opioid epidemic, and chronic health threats such as damage to children through exposure to lead.[94] Beyond the heightened threat to public health, states' credit ratings could fall due to their increased financial exposure from such funding cuts along with the loss of federal Medicaid funding.[95]

43. CBO acknowledged these and other challenges when it estimated the implications of the full repeal of the ACA in 2015. It projected that repealing the ACA would increase the federal budget deficit by

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[94] Clary A, Rosenthal J, Riley T, The Prevention and Public Health Fund – Lessons from States; Questions for Policymakers, National Academy for State Health Policy, *State Health Policy Blog,* March 2017, https://nashp.org/the-prevention-and-publichealth-fund-lessons-from-states-questions-for-policymakers/

[95] Schneider A, Fitch Report: Proposed Medicaid Cuts Could Impact States' Credit Ratings, Georgetown University Health Policy Institute, Center for Children and Families, *Say Ahhh! Blog,* June 2017, https://ccf.georgetown.edu/2017/06/28/fitchreportmedicaid-cuts-will-impact-states-schools-and-more/

$353 billion over ten years, not taking into account macroeconomic feedback. Medicare spending would increase by $802 billion over this period, raising seniors' premiums and hastening Medicare Trust Fund insolvency. CBO projected that 24 million people would become uninsured.[96]

44. CBO prepared similar estimates in 2016 and early 2017 when legislation to repeal parts of the ACA (without a replacement) was under consideration. The Urban Institute found that partial repeal would increase in the number of uninsured by 29.8 million, of whom 82 percent would be in working families and 38 percent would be young adults. This dramatic increase in the number of uninsured would increase the cost of uncompensated care by an estimated $1.1 trillion over a decade, which would put significant budget stress on state and local governments as well as the health system.[97] An analysis funded by the American Hospital Association estimated that income of hospitals would be reduced by $165.8 billion from 2018 to 2026.[98]

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[96] Congressional Budget Office, Budgetary and Economic Effects of Repealing the Affordable Care Act, June 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf

[97] Blumberg LK, Buettgens M and Holahan J, Implications of Partial Repeal of the ACA through Reconciliation, Urban Institute, *Report,* December 2016, https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repealof-the-aca-through-reconciliation_1.pdf

[98] Dobson DaVanzo & Associates, LLC, Estimating the Impact of Repealing the Affordable Care Act on Hospitals, 2016, American Hospital Association, *Report,* 2016, https://www.aha.org/system/files/2018-02/impact-repeal-aca-report_0.pdf

45. No analysis has systematically examined the immediate implications of an injunction of the entire law. It is not clear how Medicare would continue to make payments if the basis for those payment rates is nullified, whether states would get federal funding in the next quarter for service and eligibility categories authorized by the ACA, and if insurers no longer receiving premium tax credits could immediately revert to medical underwriting. Workers in programs funded by the ACA, such as CMMI programs, may become immediately unemployed. Drug discounts provided to seniors with Medicare coverage could immediate cease. People with disabilities whose care is funded by Community First Choice could immediately lose access to care without state intervention. These few examples illustrate that enjoining the entire ACA would create both chaos and inflict harm.

State-Specific Impacts

46. Enjoining the ACA would harm the health system, public health, and budgets of states across the country. If people cannot access health coverage, more people will become uninsured, uncompensated care costs for states will increase, and states will be pressured to fill the void left from the ACA. The estimates described below come from four sources: (1) state fact sheets from the Department of Health and Human Services;[99] (2) Urban Institute estimates of the impact of a repeal of the ACA's funding-related provisions;[100]

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[99] Office of the Assistant Secretary of Planning and Evaluation, Compilation of State Data on the Affordable Care Act, December 2016, https://aspe.hhs.gov/compilation-state-data-affordable-care-act. Note that some estimates are not available for all states due to small sample size.

[100] Blumberg LK, Buettgens M and Holahan J, Implications of

(3) the Trust for America's Health;[101] and (4) the Centers for Medicare and Medicaid Services.[102] While some of these numbers come from older or national versus state-specific studies, they are consistent in magnitude and direction with the likely impact of an injunction.

California

47. Between 2010 and 2015, an estimated 3,826,000 people in California gained coverage. This includes a large fraction of the people covered in the California Health Insurance Marketplace (called Covered California), an estimated 294,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the

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Partial Repeal of the ACA through Reconciliation, Urban Institute, *Report,* December 2016, https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-ofpartial-repeal-of-the-aca-through-reconciliation_1.pdf. Buettgens M, Blumberg LJ, Holahan J, The Impact on Health Care Providers of Partial ACA Repeal Through Reconciliation, Urban Institute, *Report,* January 2017, https://www.urban.org/sites/default/files/publication/86916/2001046-the-impact-onhealth-care-providers-of-partial-aca-repeal-through-reconciliation_1.pdf.

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

[102] Centers for Medicare & Medicaid Services, 2017 Effectuated Enrollment Snapshot, June 2017, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf; Centers for Medicare & Medicaid Services, Nearly 12 Million People with Medicare Have Saved over $26 Billion on Prescription Drugs since 2010, Press Release, January 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.

law's Medicaid (called Medi-Cal) expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

48. **Impact on Consumer Protections**: Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 16,133,192 people in California have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 12,092,000 people in California with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 15,867,909 people in California, including 6,324,503 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

49. **Impact on Marketplace Coverage**: The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 1,389,886 people in California covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 85 percent of Marketplace enrollees in California received a premium tax credit that averaged $4,150 per person. That financial assistance would no longer be available under an injunction.

50. Impact on Medicaid: Without the ACA, an estimated 1,188,000 fewer people in California would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 136,000 more getting all needed care, 169,000 fewer struggling to pay medical bills, 109,000 fewer experiencing symptoms of depression, and 1,430 avoided deaths each year in California. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in California's Community First Choice program could lose access to services.

51. **Impact on Medicare**: The 5,829,777 people with Medicare in California would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 403,631 people in California with $1,169 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 3,879,678 people with Medicare in California used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in California. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 5,580 fewer unnecessary returns to the hospital in California in 2015. The 29 Accountable Care Organizations (ACOs) in California that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

52. **Impact on Public Health**: Support for public health in California would also be reduced under an injunction. California received $317,998,658 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $61,653,559 for immunizations and $15,110,953 for tobacco cessation efforts.

53. **Impact on Finances**: The financial impact on California would be significant. From 2019 to 2028, it would lose $61.1 billion in federal Marketplace spending and $99.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $160.2 billion. This would have a major impact on health care providers. From 2019 to 2028, California hospitals could lose $64.1 billion and physicians could lose $24.7 billion. Uncompensated care costs in California would increase by $140.1 billion over this period.

Connecticut

54. Between 2010 and 2015, an estimated 110,000 people in Connecticut gained coverage. This includes a large fraction of the people covered in the Connecticut Health Insurance Marketplace (called AccessHealthCT), an estimated 25,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

55. **Impact on Consumer Protections**: Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,554,628 people in Connecticut have a pre-existing condition and

would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,386,000 people in Connecticut with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,819,938 people in Connecticut, including 746,444 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

56. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 98,260 people in Connecticut covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 77 percent of Marketplace enrollees in Connecticut received a premium tax credit that averaged $5,312 per person. That financial assistance would no longer be available under an injunction.

57. **Impact on Medicaid:** Without the ACA, an estimated 72,000 fewer people in Connecticut would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 8,000 more getting all needed care, 10,200 fewer struggling to pay medical bills, 7,000 fewer experiencing symptoms of depression, and 90 avoided deaths each year in Connecticut. Enjoining the law would put these

benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Connecticut's Community First Choice program could lose access to services.

58. **Impact on Medicare:** The 644,136 people with Medicare in Connecticut would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 65,248 people in Connecticut with $1,268 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 473,312 people with Medicare in Connecticut used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Connecticut. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 1,306 fewer unnecessary returns to the hospital in Connecticut in 2015. The 12 Accountable Care Organizations (ACOs) in Connecticut that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

59. **Impact on Public Health**: Support for public health in Connecticut would also be reduced under an injunction. Connecticut received $86,545,015 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $10,382,997 for immunizations and $971,964 for tobacco cessation efforts.

60. **Impact on Finances:** The financial impact on Connecticut would be significant. From 2019 to

2028, it would lose $4.3 billion in federal Marketplace spending and $10.5 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $14.8 billion. This would have a major impact on health care providers. From 2019 to 2028, Connecticut hospitals could lose $6.0 billion and physicians could lose $2.4 billion. Uncompensated care costs in Connecticut would increase by $14.9 billion over this period.

Delaware

61. Between 2010 and 2015, an estimated 35,000 people in Delaware gained coverage. This includes a large fraction of the people covered in the Delaware Health Insurance Marketplace, an estimated 7,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

62. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 383,607 people in Delaware have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 320,000 people in Delaware with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 417,265 people in Delaware, including 171,575 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's

consumer protections that could be lost if this court allows the ACA to be enjoined.

63. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 24,171 people in Delaware covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 83 percent of Marketplace enrollees in Delaware received a premium tax credit that averaged $5,010 per person. That financial assistance would no longer be available under an injunction.

64. **Impact on Medicaid:** Without the ACA, an estimated 6,000 fewer people in Delaware would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 1,000 more getting all needed care, 900 fewer struggling to pay medical bills, 1,000 fewer experiencing symptoms of depression, and 10 avoided deaths each year in Delaware. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

65. **Impact on Medicare:** The 186,835 people with Medicare in Delaware would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 23,485 people in Delaware with $1,292 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which

149,051 people with Medicare in Delaware used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Delaware. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 575 fewer unnecessary returns to the hospital in Delaware in 2015. The 7 Accountable Care Organizations (ACOs) in Delaware that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

66. **Impact on Public Health:** Support for public health in Delaware would also be reduced under an injunction. Delaware received $34,384,937 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $5,146,859 for immunizations and $314,964 for tobacco cessation efforts.

67. **Impact on Finances:** The financial impact on Delaware would be significant. From 2019 to 2028, it would lose $900 million in federal Marketplace spending and $2.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $3.6 billion. This would have a major impact on health care providers. From 2019 to 2028, Delaware hospitals could lose $1.5 billion and physicians could lose $500 million. Uncompensated care costs in Delaware would increase by $2.8 billion over this period.

District of Columbia

68. Between 2010 and 2015, an estimated 25,000 people in the District of Columbia gained coverage.

This includes a large fraction of the people covered in the District of Columbia Health Insurance Marketplace (called DC Health Link), an estimated 6,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

69. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 268,134 people in the District of Columbia have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 208,000 people in the District of Columbia with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 281,235 people in the District of Columbia including 127,531 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

70. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 18,038 people in the District of Columbia covered in the Health Insurance Marketplace

would lose coverage without the ACA. In 2017, 4 percent of Marketplace enrollees in the District of Columbia received a premium tax credit that averaged $2,967 per person. That financial assistance would no longer be available under an injunction.

71. **Impact on Medicaid:** Without the ACA, an estimated 16,000 fewer people in the District of Columbia would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 2,000 more getting all needed care, 2,300 fewer struggling to pay medical bills, 1,000 fewer experiencing symptoms of depression, and 20 avoided deaths each year in the District of Columbia. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

72. **Impact on Medicare:** The 90,492 people with Medicare in the District of Columbia would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 3,360 people in the District of Columbia with $1,181 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 54,535 people with Medicare in the District of Columbia used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in the District of Columbia. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 346 fewer unnecessary returns to the hospital in the District of Columbia in

2015. The 8 Accountable Care Organizations (ACOs) in the District of Columbia that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

73. **Impact on Public Health:** Support for public health in the District of Columbia would also be reduced under an injunction. The District of Columbia received $79,091,220 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $9,212,443 for immunizations and $2,144,515 for tobacco cessation efforts.

74. **Impact on Finances:** The financial impact on the District of Columbia would be significant. From 2019 to 2028, it would lose about $100 million in federal Marketplace spending and $1.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be about $1.7 billion. This would have a major impact on health care providers. From 2019 to 2028, District of Columbia hospitals could lose $700 million and physicians could lose $200 million. Uncompensated care costs in the District of Columbia would increase by $1.7 billion over this period.

Hawaii

75. Between 2010 and 2015, an estimated 54,000 people in Hawaii gained coverage. This includes a large fraction of the people covered in the Hawaii Health Insurance Marketplace, an estimated 9,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

76. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 560,494 people in Hawaii have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 462,000 people in Hawaii with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 631,152 people in Hawaii, including 256,448 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

77. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 16,711 people in Hawaii covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 82 percent of Marketplace enrollees in Hawaii received a premium tax credit that averaged $4,238 per person. That financial assistance would no longer be available under an injunction.

78. **Impact on Medicaid:** Without the ACA, an estimated 33,000 fewer people in Hawaii would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health.

For example, it resulted in an estimated 4,000 more getting all needed care, 4,700 fewer struggling to pay medical bills, 3,000 fewer experiencing symptoms of depression, and 40 avoided deaths each year in Hawaii. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

79. **Impact on Medicare:** The 252,514 people with Medicare in Hawaii would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 22,212 people in Hawaii with $1,361 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 158,239 people with Medicare in Hawaii used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Hawaii. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 315 fewer unnecessary returns to the hospital in Hawaii in 2015.

80. **Impact on Public Health:** Support for public health in Hawaii would also be reduced under an injunction. Hawaii received $30,145,284 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $3,914,688 for immunizations and $227,370 for tobacco cessation efforts.

81. **Impact on Finances:** The financial impact on Hawaii would be significant. From 2019 to 2028, it

would lose $500 million in federal Marketplace spending and $3.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $4.3 billion. This would have a major impact on health care providers. From 2019 to 2028, Hawaii hospitals could lose $2.6 billion and physicians could lose $800 million. Uncompensated care costs in Hawaii would increase by $2.8 billion over this period.

Illinois

82. Between 2010 and 2015, an estimated 850,000 people in Illinois gained coverage. This includes a large fraction of the people covered in the Illinois Health Insurance Marketplace, an estimated 91,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

83. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 5,635,622 people in Illinois have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 4,670,000 people in Illinois with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 5,883,105 people in Illinois, including 2,380,326 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the

ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

84. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 314,038 people in Illinois covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 81 percent of Marketplace enrollees in Illinois received a premium tax credit that averaged $4,372 per person. That financial assistance would no longer be available under an injunction.

85. **Impact on Medicaid:** Without the ACA, an estimated 340,000 fewer people in Illinois would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 39,000 more getting all needed care, 48,400 fewer struggling to pay medical bills, 31,000 fewer experiencing symptoms of depression, and 410 avoided deaths each year in Illinois. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

86. **Impact on Medicare:** The 2,118,300 people with Medicare in Illinois would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 187,357 people in Illinois with $1,133 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which

1,546,769 people with Medicare in Illinois used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Illinois. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 8,108 fewer unnecessary returns to the hospital in Illinois in 2015. The 29 Accountable Care Organizations (ACOs) in Illinois that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

87. **Impact on Public Health:** Support for public health in Illinois would also be reduced under an injunction. Illinois received $115,192,088 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $28,383,246 for immunizations and $5,106,535 for tobacco cessation efforts.

88. **Impact on Finances:** The financial impact on Illinois would be significant. From 2019 to 2028, it would lose $12.5 billion in federal Marketplace spending and $37.4 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $49.9 billion. This would have a major impact on health care providers. From 2019 to 2028, Illinois hospitals could lose $24.6 billion and physicians could lose $8.0 billion. Uncompensated care costs in Illinois would increase by $54.5 billion over this period.

Kentucky

89. Between 2010 and 2015, an estimated 404,000 people in Kentucky gained coverage. This includes a large fraction of the people covered in the Kentucky

Health Insurance Marketplace, an estimated 31,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

90. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,894,874 people in Kentucky have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,414,000 people in Kentucky with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,884,719 people in Kentucky, including 762,897 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

91. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 71,585 people in Kentucky covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 78 percent of Marketplace enrollees in Kentucky received a premium tax credit that averaged $3,519 per person. That financial

assistance would no longer be available under an injunction.

92. **Impact on Medicaid:** Without the ACA, an estimated 151,000 fewer people in Kentucky would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 17,000 more getting all needed care, 21,500 fewer struggling to pay medical bills, 14,000 fewer experiencing symptoms of depression, and 180 avoided deaths each year in Kentucky. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

93. **Impact on Medicare:** The 881,938 people with Medicare in Kentucky would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 83,989 people in Kentucky with $1,194 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 634,656 people with Medicare in Kentucky used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Kentucky. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,384 fewer unnecessary returns to the hospital in Kentucky in 2015. The 22 Accountable Care Organizations (ACOs) in Kentucky that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

94. **Impact on Public Health:** Support for public health in Kentucky would also be reduced under an injunction. Kentucky received $36,712,458 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $11,025,151 for immunizations and $2,112,229 for tobacco cessation efforts.

95. **Impact on Finances:** The financial impact on Kentucky would be significant. From 2019 to 2028, it would lose $2.9 billion in federal Marketplace spending and $46.8 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $49.7 billion. This would have a major impact on health care providers. From 2019 to 2028, Kentucky hospitals could lose $23.1 billion and physicians could lose $6.9 billion. Uncompensated care costs in Kentucky would increase by $15.6 billion over this period.

Massachusetts

96. Between 2010 and 2015, an estimated 107,000 people in Massachusetts gained coverage. This includes a large fraction of the people covered in the Massachusetts Health Insurance Marketplace (called the Massachusetts Health Connector), an estimated 52,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

97. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 2,931,068 people in Massachusetts have a pre-existing condition and

would be at risk for being charged unaffordable premiums without the ACA. Before the ACA, 2,520,000 people in Massachusetts with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,399,092 people in Massachusetts, including 1,412,394 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

98. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 242,221 people in Massachusetts covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 74 percent of Marketplace enrollees in Massachusetts received a premium tax credit that averaged $2,135 per person. That financial assistance would no longer be available under an injunction.

99. **Impact on Medicaid:** Without the ACA, an estimated 2,000 fewer people in Massachusetts would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

100. **Impact on Medicare:** The 1,252,277 people with Medicare in Massachusetts would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 90,664 people in Massachusetts with $1,194 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 938,405 people with Medicare in Massachusetts used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Massachusetts. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,213 fewer unnecessary returns to the hospital in Massachusetts in 2015. The 14 Accountable Care Organizations (ACOs) in Massachusetts that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

101. **Impact on Public Health:** Support for public health in Massachusetts would also be reduced under an injunction. Massachusetts received $108,021,166 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $12,404,884 for immunizations and $2,147,272 for tobacco cessation efforts.

102. **Impact on Finances:** The financial impact on Massachusetts would be significant. From 2019 to 2028, it would lose $5.4 billion in federal Marketplace spending and $17.2 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $22.5 billion. This would have a major impact on health care providers. From 2019 to 2028,

Massachusetts hospitals could lose $6.1 billion and physicians could lose $2.6 billion. Uncompensated care costs in Massachusetts would increase by $17.1 billion over this period.

Minnesota

103. Between 2010 and 2015, an estimated 250,000 people in Minnesota gained coverage. This number includes a large fraction of the people covered in the Minnesota Health Insurance Marketplace (called MNsure), an estimated 38,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

104. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Without the ACA up to 2,318,738 people in Minnesota have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether. Before the ACA, 2,043,000 people in Minnesota with employer or individual market coverage had lifetime limits on their insurance policies: if the ACA were enjoined, annual and lifetime limits would surely return. An estimated 2,761,583 people in Minnesota, including 1,075,362 women ages 15–64, would lose the federal guarantee of preventive services — such as flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

105. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families who have benefitted from these provisions would pay more out of pocket for health coverage or go without it altogether. Many of the 90,146 people in Minnesota covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 70 percent of Marketplace enrollees in Minnesota received premium tax credits that averaged $5,220 per person. That financial assistance would no longer be available under an injunction.

106. **Impact on Medicaid:** Without the ACA, an estimated 36,000 fewer people in Minnesota would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 4,000 more getting all needed care, 5,100 fewer struggling to pay medical bills, 3,000 fewer experiencing symptoms of depression, and 40 avoided deaths each year in Minnesota. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

107. **Impact on Medicare:** The 944,222 people with Medicare in Minnesota would also lose benefits and pay more under an injunction than they now do. Prescription drug discounts, that saved 66,930 Minnesotans an average of $1,077 per beneficiary in 2016 would end. It would roll back the coverage of proven preventive services with no cost sharing which 604,022 people with Medicare in Minnesota used in 2016. It would suspend payment policies that have

lowered premiums, cost sharing, and taxpayer costs in Minnesota. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 1,435 fewer unnecessary returns to the hospital in Minnesota in 2015. The 8 Accountable Care Organizations (ACOs) in Minnesota that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

108. **Impact on Public Health:** Support for public health in Minnesota would also be reduced under an injunction. Minnesota received $83,959,272 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This sum includes $18,224,535 for immunizations and $3,177,506 for tobacco cessation efforts.

109. **Impact on Finances:** The financial impact on Minnesota would be significant. From 2019 to 2028, Minnesota would lose $1.9 billion in federal Marketplace spending and $14.6 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $16.4 billion. Such a reduction in spending would have a major impact on health care providers. From 2019 to 2028, Minnesota hospitals could lose $7.3 billion and physicians could lose $2.7 billion. Uncompensated care costs in Minnesota would increase by $24.5 billion over this period.

New Jersey

110. Between 2010 and 2015, an estimated 398,000 people in New Jersey gained coverage. This includes a large fraction of the people covered in the New Jersey Health Insurance Marketplace, an estimated 59,000

young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

111. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 3,847,727 people in New Jersey have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 3,274,000 people in New Jersey with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 4,210,183 people in New Jersey, including 1,701,115 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

112. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 243,743 people in New Jersey covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 79 percent of Marketplace enrollees in New Jersey received a premium

tax credit that averaged $4,205 per person. That financial assistance would no longer be available under an injunction.

113. **Impact on Medicaid:** Without the ACA, an estimated 194,000 fewer people in New Jersey would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 22,000 more getting all needed care, 27,600 fewer struggling to pay medical bills, 18,000 fewer experiencing symptoms of depression, and 230 avoided deaths each year in New Jersey. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

114. **Impact on Medicare:** The 1,528,961 people with Medicare in New Jersey would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 202,098 people in New Jersey with $1,344 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,131,754 people with Medicare in New Jersey used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in New Jersey. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 6,774 fewer unnecessary returns to the hospital in New Jersey in 2015. The 29 Accountable Care Organizations (ACOs) in New Jersey that offer Medicare beneficiaries the opportunity

to receive higher quality, more coordinated care would no longer operate under an injunction.

115. **Impact on Public Health:** Support for public health in New Jersey would also be reduced under an injunction. New Jersey received $54,491,391 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $14,039,534 for immunizations and $2,578,857 for tobacco cessation efforts.

116. **Impact on Finances:** The financial impact on New Jersey would be significant. From 2019 to 2028, it would lose $6.7 billion in federal Marketplace spending and $53 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $59.7 billion. This would have a major impact on health care providers. From 2019 to 2028, New Jersey hospitals could lose $30.2 billion and physicians could lose $10.4 billion. Uncompensated care costs in New Jersey would increase by $29.0 billion over this period.

New York

117. Between 2010 and 2015, an estimated 939,000 people in New York gained coverage. This includes a large fraction of the people covered in the New York Health Insurance Marketplace (called New York State of Health), an estimated 147,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

118. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were

an injunction ending the law. Up to 8,616,234 people in New York have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 6,432,000 people in New York with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 8,619,856 people in New York, including 3,582,133 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

119. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 207,083 people in New York covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 55 percent of Marketplace enrollees in New York received a premium tax credit that averaged $2,763 per person. That financial assistance would no longer be available under an injunction.

120. **Impact on Medicaid:** Without the ACA, an estimated 143,000 fewer people in New York would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 16,000 more getting all needed care, 20,300 fewer

struggling to pay medical bills, 13,000 fewer experiencing symptoms of depression, and 170 avoided deaths each year in New York. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in New York's Community First Choice program could lose access to services.

121. **Impact on Medicare:** The 3,424,666 people with Medicare in New York would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 348,566 people in New York with $1,320 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 2,440,280 people with Medicare in New York used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in New York. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 8,407 fewer unnecessary returns to the hospital in New York in 2015. The 38 Accountable Care Organizations (ACOs) in New York that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

122. **Impact on Public Health:** Support for public health in New York would also be reduced under an injunction. New York received $211,920,470 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $49,114,866 for

immunizations and $6,245,494 for tobacco cessation efforts.

123. **Impact on Finances:** The financial impact on New York would be significant. From 2019 to 2028, it would lose $9.9 billion in federal Marketplace spending and $47.3 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $57.2 billion. This would have a major impact on health care providers. From 2019 to 2028, New York hospitals could lose $23.2 billion and physicians could lose $9.0 billion. Uncompensated care costs in New York would increase by $47.4 billion over this period.

North Carolina

124. Between 2010 and 2015, an estimated 552,000 people in North Carolina gained coverage. This includes a large fraction of the people covered in the North Carolina Health Insurance Marketplace, an estimated 70,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

125. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 4,099,922 people in North Carolina have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 3,091,000 people in North Carolina with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the

ACA. An estimated 3,966,308 people in North Carolina, including 1,631,312 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

126. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 450,822 people in North Carolina covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 93 percent of Marketplace enrollees in North Carolina received a premium tax credit that averaged $7,100 per person. That financial assistance would no longer be available under an injunction.

127. **Impact on Medicaid:** If North Carolina expanded Medicaid under the ACA, an estimated 313,000 people would gain Medicaid coverage. This coverage would improve access to care, financial security, and health. For example, it would result in an estimated 36,000 more getting all needed care, 44,500 fewer struggling to pay medical bills, 29,000 fewer experiencing symptoms of depression, and 380 avoided deaths each year in North Carolina. Enjoining the law would put these potential benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

128. **Impact on Medicare:** The 1,823,454 people with Medicare in North Carolina would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 165,931 people in North Carolina with $1,117 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,377,219 people with Medicare in North Carolina used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in North Carolina. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,472 fewer unnecessary returns to the hospital in North Carolina in 2015. The 20 Accountable Care Organizations (ACOs) in North Carolina that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

129. **Impact on Public Health:** Support for public health in North Carolina would also be reduced under an injunction. North Carolina received $109,531,769 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $12,919,323 for immunizations and $3,778,227 for tobacco cessation efforts.

130. **Impact on Finances:** The financial impact on North Carolina would be significant. From 2019 to 2028, it would lose $38.2 billion in federal Marketplace spending and $20.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $59.0 billion. This would have a major impact on health care providers. From 2019 to 2028,

North Carolina hospitals could lose $22.7 billion and physicians could lose $8.7 billion. Uncompensated care costs in North Carolina would increase by $35.0 billion over this period.

Oregon

131. Between 2010 and 2015, an estimated 403,000 people in Oregon gained coverage. This includes a large fraction of the people covered in the Oregon Health Insurance Marketplace called Oregon-HealthCare.gov, an estimated 28,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

132. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 1,692,205 people in Oregon have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 1,356,000 people in Oregon with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 1,737,240 people in Oregon, including 721,318 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

133. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 137,305 people in Oregon covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 75 percent of Marketplace enrollees in Oregon received a premium tax credit that averaged $4,144 per person. That financial assistance would no longer be available under an injunction.

134. **Impact on Medicaid:** Without the ACA, an estimated 159,000 fewer people in Oregon would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 18,000 more getting all needed care, 22,600 fewer struggling to pay medical bills, 15,000 fewer experiencing symptoms of depression, and 190 avoided deaths each year in Oregon. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Oregon's Community First Choice program could lose access to services.

135. **Impact on Medicare:** The 784,032 people with Medicare in Oregon would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 50,777 people in Oregon with $1,035 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which

496,232 people with Medicare in Oregon used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Oregon. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 75 fewer unnecessary returns to the hospital in Oregon in 2015. The 4 Accountable Care Organizations (ACOs) in Oregon that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

136. **Impact on Public Health:** Support for public health in Oregon would also be reduced under an injunction. Oregon received $52,128,626 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $15,494,592 for immunizations and $1,864,629 for tobacco cessation efforts.

137. **Impact on Finances:** The financial impact on Oregon would be significant. From 2019 to 2028, it would lose $3.3 billion in federal Marketplace spending and $35.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $38.4 billion. This would have a major impact on health care providers. From 2019 to 2028, Oregon hospitals could lose $17.5 billion and physicians could lose $5.7 billion. Uncompensated care costs in Oregon would increase by $15.2 billion over this period.

Rhode Island

138. Between 2010 and 2015, an estimated 68,000 people in Rhode Island gained coverage. This includes

a large fraction of the people covered in the Rhode Island Health Insurance Marketplace (called HealthSource RI), an estimated 8,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

139. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 462,538 people in Rhode Island have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 374,000 people in Rhode Island with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 484,193 people in Rhode Island, including 201,595 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

140. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 29,065 people in Rhode Island covered in the Health Insurance Marketplace would lose

coverage without the ACA. In 2017, 78 percent of Marketplace enrollees in Rhode Island received a premium tax credit that averaged $2,974 per person. That financial assistance would no longer be available under an injunction.

141. **Impact on Medicaid:** Without the ACA, an estimated 22,000 fewer people in Rhode Island would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 3,000 more getting all needed care, 3,200 fewer struggling to pay medical bills, 2,000 fewer experiencing symptoms of depression, and 30 avoided deaths each year in Rhode Island. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

142. **Impact on Medicare:** The 208,324 people with Medicare in Rhode Island would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 14,990 people in Rhode Island with $1,004 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 148,724 people with Medicare in Rhode Island used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Rhode Island. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 487 fewer unnecessary returns to the hospital in Rhode Island in 2015. The 5 Accountable Care Organizations (ACOs) in

Rhode Island that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

143. **Impact on Public Health:** Support for public health in Rhode Island would also be reduced under an injunction. Rhode Island received $34,890,537 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $5,997,036 for immunizations and $326,347 for tobacco cessation efforts.

144. **Impact on Finances:** The financial impact on Rhode Island would be significant. From 2019 to 2028, it would lose $700 million in federal Marketplace spending and $6.7 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $7.4 billion. This would have a major impact on health care providers. From 2019 to 2028, Rhode Island hospitals could lose $3.8 billion and physicians could lose $1.4 billion. Uncompensated care costs in Rhode Island would increase by $2.8 billion over this period.

Vermont

145. Between 2010 and 2015, an estimated 26,000 people in Vermont gained coverage. This includes a large fraction of the people covered in the Vermont Health Insurance Marketplace (called Vermont Health Connect), an estimated 5,000 young adults who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

146. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would

also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 280,727 people in Vermont have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 215,000 people in Vermont with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 285,858 people in Vermont, including 122,892 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

147. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 29,088 people in Vermont covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 76 percent of Marketplace enrollees in Vermont received a premium tax credit that averaged $3,898 per person. That financial assistance would no longer be available under an injunction.

148. **Impact on Medicaid:** Without the ACA, an estimated 3,000 fewer people in Vermont would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. Enjoining the law would put these benefits at risk, along with improvements to long-term services and

supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

149. **Impact on Medicare:** The 136,021 people with Medicare in Vermont would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 10,466 people in Vermont with $1,206 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 94,170 people with Medicare in Vermont used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Vermont. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015. The 3 Accountable Care Organizations (ACOs) in Vermont that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

150. **Impact on Public Health:** Support for public health in Vermont would also be reduced under an injunction. Vermont received $16,564,102 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $2,706,809 for immunizations and $299,828 for tobacco cessation efforts.

151. **Impact on Finances:** The financial impact on Vermont would be significant. From 2019 to 2028, it would lose $1.0 billion in federal Marketplace spending and $1.9 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $2.9 billion. This would have a major impact on health care providers. From 2019 to 2028, Vermont

hospitals could lose $500 million and physicians could lose $300 million. Uncompensated care costs in Vermont would increase by $2.4 billion over this period.

Virginia

152. Between 2010 and 2015, an estimated 327,000 people in Virginia gained coverage. This includes a large fraction of the people covered in the Virginia Health Insurance Marketplace, an estimated 59,000 young adults who gained coverage by staying on their parents' health insurance, and those who gained coverage due to the employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

153. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 3,491,076 people in Virginia have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 2,974,000 people in Virginia with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,902,716 people in Virginia, including 1,587,663 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

154. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage

through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 364,614 people in Virginia covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 83 percent of Marketplace enrollees in Virginia received a premium tax credit that averaged $3,807 per person. That financial assistance would no longer be available under an injunction.

155. **Impact on Medicaid:** Virginia is debating expanding Medicaid under the ACA, which could lead to an estimated 179,000 people in Virginia gaining coverage. This would improve access to care, financial security, and health. For example, it could result in an estimated 20,000 more getting all needed care, 25,500 fewer struggling to pay medical bills, 16,000 fewer experiencing symptoms of depression, and 220 avoided deaths each year in Virginia. Enjoining the law would put these potential benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid.

156. **Impact on Medicare:** The 1,392,261 people with Medicare in Virginia would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 109,517 people in Virginia with $1,104 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 1,026,111 people with Medicare in Virginia used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer

costs in Virginia. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 2,302 fewer unnecessary returns to the hospital in Virginia in 2015. The 25 Accountable Care Organizations (ACOs) in Virginia that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

157. **Impact on Public Health:** Support for public health in Virginia would also be reduced under an injunction. Virginia received $79,675,902 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $15,357,774 for immunizations and $3,545,823 for tobacco cessation efforts.

158. **Impact on Finances:** The financial impact on Virginia would be significant. From 2019 to 2028, it would lose $15.4 billion in federal Marketplace spending and $2.6 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $18.0 billion. This would have a major impact on health care providers. From 2019 to 2028, Virginia hospitals could lose $7.8 billion and physicians could lose $3.7 billion. Uncompensated care costs in Virginia would increase by $28.7 billion over this period.

Washington

159. Between 2010 and 2015, an estimated 537,000 people in Washington gained coverage. This includes a large fraction of the people covered in the Washington Health Insurance Marketplace (called Washington Healthplanfinder), an estimated 50,000 young adults

who gained coverage by staying on their parents' health insurance, and those gaining coverage from the law's Medicaid expansion and employer shared responsibility policy. This coverage would be at risk if the ACA were enjoined.

160. **Impact on Consumer Protections:** Numerous consumer protections in private insurance would also be lost if the ACA were enjoined or if there were an injunction ending the law. Up to 2,969,739 people in Washington have a pre-existing condition and would be at risk for being charged unaffordable premiums or denied coverage altogether without the ACA. Before the ACA, 2,427,000 people in Washington with employer or individual market coverage had a lifetime limit on their insurance policy: annual and lifetime limits would return under an injunction to the ACA. An estimated 3,079,369 people in Washington, including 1,258,201 women ages 15–64, would lose federally guaranteed of preventive services — like flu shots, cancer screenings, and contraception – which are now provided at no extra cost to consumers. These are just a few of the ACA's consumer protections that could be lost if this court allows the ACA to be enjoined.

161. **Impact on Marketplace Coverage:** The ACA provides financial support for private coverage through premium tax credits and cost-sharing reductions. If the ACA were enjoined, individuals and families that have benefitted from these provisions would pay more for health coverage or go without it altogether. Many of the 184,070 people in Washington covered in the Health Insurance Marketplace would lose coverage without the ACA. In 2017, 63 percent of Marketplace enrollees in Washington received a premium

tax credit that averaged $3,040 per person. That financial assistance would no longer be available under an injunction.

162. **Impact on Medicaid:** Without the ACA, an estimated 55,000 fewer people in Washington would have Medicaid coverage. The law's Medicaid expansion improved access to care, financial security, and health. For example, it resulted in an estimated 6,000 more getting all needed care, 7,800 fewer struggling to pay medical bills, 5,000 fewer experiencing symptoms of depression, and 70 avoided deaths each year in Washington. Enjoining the law would put these benefits at risk, along with improvements to long-term services and supports, eligibility simplifications, and policies to lower drug costs and improve the quality of care in Medicaid. This could, for example, mean that people with disabilities in Washington's Community First Choice program could lose access to services.

163. **Impact on Medicare:** The 1,238,649 people with Medicare in Washington would also lose benefits and pay more under an injunction. Prescription drug discounts, which provided 71,499 people in Washington with $1,065 in average annual savings per beneficiary in 2016, would end. It would roll back the coverage of proven preventive services with no cost sharing which 805,142 people with Medicare in Washington used in 2016. It would suspend payment policies which would increase premiums, cost sharing, and well as taxpayer costs in Washington. It would also disrupt programs to reduce preventable patient harms and avoidable readmissions. Hospital readmissions for Medicare beneficiaries dropped between 2010 and 2015, which translates into 1,388 fewer unnecessary returns to the hospital in Washington in 2015. The 6 Accountable Care Organizations (ACOs) in

Washington that offer Medicare beneficiaries the opportunity to receive higher quality, more coordinated care would no longer operate under an injunction.

164. **Impact on Public Health:** Support for public health in Washington would also be reduced under an injunction. Washington received $84,038,862 from the law's Prevention and Public Health Fund between fiscal years 2012 and 2016. This includes $21,648,368 for immunizations and $4,207,707 for tobacco cessation efforts.

165. **Impact on Finances:** The financial impact on Washington would be significant. From 2019 to 2028, it would lose $4.7 billion in federal Marketplace spending and $38.1 billion in federal Medicaid spending. The combined loss of federal spending over this period would be $42.8 billion. This would have a major impact on health care providers. From 2019 to 2028, Washington hospitals could lose $23.3 billion and physicians could lose $7.7 billion. Uncompensated care costs in Washington would increase by $33.9 billion over this period.

Conclusion

166. Based on my knowledge and experience, I believe that invalidating the Affordable Care Act would cause significant harm to the nation, across all States, to the economy and to the health insurance market. It would immediately end federal support for Medicaid coverage for nearly 12 million individuals in 32 states and the District of Columbia; it would deprive residents of the remaining states of the option to expand Medicaid coverage, an option that is under active debate in Virginia, Maine, and others, of broadening coverage in the future; it would reduce access to coverage

for low and middle income Americans; it would increase drug costs. Further, the disruption caused by such an occurrence would cause immediate financial harm to medical providers and insurance companies, and significantly disrupt their ability to conduct business across all healthcare markets, including individual, Medicaid and Medicare, and small group markets.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on May 29, 2018, in Washington, D.C.

/s/ Henry J. Aaron
Henry J. Aaron*
Bruce and Virginia MacLaury Senior Fellow
The Brookings Institution

**The views expressed here are my own and do not necessarily represent those of the trustees, officers or other staff of the Brookings Institution. Affiliation listed for identification only.*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: June 7, 2018]

DECLARATION OF SABRINA CORLETTE

I, Sabrina Corlette, declare:

1. I am a Research Professor at the Center on Health Insurance Reforms (CHIR) at Georgetown University's Health Policy Institute. At CHIR, I direct research on health insurance reform issues. My areas of focus include state and federal regulation of private health insurance plans and markets and evolving insurance market rules. I have published numerous papers relating to the regulation of private health insurance and health insurance marketplaces. I also serve on the Standards Committee for the National Committee for Quality Assurance. Prior to joining the Georgetown faculty, I was Director of Health Policy Programs at the National Partnership for Women & Families, where I provided policy expertise and strategic direction for the organization's advocacy on health care reform, with a particular focus on insurance market reform, benefit design, and the quality

and affordability of health care. I also served as an attorney at Hogan Lovells, during which time I advised clients on health insurance, health finance, and food and drug regulatory matters.

2. Since 2010, I have authored over 25 research papers about the Affordable Care Act and its implementation. I have been invited to testify as an Affordable Care Act expert before seven congressional committees (U.S. House of Representatives and U.S. Senate) in the last five years. The California General Assembly invited me in January 2018 to testify about the status of the individual health insurance market. I regularly provide technical assistance to state departments of insurance, state policymakers, and other health care organizations regarding Affordable Care Act regulations and guidance and their impact on consumers and other health care stakeholders. I am frequently consulted by journalists seeking Affordable Care Act expertise, and have been quoted numerous times on health insurance and Affordable Care Act issues in national and local print, radio, web-based, and television media. A full list of my publications and media is available on our website at https://chir.georgetown.edu.

3. I understand that this lawsuit involves a challenge to the Affordable Care Act and seeks to enjoin it. In my expert opinion, enjoining the Affordable Care Act would cause significant disruption to the U.S. health care market, resulting in harm to patients, providers, insurance carriers, and federal and state governments.

4. The Affordable Care Act was enacted in part to correct serious deficiencies in the individual health insurance market that left millions uninsured and millions more with inadequate coverage that failed to

protect them from serious financial harm if and when they got sick. In order to assess the effect the Affordable Care Act has had on the individual insurance market today, it is important to understand the market that Congress was seeking to change when it enacted the Affordable Care Act in 2010.

5. Prior to implementation of the Affordable Care Act's market reforms, approximately 48 million Americans lacked health insurance.[1] Those without health insurance have a lower life expectancy than those with coverage. Before the Affordable Care Act was enacted, an estimated 22,000 people per year died prematurely because they lacked insurance.[2] This is likely because the uninsured are more than six times as likely as the privately insured to delay or forego needed care due to costs. For example, uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.[3]

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[1] DeNavas-Walt C, Proctor BD, Smith J. *Income, Poverty, and Health Insurance Coverage in the United States*: 2012, U.S. Census Bureau, Sept. 2013. Available at https://www.census.gov/prod/2013pubs/p60-245.pdf.

[2] Dorn S. *Uninsured and Dying Because of It,* The Urban Institute, Jan. 2008. Available at https://www.urban.org/sites/default/files/publication/31386/411588-Uninsured-and-Dying-Because-of-It.PDF.

[3] *Lives on the Line: The Deadly Consequences of Delaying Health Reform*, Families USA, Feb. 2010. Available at http://familiesusa.org/sites/default/files/product_documents/delaying-reform.pdf.

6. Being uninsured also results in financial insecurity. In 2010, when the Affordable Care Act was enacted, sixty percent of the uninsured reported having problems with medical bills or medical debt.[4]

7. Additionally, prior to the Affordable Care Act, the high and rising uninsured rate led to high and rising uncompensated care costs for providers, in 2009 estimated at $1000 worth of services per uninsured person.[5] Providers ultimately passed those costs onto insured consumers and taxpayers.

8. Before the Affordable Care Act, approximately 19 million Americans purchased coverage in the individual insurance market because they lacked access to employer-based insurance or were not eligible for public programs such as Medicare or Medicaid.[6] The individual insurance market was an inhospitable place, particularly for anyone in less than perfect health. An estimated 133 million Americans have at least one pre-existing condition that could threaten their access to health care and health insurance.[7]

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[4] Cunningham, P. and Sommers, A. *Medical Bill Problems Steady for U.S. Families 2007-2010*, Center for Studying Health System Change, Dec. 2011. Available at http://www.hschange.org/CONTENT/1268/?words=tracking%20report%2028.

[5] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing*, National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[6] DeNavas-Walt C, et al. *Income, Poverty, and Health Insurance Coverage in the United States*: 2012.

[7] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, Issue Brief, Jan. 2017. Available at https://aspe.hhs.gov/system/files/pdf/255396/

9. Prior to the Affordable Care Act, in most states, applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers could also issue policies that didn't cover critical medical services like pharmacy benefits, mental health or substance use treatment, maternity, or any of the care required to treat a person's pre-existing condition. In addition, insurers often rescinded an individual's coverage if they got sick after enrolling in the plan, and many plans imposed annual or lifetime dollar limits on covered benefits.[8]

10. Prior to the Affordable Care Act, coverage was often simply not available to many individuals applying for coverage. One of the many ways insurers maximized revenue was through aggressive underwriting practices resulting in a denial of coverage to individuals posing a potential health risk.[9] In most states, when an individual wanted to buy health insurance, they had to fill out and submit a voluminous application that included detailed information about their health history and status. Insurers would then review the individual's application and assess the likelihood he or she would incur future health costs. A

Pre-ExistingConditions.pdf.

[8] Corlette S, Volk J, Lucia K. *Real Stories, Real Reforms*. Robert Wood Johnson Foundation, Sept. 2013. Available at https://georgetown.app.box.com/file/124506387872.

[9] U.S. Government Printing Office, Senate Hearing 113-663. *A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules,* U.S. Senate Health, Education, Labor & Pension Committee, Apr. 11, 2013. Available at https://www.gpo.gov/fdsys/pkg/CHRG-113shrg95186/html/CHRG-113shrg95186.htm.

Georgetown University study found that even people with minor health care conditions, such as hay fever, could be turned down for coverage.[10] Health insurers maintained underwriting guidelines that listed as many as 400 separate medical conditions that could trigger a denial of coverage.[11]

11. A U.S. Government Accountability (GAO) study in 2011 found that average insurer denial rates were 19 percent, but they varied dramatically market-to-market and insurer-to- insurer. For example, across six insurers in one state, denial rates ranged from 6 percent to 40 percent.[12] In practice, access to coverage for people with pre-existing conditions was probably less available than this study suggests, because of a common industry practice known as "street underwriting," in which an insurance agent or broker would ask a potential applicant questions about their health status, and discourage them from applying if they posed a health risk. These underwriting practices were banned by the Affordable Care Act in 2014.

12. Prior to the Affordable Care Act, it was not uncommon for insurers to rescind coverage after they had accepted an applicant. If an enrollee had any health

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[10] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?* Georgetown University and Kaiser Family Foundation, Jun. 2001. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumers-in-less-than-perfect-health-executive- summary-june-2001.pdf.

[11] U.S. Government Printing Office, Senate Hearing 113-663.

[12] U.S. Government Accountability Office. *Private Health Insurance: Data on Application and Coverage Denials*, Mar. 2011. Available at https://www.gao.gov/assets/320/316699.pdf.

care claims within their first year of coverage, the insurer would investigate that person's health history. If they found evidence that their condition was a pre-existing one and not fully disclosed during the initial underwriting process, the company would deny the relevant claims and rescind or cancel the coverage.[13] The Affordable Care Act prohibited this practice except in clear cases of fraud by the policyholder.

13. Prior to the Affordable Care Act, individual insurance was often unaffordable. Unlike those with employer sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay the full cost of their premium. According to one national survey prior to the Affordable Care Act, 31 percent of individual market respondents spent 10 percent or more of their income on premium costs.[14]

14. Prior to the Affordable Care Act the cost of premiums caused many individuals to forego coverage completely. A national survey found that nearly three-quarters (73 percent) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high. The coverage was least affordable for those individuals who needed it the most – people with pre-existing conditions. The

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[13] Girion L. *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, Los Angeles Times, Nov. 9, 2007. Available at http://articles.latimes.com/2007/nov/09/business/fi-insure9.

[14] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act,* The Commonwealth Fund, Apr. 2013. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

same national survey found that 70 percent of people with health problems reported it "very difficult" or "impossible" to find an affordable plan, compared to 45 percent of people in better health.[15]

15. Prior to the Affordable Care Act, older and less healthy individuals had to pay more for coverage because health insurers would segment their enrollees into different groups and charge them different prices based on their health or other risk factors. In practice, this meant that people would be charged more because of a pre-existing condition (even if they had been symptom-free for years), because of their age, gender (insurers assume women use more health care services than men), family size, geographic location, the work they do, and even their lifestyle.[16] A Georgetown University study of insurers' rating practices before the Affordable Care Act found rate variation of more than nine-fold for the same policy based on age and health status. In many states, people in their early sixties would be charged as much as six times the premium of someone in their early twenties, based on age alone. Even young people, when rated based on health

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[15] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, Jul. 2009. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/-Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

[16] Buntin MB, Marquis MS, Yegian JM. *The Role Of The Individual Health Insurance Market And Prospects For Change, Health Affairs,* Nov./Dec. 2004. Available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.6.79.

status, could be subjected to significant premium costs.[17]

16. Under the Affordable Care Act, using health status and gender to set premium rates is prohibited. In addition, the Affordable Care Act provides low- and moderate-income people between 100 and 400 percent of the federal poverty line with subsidies to help defray their premium costs. In 2018, the average monthly premium tax credit is $550, resulting in an average monthly premium for consumers receiving a premium tax credit of $89.[18]

17. Prior to the Affordable Care Act, coverage in the individual market was often inadequate to meet people's health care needs. In addition to paying more in premiums, people in the individual market also spent a larger share of their income on cost-sharing than those with employer-sponsored coverage. Prior to the Affordable Care Act, people in the individual market were more than twice as likely to be considered "underinsured" than those in an employer plan.[19] Someone is considered "underinsured" when they have insurance but because of high deductibles, high

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[17] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?*

[18] Kaiser Family Foundation. *Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC)*, Open Enrollment 2018. Available at https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort% 22:%22asc%22%7D.

[19] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act*.

cost-sharing, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.

18. Prior to the Affordable Care Act, a primary reason people buying individual insurance coverage had high out-of-pocket costs was that many individual plans – over half according to one study – did not meet minimum standards for coverage.[20] Coverage in the individual market was inadequate for a number of reasons, including:

19. Pre-existing condition exclusions: in many states, insurers were permitted to permanently or for a period of time exclude from covered benefits treatments for any health problem that a consumer disclosed on their application. This practice was banned under the Affordable Care Act.

20. Benefit exclusions: Insurers in the individual market often sold policies that did not cover basic benefits such as maternity care, prescription drugs, mental health, and substance use treatment services. For example, 20 percent of adults with individual insurance lacked coverage for prescription medicines before the Affordable Care Act.[21] The Affordable Care Act requires individual market insurers to cover a minimum set of essential health benefits that includes maternity

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[20] Gabel JR et al. *More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014*, Health Affairs, Jun. 2012. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1082.

[21] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*

services, prescription drugs, and mental health and substance use treatment.

21. High out-of-pocket costs: Prior to the Affordable Care Act, individual insurance policies often came with high deductibles – $10,000 or more was not uncommon – and high cost-sharing. In fact, deductibles were often three times what they were in employer-sponsored plans.[22] As a result, many individual insurance plans were extremely low-value. One study found that individual policies paid for just 55 percent of the expenses for covered services, compared to 83 percent for small employer group plans.[23] The Affordable Care Act requires insurers to meet a minimum adequacy of coverage standard of 60 percent (meaning that on average, the plan must cover 60 percent of an average enrollee's covered health care costs). The law also helps protect consumers from catastrophic medical costs by capping their annual out-of-pocket spending (for 2018, the annual cap is $7350 per individual).

22. Lifetime or annual dollar limits on coverage: Prior to enactment of the Affordable Care Act, an estimated 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. An estimated 18 million people were in plans with annual dollar limits on their benefits. For people with serious high cost medical conditions,

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[22] McDevitt R et al. *Group Insurance: A Better Deal For Most People Than Individual Plans,* Health Affairs, Jan. 2010. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0060.

[23] Gabel J et al. *Trends In The Golden State: Small-Group Premiums Rise Sharply While Actuarial Values For Individual Coverage Plummet,* Health Affairs, Jul./Aug. 2007. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.26.4.w488.

such as hemophilia, serious cancers, or end-stage renal disease, this can literally be a life or death issue. The Affordable Care Act ushered in bans on lifetime and annual dollar limits.

23. Among Congress' goals for the Affordable Care Act were to extend affordable, adequate health insurance coverage to more people and to correct many of the dysfunctions of the individual market, described above. Congress tried to achieve these goals through a three-pronged strategy:

24. (1) Insurance reforms to help people locked out of the system due to pre-existing conditions;

25. (2) An individual mandate to encourage healthy people to enroll in the insurance pool and keep premiums stable; and

26. (3) Subsidies to help people afford the insurance coverage (with Medicaid expansion available for people under 138 percent of the federal poverty line). The Affordable Care Act also created state-based insurance marketplaces where people can apply for the subsidies and shop for plans.

27. To a significant degree, the Affordable Care Act has achieved its goals. It has expanded access to insurance coverage, improved health outcomes, and improved families' financial security.

28. Under the Affordable Care Act, the percentage of people uninsured declined from 14.5 percent in 2013 to 9.1 percent in 2017. An estimated 20 million people gained insurance coverage because of the Affordable Care Act.[24]

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[24] Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Cov-*

29. The goal of expanding coverage is ultimately to improve people's health outcomes and their financial security in the event of an unexpected illness or injury. The Affordable Care Act's reforms were fully implemented in 2014, so it is still relatively early to try to assess the law's impact on access to care, health outcomes, and financial security. However, data are emerging to suggest the law is having a significant positive impact.

30. Since enactment of the Affordable Care Act, the percentage of Americans reporting that they didn't see a doctor or fill a prescription because they couldn't afford it has declined by more than one-third.[25] Further, more people are reporting that they have a primary care doctor or have had a check-up in the last 12 months.[26]

31. Research to date also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the health reforms

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erage: Early Release of Estimates From the National Health Interview Survey, 2017, Centers for Disease Control and Prevention, National Center for Health Statistics, May 2018. Available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

[25] McCarthy, J. *U.S. Women More Likely Than Men to Put Off Medical Treatment*, Gallup, Dec. 2017. Available at http://news.gallup.com/poll/223277/women-likely-men- put-off-medical-treatment.aspx.

[26] Karpman, M. et al. *Time for a Checkup: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Plan Satisfaction among Parents and Children between 2013 and 2015,* Urban Institute, Jan. 2016. Available at http://hrms.urban.org/briefs/changes_coverage_access_affordability_parents_children.pdf.

in Massachusetts, upon which the Affordable Care Act was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality.[27] A Harvard study found that expanded coverage under the Affordable Care Act was linked to major improvements in the diagnosis and treatment of chronic diseases such as hypertension, diabetes, and high cholesterol.[28]

32. In addition to improving access to care, health insurance also provides financial security, particularly in the event of a large, unanticipated medical expense. Unfortunately, in this country, health care is extremely expensive. For example, the average cost of a single MRI is $1,119. An uncomplicated hospital labor and delivery costs an average of $10,808, while a C-section will average over $16,000. One course of treatment for colon cancer will cost between $21,000 and $52,000. Yet over half of American families report that they would not be able to afford to pay just $500 in cash for an unexpected expense.[29]

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[27] Van Der Wees, PJ, et al. *Improvements In Health Status After Massachusetts Health Care Reform*, National Center for Biotechnology Information, Dec. 2013. Available at https://www.ncbi.nlm.nih.gov/pubmed/24320165

[28] Hogan DR et al. *Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions*, Health Affairs, Sept. 2015. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1435.

[29] Picchi A, *A $500 Surprise Expense Would Put Most Americans into Debt*, CBS MoneyWatch, Jan. 2017. Available at https://www.cbsnews.com/news/most-americans-cant-afford-a-500-emergency-expense/.

33. Research suggests that the Affordable Care Act is helping to improve the financial security of the newly insured. Survey data show that the number of families who say they are having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families.[30] Other studies have shown that the Affordable Care Act's Medicaid expansion has led to reductions in the amount of debt sent to collection agencies and improvements in families' credit scores.[31]

34. The Affordable Care Act has also helped reduce uncompensated care costs borne by providers. For example, hospital-based uncompensated care fell by over 25 percent between 2013 and 2015, and in Medicaid expansion states it has fallen by closer to 50 percent.[32]

35. Unfortunately, much of the progress under the Affordable Care Act is at risk due to recent federal policy decisions designed to roll back key provisions of the law and bypass consumer protections. Ultimately, some of these decisions are likely to result in many consumers facing higher premiums and fewer plan choices in the individual insurance market.

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[30] Karpman, M and Long, S. 9.4 *Million Fewer Families Are Having Problems Paying Medical Bills,* Urban Institute, May 2015. Available at http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying- Medical-Bills.pdf.

[31] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing*, National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[32] Schubel, J and Broaddus, M. *Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains,* May 2018. Available at https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every- state-as-acas-major-coverage.

36. A stable health insurance market depends on a large risk pool that is reasonably balanced between healthy individuals and sicker ones. The Affordable Care Act had a "three-prong" strategy designed to facilitate such a stable insurance market by requiring all participating insurers to play by the same rules and, through subsidies and the individual mandate, encourage healthy people to become insured before they get sick.

37. The Affordable Care Act marketplaces had a rocky early start, but that was not unexpected given that insurers had little knowledge of the new population of people they were covering, leading many to make significant adjustments to their business strategy as they gained more experience and data about their enrollees. In addition, unanticipated Congressional actions, such as the dramatic reduction in funding for a key premium stabilization program (the "risk corridor" program) resulted in significant financial losses for many insurers.

38. Specifically, the Affordable Care Act included three programs intended to ensure that premiums remain stable, both during the initial years of the law's implementation and over the long term. These are the risk corridors, reinsurance, and risk adjustment programs – often called the "3Rs." The risk corridor program in particular was a temporary program designed to provide a buffer for insurers that did not adequately price their plans due to a lack of data about the health risk of the newly insured population in the Affordable Care Act marketplaces.

39. The risk corridor program works by requiring the federal government (through the U.S. Department of Health & Human Services or HHS) to partially re-

imburse insurers whose premium revenue was insufficient to pay claims. Insurers whose premium revenue exceeded their claims were required to pay HHS a fraction of the excess premium.[33]

40. In the first two years of the Affordable Care Act marketplaces, many insurers set relatively low premiums in order to capture more market share. In late 2014, long after insurers' pricing decisions were made, a Congressional appropriations bill dramatically limited the funds available to HHS to compensate insurers for significant losses.[34]

41. Because more insurers experienced losses than gains in the first two years of the marketplaces, HHS was able to pay insurers only 12.6 percent of the risk corridor payments they were owed.[35] This decision had a serious financial impact on insurers, resulting in an estimated $12.3 billion in losses,[36] and likely accelerated the demise of several small, non-profit CO-OP health plans.[37]

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[33] 42 U.S.C. §18062.

[34] Pub. L. No. 113-235.

[35] Department of Health and Human Services, Risk Corridors Payment Proration Rate for 2014, Oct. 1, 2015, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[36] Small L. *Government's unpaid risk corridor tab swells to $12.3B,* FierceHealthcare, Nov. 2017. Available at https://www.fiercehealthcare.com/aca/government-s-unpaid-risk-corridor-tab-swells-to- 12-3b.

[37] Corlette S, Miskell S, Lerche J, Lucia K. *Why are Many CO-OPs Failing? How New Non-profit Health Plans Have Responded to Market Competition*, The Commonwealth Fund, Dec. 2015.

42. The loss of risk corridor funds contributed to the significant premium increases many insurers implemented for plan year 2016. However, it is noteworthy that premiums in the individual market were still often below or close to those in the employer-sponsored insurance market in 2016.[38] Given that Affordable Care Act individual market benefit plans are designed to be similar to a typical employer plan, this suggests that during the first two years of the Affordable Care Act marketplaces (2014 and 2015), many insurers had underpriced their products in an effort to gain market share. Many of these same insurers subsequently left the Affordable Care Act market because they were unable to compete with insurers that had been more successful in projecting a premium rate that would allow them to cover their costs.[39]

43. Going into plan year 2017, financial data from insurers demonstrate that the markets were begin-

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Available at http://www.commonwealthfund.org/~/media/files/publications/fundreport/2015/dec/1847_corlette_why_are_many_coops_failing.pdf.

[38] Holahan J, Blumberg LJ, Clemans-Cope L, McMorrow S, and Wengle E. *The Evidence on Recent Health Care Spending Growth and the Impact of the Affordable Care Act*, The Urban Institute and Robert Wood Johnson Foundation, May 2017. Available at https://www.urban.org/sites/default/files/publication/90471/2001288-the_evidence_on_recent_health_care_spending_growth_and_the_impact_of_the_afforda ble_care_act.pdf.

[39] *See e.g.*, Sprung A, *Why Insurers Thrive (Or Dive) in ACA Marketplaces*, healthinsurance.org, Apr. 2016. Available at https://www.healthinsurance.org/blog/2016/04/28/why-insurers-thrive-or-dive-in-aca- marketplaces/.

ning to stabilize and insurers were gaining their footing.[40] Indeed, in 2017 the Congressional Budget Office concluded that the Affordable Care Act's insurance markets would likely be stable in most places if left unchanged.[41] Consistent with this projection, 2017 appears to have been a profitable year for most individual market insurers.[42]

44. Unfortunately, my own review of insurers premium rate justifications (referred to as actuarial memoranda) for plan years 2018 and 2019 found that recent policy changes are putting the stability of the individual market at risk.[43] Specifically:

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[40] Banerjee D. *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer,* S&P Global Ratings, Dec. 2016. *See also* Herman B. *How some Blues made the ACA work while others failed*. Modern Healthcare. October 15, 2016. Available at www.modernhealthcare.com/article/20161015/MAGAZINE/310159989.

[41] *H.R. 1628 American Health Care Act of 2017*, Congressional Budget Office, May 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[42] Cox C, Semanskee A, Levitt L. Individual Insurance Market Performance in 2017, Kaiser Family Foundation, May 2018. Available at http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in- 2017.

[43] *See* Corlette S. *The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act*, CHIRblog, May 2018.

Available at http://chirblog.org/what-early-rate-filings-tell-us-about-future-of-aca/; Corlette S. *We Read Actuarial Memoranda so You Don't Have to: Trends from Early Health Plan Rate Filings*, CHIRblog, Jun. 2017. Available at http://chirblog.org/we-read- actuarial-memoranda-so-you-dont-have-to/; Corlette S. Proposed Premium Rates for 2018: What do Early Insurance

45. The Trump administration's decision in October of 2017 to cut off reimbursement to insurers for low cost-sharing plans (called cost-sharing reduction or CSR plans) resulted in significant premium increases in 2018. Additionally, the uncertainty about that decision, which the President had been threatening for months, was a contributing factor for some insurers to either exit the marketplaces or reduce their service areas.

46. For example, in its 2018 rate filing in Virginia, Anthem informed the state: "A lack of CSR funding introduces a level of volatility which compromises the ability to set rates responsibly. It has been estimated that lack of CSR funding could increase premium rates for Silver plans an additional 20 percent…" Anthem went on to say that if CSR reimbursements were not guaranteed for 2018, it would consider exiting the marketplaces, reducing service areas, or requesting additional rate increases.

47. Additionally, although Congress did not zero out the individual mandate penalty until 2019, many insurers increased premiums for 2018 coverage on the expectation that the Trump administration would not enforce the individual mandate. For example, in its Maryland filing for 2018, CareFirst Blue Cross BlueShield stated: "we have assumed that the coverage mandate introduced by the ACA will not be enforced in 2018 and that this will have the same impact as repeal. Based on industry and government esti-

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Company Filings Tell Us? CHIRblog, May 2017. Available at http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings- tell-us/.

mates as well as actuarial judgment, we have projected that this will cause morbidity to increase by an additional 20%."

48. Other insurers are projecting the effect of the individual mandate repeal to be felt in 2019. For example, Kaiser Foundation Health Plan projects that premiums will need to increase 32.1 percent in Virginia. "The primary cause," the company reports, is "related to nonenforcement of the Individual Mandate."

49. Similarly, insurers increased premiums due to the Trump administration's decision to decrease spending on marketplace advertising and consumer assistance, which are critical for educating and enrolling the healthy uninsured. For example, a Cigna filing for 2018 noted that they expected a smaller and sicker population in their risk pool due to the lower "overall awareness of individual health insurance products."

50. Going into 2019, insurers are also predicting that their risk pools will be smaller and sicker due to "potential movement into other markets." These markets include association health plans and short-term, limited duration insurance, both of which are exempt from many of the Affordable Care Act's consumer protections and are being promoted by the Trump administration as cheaper alternative coverage. For example, insurers such as Optima and CareFirst in Virginia note that the "availability of association health plans and expanded availability of short-term medical plans" was affecting their rate projections, with CareFirst adding 10 percent to its premium increase as a result.

51. Individuals who are eligible for the Affordable Care Act's premium tax credits are largely insulated from these premium increases because the tax credit rises, dollar for dollar, with the increase in premium for silver level health plans. The people who suffer the most from these premium increases are the working middle class: entrepreneurs who run their own businesses, freelancers and consultants, independent contractors, farmers and ranchers, and early retirees who earn too much to qualify for the Affordable Care Act's premium subsidies.

52. Granting the plaintiffs' request to enjoin the Affordable Care Act amounts to an effort to repeal the law without any clear public policy to replace it. Congress explicitly rejected repealing the Affordable Care Act without a replacement last year. This is because uprooting a complex law that has been in place for over eight years, touches almost every facet of our health care system, and includes many provisions with widespread bipartisan support (such as allowing young adults to stay on their parents' plans until age 26, closing the Medicare drug benefit "donut hole," and expanding Medicaid) will inevitably result in dramatic negative consequences, some of which are predictable, and outlined below.

53. First, millions of individuals will lose their insurance coverage. In 2017, the Congressional Budget Office and Joint Committee on Taxation estimated that repealing the Affordable Care Act without implementing a replacement would result in 32 million people losing coverage by 2026, with 17 million people losing coverage in the first year after repeal.[44]

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[44] Congressional Budget Office. *Cost Estimate: H.R. 1628,*

54. Second, those remaining in the individual market would see their premiums roughly double. The Congressional Budget Office estimated that individual market premiums would increase by 25 percent in the first year after repeal, by 50 percent by 2020, and almost double by 2026.[45] These premium increases are largely the result in the elimination of the individual mandate and the Affordable Care Act premium subsidies, resulting in fewer healthy individuals enrolling in individual market coverage and a costlier risk pool for insurers.

55. Third, even a partial repeal of the provisions of the Affordable Care Act would primarily harm working middle class Americans. The majority of people losing coverage – as many as 82 percent – would be in working families. Over half would be non-Hispanic whites, and up to 80 percent would not have college degrees. Thirty-eight percent would be young adults between ages 18 and 34.[46]

56. Fourth, repealing the Affordable Care Act will have significant negative consequences for public health and safety. For example, the Pennsylvania Budget and Policy Center found that repealing the Medicaid expansion and Affordable Care Act tax

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Obamacare Repeal Reconciliation Act of 2017, Jul. 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939- hr1628amendment.pdf.

[45] *Id*.

[46] Blumberg L, Buettgens M, Holahan J. *Implications of Partial Repeal of the ACA Through Reconciliation*, Urban Institute, Dec. 2016. Available at https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

credit subsidies would result in 3,425 premature deaths each year in that state alone.[47] Researchers from Harvard and New York University found that repealing the Affordable Care Act would result in 1.25 million Americans with serious mental conditions losing coverage. They further estimate that 2.8 million Americans with a substance use disorder, including roughly 222,000 with an opioid-related disorder, would lose coverage.[48]

57. Fifth, repealing the Affordable Care Act will drive insurance companies out of the individual market. The Congressional Budget Office estimated that legislation repealing the Affordable Care Act would leave an estimated three-fourths the nation's population in areas where no insurers are willing to offer nongroup coverage by 2026.[49] These estimates align with my own research at Georgetown, in which colleagues and I conducted interviews with 13 health insurance company executives participating in the individual markets in 28 states. In those interviews, executives told us they would "seriously consider" a market withdrawal; they further told us that a bill repealing the Affordable Care Act without an immediate

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[47] Stier M. *Devastation, Death, and Deficits: The Impact of ACA Repeal on Pennsylvania*, Pennsylvania Budget and Policy Center, Jan. 2017. Available at https://pennbpc.org/sites/pennbpc.org/files/Impact_of_ACA_Repeal_Final.pdf

[48] Frank RG, Glied SA. *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses,* The Hill, Jan. 2017. Available at http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep- progress-on-treating-opioid-disorders.

[49] Congressional Budget Office. Cost Estimate: H.R. 1628, *Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017.

replacement would destabilize the market and create "significant" downside financial risk for those companies remaining.[50]

58. Sixth, an increase in the uninsured will impose significant financial harm on hospitals and other health care providers. For example, repealing the Affordable Care Act without a replacement was estimated to cost the nation's public hospitals $54.2 billion in uncompensated care charges between 2018 and 2026.[51] The Iowa Fiscal Partnership estimated that Affordable Care Act repeal would result in a $10 billion increase in the cost of uncompensated care in that state alone, with most of the burden borne by rural hospitals.[52]

59. Seventh, repeal of the Affordable Care Act would lead to significant negative economic consequences. For example, repealing just the Medicaid expansion and Affordable Care Act tax credits would result in an estimated loss of 2.6 million jobs across the country.[53] State-specific analyses align with these

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[50] Corlette S, Lucia K, Giovannelli J, Palanker D. Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices, Georgetown University and Robert Wood Johnson Foundation, Jan. 2017. Available at https://georgetown.app.box.com/file/127781433019.

[51] America's Essential Hospitals. *ACA Replacement Must Protect Vulnerable People, Communities*, Feb. 2017. Available at https://essentialhospitals.org/wp-content/uploads/2017/02/UCC-policy-brief-February-2017-FINAL.pdf.

[52] Fisher P. *Repealing ACA: Pushing thousands of Iowans to the brink, Iowa Fiscal Partnership*, Jan. 2017. Available at http://www.iowafiscal.org/wp/wp-content/uploads/2017/01/170119-IFP-ACA.pdf.

[53] Ku L, Steinmetz E, Brantley E, Bruen B. *Repealing Federal*

findings. For example, the University of California at Berkley's Center for Labor Research and Education found that just a partial repeal of the Affordable Care Act would cause California to suffer 209,000 lost jobs, $20.3 billion in lost gross domestic product, and $1.5 billion lost in state and local tax revenue.[54] Arizona State University's Seidman Research Institute similarly found that if Arizona lost federal Affordable Care Act funding, it would leave a $5 billion dent in the state's economy, cost over 62,000 jobs state wide, and lower personal income by almost $3.5 billion.[55]

60. Eighth, and finally, a full repeal of the Affordable Care Act would not only harm the individual insurance market. Other programs would be harmed as well. For example, repealing the law is estimated to accelerate the insolvency of the Medicare Hospital Insurance Trust Fund (Part A) by five years, from 2026 to 2021.[56]

Health Reform: Economic and Employment Consequences for States, The Commonwealth Fund, Jan. 2017. Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jan/ku-aca-repeal-job-loss/1924_ku_repealing_federal_hlt_reform_ib.pdf.

[54] Lucia L and Jacobs K. *California's Projected Economic Losses under ACA Repeal*, UC Berkeley Center for Labor Research and Education, Dec. 2016.

[55] Seidman Research Institute, W.P. Carey School of Business. *Economic Impact on Arizona Of Repeal of Funding Provisions Of the Affordable Care Act*, Arizona State University, Jan. 2017. Available at http://azchildren.org/wp-content/uploads/2017/05/ACA-Impact-Feb-6-.pdf.

[56] Committee for a Responsible Federal Budget. *Full Repeal of Obamacare Would Hasten Medicare's Insolvency,* Apr. 2017. Available at http://www.crfb.org/blogs/full-repeal-obamacare-would-hasten-medicares-insolvency.

61. The plaintiff's suggestion that the Affordable Care Act be enjoined ignores the serious negative consequences of an action that would be tantamount to repealing the law without any clear federal policy to replace it. When such a strategy was proposed last year to Congress, it was rejected because of the serious economic and public health barbs that would result, including: millions of Americans losing coverage, premiums doubling, insurers exiting the market, and the costs of uncompensated care putting providers at serious financial risk. Repeal-without-replace would also result in heavy job and productivity losses. These are serious adverse repercussions that should not be taken lightly.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on June 5, 2018 in Washington, D.C.

/s/ Sabrina Corlette
Sabrina Corlette
Research Professor
Center on Health Insurance Reforms

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: June 7, 2018]

CONGRESSIONAL BUDGET OFFICE, REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE (NOV. 2017)

Congressional Budget Office

NOVEMBER 2017

Repealing the Individual Health Insurance Mandate: An Updated Estimate

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply. In response to interest from Members of Congress, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimate of the effects of repealing that mandate. As part of repealing the mandate, the policy analyzed would eliminate the penalty that people who have no health insurance and who are not exempt from the mandate must pay under current law.

The analysis underlying this estimate incorporates revised projections—of enrollment in health insurance, premiums, and other factors—made as part of the usual process CBO follows to update its baseline projections. This report updates a budget option published in December 2016 and is not based on specific legislative language.[1]

The Results of CBO and JCT's Analysis

CBO and JCT estimate that repealing that mandate starting in 2019—and making no other changes to current law—would have the following effects:

- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027 (see Table 1).
- The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027 (see Table 2).
- Nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.
- Average premiums in the nongroup market would increase by about 10 percent in most years of the decade (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections.

Those effects would occur mainly because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance.

If the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be very similar to those presented in this report. In CBO and JCT's estimation, with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law. If eliminating the mandate was accompanied by changes to tax rates or premium tax credits or by other significant changes, then the policy analyzed here would interact with those changes and have different effects.

For this analysis, CBO and JCT have measured the budgetary effects relative to CBO's summer 2017 baseline, which underlies the Concurrent Resolution on the Budget for Fiscal Year 2018.[2] In that baseline, the ACA's other provisions, including premium tax credits and

1. See Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), www.cbo.gov/publication/52142.

2. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801. For additional information about the baseline presented in that report, see *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018–2027
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	-4	-9	-19	-23	-24	-25	-26	-27	-28	-185
Medicaid	0	-5	-9	-16	-20	-22	-24	-26	-28	-29	-179
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	0	*	*	*	*	*	*	*	1
Change in Penalty Payments by Uninsured People	0	*	5	5	5	5	5	6	6	6	43
Medicare[d]	0	1	2	4	5	5	5	6	7	7	44
Other Effects on Revenues and Outlays[e]	0	*	-2	-6	-8	-8	-9	-9	-10	-10	-62
Total Effect on the Deficit	**0**	**-8**	**-13**	**-33**	**-40**	**-44**	**-47**	**-49**	**-51**	**-54**	**-338**
Memorandum:											
Total Change in Direct Spending	0	-7	-14	-30	-36	-40	-42	-44	-46	-49	-307
Total Change in Revenues[f]	0	1	-2	3	4	4	5	5	6	6	31

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline.

Changes in budget authority would equal the changes in outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. "Related spending and revenues" includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 2.

Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid[a]	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including marketplaces	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	4	7	12	12	12	12	13	13	13

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's summer 2017 baseline. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under age 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

cost-sharing reduction (CSR) subsidies in the marketplaces that the legislation established, are assumed to remain in place.[3]

In the budget option presented last year, CBO and JCT examined the same policy starting a year earlier and relative to CBO's March 2016 baseline: They estimated that the policy would reduce federal budget deficits by $416 billion between 2018 and 2026 and increase the number of uninsured people by 16 million in 2026.

The differences between the budgetary effects shown here and those estimated in December 2016 stem from several sources. The current estimate relies on updated baseline projections related to the federal costs of subsidizing health insurance. This estimate also incorporates CBO and JCT's expectation that individuals' and employers' full reaction to the elimination of the individual mandate would phase in more slowly than the agencies previously projected. (The agencies have incorporated that expectation in all estimates for legislative proposals related to the mandate that they have prepared after the 2017 budget reconciliation process ended in September.) And this estimate includes an interaction with Medicare, whose "disproportionate share hospital" payments to facilities that serve a higher percentage of uninsured patients would be affected.[4]

In addition to updates to the baseline, which occur on a regular cycle, CBO and JCT sometimes make major

3. After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies construction of the baseline, requires that CBO assume full funding of entitlement authority. CBO has long viewed the cost-sharing subsidies as a form of entitlement authority—that is, legal authority for federal agencies to incur obligations and to make payments out of the Treasury for specified purposes. On that basis, in the agencies' initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). For a related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

4. That interaction, which would add costs totaling $44 billion over the 2018–2027 period, was not included in the December 2016 estimate because, as is often the case with budget options, it followed a simplified method. However, during 2017, the interaction with Medicare has been included in estimates of the effects of major changes to policies affecting health insurance.

methodological changes to improve their estimates. Accordingly, the agencies have undertaken considerable work to revise their methods to estimate the effects of repealing the individual mandate. CBO's Panel of Health Advisers and experts at the American Enterprise Institute, the Office of the Actuary in the Centers for Medicare & Medicaid Services, the RAND Corporation, and the Urban Institute, along with other sources, have provided valuable information during that process.[5] However, the evidence available to inform CBO and JCT's work on that issue is limited. Because that work is not complete and significant changes to the individual mandate are being considered as part of the budget reconciliation process, the agencies are publishing this update now without incorporating major changes to their analytical methods.

However, the preliminary results of analysis using revised methods indicates that the estimated effects on the budget and health insurance coverage would probably be smaller than the numbers reported in this document. The agencies are continuing to work on those methods, and they expect to complete and publish an estimate including and explaining the revisions at some point after the current budget reconciliation process is complete or along with a future update to the baseline.

Uncertainty Surrounding the Estimates

CBO and JCT's estimates of this policy are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to it are all difficult to predict. The responses by individuals in the short term to a policy that would repeal the mandate are uncertain, for example.

The policy's nonfinancial effects—changes in people's tendency to comply with laws and attitudes about health insurance and their greater responsiveness to penalties than to subsidies—amplify its financial effects in CBO and JCT's analysis. The amplification from those nonfinancial effects is harder to project. In large part because of the difficulty in projecting that amplification, different organizations' estimates of the effects of repealing the mandate have varied. The effects could be smaller than those presented here: Some organizations have recently published such smaller estimates that appear to ascribe lesser effects to nonfinancial factors.[6] Alternatively, the nonfinancial effects of the mandate might grow over time—as the effects of many provisions of the tax code appear to have done after their implementation and as could occur if awareness and enforcement of the mandate changed. Under that circumstance, the effects of repealing the mandate could be larger over time.

CBO and JCT's baseline projections are also uncertain, and revisions to them would alter interactions and change the estimates of the effects of eliminating the mandate. For example, if there are no payments for CSRs, premiums in the marketplaces would probably be higher than projected in the baseline. (The Administration has halted those payments, but the baseline projections used in this estimate incorporated the assumption that they would continue.) Premiums that are higher than those in the baseline projections would tend to boost the budgetary savings under this policy by increasing the estimated per-person savings from people no longer enrolling in nongroup coverage. As another example, subsidized enrollment in the marketplaces might be lower than projected in the baseline, which would tend to decrease the budgetary savings under this policy.

Despite the uncertainty, some effects of this policy are clear: For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher.

5. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105; and Congressional Budget Office, "Panel of Health Advisers" (accessed November 7, 2017), www.cbo.gov/about/processes/panel-health-advisers.

6. Those estimates were for the early years of policies that would have initially repealed the individual mandate and later made many other changes. See Office of the Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effect of the "American Health Care Act of 2017"* (June 2017), https://go.usa.gov/xnTzU; and Linda Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), http://tinyurl.com/y6vkugs4.

This report updates CBO and JCT's estimate of the effects of a budget option that CBO published in December 2016. Susan Yeh Beyer, Kate Fritzsche, Jeffrey Kling, Sarah Masi, Kevin McNellis, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, and Robert Stewart prepared the report with guidance from Jessica Banthin, Chad Chirico, Holly Harvey, and Alexandra Minicozzi and with contributions from Ezra Porter and the staff of the Joint Committee on Taxation. Theresa Gullo, Mark Hadley, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

An electronic version is available on CBO's website (www.cbo.gov/publication/53300).

Keith Hall
Director

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: June 7, 2018]

FEDERAL DEFENDANTS' MEMORANDUM IN RESPONSE TO PLAINTIFFS' APPLICATION FOR PRELIMINARY INJUNCTION

INTRODUCTION

In the Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), Congress fundamentally altered the American health-insurance system by imposing a "[r]equirement" for most Americans "to maintain minimum essential coverage." 26 U.S.C. § 5000A(a). In light of the basis on which the Supreme Court previously held that this "individual mandate" survived constitutional scrutiny, the United States agrees with the Plaintiffs that Section 5000A(a) must now be struck down as unconstitutional in light of the amendments that were made to it in the Tax Cuts and Jobs Act (TCJA), Pub. L. No. 115-97, 131 Stat. 2054 (2017). Two years after the ACA's passage, the Supreme Court held that the individual mandate in Section 5000A(a) exceeded the scope of Congress's commerce power. *National Fed'n of Indep. Bus. v.*

Sebelius (*NFIB*), 567 U.S. 519, 572 (2012) ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity."). The Court nevertheless held that the provision "may reasonably be characterized as a tax" because, among other things, it "yields the essential feature of any tax" in that "[i]t produces at least some revenue for the Government." *Id.* at 564; *see id.* at 574. Chief Justice Roberts' controlling opinion made clear, however, that "the statute reads more naturally as a command to buy insurance than as a tax," and that "it is only because [courts] have a duty to construe a statute to save it, if fairly possible, that [the provision] can be interpreted as a tax" given the revenue raised. *Id.* at 574; *accord id.* at 562–63 (opinion of Roberts, C.J.) ("The most straightforward reading of the mandate is that it commands individuals to purchase insurance," but there is a savings construction under which it "can be regarded as establishing a condition . . . that triggers a tax" in light of "the required payment to the IRS.").

Critically, however, the Supreme Court's saving construction of the individual mandate as a tax is no longer available. The TCJA eliminated the penalty for failing to purchase minimum essential coverage (starting in 2019), but left untouched the statutory "[r]equirement to maintain minimum essential coverage" in Section 5000A(a). *See* Pub. L. No. 115-97, § 11081, 131 Stat. at 2092. The individual mandate thus still exists, but it will no longer be fairly possible to describe it as a tax because it will no longer generate any revenue.

As of 2019, therefore, the individual mandate will be unconstitutional under controlling Supreme Court precedent holding that "[t]he Federal Government

does not have the power to order people to buy health insurance." *NFIB*, 567 U.S. at 574–75 (opinion of Roberts, C.J.); *accord id.* at 547–561; *id.* at 649–60 (opinion of Scalia, Kennedy, Thomas, Alito, JJ. ("joint dissent")). Because the TCJA eliminated the basis for the Court's saving construction in *NFIB*, the individual mandate is untethered to any source of constitutional authority. Furthermore, as the United States explained to the Court in *NFIB*, Congress's own "findings establish that the guaranteed-issue and community-rating provisions are inseverable from the minimum coverage provision." Br. For Resp't (Severability) at 45, *NFIB*, No. 11-393 (citing 42 U.S.C. § 18091(2)(I)). The remainder of the ACA, however, can stand despite the invalidation of those provisions. *See id.* at 26-44.

Although Plaintiffs are likely to succeed in part on the merits, they are not entitled to a preliminary injunction. As Plaintiffs agree that the mandate will not become unconstitutional until the tax is eliminated in 2019, immediate relief is not warranted. That said, because this is a pure question of law on which the Plaintiffs and Defendants do not disagree, this Court should consider construing Plaintiffs' motion as a request for summary judgment and then entering a declaratory judgment that the ACA's provisions containing the individual mandate as well as the guaranteed-issue and community-rating requirements will all be invalid beginning on January 1, 2019.

BACKGROUND

A. The Affordable Care Act

The ACA established a framework of economic regulations and incentives concerning the health-insurance and healthcare industries. It spans more than

900 pages of the session laws and is divided into nine titles. Many of the ACA's more familiar major provisions relating to the regulation of health insurance are in Titles I and II. There, among other things, Congress:

- *Required certain individuals to maintain insurance*. As detailed below, the ACA required most Americans to maintain health insurance meeting specified standards, subject to a monetary exaction for failure to do so. 26 U.S.C. § 5000A.
- *Subjected certain employers to tax consequences concerning sponsorship of insurance*. The ACA imposed tax liabilities under certain circumstances on large employers that do not offer a minimum mandated level of coverage to full-time employees, 26 U.S.C. § 4980H—a provision sometimes referred to as the "employer mandate"—and established tax incentives for eligible small businesses to purchase health insurance for their employees, 26 U.S.C. § 45R.
- *Created health insurance exchanges*. The ACA created health insurance "exchanges" where qualified health plans could be purchased by individuals and small businesses. 42 U.S.C. §§ 18031–18044. A State may choose whether or not to set up an exchange; if it elects not to, the federal government will establish one. *Id*. § 18041(b), (c).
- *Imposed numerous insurance-market regulations*. Two of the insurance market regulations prohibit insurers from either denying coverage because of an enrollee's medical condition or history ("guaranteed issue"), *id.* §§ 300gg-1,

300gg-3, 300gg-4(a), or charging higher premiums because of an applicant's or enrollee's medical condition or history ("community rating"), *id*. §§ 300gg(a)(1), 300gg-4(b). Among other requirements, the ACA also:

- Required insurers providing family coverage to continue covering adult children until age 26. *Id*. § 300gg-14(a).
- Barred insurers from placing lifetime dollar caps on benefits. *Id*. § 300gg-11.
- Prohibited insurers from canceling insurance absent fraud or intentional misrepresentation. *Id*. § 300gg-12.
- Established medical loss ratios for insurers—*i.e.*, minimum percentages of premium revenues that insurers must spend on clinical services and activities that improve health-care quality. *See id*. § 300gg-18(b).
- Required plans to cover certain "essential health benefits." *Id*. § 18022.

- *Provided tax incentives to subsidize certain individuals' purchase of insurance.* The ACA established a system of tax credits for eligible individuals (*i.e.*, those with income between 100% and 400% of the federal poverty level) to purchase health insurance. 26 U.S.C. § 36B.
- *Expanded the scope of the Medicaid program*. The newly eligible are primarily nonelderly adults without dependent children with income

below a certain threshold. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).[1]

Perhaps foremost among the ACA's provisions is the individual mandate to maintain insurance. 26 U.S.C. § 5000A. Subsection (a) of that provision imposes a "[r]equirement to maintain minimum essential coverage" stating that certain individuals "shall . . . ensure" that they are "covered under minimum essential coverage." *Id.* § 5000A(a). Subsection (b) of that provision then imposes "a penalty," called a "shared responsibility payment," on certain taxpayers who "fail[] to meet the requirement of subsection (a)." *Id.* § 5000A(b). And subsection (c) provides "[t]he amount of the penalty imposed." *Id.* § 5000A(c). Notably, subsection (d) provides that certain individuals—*i.e.*, people with religious exemptions, individuals not lawfully present in the United States, and incarcerated individuals—are entirely exempt from the requirement to maintain minimum essential coverage, *id.* § 5000A(d), whereas subsection (e) provides that certain other individuals remain subject to that requirement but are exempt from the penalty for noncompliance, *id.* § 5000A(e) (*i.e.*, those who cannot afford coverage, taxpayers with income below the filing threshold, members of Indian tribes, those experiencing short coverage gaps, and individuals determined by the Secretary of Health and Human Services to have suffered

[1] The ACA as originally enacted required States either to expand their Medicaid programs in this manner or lose all federal Medicaid funding. The Supreme Court in *NFIB* invalidated the requirement and held that States may elect to decline this expansion without jeopardizing funding for their existing Medicaid programs. 567 U.S. at 575–88.

a hardship with respect to obtaining coverage). Finally, subsection (f) defines "minimum essential coverage" to mean various types of insurance coverage, including government-sponsored programs such as Medicare and Medicaid, *id*. § 5000A(f)(1)(A), as well as eligible employer-sponsored plans and plans offered in the non-group market, *id*. § 5000A(f)(1)(B)–(D); 42 U.S.C. § 18011.[2]

The ACA contains a specific finding by Congress that the "individual responsibility requirement" to maintain insurance is "essential" to "creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," because "many individuals would wait to purchase health insurance until they needed care" "if there were no requirement." 42 U.S.C. § 18091(1), (2)(I). More generally, Congress found that "[t]he re-

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[2] The definition of "minimum essential coverage" in Section 5000A(f) also serves a variety of other purposes throughout the Internal Revenue Code. For example, a large employer that fails to offer its employees minimum essential coverage is in certain circumstances subject to a tax. 26 U.S.C. § 4980H(a), (b). An individual's eligibility for minimum essential coverage governs his or her eligibility for a tax credit for the purchase of insurance. *Id*. § 36B(b)(3). A "person who provides minimum essential coverage" is required to make an informational return with the IRS. *Id*. § 6055. Large employers must also make a return describing whether they offer minimum essential coverage to their employees. *Id*. § 6056. The taxability of certain health insurance reimbursement arrangements for employees depends on the definition of minimum essential coverage. *Id*. § 106(g). An excise tax on high-cost health coverage also turns on the concept of minimum essential coverage, *id*. § 4980I, as does the deductibility of certain business expenses by health insurance providers, *id*. § 162(m)(6)(C)–(D).

quirement is an essential part" of the ACA's "regulation of the health insurance market." *Id.* § 18091(2)(H); *see also id.* § 18091(2)(C)–(G), (J) (identifying other ways in which the requirement furthered the ACA's objectives).

Beyond Titles I and II, the ACA addresses numerous other issues. For example:

- Title III amended Medicare. Among other provisions, it revised the Medicare Part D prescription drug program, § 3301; modified certain Medicare reimbursement rates for hospitals, § 3133; and required quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs, § 3004.
- Title IV funded existing prevention programs and created new prevention programs. For example, it created the National Prevention, Health Promotion and Public Health Council, §§ 4001, 4002; required that chain restaurants disclose nutritional information, § 4205; and funded school-based health clinics, § 4101.
- Title V sought to expand the supply of health care workers, including through modifications to the federal student loan program, § 5201, and a variety of subject-specific grants.
- Title VI enacted anti-fraud requirements for facilities participating in Medicare and Medicaid, including screening providers, § 6401, and programs to reduce elder abuse.
- Title VII expanded the 340B drug discount program, § 7101, and established a process for FDA licensing of biosimilar products, § 7002.

- Title VIII established a voluntary long-term care insurance program, § 8002 (which has since been repealed, *see* Pub. L. No. 112-240, § 642(a), 126 Stat. 2313, 2358 (2013)).
- Title IX addressed various taxes, including an excise tax on high-cost plans, § 9001, which has not yet taken effect due to postponements, *see* Pub. L. No. 114-113, § 101(a), 129 Stat. 2242, 3037 (2015); Pub. L. No. 115-120, § 4002, 132 Stat. 28, 38 (2018).

B. The Supreme Court's Decision in *NFIB v. Sebelius*

In the years immediately following the ACA's enactment, a variety of challenges to its constitutionality were filed in federal court, many of which focused on whether Congress had the power under Article I of the Constitution to enact Section 5000A. That question was resolved by the Supreme Court in *NFIB*, a case brought by a small-business association and several individuals as well as 26 States, including 16 of the State Plaintiffs here. *See* 567 U.S. at 520.

In *NFIB*, the Supreme Court held that although Section 5000A was not authorized by Congress's commerce power, it was a valid exercise of the taxing power. As Chief Justice Roberts explained in his controlling opinion, in light of the statutory language that individuals "'shall'" maintain coverage, the "most straightforward reading of the mandate is that it commands individuals to purchase insurance." 567 U.S. at 562 (quoting 26 U.S.C. § 5000A(a)). Furthermore, the Chief Justice agreed with the four dissenters that the "Commerce Clause does not authorize such a command," *id.* at 574; *accord id.* at 547–561; *id.* at 649–60 (joint dissent)—a holding of the Court that was

acknowledged in the portion of the Chief Justice's opinion that was joined by a majority of the Court. *Id.* at 572 ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity."). Nevertheless, because "[u]nder the mandate, if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes," Chief Justice Roberts agreed with the government that "the mandate can be regarded as establishing a condition . . . that triggers a tax," given the obligation to adopt "a saving construction" "if fairly possible." *Id.* at 562–63 (citing 26 U.S.C. § 5000A(b)), 574–75. A majority of the Court agreed that Section 5000A so construed could be upheld under Congress's taxing power. *Id.* at 570. But critical to the Court's saving construction and constitutional holding was the fact that the individual mandate's shared responsibility payment "yield[ed] the essential feature of any tax: [i]t produces at least some revenue for the Government." *Id.* at 564.

C. The Tax Cuts and Jobs Act

In the TCJA, Congress enacted a variety of amendments to the Internal Revenue Code. As relevant here, the Act amended Section 5000A(c) by reducing to $0 the monetary exaction imposed for noncompliance with the "[r]equirement to maintain minimum essential coverage" for tax-years 2019 and beyond. *See* Pub. L. No. 115-97, § 11081, 131 Stat. at 2092. Under the ACA, the tax penalty for failing to maintain minimum essential coverage for those years was to be the greater of 2.5% of household income or $695. The TCJA amended those figures to "Zero percent" and "$0." *Id.* The TCJA leaves the rest of Section 5000A

intact, including the "[r]equirement" in subsection (a) that applicable individuals "shall … ensure" they are covered by "minimum essential coverage." Congress also left untouched the congressional findings in Section 18091 that the "individual responsibility requirement" to maintain insurance was "essential" to the guaranteed-issue and community-rating insurance reforms. *See* 42 U.S.C. § 18091(2)(H)–(I).

D. This Case

Plaintiffs are 20 States and two individuals. Intervenors-Plaintiffs are two employers. Among other things, the individual plaintiffs have declared that the individual mandate legally obligates them to maintain minimum essential coverage, but that they wish instead to purchase non-ACA-compliant insurance that better reflects their actuarial risks. *See* App'x in Support of Application for Preliminary Injunction, Dkt. No. 41, at App.004 ("My preference would be to purchase reasonably-priced insurance coverage that is consumer-driven in accordance with my actuarial risk."); App.008 ("The ACA prevents me from obtaining care from my preferred health care providers and has greatly increased my health insurance costs. I would purchase reasonably priced insurance coverage that allowed me to access care locally from my preferred service providers, were I not limited to the plans provided through the federal health insurance marketplace.").

The complaint and the complaint-in-intervention raise five claims. Their central contention (Count 1) is that Section 5000A, as amended by the TCJA, falls outside of Congress's Article I powers and is inseverable from the rest of the ACA, which they claim is thus invalid in its entirety. Am. Compl., Dkt. No. 27, ¶¶ 55–57; Complaint-in-Intervention, Dkt. No. 81-1, ¶¶ 54–

66. In Count 2, Plaintiffs claim that if Section 5000A is unconstitutional, then "the rest of the ACA is irrational" and thus violates due process. Am. Compl. ¶ 65; Complaint-in-Intervention ¶¶ 71. In Count 3, they claim that if Section 5000A is unconstitutional, then the rest of the ACA "is outside the powers delegated to the United States by the Constitution" and thus violates the Tenth Amendment. Am. Compl. ¶ 73; Complaint-in-Intervention ¶ 79. In Count 4, Plaintiffs assert that if the ACA is invalid in its entirety, then "all regulations" issued under its authority must be declared invalid. Am. Compl. ¶ 81; Complaint-in-Intervention ¶ 87. In Count 5, Plaintiffs assert an entitlement to injunctive relief. Am. Compl. ¶ 85; Complaint-in-Intervention ¶ 91. Because Plaintiffs' preliminary injunction brief solely relies (pp. 21–40) on their Count 1 claim that Section 5000A as amended by the TCJA is unconstitutional and inseverable from the rest of the ACA, that is the only claim to which Defendants respond here.

LEGAL STANDARDS

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). A party seeking a preliminary injunction must show: "(1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest." *Jordan v. Fisher*, 823 F.3d 805, 809 (5th Cir. 2016). Due to its "extraordinary" nature, no preliminary injunction should be "granted unless the party seeking it has

clearly carried the burden of persuasion on all four requirements." *Id.* at 221 (citation omitted).

ARGUMENT

The United States agrees with Plaintiffs that the ACA's individual mandate, as amended by the TCJA, is unconstitutional. Because Section 5000A(a) can no longer fairly be described as a tax after the TCJA amendment takes effect in 2019, the saving construction adopted by *NFIB* will no longer be available. Instead, Section 5000A(a) must be interpreted per its plain text as a freestanding legal mandate to maintain insurance, which *NFIB* squarely held exceeds the powers of Congress. And as the United States explained in *NFIB*, the individual mandate cannot be severed from the guaranteed-issue and community-rating provisions, though those three provisions can be severed from the rest of the ACA. Nonetheless, as explained below, preliminary injunctive relief should not be issued; instead, this Court should simply enter a declaratory judgment.

I. THE INDIVIDUAL MANDATE IS UNCONSTITUTIONAL AFTER THE TCJA.

Starting in 2019, the TCJA will eliminate the individual mandate's tax penalty under Section 5000A(b)–(c) but it will not alter the mandate's plain-text "[r]equirement to maintain minimum essential coverage" under Section 5000A(a). The individual mandate will continue to provide that applicable individuals "shall . . . ensure" that they are "covered under minimum essential coverage." 26 U.S.C. § 5000A(a). Yet the only available interpretation of that plain text will be that it mean what it says: there is a legal mandate to obtain insurance; the mandate can no longer instead fairly be interpreted as a tax because it will raise

no revenue as Congress has eliminated the monetary penalty.

This plain-text interpretation is confirmed by the Supreme Court's decision in *NFIB*. The Chief Justice's controlling opinion repeatedly acknowledged—and the four Justices in the joint dissent asserted even more emphatically—that "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance. After all, it states that individuals 'shall' maintain health insurance." *NFIB*, 567 U.S. at 562 (quoting § 5000A(a)); *see also id.* at 574 ("the statute reads more naturally as a command to buy insurance than as a tax"); *id.* at 662–63 (joint dissent) (describing Section 5000A(a) as "unquestionably" a "mandate . . . enforced by a penalty" rather than a tax). Although the Chief Justice concluded at the time that it was "fairly possible" to interpret the mandate as merely "establishing a condition—not owning health insurance—that triggers a tax—the required payment to the IRS," *id.* at 563, that saving construction is no longer available because, post-TCJA, the mandate no longer "yields the essential feature of any tax," which is that it must "produce[] at least some revenue for the Government." *Id.* at 564 (opinion of the Court); *see also id.* at 574 (opinion of Roberts, C.J.) ("Congress's authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more.").

This plain-text interpretation is further confirmed by established canons of construction. *First*, it is "a cardinal principle" that a statute should be construed so that "no clause, sentence, or word shall be superfluous, void, or insignificant." *TRW Inc. v. Andrews*, 534 U.S. 19, 31 (2001). Here, in light of the elimination of the Section 5000A(b) penalty, Section 5000A(a) would

be utterly meaningless unless it imposes a legal requirement that covered individuals shall maintain insurance, as would Section 5000A(d)'s exemption from that requirement. *See* 26 U.S.C. §°5000A(d) (setting forth certain categories of individuals who are not subject to Section 5000A(a)'s "[r]equirement to maintain minimum essential coverage"). *Second*, "Congress is presumed to act with full awareness of existing judicial interpretations." *United States v. Fausto*, 484 U.S. 439, 460 n.6 (1987) (citing *Rodriguez v. United States*, 480 U.S. 522, 525 (1987) (per curiam)). Here, Congress was indisputably aware of *NFIB*'s saving construction of Section 5000A(a)'s individual mandate, and that it rested on the revenue raised by Section 5000A(b)'s penalty. Yet Congress eliminated the linchpin of that saving construction—the revenue-raising penalty—without altering the unambiguous language of the mandate itself. *Cf. Harris v. United States*, 536 U.S. 545, 556 (2002) (refusing to apply the canon of constitutional avoidance where doing so would contradict the "respect for Congress" upon which "[t]he avoidance canon rests").

This plain-text interpretation is also shared by at least some members of the public. *See* App'x in Support of Application for Preliminary Injunction at App.004 ("I value compliance with my legal obligations, and believe that following the law is the right thing to do. The repeal of the associated health insurance tax penalty did not relieve me of the requirement to purchase health insurance. I continue to maintain minimum essential health insurance coverage because I am obligated to comply with the Affordable Care Act's individual mandate, even though doing so is a burden to me."); App.008 (same).

In sum, once the associated financial penalty is gone, the "tax" saving construction will no longer be fairly possible and thus the individual mandate will be unconstitutional. As a majority of the Supreme Court held in *NFIB*, "[t]he Federal Government does not have the power to order people to buy health insurance. Section 5000A would therefore be unconstitutional if read as a command." *NFIB*, 567 U.S. at 575 (opinion of Roberts, C.J.); *see also id.* at 706–07 (joint dissent); *id.* at 572 (opinion of the Court). Because Section 5000A(a) must be read as a command once the TCJA's elimination of the penalty takes effect in 2019, it will exceed Congress's enumerated powers.

II. THE INDIVIDUAL MANDATE IS NOT SEVERABLE FROM THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS, BUT THOSE THREE PROVISIONS ARE SEVERABLE FROM THE REST OF THE ACA.

In addition to claiming that the individual mandate is unconstitutional in light of the TCJA, Plaintiffs claim that the rest of the ACA is not severable from the unconstitutional mandate. A plaintiff seeking to invalidate provisions of a statute as inseverable must show that it is "evident that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018); *see also Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–85 (1987). This inquiry reflects the fact that under our Constitution, the Judiciary "cannot rewrite a statute and give it an effect altogether different from that sought by the measure viewed as a whole." *Murphy*, 138 S. Ct. at 1482 (quoting *R.R. Retirement Bd. v. Alton R. Co.*, 295 U.S. 330, 362 (1935)). Although the Supreme Court's

test for severability is "essentially an inquiry into legislative intent," *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999), "the enacted text is the best indicator of intent," *Nixon v. United States*, 506 U.S. 224, 232 (1993).[3]

Here, as the United States has consistently maintained, the individual mandate is not severable from the ACA's guaranteed-issue and community-rating requirements, but it is severable from the ACA's other provisions.

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[3] In addition, plaintiffs may only seek to invalidate statutory provisions as inseverable if those provisions themselves injure them. The Supreme Court has held that it "ha[s] no business answering" questions about the inseverability of provisions that concern only "the rights and obligations of parties not before the court." *Printz v. United States*, 521 U.S. 898, 935 (1997); *see also Murphy*, 138 S. Ct. at 1485–87 (Thomas, J. concurring). And that holding is consistent with basic limitations on Article III standing and equitable remedies. *See, e.g.*, *Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) ("[S]tanding is not dispensed in gross," and "a plaintiff must demonstrate standing . . . . for each form of relief that is sought." (citations omitted)); *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (explaining that equitable relief must "be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs" (citation omitted)). Here, the individual plaintiffs have adequately alleged injury from the ACA's guaranteed-issue and community-rating provisions. *See, e.g.*, App'x in Support of Application for Preliminary Injunction at App.004 ("My preference would be to purchase reasonably-priced insurance coverage that is consumer-driven in accordance with my actuarial risk."). By contrast, Plaintiffs have not argued and cannot argue that each and every other provision in the ACA also injures them. Accordingly, regardless of whether other provisions of the ACA are inseverable and whether this Court may consider that question in analyzing the inseverability of the guaranteed-issue and community-rating provisions, it would be improper for this Court to enter judgment on the inseverability of any of the many ACA provisions that do not injure Plaintiffs.

A. The Guaranteed-Issue and Community-Rating Requirements Are Not Severable

The United States contended in *NFIB* that "Congress's findings establish that the guaranteed-issue and community-rating provisions are inseverable from the minimum coverage provision." Br. for Resp. (Severability) at 45, *NFIB*, No. 11-393. And the Supreme Court has since essentially agreed, noting that these "three reforms are closely intertwined" and that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement." *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015).

That finding, set forth at 42 U.S.C. § 18091(2)(I), specifically and expressly explains why Congress believed that the individual mandate requirement is "essential" to the operation of the guaranteed-issue and community-rating provisions. Namely, "if there were no requirement, many individuals would wait to purchase health insurance until they needed care." *Id.* But "[b]y significantly increasing health insurance coverage," the mandate, "together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.* Accordingly, the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* In short, Congress found that enforcing guaranteed issue and community-rating requirements without an individual mandate would allow individuals to game the system by waiting until they were sick to purchase health insurance, thereby increasing the price of insurance

for everyone else—the polar opposite of what Congress sought in enacting the ACA.

Indeed, Congress's conclusions regarding the linkage between the individual mandate, guaranteed-issue, and community-rating requirements were agreed upon by all of the Justices in *NFIB*. *See* 567 U.S. at 548 (opinion of Roberts, C.J.) ("The guaranteed-issue and community-rating reforms … exacerbate" the "problem" of "healthy individuals who choose not to purchase insurance to cover potential health care needs," and "threaten to impose massive new costs on insurers[.] … The individual mandate was Congress's solution to these problems."); *id.* at 597–98 (Ginsburg, J., concurring in part and dissenting in part) ("[T]hese two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. … [G]uaranteed-issue and community-rating laws alone will not work."); *id.* at 695–96 (joint dissent) ("Insurance companies bear new costs imposed by a collection of insurance regulations and taxes, including 'guaranteed issue' and 'community rating' requirements . . . but the insurers benefit from the new, healthy purchasers who are forced by the Individual Mandate to buy the insurers' product.").

In expressly finding this link between these three provisions, Congress looked to experiences from prior state experiments in restructuring their laws governing health insurance. In some States, insurers were forced to cover everyone and charge the same rates regardless of health status, and chose to raise premiums for healthy individuals. *See* Br. of America's Health Insurance Plans and the Blue Cross Blue Shield Association as Amici Curiae in Support of Reversal of the Court of Appeals' Severability Judgment at 8–11,

NFIB, No. 11-393. For example, after imposing guaranteed-issue and community-rating requirements without an individual mandate, New Hampshire experienced an increase in premiums and, ultimately, all but two insurers withdrew from the State. *See* Br. for Resp't (Severability) at 49, *NFIB*, No. 11-393; *see also id.* at 48–51 (collecting examples). Thus, Congress acted on the assumption that severing the individual mandate from the guaranteed-issue and community-rating provisions "necessarily would impose significant risks and real uncertainties on insurance companies, their customers, all other major actors in the system, and the government treasury." *NFIB*, 567 U.S. at 699 (joint dissent). Although the empirical assumptions underlying this connection may be subject to dispute (*see, e.g.*, Br. for Court-Appointed Amicus Curiae Supporting Complete Severability at 35–41, *NFIB*, No. 11-393), what is indisputable is that *Congress* believed that these three provisions were interdependent in enacting the ACA.

That conclusion is not affected by the fact that the TCJA eliminated the mandate's penalty. It still remains the case that, in the complete absence of the mandate, retention of the guaranteed-issue and community-rating requirements would expose health insurers (and their customers) to unfettered adverse selection by individuals who can game the system by waiting until they are sick to purchase insurance, contrary to Congress's express intent. 42 U.S.C. § 18091(2)(I). Nor is this conclusion undermined by the fact that the TCJA did not itself eliminate the guaranteed-issue and community-rating requirements at the same time it eliminated the mandate's penalty and thereby rendered the mandate unconstitutional. The best evidence of Congress's intent is

found in the legislative findings, which continue to remain part of the ACA after the TCJA. These express findings continue to describe the mandate as "essential" to the operation of the guaranteed-issue and community-rating provisions. *See EEOC v. Hernando Bank, Inc.*, 724 F.2d 1188, 1190–91 (5th Cir. 1984) (noting that in determining "whether Congress would have enacted the remainder of the statute in the absence of the invalid provision[,] … [c]ongressional intent and purpose are best determined by an analysis of the language of the statute in question"). Those findings cannot be deemed to have been impliedly repealed by Congress's mere elimination of the financial penalty. *See Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 662 (2007) (explaining that "'repeals by implication are not favored' and will not be presumed unless the 'intention of the legislature to repeal is clear and manifest'" (citation omitted)).[4]

B. The ACA's Other Provisions Are Severable

As the United States also contended in *NFIB*, the remainder of the ACA is severable from the individual mandate and the guaranteed-issue and community-rating requirements. Br. For Resp't (Severability) at 44–54, *NFIB*, No. 11-393.

1. The ACA's other major provisions—concerning various insurance regulations, health insurance

[4] That is especially true given that Congress passed the TCJA by a majority vote under the restrictive reconciliation process, which limits congressional action to generally fiscal matters. *See* H.R.1, 115th Cong., "An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018"; Cong. Research Serv., Bill Heniff Jr., The Budget Reconciliation Process: The Senate's "Byrd Rule" (Nov. 22, 2016), https://fas.org/sgp/crs/misc/RL30862.pdf (last visited June 7, 2018). Although Congress was able to revoke the tax penalty, it could not have revoked the guaranteed-issue or community-rating provisions through reconciliation.

exchanges and associated subsidies, the employer mandate and Medicaid expansion, and reduced federal healthcare reimbursement rates for hospitals—are severable from the individual mandate. Although Congress made clear its belief that the mandate is not severable from the guaranteed-issue and community-rating requirements, *see* 42 U.S.C. § 18091(2)(I), Congress did not do so with respect to the ACA's other major provisions.

The ACA contains numerous mechanisms designed to expand health insurance coverage through federal regulation. Each of these provisions can independently operate "consistent with Congress' basic objectives in enacting the statute," and therefore, this Court "must retain" them. *United States v. Booker*, 543 U.S. 220, 258–59 (2005). Although Plaintiffs speculate (Br. at 35–39) as to a chain reaction of failed policymaking that could occur once the individual mandate is struck down, they cannot show that striking down the individual mandate, guaranteed-issue, and community-rating requirements means that the ACA necessarily "ceases to implement any coherent federal policy." *Murphy*, 138 S. Ct. at 1483. Congress's other legislative findings in 42 U.S.C. § 18091(2) demonstrate that, instead, these other provisions are severable from the mandate. *See* 42 U.S.C. § 18091(2)(C), (E), (F) (finding that the "individual responsibility requirement," "together with the other provisions of this Act," will accomplish Congress's objectives of "increas[ing] the number and share of Americans who are insured" and "significantly reducing the number of the uninsured"). The other major provisions still serve the objectives that Congress had when enacting the ACA notwithstanding the elimination of the mandate (plus guaranteed-issue and community-rating)—especially given that Congress itself

reduced the effect of the mandate by eliminating its penalty in the TCJA, and yet did not repeal the rest of the ACA despite repeated attempts to do so.

For example, Congress has repeatedly expanded the scope of Medicaid since the inception of the program over half a century ago. There is no reason why the ACA's particular expansion of Medicaid hinges on the individual mandate. The same can be said about the health insurance exchanges, which likewise can operate as functioning "marketplace[s] for the purchase of health insurance" without the individual mandate. H.R. Rep. No. 443, 111th Cong., 2d Sess. Pt. 2, at 976 (2010) (citation omitted); *see also* 42 U.S.C. § 18091(2)(J) ("By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums."). This is not a case like *Murphy* in which the Court concluded that finding one provision severable from another would inherently bring about "a weird result." 138 S. Ct. at 1483–84 ("If the people of a State support the legalization of [an activity], federal law would make the activity illegal."). Instead, Plaintiffs rely on a chain of speculative hypotheticals, which are not strong enough to justify invalidating these other parts of the ACA's insurance market regulations.

Congress has provided further proof of its intent that the bulk of the ACA would remain in place by amending the ACA on numerous occasions after the TCJA invalidated the individual mandate. *See* Pub. L. No. 115-120, § 3002(g)(2), 132 Stat. at 35 (amending 26 U.S.C. § 5000A(f)(1) (revising definition of "minimum essential coverage," which is relevant to various

insurance reforms besides the mandate, *see supra* at 7–8 n.2)); *id.* § 4002, 132 Stat. at 38 (amending ACA § 9001(c) (delaying implementation date of excise tax on high cost employer-sponsored health coverage)); *id.* § 4003 (amending ACA § 9010(j) (suspending annual fee on health insurance providers)); *see also* Pub. L. No. 115-123, §§ 50207, 50208, 50901(a), (c), 52001, 53103, 53119, 132 Stat. 64, 186–89, 283–88, 298, 300–01, 308–13 (2018); Pub. L. No. 115-96, §§ 3101, 3103, 131 Stat. 2044, 2048–49 (2017). Congress likely would not have sought to amend a statute that it believed had been invalidated in total.

2. If the ACA's major provisions besides guaranteed-issue and community-rating are severable from the mandate, then it follows that the remaining provisions are as well. But even if some or all of the other major provisions were inseverable, this Court still should not hold "inseverable all other minor provisions scattered throughout the ACA." Pltfs. Br. 39. Many, if not all, of these "minor" provisions serve purposes far removed from the individual mandate, the guaranteed-issue and community-rating requirements, and the purchase of health insurance in general, as Plaintiffs appear to acknowledge. *Cf. id.* at 40 (arguing that the "minor provisions" "only (if at all) tangentially further the law's main purpose of near-universal affordable care"). Thus, the presence or absence of three provisions of the ACA would not affect the functioning of, for example, "regulations on the display of nutritional content at restaurants." *Id.* at 40 (citing 21 U.S.C. § 343(q)(5)(H)).

The cases that Plaintiffs cite, moreover, confirm that the tangential nature of these "minor" provisions weighs in favor of their severability. For example, in *Williams v. Standard Oil Co. of Louisiana*, 278 U.S.

235 (1929), after holding a law fixing gasoline prices unconstitutional, the Supreme Court concluded that several other provisions (including a provision requiring permits to sell gasoline and providing for the issuing of the permits) were inseverable because they were "adjuncts" with the sole purpose of enabling the problematic price-fixing provision. *Id.* at 242–43. Here, in contrast, the "minor" provisions are not "adjuncts" with the sole purpose of effectuating Section 5000A—rather, they operate in a completely different sphere.

Plaintiffs also suggest (Br. at 40) that the "minor" provisions would not have garnered the requisite votes in Congress if they were not attached to the rest of the ACA. But the severability analysis should be one of statutory construction, not parliamentary probabilities. A court should not hypothesize about the motivations of individual legislators, or speculate about the number of votes available for any number of alternatives. To the contrary, in *New York v. United States,* 505 U.S. 144 (1992), the Supreme Court recognized that the statute before it, "like much federal legislation, embodies a compromise among the States," but nonetheless held that the invalidated provision of the statute was severable from other provisions. *See id.* at 183, 186–87.

Accordingly, this Court should hold that the individual mandate is severable from all but the ACA's guaranteed-issue and community-rating requirements.

III. PRELIMINARY INJUNCTIVE RELIEF IS NOT WARRANTED AT THIS TIME, BUT A DECLARATORY JUDGMENT WOULD BE APPROPRIATE.

Although Plaintiffs have demonstrated a substantial likelihood of success on the merits, at least in part, preliminary relief is nevertheless unwarranted here. The individual mandate will not become unconstitutional under *NFIB* until the TCJA's elimination of the mandate's tax penalty goes into effect in 2019. An injunction may "be issued only if future injury is 'certainly impending.'" *Aransas Project v. Shaw*, 775 F.3d 641, 664 (5th Cir. 2014) (quoting *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979)). Here, the injury imposed by the individual mandate is not sufficiently imminent to warrant preliminary injunctive relief, especially where final adjudication would be possible before that injury occurs.

Because Plaintiffs agree that the mandate will not become unconstitutional until the tax is eliminated in 2019, immediate relief is not warranted at this time. That said, because this is a pure question of law on which the Plaintiffs and Defendants do not disagree, this Court should consider construing Plaintiffs' motion as a request for summary judgment and then entering a declaratory judgment that the ACA's provisions establishing the individual mandate as well as the guaranteed-issue and community-rating requirements will all be invalid as of January 1, 2019. That would be adequate relief against the government. *See, e.g.*, *Fla. ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1305 (N.D. Fla. 2011).

CONCLUSION

For these reasons, this Court should hold that the ACA's individual mandate will be unconstitutional as of January 1, 2019, and that the ACA's guaranteed-issue and community-rating provisions are inseverable from the mandate.

Dated: June 7, 2018 Respectfully submitted,

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Acting Assistant Attorney General

BRETT A. SHUMATE
Deputy Assistant Attorney General

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Counsel to the Assistant Attorney General

/s/ *Daniel D. Mauler*

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 5, 2018]

DECLARATION OF BLAKE FULENWIDER

My name is Blake Fulenwider and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am Deputy Commissioner and Chief of the Division of Medical Assistance Plans for the Georgia Department of Community Health (DCH). DCH's Division of Medical Assistance Plans administers Georgia Medicaid and the Children's Health Insurance Program (CHIP), known as PeachCare for Kids®.

2. Georgia Medicaid serves: (1) Low-income families; (2) Children; (3) Pregnant women; (4) Aged residents; (5) Blind persons; and (5) individuals with disabilities. PeachCare for Kids® serves children and youth from birth to age 19 who are members of a household with income above Georgia Medicaid income eligibility criteria up to 252% of the Federal Poverty Level (FPL). As a result of the Affordable Care Act (ACA), an additional category of people eligible for

Georgia Medicaid as added to this list: individuals under age 26 who aged out of foster care in the state and who were enrolled in Medicaid while in foster care. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX); Affordable Care Act, Pub. L. 111-148, 124 Stat. 865, § 2004.

3. Financial eligibility for Medicaid, CHIP, and many other social programs is based on a household's income level as compared to the Federal Poverty Level (FPL). The FPL is intended to identify the minimum amount of income a household would need to meet very basic needs and is established annually by the U.S. Department of Health and Human Services.

4. Both the state and federal governments fund Medicaid. The federal share of Medicaid funds Georgia receives is based on the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average. Currently (FFY 2018), Georgia receives FMAP of 68.50%, meaning the federal/state share of Medicaid funding is around 70/30 for medical benefit expenditures. Generally, administrative expenses are matched 50/50 between the state and federal government.

5. DCH uses several factors to determine eligibility for Medicaid including: (1) Household income; (2) age; (3) assets; and (4) other factors including but not limited to eligibility for other non-DCH administered benefits such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).

6. Household income often varies over time and is a key factor for Medicaid eligibility. Before the ACA was passed, DCH would review eligibility criteria for Medicaid enrollees every 6 months to allow for timely

disenrollment when a person no longer qualified for Medicaid.

7. The ACA imposed changes to the Medicaid eligibility renewal process. Pursuant to the ACA, eligibility redeterminations are now allowed no more frequently than once per 12 months[1], unless the enrollee volunteers to DCH that his or her household income has changed in a way that makes the beneficiary ineligible. This change mandated by the ACA restrains the frequency with which DCH can identify persons no longer eligible for Medicaid and remove them from the program, thus increasing the number of persons eligible for Medicaid services at any given time. This restriction has caused some ineligible enrollees to receive benefits for a period of time that exceeds their period of eligibility, despite DCH's desire to remove enrollees from the program promptly upon becoming ineligible for continued enrollment.

8. The ACA also required states to adopt a new measure of household income, Modified Adjusted Gross Income (MAGI) of a Non-Elderly, Non-Disabled household, for the purpose of determining eligibility for state Medicaid and CHIP programs. Adoption of MAGI standards required Georgia to marginally[2] increase income thresholds for affected categories of eligibility when Georgia's MAGI Conversion Plan was approved by the federal government in 2014.

9. The ACA's individual mandate contributed to the expansion of the Medicaid population in Georgia as well. As a result of the individual mandate, Georgia

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[1] 42 CFR Sec. 435.916(a).

[2] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-and-the-marketplace/downloads/ga-converted-thresholds-03jul2013.pdf (MAGI conversion results).

residents were necessarily required to secure health care coverage or pay a fine to the federal government. Even individuals who qualified for the federal "Hardship Exemption" sought qualified coverage through available sources, including Medicaid. Efforts to avoid imposition of the fine likely prompted more individuals to secure Medicaid from DCH.

10. Although it is difficult to quantify the exact number of Medicaid enrollees that can be attributed to the individual mandate, I believe that the individual mandate played a substantial role in the increase in the number of Medicaid recipients since 2011. This assertion is based on my experience with DCH and the Governor's Office of Planning and Budget (OPB), as well as research I have participated in to prepare policy analyses and budget projections since the ACA was enacted into law.

11. The ACA requires Georgia's Integrated Eligibility System (IES), known as "Georgia Gateway," to electronically interface with the Federally Facilitated Exchange (FFE) systems in order to receive Medicaid applications that the FFE has *assessed* as Medicaid-eligible. It is the obligation of DCH, as the Single State Agency for Medicaid, to conduct a full eligibility *determination* based upon information received by the FFE.

12. Georgia has not expanded Medicaid to cover childless adults from 0% FPL up to 138% FPL. However, the FFE has and continues to assess individuals who fall within the above range as eligible for Medicaid and transmits this assessment to DCH for an eligibility determination. DCH continues to receive thousands of such applications from the FFE each year, creating a significantly increased workload on Medicaid eligibility staff whose resources are limited.

13. The ACA also mandates the specific Medicaid services Georgia is required to cover. Rather than allowing DCH to make such determinations based on the needs of Georgia's population, the ACA imposed a "one-size-fits-all" rule upon Georgia, thereby governing the provision of inpatient hospital services, outpatient hospital services, family planning services and supplies, federally qualified health centers, nurse midwife services, certified pediatric and family nurse practitioner services, home health care services, medical transportation services, nursing facility services for individuals 21 or over, rural health clinic services, and other significant and complex medical services and systems.

14. From January 2014 — March 2018, Georgia's Medicaid enrollment has grown from 1.829 million to 2.074 million individuals.

15. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the 14th day of May, 2018.

/s/ Blake T. Fulenwider
Blake T. Fulenwider
Deputy Commissioner
Chief, Medical Assistance Plans
Georgia Department of Community Plans

County of Fulton
State of Georgia

Sworn and subscribed before me
this 14 day of May, 2018.
/s/ R. Renee Robinson
My Commission Expires 10.30.20

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 5, 2018]

DECLARATION OF TERESA MACCARTNEY

My name is Teresa MacCartney and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Chief Financial Officer of the State of Georgia and the Director of the Governor's Office of Planning and Budget ("OPB"). I have served as the state's CFO and the Director of OPB for five and a half years. As the CFO of the State of Georgia and the Director of OPB, I am responsible for overseeing the fiscal affairs of the state and developing financial policies and plans for each of its public departments, agencies, and institutions. As a part of these responsibilities, I monitor agency expenditures and develop budget recommendations to suit the state's policy goals. I am particularly familiar with changes in costs, plans, and policies related to the enactment of the Affordable Care Act ("ACA") because I oversee the budgets for the Georgia Department of Community Health ("DCH"), the University System of Georgia Board of Regents

("BOR") and the State Accounting Office ("SAO"). I have personal knowledge of the matters and information set forth herein.

2. DCH administers the state Medicaid and PeachCare for Kids programs and the State Health Benefit Plan ("SHBP"). PeachCare for Kids is a comprehensive health care program for uninsured children living in Georgia. SHBP provides health insurance coverage to state employees, retirees, and their dependents.

3. BOR administers the University System of Georgia Healthcare Plan which provides health insurance coverage to University System of Georgia employees, retirees, and their dependents.

4. SAO is responsible for facilitating the completion of federal reports to the Internal Revenue Service and insured employees and retirees.

Provider Costs Associated with ACA Regulations

5. With the passing of the Affordable Care Act, DCH and BOR have suffered and continue to suffer financial burdens because the ACA replaced the flexibility they previously had to provide health insurance plans tailored to needs of Georgia's population with federal policies. Across all programs and agencies, compliance with the ACA has cost the State of Georgia an estimated net cumulative $514 million after discounting offsets from increased employer premiums and federal funding. Moreover, because most of the relevant ACA mandates are permanent, the State of Georgia will continue to pay additional costs indefinitely.

6. Prior to the implementation of the ACA, DCH provided coverage for unmarried dependents up to age

25 who are enrolled as a full-time student at least five months during the year or are eligible to enroll but are prevented due to illness or injury to remain on their parents' insurance OR requires that a health services plan or health insurer exempt dependent children incapable of self-sustaining employment due to disability from dependent age limits. But the ACA requires health insurance coverage to provide continuing coverage for all dependents until the age of 26. Continuing health insurance coverage for adult dependents until the age of 26 imposes significant costs upon DCH because each individual insured by a DCH plan constitutes expenses for the system. Had DCH been permitted to continue providing dependent coverage that met pre-ACA requirements, these costs would not have been imposed upon DCH. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs because the dependent age requirement mandated by the ACA remains 26.

7. Prior to adoption of the ACA, DCH required insured persons to pay coinsurance and/or co-pays for preventative care that are now disallowed because the ACA requires that preventative care be covered at 100%. Covering 100% of preventative care costs more than covering less than 100% of preventative care. Thus, if DCH could have continued to provide its prior coverage plan for preventative care, it would have saved substantial sums. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs.

8. Prior to implementation of the ACA, DCH provided insurance coverage for contraceptive drugs at a rate below 100%. The ACA, however, requires contraceptives to be covered at 100%. Covering drugs at 100% of cost is more expensive for DCH than covering

drugs at less than 100%. If DCH could have maintained its prior coverage plan for contraceptives, therefore, it would have saved significant monies. Compliance with the ACA will require DCH to indefinitely continue paying these additional costs.

9. The ACA requires DCH to pay a Patient-Centered Outcomes Research Institute ("PCORI") fee. The fee increases yearly. If the PCORI fee had not been required under the ACA, DCH would not have paid it and would therefore have not seen an increase in cost. This fee is imposed currently for plans that end before October 1, 2019, and therefore, will continue to be paid into 2020 under the ACA.

10. The ACA required DCH to pay a Transitional Reinsurance Program fee. If this requirement had not been in place, DCH would not have paid the fee and would have saved substantial sums.

11. The ACA requires limits for consumer spending on in-network essential health benefits ("EHB"s) covered under most health plans. Once a person has reached the limit, the plan must cover 100% of all medical expenses. Prior to the ACA, DCH had no such limit. Covering 100% of medical expenses cost more than covering less than 100% of medical expenses. Thus, the imposition of this regulation has required DCH to spend significant funds. This is a permanent requirement under the ACA, thus the costs to DCH as a result will continue indefinitely.

12. After the implementation of the ACA's individual mandate, DCH experienced a substantial increase in employee elections to obtain health insurance. Because SHBP incurs additional costs for each additional employee who elects to obtain health insurance, the

increased number of elections resulted in substantial costs to SHBP.

13. The aforementioned ACA provisions also impact the University System of Georgia Healthcare plan. Like SHBP, BOR was and continues to be impacted by ACA mandates that differ from its pre-ACA policies. Such ACA mandates include eliminating lifetime maximums, changing coverage requirements for preventative care and out-of-pocket maximums, and instituting reoccurring fees. All of these provisions as well as increased health benefit elections have increased BOR's health plan costs.

14. As a result of the ACA, DCH and BOR increased employee premiums and participated in the Early Retiree Reinsurance Program established by the ACA to offset the cost of the law's mandates and fees. Employee premiums are paid by state employees. Thus, although DCH's costs were offset by raising employee premiums, state employee wages were negatively affected. Furthermore, when these revenue adjustments are taken into account, the net cost of the ACA to SHBP and BOR are still an estimated $442.1 million and $44.1 million, respectively, and those amounts will continue to increase each year due to the permanent and otherwise continuing mandates of the ACA.

Medicaid Costs Associated with ACA Regulations

15. With the passing of the ACA, DCH has been financially harmed and will continue to be financially harmed by the burdens imposed on it related to Medicaid and CHIP programs. To date, Medicaid and CHIP program changes as a result of the ACA have cost DCH an estimated net $24.3 million after discounting

increased rebates for CMO coverage and an increased Enhanced Federal Medical Assistance Percentage. These costs will continue year after year because the relevant ACA provisions are permanent.

16. Prior to the ACA, Georgia assessed the eligibility of Medicaid recipients every six months. To comply with the ACA, Georgia now reviews the eligibility of Medicaid recipients no more frequently than every 12 months. Less-frequent eligibility assessments result in a greater number of Medicaid recipients. Each additional Medicaid recipient represents additional costs to DCH. Thus, were it not for the implementation of this regulation, DCH would have saved substantial costs. This is a permanent requirement under the ACA, so the costs to DCH as a result will continue indefinitely.

17. The ACA imposes a fee on all for-profit entities involved in the business of providing health insurance. This fee applies to Care Management Organizations (CMOs) providing health insurance coverage to Medicaid beneficiaries. DCH is required to reimburse CMOs for the cost of the fee. If DCH was not required to pay the fee, DCH would have saved substantial sums. Compliance with the ACA will require DCH to indefinitely continue paying these growing costs.

18. The ACA allowed hospitals to determine presumptive eligibility for increased populations to include low income Medicaid categories of eligibility. It also prevents entities conducting presumptive eligibility determination from requiring proof of status. Once a qualifying hospital determines a person is presumptively eligible for Medicaid, the person can receive services for a period of 60 days. Even if the person is later found to be ineligible for Medicaid, Medicaid must pay for services rendered during the period of presumptive

eligibility. This provision of the ACA has imposed substantial costs on DCH through Medicaid match requirements. This is a permanent provision of the ACA, thus the costs to DCH as a result will continue indefinitely.

19. The ACA required the state Medicaid program to increase primary care provider (PCP) reimbursement rates to 100% of Medicare reimbursement rates between January 1, 2013 and December 31, 2014. This provision required CMOs to adjust capitation rates to account for higher reimbursement rates for primary care providers, which resulted in an increase in the Health Insurance Provider Fees paid by the CMOs and was then passed onto the state through CMO capitation rates.

20. The net cost of the ACA to DCH's Medicaid programs is estimated to be $24.3 million when the costs of eligibility review requirements, presumptive eligibility requirements, Health Insurer Provider Fee, and expansion of State Children's Insurance Plan (CHIP) coverage are offset by savings from the ACA's policy of increasing rebates for CMO coverage and its 23% increase to the Enhanced Federal Medical Assistance Percentage for CHIP beneficiaries.

Administrative Costs Associated with ACA Regulations

21. With the passing of the Affordable Care Act, SAO, DCH, and BOR have had to comply with reporting requirements that would not have otherwise been required. The cost to these agencies of compliance with the ACA's reporting requirements is an estimated net $3.6 million to date after discounting the new Enhanced Federal Medical Assistance Percentage. Since

reporting requirements are a permanent provision of the ACA, reporting costs will continue indefinitely.

22. Under the ACA, SAO is required to report coverage annually. This is a permanent provision of the ACA, thus the costs to SAO as a result will continue indefinitely.

23. Under the ACA, DCH is required to provide Medicaid and PeachCare beneficiaries with coverage information on IRS 1095-B forms. This is a permanent provision of the ACA, thus the costs to DCH as a result will continue indefinitely.

24. After the implementation of the ACA, DCH experienced increased enrollment of individuals already eligible for Medicaid benefits under pre-ACA eligibility standards. The enrollment increase required DCH to enhance its Medicaid Management Information System to process additional Medicaid applications. Enhancing its Medicaid Management Information System was very costly.

25. The total administrative costs associated with the ACA are estimated to total $11.2 million. These costs were partially offset by the ACA's increasing the Enhanced Federal Medical Assistance Percentage from 77% to 100% which reduced administrative expenditures by an estimated $7.7 million. The net cost increase for administrative programs is estimated to be $3.6 million.

26. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted this the __ day of May, 2018.

/s/ Teresa A. MacCartney
Teresa A. MacCartney
State Chief Financial Officer
Director, Officer of Planning and Budget

State of Georgia

County of Fulton

On this, the 14th day of May, 2018, before me a notary public, the undersigned officer, personally appeared Teresa A. MacCartnery, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

/s/ Felicia A. Lowe
Exp. 5/29/2018

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 5, 2018]

DECLARATION OF JAMES J. DONELON, LOUISIANA COMMISSIONER OF INSURANCE, PURSUANT TO 28 U.S.C. § 1746

INTRODUCTION

1. My name is James J. Donelon and I am the Louisiana Commissioner of Insurance.

2. As Commissioner, I am the head of the Louisiana Department of Insurance ("LDI") and the chief regulator of insurance in Louisiana pursuant to Article IV, Section 11 of the Louisiana Constitution.

3. The LDI is responsible for regulating the Louisiana health insurance market and protecting consumers in this market. The LDI performs a variety of tasks to protect insurance consumers and to ensure a competitive health insurance market environment, including:

   a. Licensing insurance companies and monitoring their financial solvency to make sure that consumers have the insurance coverage they expect when they need it;

b. Conducting examinations of foreign and domestic insurers doing business in Louisiana to ensure compliance with Louisiana laws, rules and regulations;

c. Reviewing insurance policies to be sold in Louisiana to ensure compliance with Louisiana and federal law;

d. Issuing licenses to producers, brokers, third party administrators, and other entities that sell, market and administer insurance products;

e. Investigating consumer complaints against insurance companies, producers, and other entities involved in the business of insurance doing business in Louisiana;

f. Researching special insurance issues to understand and assess their impact on the citizens of Louisiana;

g. Providing technical assistance on legislation and promulgating rules and regulations in accordance with the Louisiana Insurance Code;

h. Creating and distributing consumer education materials and public information for many types of insurance;

i. Taking administrative action including fines, license suspension, and/or license revocation against entities found to be in violation of the provisions of the Louisiana Insurance Code;

j. Taking action to initiate rehabilitation, conservation, or liquidation proceedings of companies determined to be in financially

hazardous condition or determined to be insolvent;

4. As the Louisiana Commissioner of Insurance, my duties include monitoring the impact of the Affordable Care Act ("ACA") on Louisiana's insurance market, ensuring Louisiana's compliance with the ACA, advising the Louisiana Governor and legislature on the ACA, and developing strategies for Louisiana to mitigate the numerous harms the ACA has inflicted on Louisiana's health insurance markets.

HARMS CAUSED BY THE AFFORDABLE CARE ACT

5. Title 1 of the ACA included market reforms that guaranteed minimum coverage of certain health care services, prohibited lifetime and annual limits, limited the ability of insurers to charge premiums based on gender, age, and health, as well as other lesser reforms that had an impact on pricing. The major reforms went into effect in 2014.

6. Louisiana has been very adversely affected by the market reforms of the ACA. Loss ratios for insurers operating in Louisiana skyrocketed and those sustained losses by insurers has led to market withdrawals, decreased competition, fewer product choices and higher premiums.

7. In 2013, prior to the effective date of the major provisions of the ACA, there were sixteen (16) insurance companies writing major medical insurance policies in the individual market in Louisiana. As their profits dwindled and losses mounted, companies began exiting the individual market. In 2018 there are essentially only two insurers writing individual major medical policies in Louisiana.

8. In 2013, prior to the effective date of the major provisions of the ACA, premiums increased an average of 3.7 percent (3.7%) in the Louisiana individual market. In 2014, due to the mandates of the ACA, premiums increased by fifty-three percent (53%) and have continued to increase by double digits every year. The average rate increase in the individual market was seventeen percent (17%) in 2015, fourteen percent (14%) in 2016, thirty-three percent (33%) in 2017, and eighteen and one half percent (18.5%) in 2018. Additionally, total market enrollment is down significantly as premiums continue to rise. The viability and continued existence of the individual market in Louisiana is threatened by rising premiums and reduced enrollment.

9. Health insurance premiums are predicted to continue to rise. The Congressional Budget Office's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, Federal outlays for health insurance subsidies and related spending will rise by about sixty percent (60%) over the projection period, increasing from $58 billion in 2018 to $91 billion by 2028. (cbo.gov/publication/53651). These rising premiums have a significant negative impact on Louisiana's middle-class as fewer employers offer health insurance coverage due to increasing premiums.

10. The LDI, as the primary enforcer of insurance laws, has spent the past six years reading, studying, interpreting, and enforcing federal regulations and additional guidance related to the ACA. The LDI completely revised its insurance policy review standards for health insurance products, educated the public on changes in the Law, and handled consumer complaints expressing confusion and frustration about the

limited, expensive choices that remain in the Louisiana individual market.

11. Additionally, Louisiana has been harmed by the ACA because it has preempted Louisiana law, preventing the Louisiana Department of Insurance from regulating health insurance in the manner it deems best for consumers.

12. Finally, the ACA has harmed the Louisiana health insurance market by providing for the establishment of the Consumer Operated and Oriented Plan (Co-op) Program. The program was intended to foster the creation of nonprofit health insurance issuers to offer health plans in the individual and small group markets as an alternative to commercial insurance to create competition and drive down premiums. The onerous restrictions placed on the Co-ops as well as inadequate funding contributed to the downfall of the vast majority of the original twenty-three (23) Co-ops created nationwide. Almost every Co-op has been financially troubled and most have failed, including Louisiana's Co-op, Louisiana Health Cooperative ("LAHC"). LAHC was placed in Rehabilitation by a Louisiana court on September 1, 2015 and the LDI has spent considerable resources overseeing the Rehabilitation of LAHC to protect the consumers and healthcare providers affected by the failure of the Co-op. The ACA's Co-op Program has cost taxpayers nationwide more than $1.8 billion to date.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Executed in Baton Rouge, Louisiana, this 2ND day of MAY, 2018.

/s/ James J. Donelon
James J. Donelon
Commissioner of Insurance
State of Louisiana

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 5, 2018]

DECLARATION OF ERIC A. CIOPPA, MAINE SUPERINTENDENT OF INSURANCE PURSUANT TO 28 U.S.C. § 1746

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1. My name is Eric Cioppa. I am the Superintendent of Insurance for the State of Maine.

2. As Superintendent of Insurance, I am the head of the Bureau of lnsurance within the Maine Department of Professional and Financial Regulation. Generally, my official duties include supervising the agency, serving as final adjudicator of all administrative actions, and serving on various councils and committees. As a member of the State Employee Health Commission, I have first-hand experience with the management and operations of a large self-insured health plan.

3. The duties of the Maine Bureau of Insurance include:

   a. Assisting insurance consumers with their insurance problems;

b. Conducting examinations of foreign and domestic insurers doing business in Maine to ensure compliance with Maine laws and rules;

c. Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;

d. Reviewing insurance policies sold in Maine to ensure compliance with Maine and federal law;

e. Issuing licenses to agents, brokers, consultants, and other entities that sell and market insurance products;

f. Researching special insurance issues to understand and assess their impact on Mainers;

g. Providing technical assistance on legislation, adopting rules to implement insurance laws, and issuing bulletins and other interpretive guidance;

h. Creating and distributing public information and consumer education about all types of insurance; and

i. When insurance companies are in financially hazardous condition or have become insolvent, working with the guaranty associations made up of insurance companies, which by statute must step in and pay policyholder claims when an insurer fails.

4. In addition to the implementation and enforcement of the Maine Insurance Code, my duties include the implementation and enforcement of other

state and federal statutes to the extent that they provide for administration or enforcement by the Superintendent. Federal law mandates that I enforce those provisions enacted by HIPAA and the ACA that have been codified in the federal Public Health Service Act.

5. In 1993, Maine mandated guaranteed issuance of coverage and modified community rating in its individual health insurance market without any mandate to purchase coverage.

6. As explained in Pages 30 and 31 of the Plaintiffs" Brief in Support of their Motion for Preliminary Injunction, the government argued in *NFIB v. Sebelius* that without an individual mandate, guaranteed issue and community rating "would drive up costs and reduce coverage," leading to "a marketwide adverse-selection death spiral," and "the market will blow up."

7. That is precisely what happened in Maine. Under Maine's guaranteed-issue law, coverage became increasingly unaffordable, even for consumers willing to purchase plans with per-person deductibles as high as $20,000. By 2010, there was only one carrier offering comprehensive health plans. Only 30,000 Mainers were enrolled in the individual market, while 110,000 were uninsured.

8. The ACA implementation has led to a lack of choices in coverage, and failed to live up to its promise of affordability. Consumers with one of the most widely purchased plans in 2013, the Anthem HealthChoice 15000 plan, were mapped by Anthem into the ACA-compliant Bronze Guided Access plan for 2014. The resulting premium increase for consumers aged 30 to 60 ranged from 48.1% to 122.7%, depending on age and geographic area. Outside Rating

Area 1 (which includes Portland) the smallest increase for the other three rating areas was 78.5%.

9. Premiums under the ACA continue to rise. Carriers' average individual rate increases in Maine ranged from 18.0% to 25.5% in 2017, and ranged from 19.6% to 39.7% in 2018.

10. The cost of insurance is particularly burdensome for consumers who earn more than 400% of the Federal Poverty Level ("400 % FPL") and are not eligible for premium subsidies. This year, the unsubsidized premium for a 45-year-old nonsmoking couple with two young children ranges from $16,978.80 to $25,094.40 for the lowest-priced Silver plan, depending on which county they live in. These plans are not offered on the Exchange, so the price is not artificially increased by the cost of the Cost-Sharing reductions. Even if this family were to buy a Catastrophic plan, the annual premium for the lowest-priced plan would range from $9909.84 to $14,409.12, depending on geography.

11. Even for consumers who are eligible for subsidies, the cost of ACA-compliant insurance is often out of reach. Under the ACA, subsidies are only available if the price of the second-lowest-cost Silver plan (the "baseline" plan) exceeds a specified percentage of income. When subsidies are available, they are calculated so that the consumer must pay that percentage of their income as the premium for the baseline plan, and must also pay the applicable deductible and other cost sharing. For example; for consumers making between 300% and 400% FPL, the subsidized premium for the baseline plan is equal to 9.56% of their household income in premium. This year, for a family of four, 400% of the Federal Poverty Level ("400% FPL") is $100,400 and 300% FPL is $75,300. This makes

their subsidized premium $7,198.68 per year at 300% FPL and $9,598.24 at 400% FPL.

I declare under penalty of perjury that the foregoing is true and correct, based on my personal knowledge and on information contained within the records of the Maine Bureau of Insurance, Department of Professional and Financial Regulation.

April 30, 2018

/s/ Eric A. Cioppa
Eric A. Cioppa
Superintendent of Insurance,
State of Maine

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 16, 2018]

ORDER

Before the Court is Plaintiffs' Application for Preliminary Injunction (ECF No. 39), filed April 26, 2018. In response, the Federal Defendants oppose injunctive relief because "immediate relief is not warranted at this time," and urge the Court to "consider construing Plaintiffs' motion as a request for summary judgment . . . ." Fed. Defs.' Br. Resp. Pls.' App. Prelim. Inj. 20, ECF No. 92.

The Court **ORDERS** all parties to file any additional information they wish to present in opposition to considering these issues on summary judgment. Any additional information any party wishes to present should be filed **on or before July 30, 2018.** *See* FED. R. CIV. P. 56(f)(3).

SO ORDERED on this **16th day of July, 2018.**

/s/ Reed O'Connor
Reed O'Connor
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 30, 2018]

PLAINTIFFS' STATEMENT ON CONSIDERATION OF THE CONSTITUTIONALITY OF THE INDIVIDUAL MANDATE ON SUMMARY JUDGMENT

On July 16, the Court issued an order, Doc. 176, noting Federal Defendants' opposition to Plaintiffs' request for the issuance of immediate injunctive relief and their suggestion that the Court "consider construing Plaintiffs' motion as a request for summary judgment . . . ." Doc. 92, Defs. PI Br.20. The Court has provided the parties an opportunity to present additional information in opposition to the Court considering the issues raised by Plaintiffs' application for preliminary injunction in the summary judgment posture. Doc. 176. For the reasons discussed below, Plaintiffs maintain that preliminary injunctive relief is necessary and the Court must treat Plaintiffs' application for a preliminary injunction as requesting that relief under applicable standards. That said, because the parties agree that the matters currently before the Court are purely issues of law, Plaintiffs do not oppose

the Court also and *simultaneously* considering Plaintiffs' application as a motion for partial summary judgment on the constitutionality of the ACA's mandate.

***

In their response to Plaintiffs' application for preliminary injunction, Federal Defendants assert that "the injury imposed by the individual mandate is not sufficiently imminent to warrant preliminary injunctive relief, especially where final adjudication would be possible before that injury occurs." Defs. PI Br.20 (citing *Aransas Project v. Shaw*, 775 F.3d 641, 664 (5th Cir. 2014), for the proposition that an injunction may "be issued only if future injury is 'certainly impending'").

Federal Defendants agree that the ACA's individual mandate will be unconstitutional with the repeal of the tax penalty taking effect in 2019. Defs. PI Br.20. It is thus undisputed—at least as between Plaintiffs and Federal Defendants—that Plaintiffs have met their burden of showing a constitutional injury sufficient to constitute irreparable harm. *See* Doc. 40, Pls. PI Br. 41-48; Doc. 175, Pls. PI Reply Br.21-26. This impending harm is sufficient to justify a preliminary injunction. "[T]he injury need not have been inflicted when application is made or be certain to occur; a strong threat of irreparable injury *before trial* is an adequate basis." *United States v. Emerson*, 270 F.3d 203, 262 (5th Cir. 2001) (emphasis added) (quoting 9 Wright, Miller & Kane, FED. PRAC. & PROC. § 2948.1 at 153–56)). Because the focus is on whether irreparable harms will flow to the movant prior to trial, and because Federal Defendants do not contest those harms, their focus on whether Plaintiffs' injury is "sufficiently imminent" is misplaced.

And contrary to Federal Defendants' suggestion that "final adjudication would be possible before that injury occurs," Defs. PI Br.20, it would be remarkable for this Court to resolve all issues in this case and enter final judgment before January 1, 2019. Not only are the issues in this case particularly complex and important, but only one of Plaintiffs' four claims is currently before the Court: Plaintiffs' preliminary injunction application does not address their Due Process Clause, Tenth Amendment, or APA claims. *See* Pls. 2d Am. Compl. ¶¶61-83. Because issuing a final judgment on every issue and claim raised in this suit prior to January 1, 2019—the day that the irreparable harm to the plaintiffs begins—is highly unlikely, if not nearly impossible, Plaintiffs' preliminary injunction application is the *only* way for Plaintiffs to obtain relief from the irreparable harms their record evidence has established.

Federal Defendants and Plaintiffs do agree, however, that the constitutionality of the ACA's mandate is a "pure question of law." Defs. PI Br.20. Discovery and further factual development of the record are unnecessary for the Court to determine whether the mandate falls upon the elimination of the tax penalty. For that reason, the Court could treat Plaintiffs' application for preliminary injunction as a combined application for preliminary injunction and motion for partial summary judgment on their declaratory judgment claim that the mandate exceeds Congress's Article I powers. *See* Pls. 2d Am. Compl. ¶¶48-60; e.g., *Landry v. Air Line Pilots Ass'n Int'l AFL–CIO*, 892 F.2d 1238, 1269 (5th Cir. 1990) (affirming summary judgment granted prior to discovery being conducted because "many of the issues raised by the summary judgment motions were purely legal and . . . discovery would therefore not aid their resolution"); *Rosas v.*

U.S. Small Bus. Admin., 964 F.2d 351, 359 (5th Cir. 1992) ("As the issues to be decided by the district court were purely legal in nature, the court did not abuse its discretion in deciding the summary judgment motion prior to completion of discovery.").

Construing Plaintiffs' application in this way would not change any standards for the granting or denial of either motion, but would serve judicial economy because there is no need for the parties to rehash the legal issues surrounding the unconstitutionality of the individual mandate—and the severability of the remainder of the ACA—on later summary judgment briefing en route to a final resolution of this litigation.[1]

Dated: July 30, 2018

Respectfully submitted,

BRAD D. SCHIMEL
Wisconsin Attorney General

KEN PAXTON
Attorney General of Texas

MISHA TSEYTLIN
Wisconsin Solicitor General

JEFFREY C. MATEER
First Assistant Attorney General

KEVIN M. LEROY
Wisconsin Deputy Solicitor General

BRANTLEY D. STARR
Deputy First Assistant Attorney General

[1] To the extent that the Court were to treat Plaintiff's application for a preliminary injunction as a partial summary judgment motion only, that would be the practical denial of a request for injunctive relief, which would be immediately appealable. 28 U.S.C. § 1292(a)(1) (authorizing appellate jurisdiction from orders "refusing or dissolving injunctions"); *Carson v. American Brands, Inc.*, 450 U.S. 79, 83 (1981) (orders that have the "practical effect" of denying injunctive relief are immediately appealable).

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

Civil Action No. 4:18-cv-000167-O

TEXAS, ET AL., *Plaintiffs*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants,*

CALIFORNIA, ET AL., *Intervenors-Defendants*

[Filed: July 30, 2018]

INTERVENOR STATES' RESPONSE TO JULY 16, 2018 COURT ORDER

The Intervenor States submit this response to the Court's July 16, 2018 Order directing the parties "to file any additional information they wish to present in opposition to considering" the issues raised by the briefing on Plaintiffs' Application for a Preliminary Injunction "on summary judgment." ECF No. 176. The Intervenor States understand that Order not as a request to present additional evidence or arguments they might submit in support of (or in opposition to) a motion for summary judgment, but instead a request to identify for the Court what evidence and argument they might wish to raise during summary judgment briefing.

The Intervenor States respectfully submit that this Court should not convert the briefing on the preliminary injunction application into a motion for summary

judgment. The Intervenor States' opposition to the application for a preliminary injunction focused on the legal and evidentiary standards that govern that relief. At the summary judgment stage, however, the Intervenor States would be afforded an opportunity to more fully brief legal issues that the preliminary injunction legal standard and page limitations did not permit previously. These issues include, but are not limited to: (1) whether Plaintiffs have Article III standing to challenge the constitutionality of the minimum coverage provision; (2) whether the minimum coverage requirement under 26 U.S.C. § 5000A may now be sustained under the Commerce Clause, see State Defendants' Br. In Opp. to Plaintiffs' Application for a Preliminary Injunction, ECF No. 91, at 18 n.17; (3) whether an injunction limited to the 20 Plaintiff States is legally supportable and whether it would harm the Intervenor States,[1] (4) whether regulations promulgated under the Affordable Care Act remain lawful if the minimum coverage provision, or any other provisions, are struck down; (5) whether the Supreme Court's "modern severability precedents" are consistent with "longstanding limits on judicial power," *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1487 (2018) (Thomas, J., concurring); and (6) whether Plaintiffs can meet their burden of demonstrating that they are entitled to a permanent injunction, see, e.g., *eBay Inc. v. MercExchange, LLC*, 547 U.S. 388, 391 (identifying factors that a plaintiff seeking permanent injunctive relief must satisfy). If the

[1] The Plaintiff States requested this narrower injunctive relief for the first time in their Preliminary Injunction Reply Brief. *See* ECF No. 175 at 29-30.

Court nevertheless intends to move straight to summary judgment at this time, it should permit the parties the opportunity to submit supplemental briefing which will enable the parties to place all of the legal and factual issues in this case before the Court.[2] *See Underwood v. Hunter*, 604 F.2d 367, 369 (5th Cir. 1979) (when only a preliminary injunction is pending, "we cannot say with assurance that the parties will present everything they have. The very intimation of mortality when summary judgment is at issue assures us that the motion will be rebutted with every factual and legal argument available."). Based upon all of the foregoing, the Intervenor States—in agreement with the Plaintiffs—urge the Court to decline the Federal Defendants' invitation to convert the pending preliminary injunction application into another motion. If the Court determines that summary judgment is appropriate at this time, however, the Intervenor States respectfully request that the Court grant the parties a 30-day period to file supplemental briefing on the additional issues identified above (and perhaps others).

Dated: July 30, 2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General

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[2] Whether the Court rules on the merits under the preliminary injunction standard or under the summary judgment framework, the Court's ruling should be a final appealable order or a final judgment so that the parties may promptly seek appellate review.

KATHLEEN BOERGERS
Supervising Deputy Attorney General
NIMROD P. ELIAS
Deputy Attorney General

/s/ Neli N. Palma

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UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-10011

TEXAS, ET AL., *Plaintiffs – Appellees*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants – Appellants,*

CALIFORNIA, ET AL., *Intervenor-Defendants – Appellants.*

[Filed: January 9, 2020]

OPINION

REVISED January 9, 2020
FILED December 18, 2019

Before KING, ELROD, and ENGELHARDT, Circuit Judges.

JENNIFER WALKER ELROD, Circuit Judge:

The Patient Protection and Affordable Care Act (the Act or ACA) is a monumental piece of healthcare legislation that regulates a huge swath of the nation's economy and affects the healthcare decisions of millions of Americans. The law has been a focal point of our country's political debate since it was passed nearly a decade ago. Some say that the Act is a much-needed solution to the problem of increasing healthcare costs and lack of healthcare availability. Many of the amici in this case, for example, argue that

the law has extensively benefitted everyone from children to senior citizens to local governments to small businesses. Others say that the Act is a costly exercise in burdensome governmental regulation that deprives people of economic liberty. Amici of this perspective argue, for example, that the Act "has deprived patients nationwide of a competitive market for affordable high-deductible health insurance," leaving "patients with no alternative to . . . skyrocketing premiums." Association of American Physicians & Surgeons Amicus Br. at 15.

None of these policy issues are before the court. And for good reason—the courts are not institutionally equipped to address them. These issues are far better left to the other two branches of government. The questions before the court are far narrower: questions of law, not of policy. Those questions are: First, is there a live case or controversy before us even though the federal defendants have conceded many aspects of the dispute; and, relatedly, do the intervenor-defendant states and the U.S. House of Representatives have standing to appeal? Second, do the plaintiffs have standing? Third, if they do, is the individual mandate unconstitutional? Fourth, if it is, how much of the rest of the Act is inseverable from the individual mandate?

We answer those questions as follows: First, there is a live case or controversy because the intervenor-defendant states have standing to appeal and, even if they did not, there remains a live case or controversy between the plaintiffs and the federal defendants. Second, the plaintiffs have Article III standing to bring this challenge to the ACA; the individual mandate injures both the individual plaintiffs, by requiring them to buy insurance that they do not want, and the state

plaintiffs, by increasing their costs of complying with the reporting requirements that accompany the individual mandate. Third, the individual mandate is unconstitutional because it can no longer be read as a tax, and there is no other constitutional provision that justifies this exercise of congressional power. Fourth, on the severability question, we remand to the district court to provide additional analysis of the provisions of the ACA as they currently exist.

I.

On March 23, 2010, President Barack Obama signed the ACA into law. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The Act sought to "increase the number of Americans covered by health insurance and decrease the cost of health care" through several key reforms. *See Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 538 (2012).

Some of those reforms implemented new consumer protections, aiming primarily to protect people with preexisting conditions. For example, the law prohibits insurers from refusing to cover preexisting conditions. 42 U.S.C. § 300gg-3. The "guaranteed-issue requirement" forbids insurers from turning customers away because of their health. *See* 42 U.S.C. §§ 300gg, 300gg-1. The "community-rating requirement" keeps insurers from charging people more because of their preexisting health issues. 42 U.S.C. § 300gg-4.[1] The law

[1] The ACA features a few other consumer-protection reforms of note. For example, the Act requires insurance companies to allow young adults to stay on their parents' health insurance plans until they turn 26; prohibits insurers from imposing caps on the

also requires insurers to provide coverage for certain types of care, including women's and children's preventative care. 42 U.S.C. § 300gg-13(a)(3)–(4).[2]

Other reforms sought to lower the cost of health insurance by using both policy "carrots" and "sticks."[3]

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value of benefits provided; and mandates that the insurance plans cover at least ten "essential health benefits," including emergency services, prescription drugs, and maternity and newborn care. *See* 42 U.S.C. §§ 300gg-14 (young adults), 300gg-11 (restriction on benefit caps), 18022 (essential health benefits). The ACA also requires employers with at least fifty full-time employees to pay the federal government a penalty if they fail to provide their employees with ACA-compliant coverage. 26 U.S.C. § 4980H.

[2] The women's preventative care provision was at issue in a trio of recent Supreme Court cases. *See Zubik v. Burwell*, 136 S. Ct. 1557 (2016); *Wheaton College v. Burwell*, 573 U.S. 958 (2014); *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014); *see also California v. U.S. Dep't of Health & Human Servs.*, No. 19-15072, 2019 WL 5382250 (9th Cir. Oct. 22, 2019); *Pennsylvania v. President United States*, 930 F.3d 543 (3d Cir. 2019), *as amended* (July 18, 2019); *DeOtte v. Azar*, 393 F. Supp. 3d 490, 495 (N.D. Tex. 2019).

[3] Some opponents of the ACA assert that the goal was not to lower health insurance costs, but that the entire law was enacted as part of a fraud on the American people, designed to ultimately lead to a federal, single-payer healthcare system. In a hearing before the House Committee on Oversight and Government Reform, for example, Representative Kerry Bentivolio suggested that Jonathan Gruber, who assisted in crafting the legislation, had "help[ed] the administration deceive the American people on this healthcare act or [told] the truth in [a] video . . . about how [the Act] was a fraud upon the American people." *Examining Obamacare Transparency Failures: Hearing Before the H. Comm. on Oversight and Government Reform*, 113th Cong. 83 (2014) (statement of Rep. Kerry Bentivolio).

On the stick side, the individual mandate—which plaintiffs challenge in the instant case—requires individuals to "maintain [health insurance] coverage." 26 U.S.C. § 5000A(a). If individuals do not maintain this coverage, they must make a payment to the IRS called a "shared responsibility payment."[4] *Id.*; *see also King v. Burwell*, 135 S. Ct. 2480, 2486 (2015).

The individual mandate was designed to lower insurance premiums by broadening the insurance pool. *See* 42 U.S.C. § 18091(2)(J) ("By significantly increasing . . . the size of purchasing pools, . . . the [individual mandate] will significantly . . . lower health insurance premiums."). When the young and healthy must buy insurance, the insurance pool faces less risk, which, at least in theory, leads to lower premiums for everyone. *See* 42 U.S.C. § 18091(2)(I) (positing that the individual mandate will "broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums"). The individual mandate thus serves as a counterweight to the ACA's protections for preexisting conditions, which push riskier, costlier individuals into the insurance pool. Under the protections for consumers with preexisting conditions, if there were no individual mandate, there would ar-

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[4] The Act exempts several groups of people from the shared responsibility payment. Specifically, the Act provides that "[n]o penalty shall be imposed" on those "who cannot afford [insurance] coverage," on "[t]axpayers with income below [the] filing threshold," on "[m]embers of Indian tribes," on those who had only "short coverage gaps," or on anyone who, in the Secretary of Health and Human Services' determination, has "suffered a hardship." 26 U.S.C. § 5000A(e).

guably be an "adverse selection" problem: "many individuals would," in theory, "wait to purchase health insurance until they needed care." *Id.*[5]

The Act also sought to lower insurance costs for some consumers through policy "carrots," providing tax credits to offset the cost of insurance to those with incomes under 400 percent of the federal poverty line. *See* 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082. The Act also created government-run, taxpayer-funded health insurance marketplaces—known as "Exchanges"—which allow customers "to compare and purchase insurance plans." *King*, 135 S. Ct. at 2485; *see also* 42 U.S.C. § 18031. Opponents of the law argue that the law has led to unintended subsidies to keep plans afloat and insurance companies in the black. Texas points in its brief, for example, to a Congressional Budget Office study estimating that federal outlays for health insurance subsidies and related spending will rise by about 60 percent over the next ten years, from $58 billion in 2018 to $91 billion by 2028. CBO, *The Budget and Economic Outlook: 2018 to 2028*

[5] Opponents of the ACA, however, argue that the Act goes too far in limiting individuals' freedom to choose healthcare coverage. For example, at a House committee hearing, Representative Darrell Issa argued that one of the "false claims" that the Obama administration made in passing the Act was that "[i]f you like your doctor, you will be able to keep your doctor, period. . . . [And i]f you like your [insurance] plan, you can keep your plan." *Examining Obamacare Transparency Failures: Hearing Before the H. Comm. on Oversight and Government Reform*, 113th Cong. 2 (2014) (statement of Rep. Darrell Issa, Chairman, H. Comm. on Oversight and Government Reform).

at 51 (April 2018), *available at* https://tinyurl.com/CBOBudgetEconOutlook-2018-2028; State Plaintiffs' Br. at 13–14.

The ACA also enlarged the class of people eligible for Medicaid to include childless adults with incomes up to 133 percent of the federal poverty line. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VII), 1396a(e)(14)(I)(i); *NFIB*, 567 U.S. at 541–42. The ACA originally required each state to expand its Medicaid program or risk losing "all of its federal Medicaid funds." *NFIB*, 567 U.S. at 542. In *NFIB*, however, the Supreme Court held that this exceeded Congress' powers under the Spending Clause. *Id.* at 585 (plurality opinion). But the Court allowed those states that wanted to accept Medicaid expansion funds to do so. *See id.* at 585–86 (plurality opinion); *id.* at 645–46 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). As a result, the states that have not participated in the expansion now subsidize, through their general tax dollars, the states that have participated in expansion.

Since the Act was passed, its opponents have attempted to attack it both through congressional amendment and through litigation. Between 2010 and 2016, Congress considered several bills to repeal, defund, delay, or amend the ACA. *See* Intervenor-Defendant States' Br. at 10. Except for a few modest changes, these efforts were closely fought but ultimately failed. Intervenor-Defendant States' Br. at 10–11. In 2017, the shift in presidential administrations reinvigorated opposition to the law, but many of these later legislative efforts failed as well. In March 2017, House leaders pulled a bill that would have repealed many of the ACA's essential provisions. In July 2017,

the Senate voted on three separate bills that similarly would have repealed major provisions of the Act, but each vote failed.[6] Finally, in September 2017, several Senators introduced another bill that would have repealed some of the ACA's most significant provisions, but Senate leaders ultimately chose not to bring it to the floor for a vote. Intervenor-Defendant States' Br. at 11.

The ACA's opponents also took their cause to the courts in a series of lawsuits, some of which reached the Supreme Court. Particularly relevant here, the Court, in *NFIB*, upheld the law's individual mandate. 567 U.S. at 574. Through fractured voting and shifting majorities—explained in more detail in Part V of this opinion—the Court decided that the ACA's individual mandate could be read as a tax on an individual's decision not to purchase insurance, which was a constitutional exercise of Congress' taxing powers under Article I of the U.S. Constitution. *Id.*; U.S. Const. art. I, § 8, cl. 1. The Court favored this tax interpretation to save the provision from unconstitutionality. Reading the provision as a standalone command to purchase insurance would have rendered it unconstitutional. This reading could not have been justified under the Commerce Clause because it would have done more than "regulate commerce . . . among the several states." U.S. Const. art. I, § 8, cl. 3. It would have *compelled* individuals to enter commerce in the

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[6] One of these bills failed by a razor-thin vote of fifty-one against, forty-nine in favor. *See* 163 Cong. Rec. S4415 (daily ed. July 27, 2017).

first place.[7] *NFIB*, 567 U.S. at 557–58. The Court also held that the provision could not be justified under the Constitution's Necessary and Proper Clause. *Id.* at 561 (Roberts, C.J.); *id.* at 654–55 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

In December 2017, the ACA's opponents achieved some legislative success. As part of the Tax Cuts and Jobs Act, Congress set the "shared responsibility payment" amount—the amount a person must pay for failing to comply with the individual mandate—to the "lesser" of "zero percent" of an individual's household income or "$0," effective January 2019. Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017); *see also* 26 U.S.C. § 5000A(c). The individual mandate is still "on the books" of the U.S. Code and still consists of the three fundamental components it always featured. Subsection (a) prescribes that certain individuals "shall . . . ensure" that they and their dependents are "covered under minimum essential coverage." 26 U.S.C. § 5000A(a). Subsection (b) "impose[s] . . . a penalty" called a "[s]hared responsibility payment" on those who fail to ensure they have minimum essential coverage. 26 U.S.C. § 5000A(b). Subsection (c) sets the amount of that payment. All Congress did in 2017 was change the amount in subsection (c) to zero dollars. 26 U.S.C. § 5000A(c).

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[7] Chief Justice Roberts cautioned that concluding otherwise would empower the government to compel Americans into all kinds of behavior that the government thinks is beneficial for them, including, for example, compelling them to purchase broccoli. *See NFIB*, 567 U.S. at 558 (Roberts, C.J.).

Two months after the shared responsibility payment was set at zero dollars, the plaintiffs here—two private citizens[8] and eighteen states[9]—filed this lawsuit against several federal defendants: the United States of America, the Department of Health and Human Services and its Secretary, Alex Azar, as well as the Internal Revenue Service and its Acting Commissioner, David J. Kautter. The plaintiffs argued that the individual mandate was no longer constitutional because: (1) *NFIB* rested the individual mandate's constitutionality exclusively on reading the provision as a tax; and (2) the 2017 amendment undermined any ability to characterize the individual mandate as a tax because the provision no longer generates revenue, a requirement for a tax. The plaintiffs argued further that, because the individual mandate was essential to and inseverable from the rest of the ACA, the entire ACA must be enjoined. On this theory, the plaintiffs sought declaratory relief that the individual mandate is unconstitutional and the rest of the ACA is inseverable. The plaintiffs also sought an injunction prohibiting the federal defendants from enforcing any provision of the ACA or its regulations.

The federal defendants agreed with the plaintiffs that once the shared responsibility payment was reduced to zero dollars, the individual mandate was no

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[8] Namely, Neill Hurley and John Nantz.

[9] Namely, Texas, Alabama, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, West Virginia, and Arkansas. Wisconsin, which was originally a plaintiff state, sought and was granted dismissal from the appeal.

longer constitutional. They also agreed that the individual mandate could not be severed from the ACA's guaranteed-issue and community-rating requirements. Unlike the plaintiffs, however, the federal defendants contended in the district court that those three provisions could be severed from the rest of the Act. Driven by the federal defendants' decision not to fully defend against the lawsuit, sixteen states[10] and the District of Columbia intervened to defend the ACA.

The district court agreed with the plaintiffs' arguments on the merits. Specifically, the court held that: (1) the individual plaintiffs had standing because the individual mandate compelled them to purchase insurance; (2) setting the shared responsibility payment to zero rendered the individual mandate unconstitutional; and (3) the unconstitutional provision could not be severed from any other part of the ACA. The district court granted the plaintiffs' claim for declaratory relief. Specifically, the district court's order "declares the Individual Mandate, 26 U.S.C. § 5000A(a), UNCONSTITUTIONAL," and the order further declares that "the remaining provisions of the ACA, Pub L. 111-148, are INSEVERABLE and therefore INVALID." The district court, however, denied the plaintiffs' application for a preliminary injunction. The district court entered partial final judgment[11] as to the grant

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[10] Namely, California, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Massachusetts, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, Washington, and Minnesota.

[11] The final judgment is only partial because it addresses only

of summary judgment for declaratory relief, but stayed judgment pending appeal. This appeal followed.

On appeal, the U.S. House of Representatives intervened to join the intervenor-defendant states in defending the ACA.[12] Also on appeal, the federal defendants changed their litigation position. After contending in the district court that only a few provisions of the ACA were inseverable from the individual mandate, the federal defendants contend in their opening brief for the first time that all of the ACA is inseverable. *See* Fed. Defendants' Br. at 43–49. Moreover, the federal defendants contend for the first time on appeal that—even though the entire ACA is inseverable—the court should not enjoin the enforcement of the entire ACA. The federal defendants now argue that the district court's judgment should be affirmed

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Count One of the plaintiffs' amended complaint. Count One requests a declaratory judgment that the individual mandate exceeds Congress' constitutional powers. The district court has not yet ruled on the other counts in the amended complaint. In Count Two, the plaintiffs request a declaratory judgment that the ACA violates the Due Process Clause of the Fifth Amendment. In Count Three, the plaintiffs request a declaratory judgment that the ACA violates the Tenth Amendment. In Count Four, the plaintiffs request a declaratory judgment that agency rules promulgated pursuant to the ACA are unlawful. In Count Five, the plaintiffs request an injunction prohibiting federal officials from "implementing, regulating, or otherwise enforcing any part of the ACA."

[12] In addition to the U.S. House, four other states intervened on appeal to join the original group that defended the Act in the district court: Colorado, Iowa, Michigan, and Nevada.

"except insofar as it purports to extend relief to ACA provisions that are unnecessary to remedy plaintiffs' injuries."[13] Fed. Defendants' Br. at 49. They also now argue that the district court's judgment "cannot be understood as extending beyond the plaintiff states to invalidate the ACA in the intervenor states." Fed. Defendants' Supp. Br. at 10. Simply put, the federal defendants have shifted their position on appeal more than once.

II.

We review a district court's grant of summary judgment *de novo*. *Time Warner Cable, Inc. v. Hudson*, 667 F.3d 630, 638 (5th Cir. 2012). Summary judgment is appropriate when "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see also Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 250 (5th Cir. 2019). A dispute about a material fact is genuine if "the evidence is such that a reasonable jury could return a verdict for the non-moving party." *Amerisure Ins. v. Navigators Ins.*, 611 F.3d 299, 304 (5th Cir. 2010) (quoting *Gates v. Tex. Dep't of Protective & Regulatory Servs.*, 537 F.3d 404, 417 (5th Cir. 2008)). When ruling on a motion for summary judgment, the court views all inferences drawn from the factual record "in the light most favorable to the non-moving parties below." *Trent v. Wade*, 776 F.3d 368, 373 n.1 (5th Cir. 2015).

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[13] The federal defendants do not specify which precise provisions, in their view, injure the plaintiffs and which do not.

III.

We first must consider whether there is a live "[c]ase" or "[c]ontroversy" before us on appeal, as Article III of the U.S. Constitution requires. U.S. Const. art. III, § 1. A case or controversy does not exist unless the person asking the court for a decision—in this case, asking us to decide whether the district court's judgment was correct—has standing, which requires a showing of "injury, causation, and redressability." *Sierra Club v. Babbitt*, 995 F.2d 571, 574 (5th Cir. 1993). When "standing to appeal is at issue, appellants must demonstrate some injury from the judgment below." *Id.* at 575 (emphasis omitted).

We conclude, as all parties agree, that there is a case or controversy before us on appeal. Two groups of parties appealed from the district court's judgment: the federal defendants, and the intervenor-defendant states.[14] There is a case or controversy before us because both of these groups have their own independent standing to appeal.[15]

The federal defendants have standing to appeal. The instant case is on all fours with the Supreme

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[14] The U.S. House of Representatives, also a party in this case, intervened in our court after the intervenor-defendant states and the federal government had filed notices of appeal.

[15] Even if only one of these parties had standing to appeal, that would be enough to sustain the court's jurisdiction. An intervenor needs standing only "in the absence of the party on whose side the intervenor intervened." *Sierra Club*, 995 F.2d at 574 (alteration omitted) (quoting *Diamond v. Charles*, 476 U.S. 54, 68 (1986)); *see also Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 264 & n.9 (1977) (exercising jurisdiction because "at least one" plaintiff had standing to sue).

Court's decision in *United States v. Windsor*, 570 U.S. 744 (2013). In that case, the executive branch of the federal government declined to defend a federal statute that did not allow the surviving spouse of a same-sex couple to receive a spousal tax deduction. *Id.* at 749–53. The district court ruled that the statute was unconstitutional and ordered the executive branch to issue a tax refund to the surviving spouse. *Id.* at 754–55. The executive branch agreed with the district court's legal conclusion, but it appealed the judgment and continued to enforce the statute by withholding the tax refund until a final judicial resolution. *Id.* at 757–58.

The Supreme Court ruled that "the United States retain[ed] a stake sufficient to support Article III jurisdiction." *Id.* at 757. That stake was the tax refund, which the federal government refused to pay. This threat of payment of money from the Treasury constituted "a real and immediate economic injury" to the federal government, which was sufficient for standing purposes. *Id.* at 757–58 (quoting *Hein v. Freedom From Religion Found., Inc.*, 551 U.S. 587, 599 (2007) (plurality opinion)). As the Court explained, "the refusal of the Executive to provide the relief sought suffices to preserve a justiciable dispute as required by Article III." *Id.* at 759; *see also Food Mktg. Inst. v. Argus Leader Media*, 139 S. Ct. 2356, 2362 (2019) (concluding that there was a justiciable controversy because the government "represented unequivocally" that it would not voluntarily moot the controversy absent a final judicial order, and "[t]hat is enough to satisfy Article III"); *INS v. Chadha*, 462 U.S. 919, 939 (1983) (holding that there was "adequate Art. III adverseness" because the executive branch determined

that a federal statute was unconstitutional and refused to defend it but simultaneously continued to abide by it).

The instant case is similar. Though the plaintiffs and the federal defendants are in almost complete agreement on the merits of the case, the government continues to enforce the entire Act. The federal government has made no indication that it will begin dismantling any part of the ACA in the absence of a final court order. Just as in *Windsor*, then, effectuating the district court's order would require the federal government to take actions that it would not take "but for the court's order." *Windsor*, 570 U.S. at 758. And just as in *Windsor*, the federal defendants stand to suffer financially if the district court's judgment is affirmed.[16] As just one example, the district court's judgment declares the Act's Medicare reimbursement schedules unlawful, which, if given effect, would require Medicare to reimburse healthcare providers at higher rates. *See, e.g.*, 42 U.S.C. § 1395ww(b)(3)(B)(xi)–(xii). Therefore, just as in *Windsor*, an appellate decision here will "have real meaning." 570 U.S. at 758 (quoting *Chadha*, 462 U.S. at 939).[17]

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[16] The dissenting Justices in *Windsor* objected to the *Windsor* majority's approach to standing. Justice Scalia, for example, said that this approach to standing "would have been unrecognizable to those who wrote and ratified our national charter." *Windsor*, 570 U.S. at 779 (Scalia, J., dissenting). We are bound by the *Windsor* majority opinion.

[17] Just as in *Windsor*, moreover, principles of prudential standing weigh in favor of exercising jurisdiction despite the government's alignment with the plaintiffs. Just like the intervenors in *Windsor*, the intervenor-defendant states and the U.S. House both put on a "sharp adversarial presentation of the issues." *Id.* at 761.

The intervenor-defendant states also have standing to appeal. While a party's mere "status as an intervenor below . . . does not confer standing," *Diamond v. Charles*, 476 U.S. 54, 68 (1986), intervenors may appeal if they can demonstrate injury from the district court's judgment. *Sierra Club*, 995 F.2d at 574; *see also Va. House of Delegates v. Bethune-Hill*, 139 S. Ct. 1945, 1951 (2019); *Cooper v. Tex. Alcoholic Beverage Comm'n*, 820 F.3d 730, 737 (5th Cir. 2016). The intervenor-defendant states have made this showing because the district court's judgment, if ultimately given effect, would: (1) strip these states of funding that they receive under the ACA; and (2) threaten to hamstring these states in possible future litigation because of the district court judgment's potentially preclusive effect.[18]

First, the intervenor-defendant states receive significant funding from the ACA, which would be discontinued if we affirmed the district court's judgment declaring the entire Act unconstitutional. "[F]inancial loss as a result of" a district court's judgment is an injury sufficient to support standing to appeal. *United States v. Fletcher ex rel. Fletcher*, 805 F.3d 596, 602 (5th Cir. 2015). In their supplemental briefing, the intervenor-defendant states identify a few examples of the funding sources they would lose under the district

[18] At first glance, it may not be entirely clear how a mere partial summary judgment on the issuance of a declaratory judgment would aggrieve anyone. But at oral argument, all parties agreed that the district court's partial summary judgment would have binding effect. Indeed, this is partly why the district court issued a stay. The district court acknowledged that the intervenor-defendant states would be prejudiced by the judgment, which means that the district court understood it to be binding.

court's judgment. Evidence in the record shows that eliminating the Act's Medicaid expansion provisions alone would cost the original sixteen intervening state defendants and the District of Columbia a total of more than $418 billion in the next decade. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), (e)(14)(I)(i), 1396d(y)(1). Moreover, the Act's Community First Choice Option program gives states funding to care for the disabled and elderly at home or in their communities instead of in institutions. *See* 42 U.S.C. § 1396n(k). Record evidence shows that eliminating this program would cost California $400 million in 2020, and that Oregon and Connecticut have already received $432.1 million under this program. This evidence is more than enough to show that the intervenor-defendant states would suffer financially if the district court's judgment is given effect, an injury sufficient to confer standing to appeal. *See Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2565 (2019).

The district court's judgment, if given effect, also threatens to injure the intervenor-defendant states with the judgment's potentially preclusive effect in future litigation. We have held that "[a] party may be aggrieved by a district court decision that adversely affects its legal rights or position vis-à-vis other parties in the case or other potential litigants." *Leonard v. Nationwide Mut. Ins.*, 499 F.3d 419, 428 (5th Cir. 2007) (quoting *Custer v. Sweeney*, 89 F.3d 1156, 1164 (4th Cir. 1996)). If the federal defendants began unwinding the ACA, either in reliance on the district court's judgment or on their own, the district court's judgment would potentially estop the intervenor-defendant states from challenging that action in court. This case thus stands in contrast to the cases in which

there was no chance whatsoever of a preclusive effect. *See Klamath Strategic Inv. Fund ex rel. St. Croix Ventures v. United States*, 568 F.3d 537, 546 (5th Cir. 2009) (holding that there was no threatened injury from potential estoppel from the appealed-from judgment because that judgment was interlocutory, not final, and therefore could not estop the appealing party).

Finally, we examine the standing of the U.S. House of Representatives, which intervened after the case had been appealed. The Supreme Court's recent decision in *Virginia House of Delegates v. Bethune-Hill* calls the House's standing to intervene into doubt. 139 S. Ct. at 1953 ("This Court has never held that a judicial decision invalidating a state law as unconstitutional inflicts a discrete, cognizable injury on each organ of government that participated in the law's passage."). However, we need not resolve the question of the House's standing. "Article III does not require intervenors to independently possess standing" when a party already in the lawsuit has standing and seeks the same "ultimate relief" as the intervenor. *Ruiz v. Estelle*, 161 F.3d 814, 830 (5th Cir. 1998). That is the case here: the intervenor-defendant states have standing to appeal, and the House seeks the same relief as those states. We accordingly pretermit the issue of whether the House has standing to intervene.

IV.

We now turn to the issue of whether any of the plaintiffs had Article III standing to bring this case at the time they brought the lawsuit. To be a case or controversy under Article III, the plaintiffs must satisfy the same three requirements listed above. First, a

plaintiff must have suffered an "injury in fact"—a violation of a legally protected interest that is "concrete and particularized," as well as "actual or imminent, not 'conjectural' or 'hypothetical.'" *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992) (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)). Second, that injury must be "fairly . . . trace[able] to the challenged action of the defendant, and not . . . th[e] result [of] the independent action of some third party not before the court." *Id.* (alterations in original) (quoting *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41–42 (1976)). Third, it must be "likely"—not merely "speculative"—that the injury will be "redressed by a favorable decision." *Id.* at 561 (quoting *Simon*, 426 U.S. at 38, 43).

The instant case has two groups of plaintiffs: the individual plaintiffs and the state plaintiffs. Only one plaintiff need succeed because "one party with standing is sufficient to satisfy Article III's case-or-controversy requirement."[19] *Texas v. United States (DAPA)*, 809 F.3d 134, 151 (5th Cir. 2015) (quoting *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006)), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016).[20] The individual plaintiffs and the state plaintiffs allege different injuries. We evaluate each in turn and conclude that both the individual plaintiffs and the state plaintiffs have standing.

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[19] For an academic critique of this approach, *see* Aaron-Andrew P. Bruhl, *One Good Plaintiff Is Not Enough*, 67 Duke L. J. 481 (2017).

[20] We refer to this 2015 case as "*DAPA*"—after Deferred Action for Parents of Americans, the policy at issue there—to prevent confusion with the present case of the same name.

A.

The standing issues presented by the individual plaintiffs are not novel. The Supreme Court faced a similar situation when it decided *NFIB* in 2012. At oral argument in that case, Justice Kagan asked Gregory Katsas, representing NFIB, whether he thought "a person who is subject to the [individual] mandate but not subject to the [shared responsibility payment] would have standing." Transcript of Oral Argument at 68, *Dep't of Health & Human Servs. v. Florida*, 567 U.S. 519 (2012) (No. 11-398). Mr. Katsas replied, "Yes, I think that person would, because that person is injured by compliance with the mandate." *Id.* Mr. Katsas explained, "the injury—when that person is subject to the mandate, that person is required to purchase health insurance. That's a forced acquisition of an unwanted good. It's a classic pocketbook injury." *Id.* at 68–69.

In 2012, this questioning made sense because neither the individual mandate nor the shared responsibility payment would be assessed for another two years. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 244 (2012) (requiring insurance coverage "for each month beginning after 2013" and applying the shared responsibility payment for any failure to purchase insurance "during any calendar year beginning after 2013"). It was thus certainly imminent that the private plaintiffs would be subject to the individual mandate, which applies to everyone, but not certain that they would be subject to the shared responsibility payment, which exempts certain people. 26 U.S.C. § 5000A(e) (prescribing that "[n]o penalty shall be imposed" on certain

groups of people).[21] The distinction was important because a plaintiff "must demonstrate standing for each claim he seeks to press." *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008) (quoting *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006)). To bring a claim against the individual mandate, therefore, the plaintiffs needed to show injury *from the individual mandate*—not from the shared responsibility payment.

Accordingly, the district court in *NFIB* ruled that the private plaintiffs were injured by the ACA "because of the financial expense [they would] definitively incur under the Act in 2014," and the private plaintiffs' need "to take investigatory steps and make financial arrangements now to ensure compliance then." *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1271 (N.D. Fla. 2011), *aff'd in part and rev'd in part*, 648 F.3d 1235 (11th Cir. 2011), *aff'd in part and rev'd in part*, 567 U.S. 519 (2012). The record evidence in that case supported this conclusion. Mary Brown, one of the private plaintiffs in that case, for example, had declared that "to comply with the individual insurance mandate, and well in advance of 2014, I must now investigate whether and how to rearrange my personal finance affairs." Appendix of Exhibits in Support of Plaintiffs' Motion for Summary Judgment, *Florida v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT (N.D. Fla. Nov. 10, 2010), ECF No. 80-6. At the Eleventh Circuit, all parties agreed that Mary Brown had standing. *Florida ex rel. Att'y. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1243 (11th

[21] For the full list of exemptions, *see supra* note 4.

Cir. 2011), *aff'd in part and rev'd in part*, 567 U.S. 519 (2012) ("Defendants do not dispute that plaintiff Brown's challenge to the minimum coverage provision is justiciable."). Congress could have reasonably contemplated people like Mary Brown. As Mr. Katsas explained at oral argument in the Supreme Court, "Congress reasonably could think that at least some people will follow the law precisely because it is the law." Transcript of Oral Argument at 67, *Dep't of Health & Human Servs. v. Florida*, 567 U.S. 519 (2012) (No. 11-398).

The district court in the instant case followed a similar approach with regard to the individual plaintiffs' standing.[22] It concluded that because the individual plaintiffs are the object of the individual mandate, which requires them to purchase health insurance that they do not want, those plaintiffs have demonstrated two types of "injury in fact": (1) the financial injury of buying that insurance; and (2) the "increased regulatory burden" that the individual mandate imposes. In concluding that these injuries were caused by the individual mandate, the court made specific fact findings that both Nantz and Hurley purchased insurance solely because they are "obligated to comply with the . . . individual mandate." The district court made these findings based on Nantz's and Hurley's declarations, which the intervenor-defendant states never challenged. Because the undisputed evidence showed that the individual mandate caused these injuries, the district court reasoned that

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[22] No party initially questioned the plaintiffs' standing in the district court. An amicus brief raised the issue, and the intervenor-defendant states addressed it at oral argument.

a favorable judgment would redress both injuries, allowing the individual plaintiffs to forgo purchasing health insurance and freeing them "from what they essentially allege to be arbitrary governance."

We agree with the district court. The Supreme Court has held that when a lawsuit challenges "the legality of government action or inaction, the nature and extent of facts that must be averred (at the summary judgment stage) or proved (at the trial stage) in order to establish standing depends considerably upon whether" the plaintiffs are themselves the "object[s] of the action (or forgone action) at issue." *Lujan*, 504 U.S. at 561; *see also Texas v. EEOC*, 933 F.3d 433, 446 (5th Cir. 2019). "Whether someone is in fact an object of a regulation is a flexible inquiry rooted in common sense." *EEOC*, 933 F.3d at 446 (quoting *Contender Farms, L.L.P. v. U.S. Dep't of Agric.*, 779 F.3d 258, 265 (5th Cir. 2015)). If a plaintiff is indeed the object of a regulation, "there is ordinarily little question that the action or inaction has caused [the plaintiff] injury, and that a judgment preventing or requiring the action will redress it." *Lujan*, 504 U.S. at 561–62.

It is undisputed that Hurley and Nantz are the objects of the individual mandate and that they have purchased insurance in order to comply with that mandate. Record evidence supports these conclusions. In his declaration in the district court, Nantz stated, "I continue to maintain minimum essential health coverage because I am obligated." Similarly, Hurley averred in his declaration that he is "obligated to comply with the ACA's individual mandate." They both explain in their declarations that they "value compli-

ance with [their] legal obligations" and bought insurance because they "believe that following the law is the right thing to do." Accordingly, the district court expressly found that Hurley and Nantz bought health insurance because they are obligated to, and we must defer to that factual finding. The evidentiary basis for this injury is even stronger than it was in *NFIB*. In the instant case, the individual mandate has already gone into effect, compelling Nantz and Hurley to purchase insurance *now* as opposed to two years in the future.

The intervenor-defendant states fail to point to any evidence contradicting these declarations, and they did not challenge this evidence in the district court. In fact, some of the evidence these parties rely on actually supports the conclusion that Nantz and Hurley purchased insurance to comply with the individual mandate. The intervenor-defendant states acknowledge a 2017 report from the Congressional Budget Office indicating that "a small number of people" would continue to buy insurance without a penalty "solely because" of a desire to comply with the law. Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017). This report is at least somewhat consistent with a 2008 Congressional Budget Office report, relied on by the state plaintiffs, that "[m]any individuals" subject to the mandate, but not the shared responsibility payment, will obtain coverage to comply with the mandate "because they believe in abiding by the nation's laws." Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 53 (Dec. 2008). Whether this group of law-abiding citizens in-

cludes "many individuals" or "a small number of people," Nantz and Hurley have undisputed evidence showing that they are a part of this group.

In this context, being required to buy something that you otherwise would not want is clearly within the scope of what counts as a "legally cognizable injury." "Economic injury" of this sort is "a quintessential injury upon which to base standing." *Tex. Democratic Party v. Benkiser*, 459 F.3d 582, 586 (5th Cir. 2006); *see also Vt. Agency of Nat. Res. v. United States*, 529 U.S. 765, 772–77 (1998) (finding Article III injury from financial harm); *Clinton v. New York*, 524 U.S. 417, 432 (1998) (same); *Sierra Club v. Morton*, 405 U.S. 727, 733–34 (1972) (same); *DAPA*, 809 F.3d at 155 (same). In *Benkiser*, for example, we held that a political party would suffer an injury in fact because it would need to "expend additional funds" in order to comply with the challenged regulation. 459 F.3d at 586. In the instant case, the undisputed record evidence shows that the individual plaintiffs have spent "additional funds" to comply with the statutory provision that they challenge on constitutional grounds.

This injury, moreover, is "actual," not merely a speculative fear about future harm that may or may not happen. *Lujan*, 504 U.S. at 560. The record shows that, at the time of the complaint, Hurley and Nantz held health insurance, spending money every month that they did not want to spend. Nantz reports that his monthly premium is $266.56, and Hurley says his is $1,081.70. The injury is also "concrete" because it involves the real expenditure of those funds. *See Barlow v. Collins*, 397 U.S. 159, 162–63, 164 (1970) (finding a concrete injury when a regulation caused economic harm from lost profit).

Causation and redressability "flow naturally" from this concrete, particularized injury. *Contender Farms*, 779 F.3d at 266. The evidence in the record from Hurley's and Nantz's declarations show that they would not have purchased health insurance but for the individual mandate, and the intervenor-defendant states have no evidence to the contrary. A judgment declaring that the individual mandate exceeds Congress' powers under the Constitution would allow Hurley and Nantz to forgo the purchase of health insurance that they do not want or need. They could purchase health insurance below the "minimum essential coverage" threshold, or even decide not to purchase any health insurance at all.

The intervenor-defendant states make several arguments against this straightforward injury, and all of them come up short. They first argue that there is no legally cognizable injury because there is no longer any penalty for failing to comply. In one sense, this argument misses the point. The threat of a penalty that Hurley and Nantz would face under the pre-2017 version of the statute is one potential form of injury, but it is far from the only one. We have held that the costs of compliance can constitute an injury just as much as the injuries from failing to comply. *See, e.g., Benkiser*, 459 F.3d at 586. Thus, in this instance, it is this injury—the time and money spent complying with the statute, not the penalty for failing to do so—that constitutes the plaintiffs' injury.

But the intervenor-defendant states also argue that even the costs of compliance cannot count as an injury in fact if there is no consequence for failing to comply. The individual mandate's compulsion cannot inflict a cognizable injury, they say, because it is not a

compulsion at all. Because the enforcement mechanism has been removed, the U.S. House contends, it is now merely a suggestion, at most. We recently rejected this argument in *Texas v. EEOC*, when the Equal Employment Opportunity Commission tried to argue that Texas could not challenge its allegedly non-final administrative guidance because "the Guidance does not compel Texas to do anything." 933 F.3d at 448. We concluded that it would "strain credulity to find that an agency action targeting current 'unlawful' discrimination among state employers—and declaring presumptively unlawful the very hiring practices employed by state agencies—does not require action immediately enough to constitute an injury-in-fact."[23] *Id.* The individual mandate is no different. Just like the agency guidance, the individual mandate targets as "unlawful" the decision to go without health insurance.

The dissenting opinion grounds its discussion of the issue in the Supreme Court's decision in *Poe v. Ullman*, 367 U.S. 497 (1961). There, the Supreme Court re-

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[23] The dissenting opinion states that Texas had standing in *Texas v. EEOC* because of the "consequences for disobeying the [challenged] guidance—including the possibility that the Attorney General would enforce Title VII against it." This depiction of *Texas v. EEOC* ignores that opinion's emphasis on the fact that Texas was "the object of the Guidance." 933 F.3d at 446; *see also id.* ("If, in a suit 'challenging the legality of government action,' 'the plaintiff is himself an object of the action . . . there is ordinarily little question that the action or inaction has caused him injury . . . .'" (quoting *Lujan*, 504 U.S. at 561–62)). As explained above, the individual plaintiffs in this case are the objects of the individual mandate.

jected a challenge to Connecticut's criminal prohibition on contraception. The dissenting opinion states that if there was no standing in *Ullman*, then there cannot be standing here. The dissenting opinion seems to treat *Ullman* as part of the "pre-enforcement challenge" line of cases in which the Supreme Court analyzed claims of injury based on future enforcement to determine whether the future enforcement was sufficiently imminent. *Ullman*, however, is not cited in the seminal Supreme Court cases of that line. *See, e.g.*, *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158–61 (2014); *Holder v. Humanitarian Law Project*, 561 U.S. 1, 15 (2010); *Virginia v. Am. Booksellers Ass'n, Inc.*, 484 U.S. 383, 392–93 (1988); *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979); *see also Abbott Labs. v. Gardner*, 387 U.S. 136, 154 (1967). More importantly, as we have explained, this case is not a pre-enforcement challenge because the plaintiffs have already incurred a financial injury.[24]

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[24] The dissenting opinion also relies on *City of Austin v. Paxton*, No. 18-50646, ___ F.3d ____, 2019 WL 6520769 (5th Cir. Dec. 4, 2019). That reliance is confusing because *City of Austin* is an *Ex parte Young* case, not a standing case. For the *Ex parte Young* exception to Eleventh Amendment sovereign immunity to apply, the state official sued "must have 'some connection with enforcement of the challenged act.'" *Id.* at *2 (alteration omitted) (quoting *Ex parte Young*, 209 U.S. 123, 157 (1908)). In *City of Austin*, the City's claims against the Texas Attorney General failed because the City failed to show the requisite connection to enforcement under *Ex parte Young*. Of course, because this is a lawsuit against the federal government, neither the Eleventh Amendment nor *Ex parte Young* applies. Moreover, even if *City of Austin* had been a pre-enforcement challenge standing case, it would still be irrelevant because this case is not a pre-enforcement challenge.

The plurality opinion in *Ullman* said there was insufficient adversity between the parties because there was overwhelming evidence—eighty years' worth of no enforcement of the statute—of "tacit agreement" between prosecutors and the public not to enforce the anti-contraceptive laws that the plaintiffs challenged. 367 U.S. at 507–08. As a result, the Court held that the lawsuit before it was "not such an adversary case as will be reviewed here." *Id.* The fifth, controlling vote in that case—Justice Brennan, who concurred in the judgment—emphasized that this adverseness was lacking because of the case's "skimpy record," devoid of evidence that the "individuals [were] truly caught in an inescapable dilemma." *Id.* at 509 (Brennan, J., concurring).

By contrast, as documented above, the record in the instant case contains undisputed evidence that Nantz and Hurley feel compelled by the individual mandate to buy insurance and that they bought insurance solely for that reason. Especially in light of the fact that the individual mandate lacks a similar eighty-year history of nonenforcement, Nantz and Hurley have gone much further in demonstrating that they are caught in the "inescapable dilemma" that the *Ullman* plaintiffs were not.

The intervenor-defendant states also argue that there is no causation between the individual mandate and Hurley and Nantz's purchase of insurance because Hurley and Nantz exercised a voluntary "choice" to purchase insurance. Because Nantz and Hurley would face no consequence if they went without insurance, the intervenor-defendant states argue that their purchase of insurance is not fairly traceable to the federal defendants. Instead, they claim that Nantz and

Hurley impermissibly attempt to "manufacture standing merely by inflicting harm on themselves." *Glass v. Paxton*, 900 F.3d 233, 239 (5th Cir. 2018) (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013)).

This argument fails, however, because it conflates the merits of the case with the threshold inquiry of standing. The argument assumes that 26 U.S.C. § 5000A presents not a legal command to purchase insurance, but an option between purchasing insurance and doing nothing. Because this option exists, the argument goes, any injury arising from Hurley's and Nantz's decisions to buy insurance instead of doing nothing (the other putative option) is entirely self-inflicted. This, however, is a merits question that can be reached only after determining the threshold issue of whether plaintiffs have standing.

Texas v. EEOC makes clear that courts cannot fuse the standing inquiry into the merits in this way. There, in addition to the injury described above from the Guidance's rebuke of Texas's employment practices as "unlawful," Texas claimed it was injured by the EEOC's curtailing of Texas's procedural right to notice and comment before being subject to a regulation. *EEOC*, 933 F.3d at 447. In rejecting the suggestion that Texas was not truly injured because the EEOC had not in fact violated the Administrative Procedure Act's notice-and-comment rules, we held that "[w]e assume, for purposes of the standing analysis, that Texas is correct on the merits of its claim that the Guidance was promulgated in violation of the APA." *Id.* (citing *Sierra Club v. EPA*, 699 F.3d 530, 533 (D.C. Cir. 2012)); *see also Bennett v. Spear*, 520 U.S. 154,

177–78 (1997) (treating constitutional standing and finality as distinct inquiries).

Indeed, allowing a consideration of the merits as part of a jurisdictional inquiry would conflict with the Supreme Court's express decision in *Steel Co. v. Citizens for a Better Environment* to not abandon "two centuries of jurisprudence affirming the necessity of determining jurisdiction before proceeding to the merits." 523 U.S. 83, 98 (1998). That case presented both the question of Article III standing and the merits question of whether the relevant statute authorized lawsuits for purely past violations. *Id.* at 86. The Court rejected any "attempt to convert the merits issue . . . into a jurisdictional one." *Id.* at 93. The Court further rejected the "doctrine of hypothetical jurisdiction," under which certain courts of appeals had "proceed[ed] immediately to the merits question, despite jurisdictional objections" in certain circumstances. *Id.* at 93–94. As the district court correctly noted, that is exactly what the appellants ask this court to do. They urge us to "skip ahead to the merits to determine § 5000A(a) is non-binding and therefore constitutional and then revert to the standing analysis to use its merits determination to conclude there was no standing to reach the merits in the first place."

Moreover, even if we were to consider the merits as part of our jurisdictional inquiry, it would not make a difference in this case. Because we conclude in Part IV of this opinion that the individual mandate is best read as a command to purchase insurance (and an unconstitutional one at that), rather than as an option

between buying insurance or doing nothing, the individual plaintiffs would have standing even if we considered the merits.[25]

B.

We next consider whether the eighteen state plaintiffs have standing, and we conclude that they do.[26] The state plaintiffs allege that the ACA causes them both a fiscal injury as employers and a sovereign injury "because it prevents them from applying their own laws and policies governing their own healthcare markets." State Plaintiffs' Br. at 25. In *DAPA*, we determined that the state of Texas was entitled to special solicitude because it was "exercising a procedural right created by Congress and protecting a 'quasi-sovereign' interest." *DAPA*, 809 F.3d at 162 (quoting *Massachusetts v. EPA*, 549 U.S. 497, 520 (2007)); *see also id.* at 154–55. Because the state plaintiffs in this case have suffered fiscal injuries as employers, we need not address special solicitude or the alleged sovereign injuries.

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[25] Even if the individual plaintiffs did not have standing, this case could still proceed because the state plaintiffs have standing. *DAPA*, 809 F.3d at 151 (holding that only one plaintiff needs standing for the court to exercise jurisdiction). "This circuit follows the rule that alternative holdings are binding precedent and not obiter dictum." *Id.* at 178 n.158 (quoting *United States v. Potts*, 644 F.3d 233, 237 n.3 (5th Cir. 2011)).

[26] Likewise, even if the state plaintiffs did not have standing, this case could still proceed because the individual plaintiffs have standing. *DAPA*, 809 F.3d at 151 (holding that only one plaintiff needs standing for the court to exercise jurisdiction).

Employers, including the state plaintiffs, are required by the ACA to issue forms verifying which employees are covered by minimum essential coverage and therefore do not need to pay the shared responsibility payment. *See* 26 U.S.C. § 6055(a) ("Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b)."); 26 U.S.C. § 6056(a) ("Every applicable large employer [that meets certain statutory requirements] shall . . . make a return described in subsection (b)."). These provisions have led to Form 1095-B and 1095-C statements that employees receive from their employers around tax time, which include a series of check boxes indicating the months that employees had health coverage that complies with the ACA. State Plaintiffs' Br. at 23. These legally required reporting practices exist on top of state employers' own in-house administrative systems for managing and tracking their employees' health insurance coverage.

The record is replete with evidence that the individual mandate itself has increased the cost of printing and processing these forms and of updating the state employers' in-house management systems. For example, Thomas Steckel, the director of the Division of Employee Benefits within the South Dakota Bureau of Human Resources, submitted a declaration documenting the administrative costs that the individual mandate has imposed by way of these reporting requirements. He said, "[t]he individual mandate caused significant administrative burdens and expenses to program our IT system to track and report ACA eligible employees and complete mandatory IRS

Form 1095 annual reports." Steckel noted specifically that "the individual mandate caused . . . $100,000.00 [in] ongoing costs" for Form 1095-C administration alone. The dissenting opinion discards this evidence as conclusory. But as even counsel for the intervenor-defendant states admitted at oral argument, nobody challenged this evidence as conclusory in the district court or in the appellate court.[27] Oral Argument at 5:12.

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[27] The reason why is obvious: the evidence is not conclusory. This is bread-and-butter summary judgment practice, not, as the dissenting opinion contends, any "new summary-judgment rule." Of course, a properly-included affidavit must be based on personal knowledge, and conclusory facts and statements on information and belief cannot be utilized. *See* Charles Alan Wright and Arthur R. Miller, Federal Practice and Procedure, § 2738 (4th ed. 2019). The Steckel affidavit easily satisfies this standard: it is a detailed 8-page declaration. Steckel attested, under penalty of perjury, that he is "responsible for developing and implementing the State's health plan for state employees" and that he is "particularly familiar with changes in costs, plans, and policies related to the enactment of the ACA because of my role as the Director of the Division [of Employee Benefits]." He estimates the financial costs the individual mandate has caused in nine different categories, including ongoing costs of $10,400 for review of denied appeals, ongoing costs of $100,000 for Form 1095-C administration, and a one-time cost of $3,302,942 as a Transitional Reinsurance Program fee. For other costs, such as the pre-existing conditions prohibition and the expanded eligibility for adult dependent children to age 26, he conceded that he was "unable to accurately estimate the ongoing costs of this mandate." A determination of standing is supported by the administration of Form 1095-C, the CBO's prediction that some individuals will continue to purchase insurance in the absence of a shared responsibility payment, the fact that two such individuals are before

South Dakota is far from the only state that has been harmed from the financial cost of the reporting requirements that the individual mandate aggravates. Judith Muck, the Executive Director of the Missouri Consolidated Health Care Plan, reported that Missouri's costs for preparing 1095-B forms, along with 1094-B forms, are projected to be $47,300 in fiscal year 2019 and $49,200 in fiscal year 2020. Similarly, Teresa MacCartney, the Chief Financial Officer of the State of Georgia and the Director of the Georgia Governor's Office of Planning and Budget, reported that Georgia's overall cost of compliance with the ACA's reporting requirements "is an estimated net $3.6 million to date." MacCartney also reported that after the ACA's implementation, Georgia's Department of Community Health "experienced increased enrollment of individuals already eligible for Medicaid benefits under pre-ACA eligibility standards." This enrollment increase required the Department to enhance its management systems, which was "very costly." Blaise Duran, who is the Manager for Underwriting, Data Analysis and Reporting for the Employees Retirement System of Texas, further documented Texas' costs of the reporting requirements. He declared that the Texas Employees Group Benefits Program "has made administrative process changes in connection with its ACA compliance, such as those related to the provision

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this court, and the Supreme Court's observation that "third parties will likely react in predictable ways." *Department of Commerce*, 139 S. Ct. at 2566.

of Form 1095-Bs to plan participants and the Internal Revenue Service."[28]

The intervenor-defendant states and the U.S. House have not challenged the state plaintiffs' evidence or presented any evidence to the contrary. Instead, they argue that the reporting requirements set forth in Sections 6055(a) and 6056(a) "are separate from the mandate and serve independent purposes." U.S. House Reply Br. at 19. Therefore, they claim, "any resulting injury is thus neither traceable to Section 5000A nor redressable by its invalidation." U.S. House Reply Br. at 19. But this misreads the undisputed evidence in the record. The individual mandate commands individuals to get insurance. Every time an individual gets that insurance through a state employer, the state employer must send the individual a form certifying that he or she is covered and otherwise process that information through in-house management systems.[29] Thus, the reporting requirements in

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[28] This list is not exhaustive. For instance, Arlene Larson, Manager of Federal Health Programs and Policy for Wisconsin Employee Trust Funds, declared that the state expended funds by "hir[ing] a vendor to issue 343 Form 1095-Cs" in 2017. And Mike Michael, Director of the Kansas State Employee Health Plan, averred that reporting for Form 1094 and 1095 cost the state $43,138 in 2017 and $38,048 in 2018. No record evidence indicates that these reporting requirements have been eliminated. Moreover, the "standing inquiry remains focused on whether the party invoking jurisdiction had the requisite stake in the outcome when the suit was filed." *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008).

[29] Relying on this injury, therefore, does not run afoul of *Nat'l Fed'n of the Blind of Texas v. Abbott*, 647 F.3d 202 (5th Cir. 2011).

Sections 6055(a) and 6056(a) flow from the individual mandate set forth in Section 5000A(a).

These costs to the state plaintiffs are well-established.[30] Moreover, the continuing nature of these fiscal injuries is consistent with Fifth Circuit and Supreme Court precedent.

That case prevents plaintiffs from claiming injury based on provisions whose enforcement would be enjoined only if they are inseverable from an unconstitutional provision that does not harm the plaintiff. *Id.* at 210–11. The state plaintiffs' injuries stem from the increased administrative costs created by the individual mandate itself, not from other provisions. To be sure, those costs are created in part by the individual mandate's practical *interaction* with other ACA provisions, like the reporting requirements. But this is no different from the injuries in *DAPA*, where the challenged action interacted with Texas's driver's license regulations. It is also no different from *Department of Commerce*, where the challenged census question interacted with constitutional rules tying political representation to a state's population.

[30] The dissenting opinion, citing no authority, contends that the state plaintiffs need evidence that at least one specific "employee enrolled in one of state plaintiffs' health insurance programs solely because of the unenforceable coverage requirement." We have already explained why the uncontested affidavits suffice. We note, moreover, that the *DAPA* court found that Texas had standing because "it would incur significant costs in issuing driver's licenses to DAPA beneficiaries"—without requiring that Texas first show that it had issued a specific license to a specific illegal alien because of DAPA. Finally, the dissenting opinion's rule would create a split with our sister circuits. *See Massachusetts v. United States Dep't of Health & Human Servs.*, 923 F.3d 209, 225 (1st Cir. 2019) ("[Massachusetts] need not point to a specific person who will be harmed in order to establish standing in situations like this."); *California v. Azar*, 911 F.3d 558, 572 (9th Cir. 2018), *cert. denied sub nom. Little Sisters of the Poor Jeanne Jugan Residence v. California*, 139 S. Ct. 2716 (2019) ("Appellants

In *DAPA*, we held that the state of Texas had standing to challenge the federal government's DAPA program because it stood to "have a major effect on the states' fisc." 809 F.3d at 152. This was because, if DAPA were permitted to go into effect, it would have "enable[d] at least 500,000 illegal aliens in Texas" to satisfy Texas's requirements that the Department of Public Safety "'shall issue' a license to a qualified applicant," including noncitizens who present "documentation issued by the appropriate United States agency that authorizes the applicant to be in the United States." *Id.* at 155 (quoting Tex. Transp. Code §§ 521.142(a), 521.181). Evidence in the record showed that Texas, which subsidizes its licenses, would "lose a minimum of $130.89 on each one it issued to a DAPA beneficiary." *Id.* Even a "modest estimate" of predictable third-party behavior would rack up costs of "several million dollars." *Id.*

The Supreme Court recently applied a similar analysis in *Department of Commerce v. New York*, 139 S. Ct. 2551 (2019). In that case, a group of state and local governments sued to prevent the federal government from including a question about citizenship status on the 2020 census. *Id.* at 2563. The Supreme Court held that these plaintiffs had standing because they met their burden "of showing that third parties will likely

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fault the states for failing to identify a specific woman likely to lose coverage. Such identification is not necessary to establish standing."); *Pennsylvania v. President United States*, 930 F.3d 543, 564 (3d Cir. 2019), *as amended* (July 18, 2019) ("The Government faults the States for failing to identify a specific woman who will be affected by the Final Rules, but the States need not define injury with such a demanding level of particularity to establish standing.").

react in predictable ways to the citizenship question." *Id.* at 2566. The census question would likely lead to "noncitizen households responding . . . at lower rates than other groups, which in turn would cause them to be undercounted." *Id.* at 2565. This undercounting of third parties would injure the state and local governments by "diminishment of political representation, loss of federal funds, degradation of census data, and diversion of resources." *Id.*

In both *DAPA* and *Department of Commerce*, the state plaintiffs demonstrated injury by showing that the challenged law would cause third parties to behave in predictable ways, which would inflict a financial injury on the states. The instant case is no different. The individual mandate commands people to ensure that they have minimum health insurance coverage. That predictably causes more people to buy insurance, which increases the administrative costs of the states to report, manage, and track the insurance coverage of their employees and Medicaid recipients.[31]

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[31] The dissenting opinion contends that our opinion is inconsistent because we rely on *Department of Commerce*, in which the Court found that some individuals will predictably violate the law, in explaining why some individuals will predictably "follow the law regardless of the incentives." In a large group, there will predictably be some individuals in each category. Even the dissenting opinion accepts the Congressional Budget Office's projection that some people will buy insurance solely because of a desire to comply with the law. *See* Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1 (Nov. 2017).

V.

Having concluded that both groups of plaintiffs have standing to bring this lawsuit, we must next determine whether the individual mandate is a constitutional exercise of congressional power. We conclude that it is not. We first discuss the Supreme Court's holding in *NFIB*, and then we explain why, under that holding, the individual mandate is no longer constitutional.

A.

The *NFIB* opinion was extremely fractured. In that case, Chief Justice Roberts wrote an opinion addressing several issues. Parts of that opinion garnered a majority of votes and served as the opinion of the Court.[32] In relevant part, Part III-A of the Chief Justice's opinion, joined by no other Justice, observed

[32] As a general overview, Chief Justice Roberts's opinion functioned in the following way. In Part III-A, Chief Justice Roberts said that the individual mandate was most naturally read as a command to buy insurance, which could not be sustained under either the Interstate Commerce Clause or the Necessary and Proper Clause. Though no Justice joined this part of the opinion, the four dissenting Justices—Justices Scalia, Kennedy, Thomas, and Alito—agreed with Part III-A in a separate opinion. In Part III-B, the Chief Justice wrote that even though the most natural reading of the individual mandate was unconstitutional, the Court still needed to determine whether it was "fairly possible" to read the provision in a way that saved it from being unconstitutional. In Part III-C, the Chief Justice—joined by Justices Ginsburg, Breyer, Kagan, and Sotomayor—concluded that the provision could be construed as constitutional by reading the individual mandate, in conjunction with the shared responsibility payment, as a legitimate exercise of Congress' taxing power. This last part of the opinion supported the Court's ultimate judgment: that the individual mandate was constitutional as saved.

that "[t]he most straightforward reading of the [individual] mandate is that it commands individuals to purchase insurance," and that, using that reading of the statute, the individual mandate is not a valid exercise of Congress' power under the Interstate Commerce Clause. *NFIB*, 567 U.S. at 562, 546–61 (Roberts, C.J.). The Constitution, he explained, "gave Congress the power to *regulate* commerce, not to *compel* it." *Id.* at 555 (Roberts, C.J.). For similar reasons, the Chief Justice concluded that this command to purchase insurance could not be sustained under the Constitution's Necessary and Proper Clause. *Id.* The individual mandate was not "proper" because it expanded federal power, "vest[ing] Congress with the extraordinary ability to create the necessary predicate to the exercise of" its Interstate Commerce Clause powers. *Id.* at 560.

Though no other Justices joined this part of the Chief Justice's opinion, the "joint dissent"—joined by Justices Scalia, Kennedy, Thomas, and Alito—reached the same conclusions on the Interstate Commerce Clause and Necessary and Proper Clause questions. *Id.* at 650–60 (joint dissent). A majority of the court, therefore, concluded that the individual mandate is not constitutional under either the Interstate Commerce Clause or the Necessary and Proper Clause.

This limited reading of the Interstate Commerce Clause—and, by extension, of the Necessary and Proper Clause—was necessary to preserving "the country [that] the Framers of our Constitution envisioned." *Id.* at 554 (Roberts, C.J.). As Chief Justice Roberts observed, if the individual mandate were a

proper use of the power to regulate interstate commerce, that power would "justify a mandatory purchase to solve almost any problem." *Id.* at 553 (Roberts, C.J.). If Congress can compel the purchase of health insurance today, it can, for example, micromanage Americans' day-to-day nutrition choices tomorrow. *Id.* (Roberts, C.J.); *see also id.* at 558 (Roberts, C.J.) (reasoning that, under an expansive view of the Commerce Clause, nothing would stop the federal government from compelling the purchase of broccoli).

An expansive reading of the Interstate Commerce Clause would be foreign to the Framers, who saw the clause as "an addition which few oppose[d] and from which no apprehensions [were] entertained." *Id.* at 554 (Roberts, C.J.) (quoting The Federalist No. 45, at 293 (J. Madison) (C. Rossiter ed., 1961)). Elevating Congress' power to "regulate commerce . . . among the several states," U.S. Const. art. I, § 8, cl. 3, to a power to *create* commerce among the several states would make a Leviathan of the federal government, "everywhere extending the sphere of its activity and drawing all power into its impetuous vortex." *NFIB*, 567 U.S. at 554 (Roberts, C.J.) (quoting The Federalist No. 48, at 309 (J. Madison) (C. Rossiter ed., 1961)). The joint dissenters similarly noted that the more expansive reading of the Interstate Commerce Clause would render that provision a "font of unlimited power," *id.* at 653 (joint dissent), or, in the words of Alexander Hamilton, a "hideous monster whose devouring jaws . . . spare neither sex nor age, nor high nor low, nor sacred nor profane," *id.* (quoting The Federalist No. 33, at 202 (C. Rossiter ed., 1961)).

In Part III-B, again joined by no other Justice, Chief Justice Roberts concluded that because the individual mandate found no constitutional footing in the Interstate Commerce or Necessary and Proper Clauses, the Supreme Court was obligated to consider the federal government's argument that, as an exercise in constitutional avoidance, the mandate could be read not as a command but as an *option* to purchase insurance or pay a tax. This "option" interpretation of the statute could save the statute from being unconstitutional, as it would be justified under Congress' taxing power. *Id.* at 561–63 (Roberts, C.J.); *see also id.* at 562 (Roberts, C.J.) ("No court ought, unless the terms of an act rendered it unavoidable, to give a construction to it which should involve a violation, however unintentional, of the constitution." (quoting *Parsons v. Bedford*, 28 U.S. (3 Pet.) 433, 448–49 (1830))); *see also id.* at 563 (Roberts, C.J.) ("The question is not whether that is the most natural interpretation of the mandate, but only whether it is a 'fairly possible' one." (quoting *Crowell v. Benson*, 285 U.S. 22, 62 (1932))).

In Part III-C, the Chief Justice—writing for a majority of the Court, joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan—undertook that inquiry of determining whether it was "fairly possible" to read the individual mandate as an option and thereby save its constitutionality. *See id.* at 563–74 (majority opinion). Chief Justice Roberts reasoned that the individual mandate could be read in conjunction with the shared responsibility payment in order to save the individual mandate from unconstitutionality. Read together with the shared responsibility payment, the entire statutory provision could be read as a

legitimate exercise of Congress' taxing power for four reasons.

First and most fundamentally, the shared-responsibility payment "yield[ed] the essential feature of any tax: It produce[d] at least some revenue for the Government." *Id.* at 564. Second, the shared-responsibility payment was "paid into the Treasury by taxpayers when they file their tax returns." *Id.* at 563 (alternations and internal quotation marks omitted). Third, the amount owed under the ACA was "determined by such familiar factors as taxable income, number of dependents, and joint filing status." *Id.* Fourth and finally, "[t]he requirement to pay [was] found in the Internal Revenue Code and enforced by the IRS, which . . . collect[ed] it in the same manner as taxes." *Id.* at 563–64 (internal quotation marks omitted).

Because of these four attributes of the shared responsibility payment, the Court reasoned that "[t]he Federal Government does have the power to impose a tax on those without health insurance." *Id.* at 575. The Court concluded that "[s]ection 5000A is therefore constitutional, because it can reasonably be read as a tax."[33] *Id.* We agree with the dissenting opinion that "this case begins and ought to end" with *NFIB*.

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[33] Seven Justices—Chief Justice Roberts and Justices Scalia, Kennedy, Thomas, Breyer, Alito, and Kagan—agreed that the Act's Medicaid-expansion provisions unconstitutionally coerced states into compliance. *NFIB*, 567 U.S. at 575–85 (plurality opinion); *id.* at 671–89 (joint dissent). But, in light of a severability clause, Part IV–B of the Chief Justice's opinion concluded that the unconstitutional portion of the Medicaid provisions could be severed. *Id.* at 585–88 (plurality opinion). Meanwhile, Justice Ginsburg, joined by Justice Sotomayor, disagreed that the Act's

B.

Now that the shared responsibility payment amount is set at zero,[34] the provision's saving construction is no longer available. The four central attributes that once saved the statute because it could be read as a tax no longer exist. Most fundamentally, the provision no longer yields the "essential feature of any tax" because it does not produce "at least some revenue for the Government." *Id.* at 564. Because the provision no longer produces revenue, it necessarily lacks the three other characteristics that once rendered the provision a tax. The shared-responsibility payment is no longer "paid into the Treasury by taxpayer[s] when they file their tax returns" because the payment is no longer paid by anyone. *Id.* at 563 (alteration in original and internal quotation marks omitted). The payment amount is no longer "determined by such familiar factors as taxable income, number of dependents, and joint filing status." *Id.* The amount is zero for everyone, without regard to any of these factors. The IRS no longer collects the payment "in the same manner as taxes" because the IRS cannot

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mandatory Medicaid expansion was unconstitutional. *Id.* at 633 (Ginsburg, J., concurring in the judgment in part, and dissenting in part). Those two Justices concurred in the judgment with respect to the Chief Justice's conclusion that the unconstitutional provisions could be severed from the remainder of the Act. *Id.* at 645–46 (Ginsburg, J., concurring in the judgment in part, and dissenting in part). The four dissenting Justices concluded that the Act's Medicaid-expansion provisions were unconstitutionally coercive and rejected the relief of allowing states to opt into Medicaid expansion. *Id.* at 671–90 (joint dissent).

[34] 26 U.S.C. §§ 5000A(c)(2)(B)(iii), (c)(3)(A).

collect it at all. *Id.* at 563–64 (internal quotation marks omitted).

Because these four critical attributes are now missing from the shared responsibility payment, it is, in the words of the state plaintiffs, "no longer 'fairly possible' to save the mandate's constitutionality under Congress' taxing power." State Plaintiffs' Br. at 32. The proper application of *NFIB* to the new version of the statute is to interpret it according to what Chief Justice Roberts—and four other Justices of the Court—said was the "most straightforward" reading of that provision: a command to purchase insurance. *Id.* at 562 (Roberts, C.J.). As the district court properly observed, "the only reading available is the most natural one." Under that reading, the individual mandate is unconstitutional because, under *NFIB*, it finds no constitutional footing in either the Interstate Commerce Clause or the Necessary and Proper Clause. *Id.* at 546–61 (Roberts, C.J.); *id.* at 650–60 (joint dissent).

The intervenor-defendant states have several arguments against this conclusion, all of which fail. They first argue that the saving construction of the individual mandate, interpreting the provision as an option to buy insurance or pay a tax, is still "fairly possible." As the individual plaintiffs point out, the Court interpreted the individual mandate as an option only because doing so would save it from being unconstitutional. Accordingly, the intervenor-defendant states must show that the "option" would still be a constitutional exercise of Congress' taxing power. To make that showing, the intervenor-defendant states reject the plaintiffs' attempt to read a "some revenue" requirement into the Constitution's Taxing and

Spending Clause, arguing instead for a potential-to-produce-revenue requirement. The individual mandate, they say, is still set out in the Internal Revenue Code. It still provides a "statutory structure through which" Congress could eventually tax people for failing to buy insurance. It still includes references to taxable income, number of dependents, and joint filing status. 26 U.S.C. §§ 5000A(b)(3), (c)(2), (c)(4). Further, it still does not apply to individuals who pay no federal income taxes. 26 U.S.C. § 5000A(e)(2).

The intervenor-defendant states have little support for this reading of the Taxing and Spending Clause. For starters, *NFIB* could not be clearer that the "produc[tion]" of "at least some revenue for the Government"—not the potential to produce that revenue—is "the *essential* feature of any tax." 567 U.S. at 564 (majority opinion) (emphasis added). As the district court observed, when determining whether a statute is a tax, the actual production of revenue is "not indicative, not common—[but] essential."

The intervenor-defendant states also find no support in *United States v. Ardoin*, 19 F.3d 177, 179–80 (5th Cir. 1994). In that unusual case, Congress had imposed a tax on machine guns, but subsequently outlawed machine guns altogether, which prompted the relevant agency to stop collecting the tax. *Id.* at 179–80. The defendant was convicted not only for possessing a machine gun but also for failing to pay the tax, which remained on the books. *Id.* at 178. The court upheld the conviction on the basis that the tax law at issue could "be upheld on the preserved, but unused, power to tax or on the power to regulate interstate commerce." *Id.* at 180. But the taxing power was

"preserved" in *Ardoin* because it was non-revenue-producing only in practice whereas the "tax" here is actually $0.00 as written on the books.[35] *See* Fed. Defendants' Br. at 32. Expanding *Ardoin* to apply here would, as the federal defendants point out, puzzlingly allow Congress to "prohibit conduct that exceeds its commerce power through a two-step process of first taxing it and then eliminating the tax while retaining the prohibition." Fed. Defendants' Br. at 32.

The intervenor-defendant states argue further that the individual mandate does not even need constitutional justification because it is merely a suggestion, not binding legislative action. The individual mandate, they contend, is no different from the Flag Code, which, though entered into the pages of the U.S. Code, "was not intended to proscribe conduct." *Dimmitt v. City of Clearwater*, 985 F.2d 1565, 1573 (11th Cir. 1993) (analyzing 36 U.S.C. §§ 174–76). This argument is just a repackaged version of their argument that the individual mandate can still be read as an option. But, as the state plaintiffs, the individual plaintiffs, and the federal defendants point out, the Supreme Court has already held that the "most straightforward" reading of the individual mandate—which emphatically demands that individuals "shall" buy insurance, 26 U.S.C. § 5000A(a)—is as a command

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[35] This distinction also disposes of the intervenor-defendant states' concern about "cast[ing] constitutional doubt on taxes with delayed start dates or that Congress has temporarily suspended for periods of time." Intervenor-Defendant States' Br. at 43. In none of the examples the intervenor-defendant states cite did the statute purport to levy a "tax" of $0.00.

to purchase health insurance. The Court then concluded that that command lacked constitutional justification. The zeroing out of the shared responsibility payment does not render the provision any less of a command. Quite the opposite: Chief Justice Roberts concluded that the greater-than-zero shared responsibility payment actually converted the individual mandate into an option. *NFIB*, 567 U.S. at 563–64 (majority opinion). Now that the shared responsibility payment has been zeroed out, the only logical conclusion under *NFIB* is to read the individual mandate as a command, quite unlike the Flag Code. It is an individual *mandate*, not an individual suggestion.

Moreover, it is not true that when the Court adopts a limiting construction to avoid constitutional questions, that construction controls as to all applications of the statute, regardless of whether the original constitutional implications are present. The case on which the U.S. House relies involved different applications of an identical statute to different facts. *Clark v. Martinez*, 543 U.S. 371, 380 (2005) (rejecting the argument that "the constitutional concerns that influenced" a previous interpretation of a provision of the Immigration and Nationality Act were "not present for" the aliens at issue in that case). This case is readily distinguishable because the four characteristics that made the previous interpretation possible—the production of revenue and other tax-like features—have now been legislatively removed. The limiting construction is no longer available as a matter of statutory interpretation. The interpretation must accordingly change to comport with what five Justices of the

Supreme Court have said is the "most straightforward reading" of that interpretation.[36]

The dissenting opinion justifies its continued reliance on the saving construction—even though it is no longer applicable—by citing *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401 (2015). This approach fares no better. The dissenting opinion quotes *Kimble* to say that "in whatever way reasoned," the Court's interpretation "effectively become[s] part of the statutory scheme, subject . . . to congressional change." *Id.* at 2409. The dissenting opinion correctly acknowledges that the individual mandate was never changed. But what did change was the provision that actually mattered: the shared responsibility payment. When it was set above zero, it could be saved as a tax, even though five justices agreed this was an unnatural reading. It would be puzzling if Congress could change a statute at will, entirely insulated from constitutional infirmity, just because the Court had previously used constitutional avoidance to save a previous version of the statute.

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[36] Contrary to the dissenting opinion's suggestion, a saving construction is no longer available. The canon of constitutional avoidance applies only "when statutory language is susceptible of multiple interpretations." *Jennings v. Rodriguez*, 138 S. Ct. 830, 836 (2018). In *NFIB*, § 5000A was amenable to two possible interpretations. It was either "a command to buy insurance" or "a tax." *NFIB,* 567 U.S. at 574 (Roberts, C.J.). After Congress zeroed out the shared responsibility payment, one of those possible interpretations fell away. What was then the "most straightforward reading" is now the only available reading: it is a "command to buy insurance" and "the Commerce Clause does not authorize such a command." *Id.*

The intervenor-defendant states argue furthermore that the individual mandate can now be constitutional under the Interstate Commerce Clause because it does not *compel* anyone into commerce. This is again a repackaged version of their argument that the individual mandate is an option even without a revenue-generating shared responsibility payment, an argument that, as the state plaintiffs point out, the Supreme Court has already rejected. This argument, as the district court observed, is also logically inconsistent. If the individual mandate no longer truly compels anything, then it can hardly be said to be a "regulat[ion]" of interstate commerce. In the words of the district court, the intervenor-defendant states "hope to have their cake and eat it too."[37]

Finally, we would be remiss if we did not engage with the dissenting opinion's contention that § 5000A is not an exercise of legislative power. This would likely come as a shock to the legislature that drafted it, the president who signed it, and the voters who celebrated or lamented it. It is not surprising that the dissenting opinion can cite no case in which a federal court deems a duly enacted statute *not* an exercise of legislative power, much less a statute that clearly commands that an individual "shall" do something.[38]

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[37] Any argument that the individual mandate can now be sustained under the Necessary and Proper Clause fails for the same reasons. The individual mandate now must be read as a command, and five Justices in *NFIB* already rejected the argument that such a command could be sustained under the Necessary and Proper Clause. *NFIB*, 567 U.S. at 561 (Roberts, C.J.); *id.* at 654–55 (joint dissent).

[38] The dissenting opinion's theory of the "law that does nothing"

The dissenting opinion is inconsistent on this point: it argues that the provision's status as an exercise of legislative power fluctuates according to the amount of the shared responsibility payment while simultaneously contending that "if the text of the coverage requirement has not changed, its meaning could not have changed either." Our decision breaks no new ground. We simply observe that § 5000A was originally cognizable as either a command or a tax. Today, it is only cognizable as a command. It has always been an exercise of legislative power.

* * *

In *NFIB*, the individual mandate—most naturally read as a command to purchase insurance—was saved from unconstitutionality because it could be read together with the shared responsibility payment as an option to purchase insurance or pay a tax. It could be read this way because the shared responsibility payment produced revenue. It no longer does so. Therefore, the most straightforward reading applies: the mandate is a command. Using that meaning, the individual mandate is unconstitutional.

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results in some bizarre metaphysical conclusions. The ACA was signed into law in 2010. No one questions that when it was signed, § 5000A was an exercise of legislative power. Yet today, the dissenting opinion asserts, § 5000A is not an exercise of legislative power. So did Congress exercise legislative power in 2010, as seen from 2015? As seen from 2018? Does § 5000A ontologically re-emerge should a future Congress restore the shared responsibility payment? Perhaps, like Schrödinger's cat, § 5000A exists in both states simultaneously. The dissenting opinion does not say. Our approach requires no such quantum musings.

VI.

Having concluded that the individual mandate is unconstitutional, we must next determine whether, or how much of, the rest of the ACA is severable from that constitutional defect. On this question, we remand to the district court to undertake two tasks: to explain with more precision what provisions of the post-2017 ACA are indeed inseverable from the individual mandate; and to consider the federal defendants' newly-suggested relief of enjoining the enforcement only of those provisions that injure the plaintiffs or declaring the Act unconstitutional only as to the plaintiff states and the two individual plaintiffs. We address each issue in turn.

A.

The Supreme Court has said that the "standard for determining the severability of an unconstitutional provision is well established." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987). Unless it is "evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Id.* (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)).

This inquiry into counterfactual Congressional intent has been crystallized into a "two-part . . . framework." *NFIB*, 567 U.S. at 692 (joint dissent). First, if a court holds a statutory provision unconstitutional, it then determines whether the now-truncated statute will operate in "a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted). This first step asks whether the constitutional provisions—standing on their own, without the

unconstitutional provisions—are "fully operative as a law," not whether they would simply "operate in some coherent way" not designed by Congress. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010) (quoting *New York v. United States*, 505 U.S. 144, 186 (1992)); *NFIB*, 567 U.S. at 692 (joint dissent). Second, even if the remaining provisions can operate as Congress designed them to, the court must determine if Congress would have enacted the remaining provisions without the unconstitutional portion. If Congress would not have done so, then those provisions must be deemed inseverable. *Alaska Airlines*, 480 U.S. at 685 ("[T]he unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted."); *Free Enter. Fund*, 561 U.S. at 509 ("[N]othing in the statute's text or historical context makes it evident that Congress, faced with the limitations imposed by the Constitution, would have preferred no Board at all to a Board whose members are removable at will." (internal quotation marks omitted)).

Severability doctrine places courts between a rock and a hard place. On the one hand, courts strive to be faithful agents of Congress,[39] which often means refusing to create a hole in a statute in a way that creates legislation Congress never would have agreed to or passed. *See Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) ("[Courts] cannot rewrite a statute and give it an effect altogether different from that sought by the

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[39] *See* Frank H. Easterbrook, *Text, History, and Structure in Statutory Interpretation*, 17 Harv. J. L. & Pub. Pol'y 61, 63 (1994) ("[Courts] are supposed to be faithful agents, not independent principals.").

measure viewed as a whole." (quoting *R.R. Ret. Bd. v. Alton R.R.*, 295 U.S. 330, 362 (1935))). On the other hand, courts often try to abide by the medical practitioner's maxim of "first, do no harm," aiming "to limit the solution to the problem" by "refrain[ing] from invalidating more of the statute than is necessary." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328 (2006); *Collins v. Mnuchin*, 938 F.3d 553, 592 (5th Cir. 2019) (en banc) (Haynes, J.) (severing unconstitutional removal restriction from remainder of Federal Housing Finance Agency's enabling statute).[40] In fact, courts have a "duty" to "maintain the act in so far as it is valid" if it "contains unobjectionable provisions separable from those found to be unconstitutional." *Alaska Airlines*, 480 U.S. at 684 (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)).

The Supreme Court emphasizes this duty so strongly that commentators have identified "a presumption [of severability] implicit in the Court's" severability jurisprudence. Adrian Vermeule, *Saving Constructions*, 85 Geo. L.J. 1945, 1950 n.28 (1997); *see also* Brian Charles Lea, *Situational Severability*, 103 Va. L. Rev. 735, 744 (2017) ("[C]ourts assume that a legislature intends for any unlawful part of its handiwork to be severable from all lawful parts in the absence of indicia of a contrary intention."). This presumption is strongest when Congress includes a severability clause in the statutory text; however, "[i]n the absence of a severability clause . . . Congress's si-

[40] Judge Haynes wrote the opinion of the court as to the question of remedy. *See Collins*, 938 F.3d at 591.

lence is just that—silence—and does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686.

Nevertheless, the meticulous analysis required by severability doctrine defies reliance on presumptions or generalities. The Supreme Court's latest venture into severability territory, *Murphy v. NCAA*, 138 S. Ct. 1461 (2018), provides an example. There, the Court held that the entirety of the Professional and Amateur Sports Protection Act was unconstitutional because one of its provisions—authorizing private sports gambling—violated the anti-commandeering doctrine. *Id.* at 1484. Justice Alito's majority opinion separately explored each of the other operative provisions in the act, reasoning that all of the act's provisions were "obviously meant to work together" and be "deployed in tandem." *Id.* at 1483. Because Congress would not have wanted the otherwise-valid provisions "to stand alone," the Court declined to sever them. *Id.* This conclusion prompted a dissent from Justice Ginsburg, who characterized the majority as "wield[ing] an ax . . . instead of using a scalpel to trim the statute" and reiterated that "the Court ordinarily engages in a salvage rather than a demolition operation." *Id.* at 1489–90 (Ginsburg, J., dissenting).

These *Murphy* opinions draw attention to one difficulty inherent in severability analysis: selecting the right tool for the job. Justice Thomas' concurring opinion goes further, providing two reasons why navigating between the Scylla of poking small but critical holes in complex, carefully crafted legislative bargains and the Charybdis of invalidating more duly enacted legislation than necessary stands "in tension with traditional limits on judicial authority." *Murphy*,

138 S. Ct. at 1485 (Thomas, J., concurring). "[T]he judicial power is, fundamentally, the power to render judgments in individual cases," and severability doctrine threatens to violate that vital separation-of-powers principle in more than one way. *Id.* (Thomas, J., concurring).

First, severability doctrine requires "a nebulous inquiry into hypothetical congressional intent," as opposed to the usual judicial bread-and-butter of "determin[ing] what a statute means." *Id.* at 1486 (Thomas, J., concurring) (quoting *United States v. Booker*, 543 U.S. 220 at 321 n.7 (2005) (Thomas, J., dissenting in part)). Because "Congress typically does not pass statutes with the expectation that some part will later be deemed unconstitutional," *id.* at 1487, this requirement often leaves courts to exercise their imagination or "intuitions regarding what the legislature would have desired had it considered the severability issue." Lea, *supra*, at 747. This, in turn, "enmeshes the judiciary in making policy choices" the Constitution reserves for the legislature, David H. Gans, *Severability as Judicial Lawmaking*, 76 Geo. Wash. L. Rev. 639, 663 (2008), providing unelected judicial officers with cover to simply implement their own policy preferences.

Second, severability doctrine forces courts to "weigh in on statutory provisions that no party has standing to challenge, bringing courts dangerously close to issuing advisory opinions." *Murphy*, 138 S. Ct. at 1487 (Thomas, J., concurring); *see also* Jonathan F. Mitchell, *The Writ-of-Erasure Fallacy*, 104 Va. L. Rev. 933, 936 (2018) ("The federal courts have no authority to erase a duly enacted law from the statute books,

[but can only] decline to enforce a statute in a particular case or controversy."[41]). As Justice Thomas points out, when Chief Justice Marshall famously declared that "[i]t is emphatically the province and duty of the judicial department to say what the law is," he justified that assertion by explaining that "[t]hose who apply [a] rule to particular cases, must of necessity expound and interpret that rule." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803). Yet severability doctrine directs courts to go beyond the necessary—that is, the application of a particular statutory provision to a particular case—to consider the viability of other provisions without even "ask[ing] whether the plaintiff has standing to challenge those other provisions." *Murphy*, 138 S. Ct. at 1487 (Thomas, J., concurring). "[S]everability doctrine is thus an unexplained exception to the normal rules of standing, as well as the separation-of-powers principles that those rules protect." *Id.*

Severability analysis is at its most demanding in the context of sprawling (and amended) statutory schemes like the one at issue here. The ACA's framework of economic regulations and incentives spans over 900 pages of legislative text and is divided into ten titles. Most of the provisions directly regulating health insurance, including the one challenged in this case, are found in Titles I and II. *See, e.g.*, 26 U.S.C. § 5000A(a) (individual mandate); 42 U.S.C. § 300gg-14(a) (requiring insurers offering family plans to cover adult children until age 26), §§ 18031–18044 (creating

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[41] If that is true, then courts are speaking loosely when they state that they are "invalidating" or "striking down" a law.

health insurance exchanges). The other titles generally amend Medicare (Title III), fund preventative healthcare programs (Title IV), seek to expand the supply of healthcare workers (Title V), enact anti-fraud requirements for Medicare/Medicaid facilities (Title VI), establish or expand drug regulations (Title VII), create a voluntary long-term care insurance program (Title VIII), address taxation (Title IX), and improve health care for Native Americans (Title X[42]).

The plaintiffs group this host of provisions into three categories for ease of reference. State Plaintiffs' Br. at 38. The first category includes the three core ACA provisions the Supreme Court has called "closely intertwined": the individual mandate, 26 U.S.C. § 5000A(a), the guaranteed-issue requirement, 42 U.S.C. §§ 300gg, 300gg-1, and the community-rating requirement, 42 U.S.C.§ 300gg-4. *King*, 135 S. Ct. at 2487. The second category includes the remaining "[m]ajor provisions of the Affordable Care Act," *NFIB*, 567 U.S. at 697 (joint dissent), namely other provisions dealing with "insurance regulations and taxes," "reductions in federal reimbursements to hospitals and other Medicare spending reductions," the insurance "exchanges and their federal subsidies," and "the employer responsibility assessment." *See, e.g.*, 25 U.S.C. § 4980H; 26 U.S.C. § 36B; 42 U.S.C. §§ 1395ww, 18021–22. The third category includes a variety of minor provisions, for example taxes on certain medical devices or provisions requiring the display of nutritional content at restaurants. *See, e.g.*, 21 U.S.C. § 343(q)(5)(H); 26 U.S.C. § 4191(a).

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[42] Title X also includes a number of miscellaneous provisions relating to the other titles.

Moreover, Congress has made a number of substantive amendments to the ACA, revising the statute in 2010, 2011, 2014, 2017, and 2018. *See, e.g.*, Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, 124 Stat. 3285 (2010) (modifying tax credit scale and Medicaid requirements); Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, 125 Stat. 38 (2011) (repealing program that required some employers to provide some employees with vouchers for purchasing insurance); Bipartisan Budget Act of 2015, Pub. L. No. 114-74, 129 Stat. 584 (2015) (repealing requirement that employers with more than 200 employees enroll new full-time employees in health insurance and continue coverage for current employees). Most of these amendments occurred prior to the 2017 legislation eliminating the shared responsibility payment, but some are more recent. *See, e.g.*, Bipartisan Budget Act of 2018, Pub. L. No. 115-123, 132 Stat. 64 (2018) (repealing Independent Payment Advisory Board).

In summary, then, this issue involves a challenging legal doctrine applied to an extensive, complex, and oft-amended statutory scheme. All together, these observations highlight the need for a careful, granular approach to carrying out the inherently difficult task of severability analysis in the specific context of this case. We are not persuaded that the approach to the severability question set out in the district court opinion satisfies that need. The district court opinion does not explain with precision how particular portions of the ACA as it exists post-2017 rise or fall on the constitutionality of the individual mandate. Instead, the opinion focuses on the 2010 Congress' labeling of the individual mandate as "essential"

to its goal of "creating effective health insurance markets," 42 U.S.C. § 18091(2)(I), and then proceeds to designate the entire ACA inseverable. In using this approach, the opinion does not address the ACA's provisions with specificity, nor does it discuss how the individual mandate fits within the post-2017 regulatory scheme of the ACA.

The district court opinion begins by addressing the 2010 version of the ACA. Starting with the text of the ACA, the district court opinion points out that the 2010 Congress incorporated into the text its view that "the absence of the [individual mandate] would undercut Federal regulation of the health insurance market." 42 U.S.C. § 18091(2)(H). The district court opinion notes that the 2010 Congress devised the individual mandate, "together with the other provisions" of the ACA, to "add millions of new customers to the health insurance market." 42 U.S.C. § 18091(2)(C). In this way, the 2010 Congress sought to "minimize th[e] adverse selection" that might otherwise occur if healthy individuals "wait[ed] to purchase health insurance until they needed care," 42 U.S.C. § 18091(2)(I)—a strategic choice that would otherwise be available given the ACA's guaranteed-issue and community-rating provisions. According to the district court opinion: because the 2010 Congress found the individuate mandate "essential" to this plan to reshape health insurance markets, the individual mandate is inseverable from the rest of the ACA "[o]n the unambiguous enacted text alone."

The district court opinion also addresses ACA caselaw. Citing the Supreme Court's decisions in *NFIB* and *King*, the district court opinion states that "[a]ll nine Justices . . . agreed the Individual Mandate

is inseverable from at least the pre-existing-condition provisions." *See NFIB*, 567 U.S. at 548 (Roberts, C.J.), 596–98 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ.), 695–96 (joint dissent of Scalia, Kennedy, Thomas, and Alito, JJ.); *King*, 135 S. Ct. at 2487 (stating that the individual mandate is "closely intertwined" with the guaranteed-issue and community-rating provisions). As to the ACA's other provisions, the district court opinion notes that the only group of Justices who fully considered whether the other major and minor provisions were severable was the joint dissent in *NFIB*—and those Justices would have held that "invalidation of the ACA's major provisions requires the Court to invalidate the ACA's other provisions." *NFIB*, 567 U.S. at 704 (joint dissent).

Beyond these points, the district court opinion states that its "conclusion would only be reinforced" if it "parse[d] the ACA's provisions one by one." The district court opinion arrives at this conclusion by reasoning that declaring only the individual mandate unlawful would disrupt the Act's careful balance of "shared responsibility." The district court opinion lists a few examples of how it would expect this to happen with regard to the ACA's major provisions. First, the district court opinion reasons that "the Individual Mandate reduces the financial risk forced upon insurance companies and their customers by the ACA's major regulations and taxes." If the individual mandate fell and the regulations and taxes did not, insurance companies would suffer a burden without enjoying a countervailing benefit—"a choice no Congress made and one contrary to the text." Second, if a court were to declare just the individual mandate and the protections for preexisting conditions unlawful—but not the

subsidies for health insurance—then the Act would be transformed into "a law that subsidizes the kinds of discriminatory products Congress sought to abolish at, presumably, the re-inflated prices it sought to suppress." Third, Congress never intended "a duty on employers, *see* 26 U.S.C. § 4980H, to cover the skyrocketing insurance premium costs" that would "inevitably result from removing" the individual mandate. Fourth, because "the Medicaid-expansion provisions were designed to serve and assist fulfillment of the Individual Mandate," removing the individual mandate would remove the need for that expansion.

As to the ACA's minor provisions, the district court opinion states that it is "impossible to know which minor provisions Congress would have passed absent the Individual Mandate," and that such an inquiry involves too much "legislative guesswork." Relying on the 2010 Congress' labeling of the individual mandate as "essential," the district court opinion ultimately determines that there is "no reason to believe that Congress would have enacted" the minor provisions independently. The district court opinion similarly disclaims the ability to divine the intent of the 2017 Congress—which had zeroed out the shared responsibility payment but left the rest of the ACA untouched—labeling such an inquiry "a fool's errand." To the extent it analyzed the intent of the 2017 Congress, the district court opinion determines that Congress' failure to repeal the individual mandate shows that it "knew that provision is essential to the ACA." In sum, the district court opinion concludes that the entire ACA is inseverable from the individual mandate.

The plaintiffs urge affirmance for essentially the same reasons stated in the district court opinion.[43] As to the guaranteed-issue and community-rating provisions, they rely primarily on the 2010 Congress' express findings linking those provisions to the individual mandate. State Plaintiffs' Br. at 39–44; Individual Plaintiffs' Br. at 47–48. The 2010 Congress found that, without the individual mandate, "many individuals would wait to purchase health insurance until they needed care," creating an "adverse selection" problem. 42 U.S.C. § 18091(2)(I); *see also id.* (finding that the individual mandate is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold"). As to the remaining major and some of the minor provisions, the plaintiffs rely primarily on the joint dissent in *NFIB* for the proposition that leaving these provisions standing would "undermine Congress' scheme of shared responsibility," throwing off the balance of the interlocking insurance market reforms set out in the ACA. 567 U.S. at 698 (joint dissent) (internal quotation marks omitted); State Plaintiffs' Br. at 44–49. As for the most minor provisions, they argue that these were "mere adjuncts" of the more important provisions and would not have been independently enacted. State Plaintiffs' Br. at 50.

On appeal, the federal defendants agree with the plaintiffs that the entirety of the ACA is inseverable from the individual mandate. Fed. Defendants' Br. at

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[43] The individual plaintiffs adopt the state plaintiffs' severability arguments by reference. *See* Fed. R. App. P. 28(i).

36–49. This marks a significant change in litigation position, as the federal defendants had previously submitted to the district court that only the guaranteed-issue and community-rating provisions were inseverable. And that is not the only new argument the federal defendants make on appeal. For the first time on appeal, the federal defendants argue that the remedy in this case should be limited to enjoining enforcement of the ACA only to the extent it harms the plaintiffs. *See* Fed. Defendants' Br. at 26–29 (arguing that the individual "plaintiffs do not have standing to seek relief against provisions of the ACA that do not in any way affect them"); Fed. Defendants' Supp. Br. at 10 ("[T]he judgment itself, as opposed to its underlying legal reasoning, cannot be understood as extending beyond the plaintiff states to invalidate the ACA in the intervenor states.").

The intervenor-defendant states, meanwhile, argue that *every* provision of the ACA is severable from the individual mandate. They argue that the 2017 Congress' decision not to repeal or otherwise undermine any other provision of the ACA shows that it intended the rest of the ACA to remain operative—and that the court should not focus on the intent of the 2010 Congress. Intervenor-Defendant States' Br. at 34–35, 43. They point to the statements of several legislators in the 2017 Congress that seem to evince an assumption that other parts of the ACA would not be altered,[44] and to Congress' knowledge of reports highlighting the severe consequences a total invalidation

[44] Although we decline to opine on the merits of the parties' arguments at this juncture, we caution against relying on individual

of the ACA would have. Intervenor-Defendant States' Br. at 40. Finally, they argue that the passage of time since the ACA's enactment has shown that the individual mandate is not all that crucial after all, and they provide examples of ACA provisions they say have nothing to do with insurance markets or became operative years before the individual mandate took effect. Intervenor-Defendant States' Br. at 45.

Although we understand and share the district court's general disinclination to engage in what it refers to as "legislative guesswork"—and what a Supreme Court Justice has described as "a nebulous inquiry into hypothetical congressional intent," *Murphy*, 138 S. Ct. at 1486 (Thomas, J., concurring) (quoting *Booker*, 543 U.S. at 321 n.7 (Thomas, J., dissenting in part))—we nevertheless conclude that the severability analysis in the district court opinion is incomplete in two ways.

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statements by legislators to determine the meaning of the law. "[L]egislative history is not the law." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1631 (2018); *see also Asadi v. G.E. Energy (USA), LLC*, 720 F.3d 620, 626 n.9 (5th Cir. 2013) ("[T]he authoritative statement is the statutory text, not the legislative history or any other extrinsic material." (quoting *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005))); Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts 392–93 (2012) ("Each member voting for the bill has a slightly different reason for doing so. There is no single set of intentions shared by all . . . [y]et a majority has undeniably agreed on the final language that passes into law . . . and that is the sole means by which the assembly has the authority to make law."). And even among legislative history devotees, "floor statements by individual legislators rank among the least illuminating forms." *N.L.R.B. v. SW Gen., Inc.*, 137 S. Ct. 929, 943 (2017).

First, the opinion gives relatively little attention to the intent of the 2017 Congress, which appears in the analysis only as an afterthought despite the fact that the 2017 Congress had the benefit of hindsight over the 2010 Congress: it was able to observe the ACA's actual implementation. Although the district court opinion states that burdening insurance companies with taxes and regulations without giving them the benefit of compelling the purchase of their product is "a choice no Congress made," it only links this observation to the 2010 Congress. It does not explain its statement that the 2017 Congress' failure to repeal the individual mandate is evidence of an understanding that no part of the ACA could survive without it.

Second, the district court opinion does not do the necessary legwork of parsing through the over 900 pages of the post-2017 ACA, explaining how particular segments are inextricably linked to the individual mandate. The opinion lists a few examples of major provisions and cogently explains their link to the individual mandate, at least as it existed in 2010. For example, the opinion discusses the individual mandate's interplay with the guaranteed- issue and community-rating provisions—all of which are found in Title I of the ACA—analyzing how Congress intended those provisions to work and how they might be expected to work without the individual mandate. But in order to strike the delicate balance that severability analysis requires, the district court must undertake a similar inquiry for each segment of the post-2017 law that it ultimately declares unlawful—and it has not done so. Instead, the district court opinion focuses on the 2010 Congress' designation of the individual mandate as "essential to creating effective health

insurance markets" and intention that, for at least one set of legislative goals, the individual mandate was intended to work "together with the other provisions" of the ACA. *E.g.*, 42 U.S.C. § 18091(2)(I). On this basis, and on the views of the dissenting Justices in *NFIB* addressing the ACA as it stood in 2012, the district court opinion renders the entire ACA inoperative. More is needed to justify the district court's remedy.

Take, for example, the ACA provisions in Title IV requiring certain chain restaurants to disclose to consumers nutritional information like "the number of calories contained in the standard menu item." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4206, 124 Stat. 119, 573–74 (2012) (codified at 21 U.S.C. § 343). Or consider the provisions in Title X establishing the level of scienter necessary to be convicted of healthcare fraud. Patient Protection and Affordable Care Act § 10606, 124 Stat. 119, 1006–09, (codified at 18 U.S.C. § 1347). Without more detailed analysis from the district court opinion, it is unclear how provisions like these—which certainly do not directly regulate the health insurance marketplace—were intended to work "together" with the individual mandate. Similarly, the district court opinion's assertion that "most of the minor provisions" of the ACA "are mere adjuncts of" or "aids to the[] effective execution" of the project of the individual mandate is not supported by the actual analysis in the district court opinion, which does not dive into those provisions. Finally, some insurance-related reforms became law years before the effective date of the individual mandate; the district court opinion does not explain how provisions like these are inextricably linked to the individual mandate. *See, e.g.*, 42 U.S.C.

§§ 300gg-11, 300gg-14(a). Whatever the solution to the problem of "legislative guesswork" the district court opinion identifies in severability doctrine as it currently stands, it must include a careful parsing of the statutory scheme at issue to address questions like these.

We have long "require[d] that a district court explain its reasons for granting a motion for summary judgment in sufficient detail for us to determine whether the court correctly applied the appropriate legal test." *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 644 (5th Cir. 1992). This is because we have "little opportunity for effective review" when the district court opinion leaves some reasoning "vague" or "unsaid." *Myers v. Gulf Oil Corp.*, 731 F.2d 281, 284 (5th Cir. 1984). "In such cases, we have not hesitated to remand . . . ." *Id.* In this case, the analysis the district court opinion provides is substantial and far exceeds the sort of cursory reasoning that normally prompts us to remand. Yet, the vast, wide-ranging statutory scheme at issue in this case also far exceeds the comparatively small number of provisions at issue in other severability cases, *see, e.g.*, *Chadha*, 462 U.S. at 931–35 (considering whether 8 U.S.C. § 244(c)(2) could be severed from the rest of § 244)—especially cases in which entire legislative acts are determined to be inseverable, *see, e.g.*, *Murphy*, 138 S. Ct. at 1481–84 (considering whether part of 28 U.S.C. § 3702(1) could be severed from §§ 3701–04).

Moreover, the Supreme Court has remanded in the severability context upon a determination that additional analysis was necessary. In *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006), the Supreme Court took up the issue of what

relief was appropriate upon a determination that a New Hampshire provision requiring parental notification prior to abortion was unconstitutional in some applications. *Id.* at 328–32. The Supreme Court determined that, although the district court's choice to use "the most blunt remedy"—total inseverability—was "understandable" under its own precedent, more analysis was needed to determine "whether New Hampshire's legislature intended the statute to be susceptible to" severability. *Id.* at 330–31. As a result, the Supreme Court remanded for "lower courts to determine legislative intent in the first instance." *Id.*

We do the same here, directing the district court to employ a finer-toothed comb on remand and conduct a more searching inquiry into which provisions of the ACA Congress intended to be inseverable from the individual mandate. We do not hold forth on just how fine-toothed that comb should be—the district court may use its best judgment to determine how best to break the ACA down into constituent groupings, segments, or provisions to be analyzed. Nor do we make any comment on whether the district court should take into account the government's new posture on appeal or what the ultimate outcome of the severability analysis should be.[45] Although "we cannot affirm the order as it is presently supported," we do not suggest what result will be merited "[a]fter a more thorough inquiry." *Unger v. Amedisys Inc.*, 401 F.3d 316, 325 (5th Cir. 2005). We only note that the inquiry must be

[45] The district court should also consider this court's recent severability analysis in *Collins v. Mnuchin*, 938 F.3d 553 (5th Cir. 2019) (en banc). That opinion was issued after both the district court's decision and the oral argument here.

made, and that the district court—which has many tools at its disposal—is best positioned to determine in the first instance whether the ACA "remains 'fully operative as a law'" and whether it is evident from "the statute's text or historical context" that Congress would have preferred no ACA at all to an ACA without the individual mandate. *Free Enter. Fund*, 561 U.S. at 509 (quoting *New York*, 505 U.S. at 186).

It may still be that none of the ACA is severable from the individual mandate, even after this inquiry is concluded. It may be that all of the ACA is severable from the individual mandate. It may also be that some of the ACA is severable from the individual mandate, and some is not.[46] But it is no small thing for unelected, life-tenured judges to declare duly enacted legislation passed by the elected representatives of the American people unconstitutional. The rule of law demands a careful, precise explanation of whether the provisions of the ACA are affected by the unconstitutionality of the individual mandate as it exists today.

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[46] For an explanation of some, but certainly not all, of the potential conclusions with regard to severability, *see* Josh Blackman, *Undone: The New Constitutional Challenge to Obamacare*, 23 Tex. Rev. L. & Pol. 1, 28–51 (2018) (stating that the district court could halt the enforcement of just the individual mandate, halt the enforcement of the entire Act, or halt the enforcement of the community-rating and guaranteed-issue provisions along with the individual mandate, for example). The district court could also issue a declaratory judgment without enjoining any government official.

B.

Remand is appropriate in this case for a second reason: so that the district court may consider the federal defendants' new arguments as to the proper scope of relief in this case. The relief the plaintiffs sought in the district court was a universal nationwide injunction: an order that totally "enjoin[ed] Defendants from enforcing the Affordable Care Act and its associated regulations." Before the district court, the federal defendants urged entry of a declaratory judgment stating that the guaranteed-issue and community-rating provisions—at that time, the only provisions the federal defendants argued were inseverable—were "invalid[ated]" by the zeroing out of the shared responsibility payment. This would be "sufficient relief against the Government," the federal defendants argued, because a declaratory judgment would "operate[] in a similar manner as an injunction" against the federal government, which would be "presumed to comply with the law" once the court provides "a definitive interpretation of the statute."

Ultimately, of course, the district court opinion determined that no ACA provision was severable and resulted in a judgment declaring the entire ACA "invalid." On appeal, the federal defendants first changed their litigation position to agree that no ACA provision was severable. Now they have changed their litigation position to argue that relief in this case should be tailored to enjoin enforcement of the ACA in only the plaintiff states—and not just that, but that the declaratory judgment should only reach ACA provisions that injure the plaintiffs. They argue that the Supreme Court has made clear that "[a] plaintiff's

remedy must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018); *see also Printz v. United States*, 521 U.S. 898, 935 (1997) (reasoning that the Court has "no business answering" questions dealing with enforcement of provisions that "burden . . . no plaintiff"); *see also Murphy*, 138 S. Ct. at 1485–86 (Thomas, J., concurring). This argument came as a surprise to the plaintiffs, who explained at oral argument that they saw the government's new position as a possible "bait and switch." The federal defendants admitted at oral argument that they had raised the scope-of-relief issue on appeal "for the first time," but argued that it was necessary to address, as it went to the district court's Article III jurisdiction. The federal defendants therefore suggested that it "would be appropriate to remand to consider the scope of the judgment."

The court agrees that remand is appropriate for the district court to consider these new arguments in the first instance. The district court did not have the benefit of considering them when it crafted the relief now on appeal.[47] On remand, the district court—which is in a far better position than this court to determine which ACA provisions actually injure the plaintiffs—may consider the federal defendants' position on the proper relief to be afforded. As part of this inquiry, the district court may consider whether the federal defendants' arguments were timely raised, and whether limiting the remedy in this case is supported by Supreme Court precedent. Once again, we place no

[47] The consideration of limited relief may affect the intervenors as well. The district court is better suited to resolving these issues in the first instance.

thumb on the scale as to the ultimate outcome; the district court is free to weigh the federal defendants' changed arguments as it sees fit.

VII.

For these reasons, the judgment of the district court is AFFIRMED in part and VACATED in part. We REMAND for proceedings consistent with this opinion.

KING, Circuit Judge, dissenting:

Any American can choose not to purchase health insurance without legal consequence. Before January 1, 2018, individuals had to choose between complying with the Affordable Care Act's coverage requirement or making a payment to the IRS. For better or worse, Congress has now set that payment at $0. Without any enforcement mechanism to speak of, questions about the legality of the individual "mandate" are purely academic, and people can purchase insurance—or not—as they please. No more need be said; it has long been settled that the federal courts deal in cases and controversies, not academic curiosities.

The majority sees things differently and today holds that an unenforceable law is also unconstitutional. If the majority had stopped there, I would be confident its extrajurisdictional musings would ultimately prove harmless. What does it matter if the coverage requirement is unenforceable by congressional design or constitutional demand? Either way, that law does not do anything or bind anyone.

But again, the majority disagrees. It feels bound to ask whether Congress would want the rest of the Affordable Care Act to remain in force now that the coverage requirement is unenforceable. Answering that question should be easy, since Congress removed the coverage requirement's only enforcement mechanism but left the rest of the Affordable Care Act in place. It is difficult to imagine a plainer indication that Congress considered the coverage requirement entirely dispensable and, hence, severable. And yet, the majority is unwilling to resolve the severability issue. Instead, it merely identifies serious flaws in the district court's analysis and remands for a do-over, which will

unnecessarily prolong this litigation and the concomitant uncertainty over the future of the healthcare sector.

I would vacate the district court's order because none of the plaintiffs have standing to challenge the coverage requirement. And although I would not reach the merits or remedial issues, if I did, I would conclude that the coverage requirement is constitutional, albeit unenforceable, and entirely severable from the remainder of the Affordable Care Act.

I.

To my mind, this case begins and ought to end with the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012). In that case, the Court held that the coverage requirement would be unconstitutional if it were a legal command, because neither the Commerce Clause nor the Necessary and Proper Clause allows Congress to compel individuals to engage in commerce by purchasing health insurance. *See NFIB*, 567 U.S. at 552, 560 (opinion of Roberts, C.J.); *id.* at 652-53 (joint dissent). The Court concluded, however, that the coverage requirement was constitutional, because—notwithstanding the most natural reading of the provision's text— the coverage requirement was not *actually* a legal command to purchase insurance.

Instead, according to the *NFIB* Court, the coverage requirement "leaves an individual with a lawful choice to do or not do a certain act," i.e., purchase health insurance. *Id.* at 574 (Roberts, C.J., majority opinion). All that is required, under this reading, is "a payment to the IRS" if one chooses not to purchase health insurance. *Id.* at 567. Beyond this shared-responsibility

payment, there are no further "negative legal consequences to not buying health insurance," and individuals who forgo insurance do not violate the law as long as they make the required payment. *Id.* at 567. "Those subject to the [coverage requirement] may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes. The only thing they may not lawfully do is not buy health insurance and not pay the resulting tax." *Id.* at 574 n.11. Forcing individuals to make that choice was constitutional, per *NFIB*, because Congress could "impose a tax on not obtaining health insurance" by exercising its enumerated power to lay and collect taxes, duties, imposts, and excises. *Id.* at 570.

Contrary to the suggestion of the majority, which I address specifically *infra* at Part III, Congress did not alter the coverage requirement's operation when it amended the ACA in 2017. *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 ("TCJA"). All the TCJA did, with respect to healthcare, was change the amount of the shared-responsibility payment to zero dollars. Thus, despite textual appearances, the post-TCJA coverage requirement does nothing more than require individuals to pay zero dollars to the IRS if they do not purchase health insurance, which is to say it does nothing at all.

This insight, that the coverage requirement now does nothing, should be the end of this case. Nobody has standing to challenge a law that does nothing. When Congress does nothing, no matter the form that nothing takes, it does not exceed its enumerated powers. And since courts do not change anything when they invalidate a law that does nothing, every other

law retains, or at least should retain, its full force and effect.

II.

But as the majority goes well past *NFIB*, I respond. To begin, I emphasize the importance of the rule that a plaintiff must have standing to invoke a federal court's power. This is not an anachronism lingering from some era in which empty formalities abounded in legal practice. Quite the opposite: "[T]he requirement that a claimant have 'standing is an essential and unchanging part of the case-or-controversy requirement of Article III.'" *Davis v. FEC*, 554 U.S. 724, 733 (2008) (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992)); *see also Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 157 (2014) ("Article III of the Constitution limits the jurisdiction of federal courts to 'Cases' and 'Controversies.'" (quoting U.S. Const. art. III, § 2)). And "[n]o principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013) (alteration in original) (quoting *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 341 (2006)); *accord Raines v. Byrd*, 521 U.S. 811, 818 (1997).

The Constitution's case-or-controversy requirement reflects the Framers' view of the judiciary's place among the coequal branches of the federal government: to fulfill "the traditional role of Anglo–American courts, which is to redress or prevent actual or imminently threatened injury to persons caused by private or official violation of law." *Summers v. Earth Island Inst.*, 555 U.S. 488, 492 (2009). Strict adherence to the case-or-controversy requirement—and to standing in

particular—thus "serves to prevent the judicial process from being used to usurp the powers of the political branches." *Clapper*, 568 U.S. at 408; *see also Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) ("This fundamental limitation preserves the 'tripartite structure' of our Federal Government, prevents the Federal Judiciary from 'intrud[ing] upon the powers given to the other branches,' and 'confines the federal courts to a properly judicial role.'" (alteration in original) (quoting *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016))). Thus, "federal courts may exercise power only 'in the last resort, and as a necessity,' and only when adjudication is 'consistent with a system of separated powers and [the dispute is one] traditionally thought to be capable of resolution through the judicial process.'" *Allen v. Wright*, 468 U.S. 737, 752 (1984) (alteration in original) (citation omitted) (first quoting *Chi. & Grand Trunk Ry. Co. v. Wellman*, 143 U.S. 339, 345 (1892); then quoting *Flast v. Cohen*, 392 U.S. 83, 97 (1968)), *abrogated on other grounds*, *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014). And needless to say, a federal court must conduct an "especially rigorous" standing inquiry "when reaching the merits of the dispute would force [it] to decide whether an action taken by one of the other two branches of the Federal Government was unconstitutional." *Amnesty Int'l*, 568 U.S. at 408 (quoting *Raines*, 521 U.S. at 819-20). "The importance of this precondition should not be underestimated as a means of 'defin[ing] the role assigned to the judiciary in a tripartite allocation of power.'" *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State*, 454 U.S. 464, 474 (1982) (alteration in original) (quoting *Flast*, 392 U.S. at 95).

The standing doctrine polices this constitutional limit on the judiciary's power "by 'identify[ing] those

disputes which are appropriately resolved through the judicial process.'" *Susan B. Anthony List*, 573 U.S. at 157 (alteration in original) (quoting *Lujan*, 504 U.S. at 560). The party seeking redress in the courts has the burden to establish standing. *See Spokeo*, 136 S. Ct. at 1547. To do so, the plaintiff must show it has "(1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Id.* "To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Id.* at 1548 (quoting *Lujan*, 504 U.S. 560). This means the injury must be "personal" to the plaintiff and, although the injury does not need to be "tangible," "it must actually exist." *Id.* at 1548-49.

The plaintiffs' evidentiary burden depends on the stage of the litigation. At each stage, the plaintiffs must demonstrate standing "with the manner and degree of evidence" otherwise required to establish the plaintiffs' merits case. *Lujan*, 504 U.S. at 561. Thus, because this case comes to us on the plaintiffs' own motion for summary judgment, the plaintiffs must conclusively prove all three elements of standing with evidence that "would 'entitle [them] to a directed verdict if the evidence went uncontroverted at trial.'" *Int'l Shortstop, Inc. v. Rally's, Inc.*, 939 F.2d 1257, 1264-65 (5th Cir. 1991) (quoting *Golden Rule Ins. Co. v. Lease*, 755 F. Supp. 948, 951 (D. Colo. 1991)). If a plaintiff meets its burden, the defendant can nevertheless defeat summary judgment "by merely demonstrating the existence of a genuine dispute of material fact." *Id.* at 1265. In other words, the plaintiffs here must show that, considering the summary-judgment record, all reasonable factfinders would agree that the plaintiffs

demonstrate an injury traceable to the coverage requirement and redressable by a favorable decision. *See Alonso v. Westcoast Corp.*, 920 F.3d 878, 885-86 (5th Cir. 2019).

These general principles alone should make the majority's error apparent. More specific authority illuminates it. I explain first why the majority errs in concluding the individual plaintiffs have standing, then I explain why the majority errs in concluding the state plaintiffs have standing.

A.

The majority concludes that the individual plaintiffs have standing to challenge the coverage requirement in the Patient Protection and Affordable Care Act (the "ACA"), 26 U.S.C. § 5000A(a),[1] because it forces them to purchase health insurance that they would not purchase otherwise. The majority overlooks what will happen if the individual plaintiffs fail to purchase insurance: absolutely nothing. The individual plaintiffs will be no worse off by any conceivable measure if they choose not to purchase health insurance. Thus, whatever injury the individual plaintiffs have incurred by purchasing health insurance is entirely self-inflicted.

A long line of cases establishes that self-inflicted injuries cannot establish standing because a self-inflicted injury, by definition, is not traceable to the challenged action. *See, e.g.*, *Amnesty Int'l*, 568 U.S. at 416 ("[R]espondents cannot manufacture standing merely by inflicting harm on themselves . . . ."); *Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976) ("The injuries

[1] The coverage requirement is sometimes colloquially known as the "individual mandate." For reasons that will become clear, this nickname can be misleading.

to the plaintiffs' fiscs were self-inflicted, resulting from decisions by their respective state legislatures. . . . No State can be heard to complain about damage inflicted by its own hand."); *Zimmerman v. City of Austin*, 881 F.3d 378, 389 (5th Cir.) ("[S]tanding cannot be conferred by a self-inflicted injury."), *cert. denied*, 139 S. Ct. 639 (2018). When a plaintiff chooses to incur an expense, the plaintiff must show that the challenged law forced the plaintiff to incur that expense to avoid some other concrete injury. *See Amnesty Int'l*, 568 U.S. at 415-16 (concluding costs plaintiffs incurred trying to avoid surveillance were self-inflicted because plaintiffs' fear of surveillance was speculative); *Contender Farms, L.L.P. v. USDA*, 779 F.3d 258, 266 (5th Cir. 2015) (finding plaintiff had standing to challenge regulations that required plaintiff to either "take additional measures" to comply with regulation or "face harsher, mandatory penalties" and prosecution). In other words, a plaintiff can show standing if the challenged act placed him between the proverbial rock and hard place. But without showing such a dilemma, a plaintiff "cannot manufacture standing" by expending costs to avoid an otherwise noncognizable injury, which is exactly what the individual plaintiffs did here. *Amnesty Int'l*, 568 U.S. at 416.

The majority brushes off this authority by insisting—without explanation—that labeling the plaintiffs' injuries self-inflicted "assumes" that the coverage requirement does not act as a legal command to purchase insurance, which the majority refuses to question at the standing stage. The majority misunderstands the argument. Even accepting that the coverage requirement acts as a legal command, the individual plaintiffs are still free to disregard that command without legal consequence. Therefore, any

injury they incur by freely choosing to obtain insurance is still self-inflicted.

Nor does it matter that to avoid inflicting injury upon themselves, the plaintiffs would have to violate an unenforceable statute. Plaintiffs may challenge a statute that requires them "to take significant and costly compliance measures *or risk criminal prosecution*." *Virginia v. Am. Booksellers Ass'n*, 484 U.S. 383, 392 (1988) (emphasis added); *see also, e.g.*, *Int'l Tape Mfrs. Ass'n v. Gerstein*, 494 F.2d 25, 28 (5th Cir. 1974) (explaining that standing to challenge a statute requires a "realistic possibility that the challenged statute will be enforced to [the plaintiff's] detriment"). But "[w]hen plaintiffs 'do not claim that they have ever been threatened with prosecution, that a prosecution is likely, or even that a prosecution is remotely possible,' they do not allege a dispute susceptible to resolution by a federal court." *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298-99 (1979) (quoting *Younger v. Harris*, 401 U.S. 37, 42 (1971)); *see also Poe v. Ullman*, 367 U.S. 497, 507 (1961) (Frankfurter, J., plurality) ("It is clear that the mere existence of a state penal statute would constitute insufficient grounds to support a federal court's adjudication of its constitutionality in proceedings brought against the State's prosecuting officials if real threat of enforcement is wanting."); *cf. Zimmerman*, 881 F.3d at 389-90 ("[T]o confer standing, allegations of chilled speech or 'self-censorship must arise from a fear of prosecution that is not "imaginary or wholly speculative."'" (quoting *Ctr. for Individual Freedom v. Carmouche*, 449 F.3d 655, 660 (5th Cir. 2006))).

Ullman illustrates this principle well.[2] The plaintiffs there sought to challenge Connecticut's criminal prohibition on contraception. *Ullman*, 367 U.S. at 498 (Frankfurter, J., plurality). But in the more than 75 years that the statute had been on the books, only one violation had been prosecuted—and even that was a collusive prosecution brought to challenge the law. *Id.* at 501-02. The Court dismissed the challenge for lack of standing, holding that "[t]he fact that Connecticut has not chosen to press the enforcement of this statute deprives these controversies of the immediacy which is an indispensable condition of constitutional adjudication." *Id.* at 508. The Court explained that it could not "be umpire to debates concerning harmless, empty shadows." *Id.*[3]

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[2] The majority dismisses *Ullman* as an adversity case. Nonetheless, as this court and the Supreme Court have repeatedly recognized, *Ullman* grounds its analysis in terms of standing and ripeness. *See, e.g.*, *Blum v. Yaretsky*, 457 U.S. 991, 1000 (1982); *Roark & Hardee LP v. City of Austin*, 522 F.3d 533, 544 (5th Cir. 2008); *Thomes v. Equitable Sav. & Loan Ass'n*, 837 F.2d 1317, 1318 (5th Cir. 1988). In any event, *Ullman* is just one example; other cases demonstrate this concept just as well. *See, e.g.*, *Driehaus*, 573 U.S. at 158-59 ("One recurring issue in our cases is determining when the threatened enforcement of a law creates an Article III injury. . . . [W]e have permitted pre-enforcement review under circumstances that render the threatened enforcement sufficiently imminent.").

[3] The lead opinion in *Ullman* garnered only a four-judge plurality. But Justice Brennan, who concurred in the judgment, wrote that he "agree[d] that this appeal must be dismissed for failure to present a real and substantial controversy" and that "until the State makes a definite and concrete threat to enforce these laws . . . this Court may not be compelled to exercise its most delicate power of constitutional adjudication." *Ullman*, 367 U.S. at 509 (Brennan, J., concurring in judgment). Accordingly, five Justices

Ullman makes this an easy case. Connecticut's contraception law at least allowed the *possibility* of enforcement, even if it was speculative and unlikely to ever occur. Here, as I cannot say often enough, the coverage requirement *has no enforcement mechanism*. It is impossible for the individual plaintiffs to ever be prosecuted (or face any other consequences) for violating it. In "find[ing] it necessary to pass on" the coverage requirement, the majority "close[s] [its] eyes to reality." *Id.*[4]

The majority does not engage with the lessons of *Ullman* and its progeny. The closest it comes is in its citation to *Texas v. EEOC*, 933 F.3d 433 (5th Cir. 2019). That case does not abrogate *Ullman*, *Younger*, *Babbitt*, *American Booksellers*, or *Tape Manufacturers*—nor could it. In *Texas v. EEOC*, Texas challenged EEOC administrative guidance stating that employers who screen out job applicants with criminal records could be held liable for disparate-impact discrimination. *Id.* at 437-38. The EEOC argued that Texas did not have standing to challenge the guidance because the guidance reflected only the EEOC's interpretation of Title VII, and the Attorney General, not the EEOC, has the sole power to enforce Title VII

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agreed that plaintiffs lacked standing absent any real threat of enforcement.

[4] For the same reason, it does not matter that the district court "expressly found" that the individual plaintiffs "are obligated to" purchase health insurance. Even ignoring the conclusory nature of this supposed finding of fact, it is not the abstract obligation that matters; it is the concrete consequences, if any, that follow from a violation of that obligation. And the district court did not find (and there would be no basis for it to find) that the individual plaintiffs would face any consequences.

against states. *See* Brief for Appellants Cross-Appellees at 18-19, *Texas v. EEOC*, 933 F.3d 433 (5th Cir. 2019) (No. 18-10638). In rejecting that argument, this court explained that Title VII's enforcement scheme is not so simple. Although the EEOC may not itself bring enforcement actions against states, it may investigate states and refer cases to the Attorney General for enforcement actions. *EEOC,* 933 F.3d at 447. Therefore, "the possibility of investigation by EEOC and referral to the Attorney General for enforcement proceedings if it fails to align its laws and policies with the Guidance" put pressure on Texas to conform to the EEOC's guidance. *Id.*

In other words, even absent a direct threat of a formal enforcement action from the EEOC, Texas faced other consequences for disobeying the guidance—including the possibility that the Attorney General would enforce Title VII against it. In fact, we noted that "[o]ne Texas agency ha[d] already been required to respond to a charge of discrimination filed with EEOC based on its no-felon hiring policy." *Id.* at 447 n.26. The majority here cites no similar concrete consequences that will (or even plausibly could) follow if the plaintiffs violate the coverage requirement.

My conclusion that individual plaintiffs lack standing is only bolstered by a unanimous opinion issued mere weeks ago by a panel that included the author of today's majority opinion. In that case, the court held that Austin, Texas could not use a suit against the Texas Attorney General to challenge a state statute, which the Attorney General was authorized to enforce, that barred the city from enforcing one of its ordinances. *City of Austin v. Paxton*, No. 18-50646, ___ F.3d ___, 2019 WL 6520769, at *6 (5th Cir Dec. 4, 2019). Although the *Paxton* court based its holding on

sovereign immunity, it looked to "our standing jurisprudence," and "note[d] that it's unlikely the City had standing," because it did not show that the Attorney General would likely "inflict 'future harm'" by enforcing the statute against Austin. *Id.* at *6-7. If standing was absent in *Paxton* because enforcement was insufficiently probable, I have no idea why standing should be present in this case, where enforcement of the challenged portion of the ACA is altogether impossible.

In sum, even if the unenforceable coverage requirement must be read as a command to purchase health insurance, it does not harm the individual plaintiffs because they can disregard it without consequence. Binding precedent squarely establishes that plaintiffs may not sue in such circumstances—and with good reason. The great power of the judiciary should not be invoked to disrupt the work of the democratic branches when the plaintiffs can easily avoid injury on their own.[5]

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[5] The majority's suggestion that *NFIB*, 567 U.S. at 552 (opinion of Roberts, C.J.), supports the individual plaintiffs' standing does not warrant above-the-line attention. In short, the *NFIB* Court did not address standing. *See id.* at 530-708. At the time *NFIB* was decided, the coverage requirement was set to take effect with the shared-responsibility payment as an enforcement mechanism. And there is no indication that any of the *NFIB* plaintiffs were exempt from the shared-responsibility payment. Thus, even if the majority seeks to infer from *NFIB* some jurisdictional ruling in violation of the Supreme Court's "repeated[]" command "that the existence of unaddressed jurisdictional defects has no precedential effect," *Lewis v. Casey*, 518 U.S. 343, 352 n.2 (1996), *NFIB* offers no inferences of value for the majority to draw. Further, counsel's answer to a Justice's hypothetical question does not bind this court.

B.

The majority's conclusion that the state plaintiffs have standing to challenge the coverage requirement fares no better. I would deny the state plaintiffs standing because there is no evidence in the record, much less conclusive evidence, to support the state plaintiffs' alleged injuries.

1.

The majority first concludes that the state plaintiffs have standing because it believes that the coverage requirement increases the number of state employees who enroll in the states' employee healthcare programs. And with more enrollees, the logic goes, the states as employers must file more forms with the IRS at a higher cost to the states.

The majority's biggest mistake is that it ignores the posture of this case: the defendants appeal from the district court's order granting summary judgment *to the plaintiffs*. Accordingly, the state plaintiffs face a tremendous evidentiary burden—they must produce evidence so conclusive of the coverage requirement's effect on their healthcare-administration costs that the evidence "would 'entitle [them] to a directed verdict if the evidence went uncontroverted at trial.'" *Int'l Shortstop*, 939 F.2d at 1264-65 (quoting *Golden Rule Ins.*, 755 F. Supp. at 951).[6] And the state plaintiffs provided

[6] The district court was free to—but did not—make findings of jurisdictional fact, which we would review for clear error. *See Krim v. pcOrder.com, Inc.*, 402 F.3d 489, 494 (5th Cir. 2005). Indeed, the district court did not address the state plaintiffs' standing at all. Thus, for the state plaintiffs to establish standing on their own motion for summary judgment, they must show the summary-judgment evidence is conclusive.

no evidence *at all*, never mind conclusive evidence, to support the dubious notion that even a single state employee enrolled in one of state plaintiffs' health insurance programs solely because of the unenforceable coverage requirement.[7]

The majority relies on affidavits from several of the state plaintiffs' healthcare administrators. But these affidavits only establish that the state plaintiffs incur costs complying with the IRS reporting requirements found in 26 U.S.C. §§ 6055(a) and 6056(a). And as the majority recognizes, these requirements are distinct from the coverage requirement. Accordingly, to trace the state plaintiffs' reporting burden to the coverage requirement, the majority must additionally show that at least some state employees have enrolled in employer-sponsored health insurance solely because of the unenforceable coverage requirement. The majority comes up empty at this step, pointing only to a conclusory statement from a South Dakota human-resources director claiming that the coverage requirement, not §§ 6055(a) and 6056(a), caused South Dakota to incur its reporting expenses. This will not do. *See, e.g.*, *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 888 (1990) ("The object of [summary judgment] is not to replace conclusory allegations of the complaint or answer with conclusory allegations of an affidavit."); *Shaboon v.*

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[7] The majority misunderstands my position. *See* Maj. Op. 32 n.31. The state plaintiffs do not need to identify a "specific" person that is likely to enroll, but they still must establish that at least *one* state employee will enroll as a result of the post-TCJA coverage requirement. Otherwise, the state plaintiffs' injuries are not traceable to the provision they challenge and would not be redressed by its elimination.

Duncan, 252 F.3d 722, 737 (5th Cir. 2001) ("[U]nsupported affidavits setting forth 'ultimate or conclusory facts and conclusions of law' are insufficient to either support or defeat a motion for summary judgment." (alteration in original) (quoting *Orthopedic & Sports Injury Clinic v. Wang Labs., Inc.*, 922 F.2d 220, 225 (5th Cir. 1991))).[8]

Citing *Department of Commerce v. New York*, 139 S. Ct. 2551 (2019), the majority argues the state plaintiffs can establish standing by "showing that third parties will likely react in predictable ways" to the coverage requirement. *Id.* at 2566. But the majority

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[8] The majority suggests we must accept this statement as true because the defendants did not "challenge" this evidence. The majority cites no authority for this proposition, and I am at a loss to understand where the majority came up with its challenge rule. I know of nothing in the Federal Rules of Civil Procedure or the caselaw requiring litigants to "challenge" conclusory statements in declarations. On the contrary, courts in this circuit regularly confront and disregard conclusory statements in the summary-judgment record. *See, e.g.*, *Tex. Capital Bank N.A. v. Dall. Roadster, Ltd. (In re Dall. Roadster, Ltd.)*, 846 F.3d 112, 124 (5th Cir. 2017); *Brown v. Mid-Am. Apartments*, 348 F. Supp. 3d 594, 602-03 (W.D. Tex. 2018). The district courts and litigants of this circuit will be surprised to learn about the majority's new summary-judgment rule.

The majority also claims that the statement is not conclusory. But nothing in the affidavit addresses the post-TCJA coverage requirement. The affiant states that his knowledge is "related to the enactment of the ACA," which occurred in 2010. He focuses on "financial costs associated with ACA regulations" and concludes that "South Dakota would be significantly burdened if the ACA remained law." The affidavit does not explain how the post-TCJA coverage requirement harms South Dakota. Such generalities, untethered to the actual law at issue in this appeal, cannot establish standing—especially not at the summary-judgment stage.

fails to explain why state employees who do not want health insurance would nevertheless predictably enroll in health insurance solely because an unenforceable statute, here the coverage requirement, directs them to do so. What the majority fails to mention in its discussion of *Department of Commerce* is that the "predictable" behavior at issue there was individuals "choosing to *violate their legal duty* to respond to the census." *Id.* at 2565 (emphasis added). Thus, *Department of Commerce* shows that people will predictably violate the law when sufficiently incentivized to do so. This directly contradicts the assumption undergirding much of the majority's analysis—that people tend to follow the law regardless of the incentives. And state employees who do not want to enroll in insurance have every incentive to violate the coverage requirement.[9]

2.

The majority similarly argues that the coverage requirement increases the number of individuals enrolled in the state plaintiffs' Medicaid programs. This

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[9] A Congressional Budget Office report released shortly before Congress repealed the shared-responsibility payment further supports this notion. It concluded:

> If the [shared-responsibility payment] was eliminated but the [coverage requirement] itself was not repealed . . . . only a small number of people who enroll in insurance because of the [coverage requirement] under current law would continue to do so solely because of a willingness to comply with the law.

Cong. Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate at 1 (2017) (hereinafter "CBO Report"). On this record, we have been given no reason to believe that any of the state plaintiffs' employees are among this "small number of people." *Id.*

argument fails for the same reason: the state plaintiffs produce no evidence—let alone conclusive evidence—showing that anyone has enrolled in their Medicaid programs solely because of the unenforceable coverage requirement. To this end, the best the majority can scrape up is a statement from Teresa MacCartney, a Georgia budget official, stating that "[a]fter the implementation of the ACA, [Georgia] experienced increased enrollment of individuals already eligible for Medicaid benefits under pre-ACA eligibility standards." The majority's takeaway is that the coverage requirement caused this increase. Maybe so. But MacCartney's statement refers specifically to the coverage requirement at the time of the ACA's enactment, when the coverage requirement interacted with the shared-responsibility payment. This statement provides no insight into how the coverage requirement affects Medicaid rolls after the shared-responsibility payment's repeal. In fact, MacCartney signed her declaration on May 14, 2018, more than seven months before the shared-responsibility payment's repeal went into effect. *See* Budget Fiscal Year, 2018, Pub. L. No. 115-97, § 11081(b), 131 Stat. 2054, 2092 (2017).

Accordingly, the majority's analysis again rests on the necessary assumption that people will obey the coverage requirement regardless of the incentives, in direct contradiction to *Department of Commerce*. And because Medicaid is available to eligible recipients at little to no cost, it is especially unlikely that the unenforceable coverage requirement would play any significant part in anyone's decision to enroll. It belies common sense to conclude that anyone who would otherwise pass on the significant benefits of Medicaid would be motivated to enroll solely because of an unenforceable law.

In sum, the majority cites no actual evidence tying any costs the state plaintiffs have incurred to the unenforceable coverage requirement. The state plaintiffs accordingly cannot show an injury traceable to the coverage requirement, so they do not have standing to challenge the coverage requirement.

III.

I would not reach the merits of this case because, as explained in Part II, I would vacate the district court's order for lack of standing. But as the majority errs on the merits too, I voice my disagreement.

"Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS." *NFIB*, 567 U.S. at 568 (Roberts, C.J., majority opinion). Now that Congress has zeroed out that payment, the coverage requirement affords individuals the same choice individuals have had since the dawn of private health insurance, either purchase insurance or else pay zero dollars. Thus, to my mind, the majority's focus on whether Congress's taxing power or the Necessary and Proper Clause authorizes Congress to pass a $0 tax is a red herring; the real question is whether Congress exceeds its enumerated powers when it passes a law

that does nothing.[10] And of course it does not.[11] Congress exercises its legislative power when it "alter[s] the legal rights, duties and relations of persons." *INS v. Chadha*, 462 U.S. 919, 952 (1983); *cf. id.* ("Not every action taken by either House is subject to the bicameralism and presentment requirements of Art. I. Whether actions taken by either House are, in law and fact, an exercise of legislative power depends not on their form but upon 'whether they contain matter which is properly to be regarded as legislative in its character and effect.'" (citation omitted) (quoting S. Rep. No. 1335, 54th Cong., 2d Sess., 8 (1897))).

Lest the majority mistake my position and end up shadowboxing with "bizarre metaphysical conclusions," "quantum musings," or ersatz inconsistencies, Maj. Op. at 44 & n.40, I need to make something explicit at the outset. The TCJA did not change the text or the *meaning* of the coverage requirement, but it did change the real-world *effects* it produces. Before the TCJA, the two options afforded by the coverage requirement—purchasing insurance or making a shared-responsibility payment—were both burdensome, but Congress could force individuals to choose one of those options by exercising its Taxing Power. Today, the shared-responsibility payment's meaning

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[10] "In litigation generally, and in constitutional litigation most prominently, courts in the United States characteristically pause to ask: Is this conflict really necessary?" *Arizonans for Official English v. Arizona*, 520 U.S. 43, 75 (1997). The majority would do well if it paused to ask whether it is necessary for a federal court to rule on whether the Constitution authorizes a $0 tax or otherwise prohibits Congress from passing a law that does nothing. The absurdity of these inquiries highlights the severity of the majority's error in finding the plaintiffs have standing to challenge this dead letter.

[11] The majority does not argue otherwise.

has not changed—it still gives individuals the choice to purchase insurance or make a shared-responsibility payment—but the amount of that payment is zero dollars, which means that the coverage requirement now does nothing. The majority's contrary conclusion rests on the premise that the coverage requirement compels individuals to purchase health insurance. With this understanding, the majority says that the coverage requirement does exactly what the Supreme Court said it cannot do: compel participation in commerce. *See NFIB*, 567 U.S. at 552 (opinion of Roberts, C.J.); *id.* at 652-53 (joint dissent). This conclusion follows fine from the premise, but the premise is wrong. Despite its seemingly mandatory language, the coverage requirement does not compel anyone to purchase health insurance.

In *NFIB*, although five Justices agreed that "[t]he most straightforward reading of the [coverage requirement] is that it commands individuals to purchase insurance," *id.* at 562 (opinion of Roberts, C.J.); *accord id.* at 663 (joint dissent), applying the canon of constitutional avoidance, the Court rejected this interpretation. Instead, the Court interpreted the coverage requirement to offer applicable individuals a "lawful choice" between purchasing health insurance and paying the shared-responsibility payment, which the Court interpreted as a valid exercise of Congress's taxing power. *Id.* at 574 (Roberts, C.J., majority opinion). This is a permissible construction, the Court concluded, because "[w]hile the [coverage requirement] clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful." *Id.* at 567-68. The Court observed that "[n]either the [ACA] nor any other law attaches

negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS." *Id.* at 568. And the Court further explained:

> Indeed, it is estimated that four million people each year will choose to pay the IRS rather than buy insurance. We would expect Congress to be troubled by that prospect if such conduct were unlawful. That Congress apparently regards such extensive failure to comply with the [coverage requirement] as tolerable suggests that Congress did not think it was creating four million outlaws.

Id. (citation omitted).

The *NFIB* Court's application of constitutional avoidance as an interpretive tool does not mean that the Court rewrote the statute. Only Congress can do that. Rather, the Court was "choosing between competing plausible interpretations of a statutory text, resting on the reasonable presumption that Congress did not intend the alternative which raises serious constitutional doubts." *Clark v. Martinez*, 543 U.S. 371, 381 (2005). "The canon is thus a means of giving effect to congressional intent, not of subverting it." *Id.* at 382. Accordingly, when the Court ruled in *NFIB* that "[t]hose subject to the [coverage requirement] may lawfully forgo health insurance," *NFIB*, 567 U.S. at 574 n.11, that was an authoritative determination regarding what the text of the coverage requirement meant and what Congress intended.

The majority pushes aside *NFIB*'s construction, acting as though the fact that the *NFIB* Court applied the

canon of constitutional avoidance means that its interpretation no longer governs following the repeal of the shared-responsibility payment. But when the Court construes statutes, its "interpretive decisions, *in whatever way reasoned*, effectively become part of the statutory scheme, subject (just like the rest) to congressional change." *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2409 (2015) (emphasis added). While Congress can change its mind and could have amended the coverage requirement to turn the "lawful choice" described by *NFIB*, 567 U.S. at 574, into an unwavering command, the majority does not suggest that Congress ever made such a choice. Sure, Congress amended the *shared-responsibility payment* in 2017. Yet as the district court went to great lengths to establish and the majority is elsewhere eager to point out, the coverage requirement and the shared-responsibility payment are distinct provisions. *See* Maj. Op. at 19 ("To bring a claim against the [coverage requirement], therefore, the plaintiffs needed to show injury *from the individual mandate*—not from the shared responsibility payment."); *Texas v. United States*, 340 F. Supp. 3d 579, 596 (N.D. Tex. 2018) ("It is critical to clarify something at the outset: the shared-responsibility payment, 26 U.S.C. § 5000A(b), is distinct from the [coverage requirement], *id.* § 5000A(a)."). And Congress did not touch the text of the coverage requirement when it amended the shared-responsibility payment. *See* Budget Fiscal Year, 2018, Pub. L. No. 115-97, § 11081. *Compare* § 5000A(a), *with* 26 U.S.C. § 5000A(a) (2011). At risk of stating the obvious, if the text of the coverage requirement has not changed, its meaning could not have changed either. By "giv[ing] these same words a different meaning," the majority "invent[s] a statute rather than interpret[s] one." *Clark*, 543 U.S. at 378.

The majority is thus left on unsteady ground: amendment by implication, which "will not be presumed unless the legislature's intent is 'clear and manifest.'" *In re Lively*, 717 F.3d 406, 410 (5th Cir. 2013) (quoting *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 662 (2007)); *see also, e.g.*, *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018) ("[I]n approaching a claimed conflict, we come armed with the 'stron[g] presum[ption]' that repeals by implication are 'disfavored' and that 'Congress will specifically address' preexisting law when it wishes to suspend its normal operations in a later statute." (second and third alterations in original) (quoting *United States v. Fausto*, 484 U.S. 439, 452-53 (1988))). This rule operates with equal force when a judicial construction previously illuminated the meaning of the purportedly amended statute. *See TC Heartland LLC v. Kraft Foods Grp. Brands LLC*, 137 S. Ct. 1514, 1520 (2017) ("When Congress intends to effect a change of [a statute's earlier judicial interpretation], it ordinarily provides a relatively clear indication of its intent in the text of the amended provision."); *Midlantic Nat'l Bank v. N.J. Dep't of Envtl. Prot.*, 474 U.S. 494, 501 (1986) ("The normal rule of statutory construction is that if Congress intends for legislation to change the interpretation of a judicially created concept, it makes that intent specific."); *cf. Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 468 (2001) ("Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes."). Congress's silence on the matter is thus conclusive.

Yet even if one probes further, it boggles the mind to suggest that Congress intended to turn a non-mandatory provision into a mandatory provision by

doing away with the only means of incentivizing compliance with that provision. Congress quite plainly intended to relieve individuals of the burden the coverage requirement put on them; it did not intend to *increase* that burden. And if it did, it certainly did not make that intent "clear and manifest." *Lively*, 717 F.3d at 410. Moreover, the considerations that led the *NFIB* Court to conclude that Congress did not intend the coverage requirement to impose a legal command to purchase health insurance are even more compelling in the absence of the shared-responsibility payment. Whereas before the only "negative legal consequence[] to not buying health insurance" was the payment of a tax, *NFIB*, 567 U.S. at 567-68, now there are no consequences *at all*. And as the Congressional Budget Office ("CBO") has predicted, without the shared-responsibility payment, most applicable individuals will not maintain health insurance solely for the purpose of obeying the coverage requirement. *See* Cong. Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate at 1 (2017). "That Congress apparently regards such extensive failure to comply with the [coverage requirement] as tolerable suggests that Congress did not think it was creating [millions of] outlaws." *NFIB*, 567 U.S. at 568.

Ergo, when Congress zeroed-out the shared-responsibility payment without amending the coverage requirement, it did not do away with the lawful choice it previously offered applicable individuals; it simply changed the parameters of that choice. Under the old scheme, applicable individuals could lawfully choose between maintaining health insurance and paying a tax. Under the new scheme, applicable individuals can lawfully choose between maintaining health insurance and doing nothing. In other words, the coverage

requirement is a dead letter—it functions as an expression of national policy or words of encouragement, at most. Accordingly, although I would not reach the merits, I would reverse if I did.

IV.

I agree with much of what the majority has to say about the district court's severability ruling. But I fail to understand the logic behind remanding this case for a do-over. Severability is a question of law that this court can review de novo. And the answer here is quite simple—indeed, a severability analysis will rarely be easier. After all, "[o]ne determines what Congress would have done by examining what it did," and Congress declawed the coverage requirement without repealing any other part of the ACA. *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 560 (2001) (Scalia, J., dissenting); *see also Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006) ("[T]he touchstone for [severability analysis] is legislative intent."). Consequently, little guesswork is needed to determine that Congress believed the ACA could stand in its entirety without the unenforceable coverage requirement.

The majority suggests that remand is necessary because the district court "has many tools at its disposal" and is thus "best positioned to undertake" the severability inquiry. Maj. Op. at 60. It is true that the district court is better able to assess factual issues than appellate judges, because it can hold evidentiary hearings, but I cannot see how that could be relevant, since severability is a question of law that we review de novo. Further, it is not clear what sort of evidence the district court could receive that would be useful when deciding severability questions except perhaps legislative history, a source which the majority derides. *See* Maj. Op.

at 56 n.45 ("[W]e caution against relying on individual statements by legislators to determine the meaning of the law."). When it comes to analyzing the statute's text and historical context, *see id.*, we are just as competent as the district court. There is thus no reason to prolong the uncertainty this litigation has caused to the future of this indubitably significant statute.[12]

A.

Before I address the more specific problems with the district court's inseverability ruling, some background on the ACA is in order. Congress passed the ACA in 2010 to address a growing crisis of Americans living without health insurance. Prior to the ACA, nearly 50 million Americans (about 15 percent of the population at the time) were uninsured. *Florida ex rel. Att'y Gen. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1244 (11th Cir. 2011), *rev'd on other grounds*, *NFIB*, 567 U.S. 519. Although many large employers provided health insurance, coverage was often cost prohibitive for small businesses and consumers seeking insurance through the individual market (i.e., directly instead of through an employer). *See* U.S. Gov't Accountability Office, GAO-12-166R, Health Care Coverage: Job Lock and the Potential Impact of

[12] The majority also suggests that remand is necessary so that the district court can consider remedial issues, raised by the United States for the first time on appeal, regarding the appropriate scope of relief. But such issues are largely moot if, as I believe, the coverage requirement is completely severable from the rest of the ACA. For example, I do not perceive a meaningful difference between a nationwide injunction prohibiting enforcement of the already-unenforceable coverage requirement versus an injunction against enforcement that is limited to the plaintiff states. In any case, this court could—and, in my view, should—resolve the severability issue even if remanding remedial issues is appropriate.

the Patient Protection and Affordable Care Act 3-4 (2011). Moreover, insurance companies could—and regularly would—deny coverage to high-risk consumers, especially those with preexisting medical conditions. *Id.* at 4.

The pre-ACA status quo created numerous economic and social problems. Most obviously, America's uninsured population could not afford spiraling healthcare costs, thus exacerbating health problems, leading to an estimated 45,000 premature deaths annually, Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 Am. J. Pub. Health 2289, 2292 (2009), and causing "62 percent of all personal bankruptcies," 42 U.S.C. § 18091(2)(G). The uninsured crisis caused some subtler problems too. For one thing, hospitals would have to absorb the costs of treating uninsured patients and would inevitably pass those costs along to insurance companies, which would then pass them along to consumers. *See* § 18091(2)(F) ("The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families."). *See generally* Amicus Br. of HCA Healthcare, Inc. at 9-13. And dependency on employer-based healthcare decreased labor mobility, discouraged entrepreneurship, and kept potential caregivers away from the home. *See* GAO-12-166R, *supra*, at 5-6.

In enacting the ACA, Congress sought to address these and other problems with the national healthcare system by drastically reducing the number of uninsured and underinsured Americans. To achieve this goal, the ACA undertook a series of reforms, most notably to the individual insurance market. *See generally* Patient Protection and Affordable Care Act, Pub.

L. No. 111-148, tit. I, 124 Stat. 119 (2010). Among the ACA's most important (and visible) reforms are two related provisions: guaranteed issue and community rate. *See* 42 U.S.C. §§ 300gg, 300gg-1. The guaranteed-issue provision requires health-insurance providers to accept every individual who applies for coverage, thus preventing insurers from denying coverage based on a consumer's preexisting medical condition. *See* § 300gg-1(a). The community-rate provision prevents insurers from charging a higher rate because of a policyholder's medical condition. *See* § 300gg(a).

Left without some counterbalance, the guaranteed-issue and community-rate provisions threatened to overload insurers' risk pools with high-risk policyholders. Beyond allowing more high-risk consumers to purchase health insurance (as intended), these provisions disincentivized healthy (i.e., low risk) consumers from purchasing health insurance because it allowed them to wait until they developed costly health problems to purchase insurance.[13] This would have caused premiums to skyrocket, exacerbating many of the problems Congress sought to solve. *See generally* Amicus Br. of Blue Cross Blue Shield Ass'n at 3-4. Thus, the ACA included several provisions to incentivize low-risk consumers to purchase health insurance. It offered tax credits to offset much of the cost of health insurance for middle-income consumers. *See* 26 U.S.C. § 36B(b). It created healthcare exchanges to facilitate competition among health plans and to lower transaction costs. *See* 42 U.S.C. §§ 18031, 18041. It limited new enrollments to an open-enrollment period set by the Secretary of Health and Human Services, which mitigates the adverse-selection problem by preventing consumers from purchasing health insurance only

[13] This is known as the adverse-selection problem.

when they need it. *See* § 18031(c)(6). And it included the coverage requirement at issue in this lawsuit. *See* § 5000A(a).

Although the coverage requirement has been among the ACA's best-known provisions, the ACA's reforms to the private insurance market extend well beyond it. As just mentioned, Congress created other mechanisms to achieve the same goal as the coverage requirement: incentivize low-risk consumers to purchase health insurance. The ACA also included other provisions expanding access to the private insurance market, including a requirement that employers with 50 or more employees offer health insurance, *see* 26 U.S.C. § 4980H, and a requirement that health-insurance providers allow young adults to remain on their parents' insurance until they turn 26, *see* 42 U.S.C. § 300gg-14. And it included provisions designed to make health-insurance policies more attractive, such as those directly regulating premiums, *see, e.g.*, *id.* § 300gg-18(b), limiting benefits caps, *see id.* § 300gg-11, and prescribing certain minimum-coverage requirements for health plans, *see, e.g.*, *id.* § 300gg-13. Moreover, the ACA contains countless other provisions that are unrelated to the private insurance market—and many that are only tangentially related to health insurance at all.[14] The following are only some of many possible examples:

- Section 3006, which directs the Secretary of Health and Human Services to "develop a plan to

[14] The ACA contains ten titles. Only the first title focuses on the private insurance industry. The other titles address wide-ranging topics from the "prevention of chronic disease," ACA tit. IV, to the "health care work force," *id.* tit. V.

> implement a value-based purchasing program for payments under the Medicare program . . . for skilled nursing facilities."
>
> - Section 4205, which requires chain restaurants to conspicuously display "the number of calories contained in . . . standard menu item[s]."
> - Section 5204, which creates a student-loan repayment assistance program "to eliminate critical public health workforce shortages in Federal, State, local and tribal public health agencies."
> - Section 6402, which, among other things, strengthens criminal laws prohibiting healthcare fraud.
> - Title III of Part X, which reauthorizes and amends the Indian Health Care Improvement Act, a decades-old statute creating and maintaining the infrastructure for tribal healthcare services.

Given the breadth of the ACA and the importance of the problems that Congress set out to address, it is simply unfathomable to me that Congress hinged the future of the entire statute on the viability of a single, deliberately unenforceable provision.[15]

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[15] I do not mean to suggest that, as a policy matter, Congress chose the best (or even worthwhile) solutions to these problems.

B.

In *Planned Parenthood of Northern New England*, the Court announced the three principles that must guide our severability analysis. "First, we try not to nullify more of a legislature's work than is necessary, for we know that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'" *Planned Parenthood of N. New Eng.*, 546 U.S. at 329 (alteration in original) (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)). "Second, mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from 'rewrit[ing] [a] law to conform it to constitutional requirements' even as we strive to salvage it." *Id.* (first alteration in original) (quoting *Am. Booksellers*, 484 U.S. at 397). "Third, the touchstone for any decision about remedy is legislative intent, for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'" *Id.* at 330 (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)).

In accordance with these principles, the Court's cases suggest a two-part inquiry. First, we must ask "whether the law remains 'fully operative' without the invalid provisions." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018); *see also United States v. Booker*, 543 U.S. 220, 258-59 (2005); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987). If so, the remaining provisions are "presumed severable" from the invalid provision. *Chadha*, 462 U.S. at 934 (quoting *Champlin Ref. Co.*

Such matters are beyond my job description, so I express no opinion on them. But the district court should have thought more critically about whether Congress likely intended to leave its chosen solution to a serious problem so vulnerable to judicial invalidation.

v. Corp. Comm'n, 286 U.S. 210, 234 (1932)). This presumption is rebutted only if "the statute's text or historical context makes it 'evident' that Congress, faced with the limitations imposed by the Constitution, would have preferred" no statute over the statute with only the permissible provisions. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010). And as should be clear by now, "the 'normal rule' is 'that partial, rather than facial, invalidation is the required course.'" *Id.* at 508 (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)).

1.

The majority has identified the most glaring flaw in the district court's severability analysis: the district court "gives relatively little attention to the intent of the 2017 Congress, which appears in the analysis only as an afterthought." When one takes this fact into account, there can be little doubt as to Congress's intent.

We have unusual insight into Congress's thinking because Congress was given a chance to weigh in on the ACA's future without an effective coverage requirement and it decided the ACA should remain in place. By zeroing out the shared-responsibility payment, the 2017 Congress left the coverage requirement unenforceable. If Congress viewed the coverage requirement as so essential to the rest of the ACA that it intended the entire statute to rise and fall with the coverage requirement, it is inconceivable that Congress would have declawed the coverage requirement as it did. And make no mistake: Congress declawed the coverage requirement. As the CBO found only a month before Congress passed the TCJA, "[i]f the [coverage requirement] penalty was eliminated but the [coverage requirement] itself was not repealed, the results would be very similar to" if the coverage requirement

itself were repealed. 2017 CBO Report, *supra*, at 1. Regardless of lofty civic notions about people who follow the law for the sake of following the law, the objective evidence before Congress was that "only a small number of people" would obey the coverage requirement without the shared-responsibility payment. *Id.*; *cf. Dep't of Commerce*, 139 S. Ct. at 2565-66 (concluding people will "predictabl[y]" "violate their legal duty" when incentivized to do so). Congress accordingly knew that repealing the shared-responsibility payment would have the same essential effect on the ACA's statutory scheme as would repealing the coverage requirement.

Furthermore, as various amici highlight, judicial repeal of the ACA would have potentially devastating effects on the national healthcare system and the economy at large. *See, e.g.*, Amicus Br. of Am.'s Health Ins. Plans (discussing impact on health-insurance industry); Amicus Br. of 35 Counties, Cities, and Towns (discussing impact on municipalities); Amicus Br. of Bipartisan Econ. Scholars (discussing impact on economy); Amicus Br. of Am. Hosp. Ass'n et al. (discussing impact on hospitals). Regardless of whether the ACA is good or bad policy, it is undoubtedly *significant* policy. It is unlikely that Congress would want a statute on which millions of people rely for their healthcare and livelihoods to disappear overnight with the wave of a judicial wand. If Congress wanted to repeal the ACA through the deliberative legislative process, it could have done so. But with the stakes so high, it is difficult to imagine that this is a matter Congress intended to turn over to the judiciary.

2.

A second flaw in the district court's analysis is the great weight it places on the fact that Congress in 2017

did not repeal its statutory findings emphasizing the coverage requirement's importance to the guaranteed-issue and community-rate provisions. *See* 42 U.S.C. § 18091. The district court overread the significance of § 18091. Congress enacted the findings in § 18091 to demonstrate the coverage requirement's role in regulating interstate commerce. When it invokes its commerce power, Congress routinely makes such findings to facilitate judicial review. *See United States v. Morrison*, 529 U.S. 598, 612 (2000) ("While 'Congress normally is not required to make formal findings as to the substantial burdens that an activity has on interstate commerce,' the existence of such findings may 'enable us to evaluate the legislative judgment that the activity in question substantially affect[s] interstate commerce, even though no such substantial effect [is] visible to the naked eye.'" (alterations in original) (citation omitted) (quoting *United States v. Lopez*, 514 U.S. 549, 562-63 (1995))). Indeed, § 18091(2), the subsection the district court focused its attention on, is entitled "Effects on the national economy and interstate commerce."

Section 18091 is not an inseverability clause, and nothing in its text suggests that Congress intended to make the coverage requirement inseverable from the remainder of the ACA. If Congress intended to draft an inseverability clause, it knew how to do so. *See* Office of Legislative Counsel, U.S. Senate, Senate Legislative Drafting Manual § 131(b) (1997) (explaining purpose of inseverability clause). *Compare id.* § 131(c) (providing as example of proper form for inseverability clause: "EFFECT OF INVALIDITY ON OTHER PROVISIONS OF ACT.—If section 501, 502, or 503 of the Federal Election Campaign Act of 1971 (as added by this section) or any part of those sections is held to be invalid, all provisions of and amendments made by

this Act shall be invalid"), *with* § 18091(2)(H) ("The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market."). In fact, both the House and the Senate legislative drafting guides suggest that Congress should include an inseverability clause if it wants to make a statute inseverable because "[t]he Supreme Court has made it quite clear that invalid portions of statutes are to be severed 'unless it is evident that the Legislature would not have enacted those provisions which are within its powers, independently of that which is not.'" Office of Legislative Counsel, U.S. House of Representatives, House Legislative Counsel's Manual on Drafting Style § 328 (1995) (quoting *Chadha*, 462 U.S. at 931); *accord* Senate Legislative Drafting Manual, *supra*, at § 131(a). The absence of a genuine inseverability clause should be all but conclusive in assessing the legislature's intent.

Moreover, the argument that § 18091 is meant to signal Congress's intent that the coverage requirement be inseverable proves far too much. Section 18091 discusses the coverage requirement's importance to the entire federal healthcare regulatory scheme, including—along with the ACA—the Public Health Service Act ("PHSA") and the Employee Retirement Income Security Act ("ERISA"). *See* § 18091(2)(H) ("Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The [coverage] requirement is an essential part of *this larger regulation* of economic activity, and the absence of the requirement would undercut Federal regulation of the health

insurance market." (emphasis added)). It is not suggested that Congress intended a court to strike down the PHSA and ERISA if it found the coverage requirement unconstitutional. This would be especially implausible given the intensity of the debate over the coverage requirement's constitutionality from the get-go. *See NFIB*, 567 U.S. at 540 ("On the day the President signed the [ACA] into law, Florida and 12 other States filed a complaint in the Federal District Court for the Northern District of Florida."). Yet in signaling that the coverage requirement is "an essential part of this larger regulation," Congress did not distinguish between the ACA and these prior statutes. Thus, § 18091 cannot reasonably be read to bear on the coverage requirement's severability.

3.

Another flaw in the district court's analysis is its suggestion that the Supreme Court concluded in *NFIB* and *King v. Burwell*, 135 S. Ct. 2480 (2015), that the coverage requirement is inseverable from the ACA's guaranteed-issue and community-rate provisions. The district court misconstrued these opinions. And even if the district court read them correctly, these opinions address the coverage requirement as enforced by the shared-responsibility payment. They give little valuable insight into the coverage requirement's role in the post-TCJA ACA.

In *NFIB*, only the dissenters addressed the coverage requirement's severability. The district court did not suggest it is bound by a Supreme Court dissent, and of course it is not. The district court instead took language from the other five Justices out of context to conclude that each of them viewed the coverage requirement as inseverable. But none of the language the district court cited addresses severability. *See*

NFIB, 567 U.S. at 547-48 (opinion of Roberts, C.J.) (discussing Government's argument that coverage requirement plays a role in regulating interstate commerce); *id.* at 597 (Ginsburg, J., dissenting in part) (same). Although the Justices' reasoning certainly suggests that they saw the coverage requirement as an important part of the statutory scheme as it existed in 2012, this does not mean the Justices found it "evident" that Congress would have preferred the entire statute to fall without the coverage requirement. *Alaska Airlines*, 480 U.S. at 684.

King likewise contains some helpful commentary about the ACA's original statutory scheme, but it does not discuss severability or otherwise control the severability analysis. The Court ruled in *King* that the ACA's tax credits were available to every eligible consumer regardless of whether the state in which a consumer lived established its own exchange or relied on the federally operated exchange. 135 S. Ct. at 2496. The coverage requirement came up because many more individuals would have been exempt from the shared-responsibility payment if tax credits were not available to them. *Id.* at 2493-95; *see also* § 5000A(e)(1)(A) ("No penalty shall be imposed . . . with respect to . . . [a]ny applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income . . . .").[16] Noting the importance of the tax

[16] Lest there be any confusion, the exemption at issue in *King* exempted individuals otherwise subject to the coverage requirement from the shared-responsibility payment; it did not exempt them from the coverage requirement itself. Exemptions from the shared-responsibility payment are listed in § 5000A(e)(1),

credits and coverage requirement (as enforced by the shared-responsibility payment) to the statutory structure, the Court concluded as a matter of statutory interpretation that Congress did not intend a scheme in which neither tax credits nor the coverage requirement were operating to bring low-risk consumers into the insurance pools. *See King*, 135 S. Ct. at 2492-94 ("The combination of no tax credits and an ineffective coverage requirement could well push a State's individual insurance market into a death spiral. . . . It is implausible that Congress meant the [ACA] to operate in this manner.").

The district court framed *King* as saying that Congress intrinsically tied the community-rate and guaranteed-issue provisions to the coverage requirement, meaning that those provisions must be inseverable from the coverage requirement. But the district court ignored a crucial aspect of the *King* Court's analysis: it explicitly discussed the coverage requirement as enforced by the shared-responsibility payment. *See id.* at 2493 (referring to the coverage requirement as "a requirement that individuals maintain health insurance coverage *or make a payment to the IRS*" (emphasis added)). Indeed, as the Court identified it, the crux of the problem with denying consumers tax credits in federal-exchange states was that doing so would make a large number of individuals unable to afford insurance, thus exempting them from the shared-responsibility payment. *See id.* These widespread exemptions would, in turn, make the coverage requirement "ineffective." *Id. King* thus speaks far more to the shared-responsibility payment's role in the ACA's pre-TCJA

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whereas exemptions from the coverage requirement itself are listed in § 5000A(d).

statutory scheme than it does the coverage requirement's role in the statutory scheme.

Even to the extent the Court in *NFIB* or *King* meant to opine on the coverage requirement's severability, these cases were both decided before the TCJA. They thus give no insight into how the coverage requirement fits into the post-TCJA scheme. Whatever reservations the Court previously harbored about severing the coverage requirement, Congress plainly did not share those concerns when it zeroed out the shared-responsibility payment. Congress either concluded that healthcare markets under the ACA had reached a point of stability at which they no longer needed an effective coverage requirement,[17] or it chose to accept the negative side effects of effectively repealing the coverage requirement as a cost of relieving the burden it placed on applicable individuals. Either way, the legislative considerations have necessarily shifted.

In sum, there was no reason for the district court to conclude that *any* provision in the ACA was inseverable from the coverage requirement. The majority does not necessarily disagree. I thus do not understand its decision to remand when, even on the majority's analysis of the case, it could instead reverse and render a judgment declaring only the coverage requirement unconstitutional.

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[17] *See* CBO Report, *supra*, at 1 (concluding that "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade" if the coverage requirement were repealed); Amicus Br. of Blue Cross Blue Shield Ass'n at 24-27 (explaining that tax credits and other ACA provisions are driving enough consumers into insurance markets to make the coverage requirement unnecessary).

V.

Limits on judicial power demand special respect in a case like this. For one thing, careless judicial interference has the potential to be especially pernicious when it involves a complex statute like the ACA, which carries such significant implications for the welfare of the economy and the American populace at large. For another, the legitimacy of the judicial branch as a countermajoritarian institution in an otherwise democratic system depends on its ability to operate with restraint—and especially so in a high-profile case such as the one at bar. The district court's opinion is textbook judicial overreach. The majority perpetuates that overreach and, in remanding, ensures that no end for this litigation is in sight.

I respectfully dissent.

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-10011

TEXAS,[1] ET AL., *Plaintiffs – Appellees*,

v.

UNITED STATES OF AMERICA, ET AL., *Defendants – Appellants,*

CALIFORNIA, ET AL., *Intervenor-Defendants – Appellants.*

[Filed: January 29, 2020]

ORDER DENYING EN BANC REVIEW

Before KING, ELROD, and ENGELHARDT, Circuit Judges.

PER CURIAM:

The court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor (FED. R. APP. P. 35 and 5TH CIR. R. 35), rehearing en banc is DENIED.[2]

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[1] Governor Tate Reeves is substituted pursuant to Federal Rule of Appellate Procedure 43(c)(2).

[2] Judges Ho and Oldham are recused and did not participate in the en banc poll.

In the poll, 6 judges voted in favor of rehearing en banc, and 8 voted against. Judges Smith, Stewart, Dennis, Graves, Higginson, and Costa voted in favor. Chief Judge Owen and Judges Jones, Elrod, Southwick, Haynes, Willett, Duncan, and Engelhardt voted against.

ENTERED FOR THE COURT:

/s/ Jennifer Walker Elrod

Jennifer Walker Elrod
United States Circuit Judge

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[Filed: February 6, 2020]

JUDGMENT

FILED December 18, 2019

Before KING, ELROD, and ENGELHARDT, Circuit Judges.

J U D G M E N T

This cause was considered on the record on appeal and was argued by counsel.

It is ordered and adjudged that the judgment of the District Court is affirmed in part, and remanded to the District Court for further proceedings in accordance with the opinion of this Court.

IT IS FURTHER ORDERED that each party bear its own costs on appeal.

KING, Circuit Judge, dissenting.