[EN BANC ORAL ARGUMENT SCHEDULED FOR DECEMBER 17, 2014]

No. 14-5018

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

JACQUELINE HALBIG, ET AL.,

Appellants,

v.

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

Appellees.

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

JOINT APPENDIX

ALISA B. KLEIN
MARK B. STERN
U.S. DEPARTMENT OF JUSTICE
950 Pennsylvania Avenue, NW
Washington, DC 20530
Telephone: 202-514-2000
Email: alisa.klein@usdoj.gov

Counsel for Appellees

MICHAEL A. CARVIN
YAAKOV M. ROTH
JONATHAN BERRY
JONES DAY
51 Louisiana Avenue, NW
Washington, DC 20001
Telephone: 202-879-3939
Email: macarvin@jonesday.com

Counsel for Appellants

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(Continued)

Page

APPEAL,CLOSED,TYPE-E

U.S. District Court
District of Columbia (Washington, DC)
CIVIL DOCKET FOR CASE #: 1:13-cv-00623-PLF

HALBIG et al v. SEBELIUS et al
Assigned to: Judge Paul L. Friedman
Case in other court: 14-05018
Cause: 05:0706 Judicial Review of Agency Actions

Date Filed: 05/02/2013
Date Terminated: 01/15/2014
Jury Demand: None
Nature of Suit: 899 Administrative Procedure Act/Review or Appeal of Agency Decision
Jurisdiction: U.S. Government Defendant

Date Filed	#	Docket Text
05/02/2013	1	COMPLAINT against All Defendants (Filing fee $ 400 receipt number 0090-3305749) filed by OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE, LTD, DAVID KLEMENCIC, JACQUELINE HALBIG, GC RESTAURANTS SA, LLC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE FORUM, LLC, COMMUNITY NATIONAL BANK, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, SARAH RUMPF, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, INNOVARE HEALTH ADVOCATES. (Attachments: # 1 Civil Cover Sheet, # 2 Summons, # 3 Summons, # 4 Summons, # 5 Summons, # 6 Summons, # 7 Summons, # 8 Summons, # 9 Summons) (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013		Case Assigned to Judge Richard W. Roberts. (ls,) (Entered: 05/02/2013)
05/02/2013	2	ELECTRONIC SUMMONS (8) Issued as to INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY, U.S. Attorney and U.S. Attorney General (Attachments: # 1 Summons, # 2 Summons, # 3 Summons, # 4 Summons, # 5 Summons, # 6 Summons, # 7 Summons, # 8 Consent Notice)(ls,) (Entered: 05/02/2013)
05/02/2013	3	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by COMMUNITY NATIONAL BANK (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	4	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by INNOVARE HEALTH ADVOCATES (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	5	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial

		Interests by GC RESTAURANTS SA, LLC (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	6	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by OLDE ENGLAND'S LION & ROSE, LTD (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	7	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	8	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by OLDE ENGLAND'S LION & ROSE FORUM, LLC (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	9	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD (Carvin, Michael) (Entered: 05/02/2013)
05/02/2013	10	LCvR 7.1 CERTIFICATE OF DISCLOSURE of Corporate Affiliations and Financial Interests by OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC (Carvin, Michael) (Entered: 05/02/2013)
06/06/2013	11	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed on United States Attorney General. Date of Service Upon United States Attorney General May 7, 2013. (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	12	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed. KATHLEEN SEBELIUS served on 5/6/2013 (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	13	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed. STEVEN MILLER served on 5/7/2013 (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	14	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES served on 5/6/2013 (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	15	RETURN OF SERVICE/AFFIDAVIT of Summons and Complaint Executed as to the United States Attorney. Date of Service Upon United States Attorney on 5/7/2013. Answer due for ALL FEDERAL DEFENDANTS by 7/6/2013. (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	16	NOTICE of Appearance by Jacob M. Roth on behalf of All Plaintiffs (Roth, Jacob) (Entered: 06/06/2013)
06/06/2013	17	MOTION for Summary Judgment by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Attachments: # 1 Text of Proposed Order)(Carvin,

		Michael) (Entered: 06/06/2013)
06/13/2013	18	MOTION Defer Briefing on Summary Judgment Pending the Resolution of Motion to Dismiss and Extension of Time to File Motion to Dismiss by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Text of Proposed Order)(McElvain, Joel) (Entered: 06/13/2013)
06/14/2013	19	Memorandum in opposition to re 18 MOTION Defer Briefing on Summary Judgment Pending the Resolution of Motion to Dismiss and Extension of Time to File Motion to Dismiss filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Carvin, Michael) (Entered: 06/14/2013)
06/17/2013	20	REPLY to opposition to motion re 18 MOTION Defer Briefing on Summary Judgment Pending the Resolution of Motion to Dismiss and Extension of Time to File Motion to Dismiss filed by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (McElvain, Joel) (Entered: 06/17/2013)
07/08/2013	21	NOTICE *Defendants' Notice with Respect to Their Motion to Defer Briefing on Summary Judgment* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY re 18 MOTION Defer Briefing on Summary Judgment Pending the Resolution of Motion to Dismiss and Extension of Time to File Motion to Dismiss (McElvain, Joel) (Entered: 07/08/2013)
07/09/2013	22	NOTICE *with respect to Defendants' motion to defer summary judgment briefing and for extension of time* by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF re 18 MOTION Defer Briefing on Summary Judgment Pending the Resolution of Motion to Dismiss and Extension of Time to File Motion to Dismiss (Carvin, Michael) (Entered: 07/09/2013)
07/29/2013	23	MOTION to Dismiss by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT

		OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Memorandum in Support, # 2 Exhibit Exhibit A - Declaration of David Klemencic in Florida v. U.S. Dep't of Health & Human Servs. (N.D. Fla. Nov. 4, 2010))(McElvain, Joel) (Entered: 07/29/2013)
08/09/2013	24	Memorandum in opposition to re 23 MOTION to Dismiss filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Attachments: # 1 Declaration of David Klemencic, # 2 Affidavit of Prof. Daniel Kessler, # 3 Declaration of J. Allen Tharp, # 4 Text of Proposed Order)(Carvin, Michael) (Entered: 08/09/2013)
08/09/2013	25	MOTION for Default Judgment as to *all Defendants* by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Attachments: # 1 Text of Proposed Order)(Carvin, Michael) (Entered: 08/09/2013)
08/14/2013	26	MOTION for Extension of Time to File Response/Reply as to 23 MOTION to Dismiss by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Text of Proposed Order)(McElvain, Joel) (Entered: 08/14/2013)
08/16/2013	27	RESPONSE re 25 MOTION for Default Judgment as to *all Defendants Defendants' Opposition to Motion for Default Judgment* filed by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (McElvain, Joel) (Entered: 08/16/2013)
08/20/2013	28	NOTICE OF SUPPLEMENTAL AUTHORITY by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Attachments: # 1 Exhibit Order in Oklahoma v. Sebelius)(Carvin, Michael) (Entered: 08/20/2013)
09/03/2013	29	REPLY to opposition to motion re 23 MOTION to Dismiss filed by INTERNAL

		REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (Attachments: # 1 Exhibit A - Kaiser Family Foundation Subsidy Calculator)(McElvain, Joel) (Entered: 09/03/2013)
09/10/2013	30	MOTION for Preliminary Injunction *and Expedited Hearing* by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Attachments: # 1 Declaration Declaration of David Klemencic, # 2 Affidavit Affidavit of Prof. Daniel Kessler, # 3 Declaration Declaration of W. Thomas Haynes, # 4 Text of Proposed Order)(Carvin, Michael) (Entered: 09/10/2013)
09/10/2013	31	MOTION to Reassign Case by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Carvin, Michael) (Entered: 09/10/2013)
09/13/2013	32	Case reassigned to Judge Paul L. Friedman. Chief Judge Richard W. Roberts no longer assigned to the case. (ds) (Entered: 09/13/2013)
09/16/2013	33	RESPONSE *30 Defendants' Opposition to Plaintiffs' Request for Expedition of Preliminary Injunction Motion* filed by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (McElvain, Joel) Modified to add linkage on 9/16/2013 (td,). (Entered: 09/16/2013)
09/16/2013	34	MOTION for Extension of Time to File Response/Reply as to 30 MOTION for Preliminary Injunction *and Expedited Hearing* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Text of Proposed Order) (McElvain, Joel) (Entered: 09/16/2013)
09/16/2013		VACATED PER MINUTE ORDER FILED 9/16/2013.....MINUTE ORDER. The parties are directed to meet and confer regarding a schedule with respect to 30 plaintiffs motion for preliminary injunction. On or before September 20, 2013, the parties shall file a joint report containing a proposed schedule for the remaining briefing on the motion and a proposed date and time for oral argument. The Court is available to hear argument on October 9 or October 10, 2013. Pursuant to Local Civil Rule 65.1, preliminary injunction

		motions typically are decided without live testimony. Signed by Judge Paul L. Friedman on September 16, 2013. (MA) Modified on 9/16/2013 (zmm,). (Entered: 09/16/2013)
09/16/2013		MINUTE ORDER denying as moot 31 plaintiffs motion to reassign. Signed by Judge Paul L. Friedman on September 16, 2013. (MA) (Entered: 09/16/2013)
09/16/2013		MINUTE ORDER: The Minute Order issued this same day directing the parties to meet and confer regarding a schedule with respect to plaintiffs' motion for preliminary injunction is VACATED in its entirety. Signed by Judge Paul L. Friedman on September 16, 2013. (MA) (Entered: 09/16/2013)
09/16/2013	35	RESPONSE re 34 MOTION for Extension of Time to File Response/Reply as to 30 MOTION for Preliminary Injunction *and Expedited Hearing* filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Carvin, Michael) (Entered: 09/16/2013)
09/16/2013		Set/Reset Deadlines: Joint Report due by 9/20/2013. (zmm,) (Entered: 09/16/2013)
09/17/2013	36	NOTICE *of Availability for Hearing* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY re 34 MOTION for Extension of Time to File Response/Reply as to 30 MOTION for Preliminary Injunction *and Expedited Hearing* (McElvain, Joel) (Entered: 09/17/2013)
09/18/2013	37	REPLY re 30 Response to Document, *Plaintiffs' Reply in Support of Expedition of Preliminary Injunction Motion* filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Carvin, Michael) Modified linkage on 9/19/2013 (td,). (Entered: 09/18/2013)
09/18/2013		MINUTE ORDER granting 34 defendants motion for extension to file opposition to plaintiffs motion for preliminary injunction. Defendants opposition shall be due September 27, 2013. Plaintiffs may file a reply on or before October 4, 2013. Oral argument on 23 defendants motion to dismiss and 30 plaintiffs motion for preliminary injunction is set for October 21, 2013, at 10:00 a.m. Signed by Judge Paul L. Friedman on September 13, 2013. (MA) (Entered: 09/18/2013)
09/20/2013		Set/Reset Deadlines/Hearings: Response to motion for preliminary injunction due by 9/27/2013. Reply due by 10/4/2013. Preliminary Injunction Hearing set for 10/21/2013

		10:00 AM in Courtroom 29A before Judge Paul L. Friedman. (zmm,) (Entered: 09/20/2013)
09/27/2013	38	Memorandum in opposition to re 30 MOTION for Preliminary Injunction *and Expedited Hearing* filed by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (Attachments: # 1 Exhibit Exhibit 1: Declaration of Donald Moulds, # 2 Exhibit Exhibit 2: Excerpt from Transcript of House Rules Committee Hearing (Mar. 20, 2010))(McElvain, Joel) (Entered: 09/27/2013)
10/04/2013	39	REPLY to opposition to motion re 30 MOTION for Preliminary Injunction *and Expedited Hearing* filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Attachments: # 1 Declaration (Supplemental) of David Klemencic)(Carvin, Michael) (Entered: 10/04/2013)
10/09/2013		MINUTE ORDER granting nunc pro tunc 26 defendants motion for extension of time in which to file their reply brief in support of their motion to dismiss. Signed by Judge Paul L. Friedman on October 9, 2013. (MA) (Entered: 10/09/2013)
10/15/2013	40	MEMORANDUM OPINION AND ORDER denying 25 plaintiffs' motion for entry of default judgment; granting nunc pro tunc 18 defendants' motion to defer briefing on summary judgment pending resolution of motion to dismiss, and for extension of time to file motion to dismiss. Signed by Judge Paul L. Friedman on October 15, 2013. (MA) (Entered: 10/15/2013)
10/18/2013	41	NOTICE *of Filing of Supplemental Declaration* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY re 38 Memorandum in Opposition, (McElvain, Joel) (Entered: 10/18/2013)
10/21/2013		Minute Entry for proceedings held before Judge Paul L. Friedman: Motion Hearing held on 10/21/2013 re 23 MOTION to Dismiss filed by STEVEN MILLER, INTERNAL REVENUE SERVICE, JACOB J. LEW, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF THE TREASURY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; heard and taken under advisement; 30 MOTION for Preliminary Injunction filed by OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, INNOVARE HEALTH ADVOCATES, CARRIE LOWERY, JACQUELINE HALBIG, GC RESTAURANTS SA, LLC, COMMUNITY NATIONAL BANK, DAVID

		KLEMENCIC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD; heard and taken under advisement. Oral Ruling set for 10/22/2013, at 10:00 AM in Courtroom 29A before Judge Paul L. Friedman. (Court Reporter: Crystal Pilgrim) (tth) (Entered: 10/21/2013)
10/22/2013	42	ORDER denying 23 defendants' motion to dismiss the complaint. The parties shall file a joint report proposing a schedule for summary judgment briefing on or before 5:00pm on October 24, 2013. If the parties cannot agree on a briefing schedule, the parties are directed to attend a conference call on October 25, 2013 at 10:00am. Signed by Judge Paul L. Friedman on October 22, 2013. (MA) (Entered: 10/22/2013)
10/22/2013	43	ORDER denying 30 plaintiffs' motion for a preliminary injunction. Signed by Judge Paul L. Friedman on October 22, 2013. (MA) (Entered: 10/22/2013)
10/22/2013		Minute Entry for proceedings held before Judge Paul L. Friedman: Oral Ruling held on 10/22/2013. Denying 23 MOTION to Dismiss and 30 MOTION for Preliminary Injunction, for reasons stated on the record in opened court. Parties should file a Purposed Briefing Schedule by the C.O.B. on 10/24/2013. Telephone Conference set for 10/25/2013 at 10:00 AM in Chambers before Judge Paul L. Friedman. (Court Reporter: Lisa Foradori) (gdf) (Entered: 10/22/2013)
10/23/2013		Set/Reset Deadlines: Joint Report due on or before 5:00 p.m. 10/24/2013. (zmm,) (Entered: 10/23/2013)
10/24/2013	44	MEET AND CONFER STATEMENT. (Carvin, Michael) (Entered: 10/24/2013)
10/25/2013		Minute Entry for proceedings held before Judge Paul L. Friedman: Telephone Conference held on 10/25/2013. Order to follow. (Court Reporter: Lisa Foradori.) (tj) (Entered: 10/25/2013)
10/25/2013	45	SCHEDULING ORDER. Defendants cross-motion for summary judgment, combined with their opposition to plaintiffs motion for summary judgment, shall be filed on or before November 12, 2013; plaintiffs combined opposition to the defendants cross-motion and reply in support of their motion shall be filed on or before November 18, 2013; defendants reply in support of their cross-motion shall be filed on or before November 25, 2013; and oral argument on the parties cross-motions shall be held at 2:00 p.m. on December 3, 2013, in Courtroom 29A. Signed by Judge Paul L. Friedman on October 25, 2013. (MA) (Entered: 10/25/2013)
10/28/2013		Set/Reset Deadlines/Hearings: Cross Motions due by 11/12/2013. Response to Cross Motions due by 11/18/2013. Reply to Cross Motions due by 11/25/2013. Response to Dispositive Motions due by 11/12/2013. Reply to Dispositive Motions due by 11/18/2013. Motion Hearing set for 12/3/2013, at 02:00 PM before Judge Paul L. Friedman. (tth) (Entered: 10/28/2013)
10/28/2013	46	TRANSCRIPT OF PROCEEDINGS before Judge Paul L. Friedman held on 10-22-13; Page Numbers: 1-57. Date of Issuance:10-28-13. Court Reporter/Transcriber Lisa M. Foradori, Telephone number 202-354-3269, Court Reporter Email Address : L4dori@hotmail.com.<P></P>For the first 90 days after this filing date, the transcript

		may be viewed at the courthouse at a public terminal or purchased from the court reporter referenced above. After 90 days, the transcript may be accessed via PACER. Other transcript formats, (multi-page, condensed, CD or ASCII) may be purchased from the court reporter.<P>**NOTICE RE REDACTION OF TRANSCRIPTS:** The parties have twenty-one days to file with the court and the court reporter any request to redact personal identifiers from this transcript. If no such requests are filed, the transcript will be made available to the public via PACER without redaction after 90 days. The policy, which includes the five personal identifiers specifically covered, is located on our website at ww.dcd.uscourts.gov.<P></P> Redaction Request due 11/18/2013. Redacted Transcript Deadline set for 11/28/2013. Release of Transcript Restriction set for 1/26/2014.(Foradori, Lisa) (Entered: 10/28/2013)
11/04/2013		Set/Reset Deadlines/Hearings: Cross Motion for Summary Judgment and Response to Plaintiffs' Motion for Summary Judgment due 11/12/2013. Response to Cross Motion and Reply to Motion for Summary Judgment due by 11/18/2013. Defendants' Reply in Support of Cross-Motion due 11/25/2013. Motion Hearing set for 12/3/2013 02:00 PM in Courtroom 29A before Judge Paul L. Friedman. (zmm,) (Entered: 11/04/2013)
11/08/2013	47	MOTION for Leave to File *Oversize Brief in Support of Cross-Motion for Summary Judgment and in Opposition to Plaintiffs' Summary Judgment Motion* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Text of Proposed Order)(McElvain, Joel) (Entered: 11/08/2013)
11/12/2013		MINUTE ORDER granting 47 defendants' motion for leave to file an oversize brief. The defendants may file a combined brief, not to exceed 55 pages, in support of their cross-motion for summary judgment and in opposition to the plaintiffs' summary judgment motion. Signed by Judge Paul L. Friedman on November 12, 2013. (MA) (Entered: 11/12/2013)
11/12/2013	48	Consent MOTION for Leave to File *Brief of Amicus Curiae* by FAMILIES USA (Attachments: # 1 Exhibit Brief of Amicus Curiae)(Hussain, Murad) (Entered: 11/12/2013)
11/12/2013	49	Cross MOTION for Summary Judgment by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Memorandum in Support, # 2 Affidavit Third Declaration of Donald Moulds, # 3 Text of Proposed Order)(McElvain, Joel) (Entered: 11/12/2013)
11/12/2013	50	Memorandum in opposition to re 17 MOTION for Summary Judgment filed by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (McElvain, Joel) (Entered: 11/12/2013)

11/13/2013	51	NOTICE *of Filing of Exhibits in Support of Cross-Motion for Summary Judgment* by INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY re 49 Cross MOTION for Summary Judgment (Attachments: # 1 Appendix Exhibits in Support of Defendants' Cross-Motion for Summary Judgment)(McElvain, Joel) (Entered: 11/13/2013)
11/13/2013	52	MOTION for Leave to File *Amicus Curiae Brief* by AMERICAN HOSPITAL ASSOCIATION (Attachments: # 1 Exhibit Proposed Amicus Curiae Brief, # 2 Exhibit Local Civil Rule 7.1 Corporate Disclosure Statement)(Perella, Dominic) (Entered: 11/13/2013)
11/13/2013	53	Unopposed MOTION for Leave to File Excess Pages *in Opposition to Defendants' Cross-Motion for Summary Judgment* by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Carvin, Michael) (Entered: 11/13/2013)
11/14/2013		MINUTE ORDER granting [Dkt. 53] plaintiffs' unopposed motion for leave to file oversize brief. Plaintiffs are permitted to file a 50-page reply brief in support of their motion for summary judgment and opposition to defendants' cross-motion for summary judgment. Signed by Judge Paul L. Friedman on November 14, 2013. (MA) (Entered: 11/14/2013)
11/14/2013		MINUTE ORDER granting 48 Families USAs unopposed motion for leave to submit brief as amicus curiae. Signed by Judge Paul L. Friedman on November 14, 2013.(MA) (Entered: 11/14/2013)
11/14/2013		MINUTE ORDER. Any opposition to 52 the motion of the American Hospital Association for leave to file a brief as amicus curiae shall be filed on or before November 18, 2013. Signed by Judge Paul L. Friedman on November 14, 2013. (MA) (Entered: 11/14/2013)
11/14/2013	54	AMICUS BRIEF by FAMILIES USA. (td,) (Entered: 11/14/2013)
11/15/2013	55	RESPONSE re 52 MOTION for Leave to File *Amicus Curiae Brief* filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Carvin, Michael) (Entered: 11/15/2013)
11/18/2013		Set/Reset Deadlines: Response to motion 52 for leave to file brief as amicus curiae due

		by 11/18/2013. (zmm,) (Entered: 11/18/2013)
11/18/2013	56	MOTION for Leave to File *Amicus Memorandum* by COMMONWEALTH OF VIRGINIA (Attachments: # 1 Text of Proposed Order - Proposed Order, # 2 Exhibit - Amicus Memorandum in Support of Plaintiffs' Motion for Summary Judgment)(Getchell, Earle) (Entered: 11/18/2013)
11/18/2013		MINUTE ORDER granting 52 American Hospital Associations unopposed motion for leave to submit brief as amicus curiae. Signed by Judge Paul L. Friedman on November 18, 2013. (MA) (Entered: 11/18/2013)
11/18/2013	57	Memorandum in opposition to re 49 Cross MOTION for Summary Judgment filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Attachments: # 1 Exhibit HHS Website)(Carvin, Michael) (Entered: 11/18/2013)
11/18/2013	58	REPLY to opposition to motion re 17 MOTION for Summary Judgment filed by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. (Carvin, Michael) (Entered: 11/18/2013)
11/18/2013	59	Consent MOTION for Leave to File *Amicus Curiae Brief* by Jonathan H. Adler, Michael F. Cannon (Attachments: # 1 Amicus Brief)(Grossman, Andrew) (Entered: 11/18/2013)
11/19/2013		MINUTE ORDER granting 56 unopposed Motion for Leave to File Amicus Memorandum of the Commonwealth of Virginia in support of plaintiffs' motion for summary judgment. Signed by Judge Paul L. Friedman on November 19, 2013. (MA) (Entered: 11/19/2013)
11/19/2013	60	AMICUS BRIEF by COMMONWEALTH OF VIRGINIA. (td,) (Entered: 11/19/2013)
11/19/2013		MINUTE ORDER granting 59 Jonathan H. Adler and Michael F. Cannons unopposed motion for leave to submit brief as amicus curiae. Signed by Judge Paul L. Friedman on November 19, 2013. (MA) (Entered: 11/19/2013)
11/19/2013	61	AMICUS BRIEF by JONATHAN H. ADLER, MICHAEL F. CANNON. (td,) (Entered: 11/20/2013)
11/25/2013	62	REPLY to opposition to motion re 49 Cross MOTION for Summary Judgment filed by

		INTERNAL REVENUE SERVICE, JACOB J. LEW, STEVEN MILLER, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY. (McElvain, Joel) (Entered: 11/25/2013)
11/26/2013		MINUTE ORDER. Oral argument on the parties' cross-motions for summary judgment is scheduled for December 3, 2013, at 2 p.m. in Courtroom 29A. Each side shall be allotted 45 minutes, including time reserved for rebuttal. The Court will not hear oral argument from amici. Signed by Judge Paul L. Friedman on November 26, 2013. (MA) (Entered: 11/26/2013)
12/03/2013		Minute Entry for proceedings held before Judge Paul L. Friedman: Motion Hearing held on 12/3/2013 re 17 MOTION for Summary Judgment filed by OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, INNOVARE HEALTH ADVOCATES, CARRIE LOWERY, JACQUELINE HALBIG, GC RESTAURANTS SA, LLC, COMMUNITY NATIONAL BANK, DAVID KLEMENCIC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD. and 49 Cross MOTION for Summary Judgment filed by STEVEN MILLER, INTERNAL REVENUE SERVICE, JACOB J. LEW, KATHLEEN SEBELIUS, UNITED STATES DEPARTMENT OF THE TREASURY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, (Court Reporter Lisa Griffith.) (tg,) (Entered: 12/03/2013)
12/09/2013	63	NOTICE OF SUPPLEMENTAL AUTHORITY by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF (Attachments: # 1 Exhibit Slip Opinion)(Carvin, Michael) (Entered: 12/09/2013)
12/30/2013	64	TRANSCRIPT OF PROCEEDINGS before Judge Paul L. Friedman held on 10/21/13; Page Numbers: 1-140. Date of Issuance:12/30/13. Court Reporter/Transcriber Crystal M. Pilgrim, Telephone number 202.354.3127, Court Reporter Email Address : crystalpilgrim@aol.com. For the first 90 days after this filing date, the transcript may be viewed at the courthouse at a public terminal or purchased from the court reporter referenced above. After 90 days, the transcript may be accessed via PACER. Other transcript formats, (multi-page, condensed, CD or ASCII) may be purchased from the court reporter. **NOTICE RE REDACTION OF TRANSCRIPTS:** The parties have twenty-one days to file with the court and the court reporter any request to redact personal identifiers from this transcript. If no such requests are filed, the transcript will be made available to the public via PACER without redaction after 90 days. The policy, which includes the five

		personal identifiers specifically covered, is located on our website at ww.dcd.uscourts.gov. Redaction Request due 1/20/2014. Redacted Transcript Deadline set for 1/30/2014. Release of Transcript Restriction set for 3/30/2014.(Pilgrim, Crystal) (Entered: 12/30/2013)
01/02/2014	65	TRANSCRIPT OF PROCEEDINGS before Judge Paul L. Friedman held on 12-3-13; Page Numbers: 1-83. Date of Issuance:1-2-14. Court Reporter/Transcriber Lisa Griffith, Telephone number (202) 354-3247, Court Reporter Email Address : Lisa_Griffith@dcd,uscourts.gov.<P></P>For the first 90 days after this filing date, the transcript may be viewed at the courthouse at a public terminal or purchased from the court reporter referenced above. After 90 days, the transcript may be accessed via PACER. Other transcript formats, (multi-page, condensed, CD or ASCII) may be purchased from the court reporter.<P>**NOTICE RE REDACTION OF TRANSCRIPTS:** The parties have twenty-one days to file with the court and the court reporter any request to redact personal identifiers from this transcript. If no such requests are filed, the transcript will be made available to the public via PACER without redaction after 90 days. The policy, which includes the five personal identifiers specifically covered, is located on our website at ww.dcd.uscourts.gov.<P></P> Redaction Request due 1/23/2014. Redacted Transcript Deadline set for 2/2/2014. Release of Transcript Restriction set for 4/2/2014.(Griffith, Lisa) (Entered: 01/02/2014)
01/15/2014	66	ORDER granting 49 defendants' Motion for Summary Judgment; denying 17 plaintiffs' Motion for Summary Judgment. The Clerk of Court shall remove this case from the court docket. Signed by Judge Paul L. Friedman on January 15, 2014. (MA) (Entered: 01/15/2014)
01/15/2014	67	OPINION denying plaintiffs' motion for summary judgment and granting defendants' motion for summary judgment. An order consistent with this opinion will issue this same day. Signed by Judge Paul L. Friedman on January 15, 2014. (MA) (Entered: 01/15/2014)
01/15/2014	68	NOTICE OF APPEAL TO DC CIRCUIT COURT as to 66 Order on Motion for Summary Judgment,,, by COMMUNITY NATIONAL BANK, GC RESTAURANTS SA, LLC, JACQUELINE HALBIG, INNOVARE HEALTH ADVOCATES, DAVID KLEMENCIC, CARRIE LOWERY, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD, OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF. Filing fee $ 505, receipt number 0090-3592283. Fee Status: Fee Paid. Parties have been notified. (Carvin, Michael) (Entered: 01/15/2014)
01/16/2014	69	Transmission of the Notice of Appeal, Order Appealed, and Docket Sheet to US Court of Appeals. The Court of Appeals fee was paid this date 1/15/14 re 68 Notice of Appeal to DC Circuit Court,,. (td,) (Entered: 01/16/2014)

01/23/2014		USCA Case Number 14-5018 for 68 Notice of Appeal to DC Circuit Court,, filed by OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC, OLDE ENGLAND'S LION & ROSE, LTD, SARAH RUMPF, OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD, INNOVARE HEALTH ADVOCATES, CARRIE LOWERY, JACQUELINE HALBIG, GC RESTAURANTS SA, LLC, COMMUNITY NATIONAL BANK, DAVID KLEMENCIC, OLDE ENGLAND'S LION & ROSE FORUM, LLC, OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD. (td,) (Entered: 01/27/2014)

PACER Service Center

Transaction Receipt

01/29/2014 09:30:12

PACER Login:	jd8166	**Client Code:**	011203-600001
Description:	Docket Report	**Search Criteria:**	1:13-cv-00623-PLF
Billable Pages:	10	**Cost:**	1.00

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG
204 Guthrie Avenue
Alexandria, Virginia 22305;

DAVID KLEMENCIC
1780 Long Run Road
Cairo, West Virginia 26337;

CARRIE LOWERY
305 South 14th Street, Apt. A
Nashville, Tennessee 37206;

SARAH RUMPF
1500 South Lamar Boulevard
Austin, Texas 78704;

INNOVARE HEALTH ADVOCATES
9915 Kennerly Road, Suite J
St. Louis, Missouri 63128;

GC RESTAURANTS SA, LLC
OLDE ENGLAND'S LION & ROSE, LTD
OLDE ENGLAND'S LION & ROSE AT CASTLE HILLS, LTD
OLDE ENGLAND'S LION & ROSE FORUM, LLC
OLDE ENGLAND'S LION & ROSE AT SONTERRA, LTD
OLDE ENGLAND'S LION & ROSE AT WESTLAKE, LLC
16109 University Oak
San Antonio, Texas 78249; and

COMMUNITY NATIONAL BANK
210 Main Street
Seneca, Kansas 66538,

Plaintiffs,

(continued on next page)

Civ. No. 13-623

v.

KATHLEEN SEBELIUS, in her official capacity as U.S. Secretary of Health and Human Services; and the UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue SW
Washington, District of Columbia 20201;

JACOB LEW, in his official capacity as U.S. Secretary of the Treasury; and the UNITED STATES DEPARTMENT OF THE TREASURY
1500 Pennsylvania Avenue NW
Washington, District of Columbia 20220; and

STEVEN MILLER, in his official capacity as Acting Commissioner of Internal Revenue; and the INTERNAL REVENUE SERVICE
1111 Constitution Avenue NW
Washington, District of Columbia 20004,

Defendants.

COMPLAINT

1. One of the pillars of the Patient Protection and Affordable Care Act ("ACA" or "the Act") is its creation of new health insurance "Exchanges"—state-level clearinghouses for standardized insurance products, where insurers will be regulated and individuals can satisfy the individual mandate, the new statutory obligation to purchase comprehensive insurance policies.

2. To encourage states to establish Exchanges, Congress used carrots, such as start-up grants to help fund the creation of Exchanges; and sticks, such as prohibiting states from tightening Medicaid eligibility standards before setting up Exchanges. The biggest carrot was the offer of premium-assistance subsidies from the Federal Treasury—refundable tax credits to help a state's low- and moderate-income residents buy insurance—if that state set up its own Exchange.

States rejecting the offer got a stick instead: the imposition of a federally-established, federally-operated Exchange in the state, with no subsidies at all.

3. As it turns out, a majority of states have declined to establish Exchanges. That choice has left the federal government with the burden of establishing Exchanges in those states, but without the burden of paying for premium-assistance subsidies to the residents of those states—just the balance that Congress struck.

4. Notwithstanding express statutory language limiting premium-assistance subsidies to Exchanges established by states, the Internal Revenue Service ("IRS") has promulgated a regulation ("the IRS Rule" or "the Subsidy Expansion Rule") purporting to authorize subsidies even in states with only federally-established Exchanges, thereby disbursing monies from the Federal Treasury in excess of the authority granted by the Act. The IRS Rule squarely contravenes the express text of the ACA, ignoring the clear limitations that Congress imposed on the availability of the federal subsidies. And the IRS promulgated the regulation without any reasoned effort to reconcile it with the contrary provisions of the statute.

5. While most subsidies benefit recipients, the ACA's subsidies actually serve to financially injure and restrict the economic choices of certain individuals. Some individuals would, but for their eligibility for federal subsidies, be exempt from the Act's individual mandate penalty under an exemption applicable to low- or moderate-income individuals for whom insurance is "unaffordable." For these people, the Subsidy Expansion Rule, by making insurance less "unaffordable," subjects them to the individual mandate's requirement to purchase costly, comprehensive health insurance that they otherwise would forgo. (The Act's subsidies do not usually cover 100% of insurance premiums.)

6. Furthermore, many employers would, but for their employees' eligibility for subsidies, be effectively exempt from the "assessable payments" imposed for failure to adhere to the Act's "employer mandate." That provision of the ACA imposes an assessable payment on certain businesses that do not offer their full-time employees the chance to enroll in employer-sponsored coverage that satisfies various statutory requisites. Critically, that payment is triggered only if such employees receive federal subsidies by purchasing coverage on an Exchange. Thus, the IRS Rule also has the effect of triggering the employer mandate payment for businesses in states that declined to establish their own Exchanges.

7. The IRS Rule's unauthorized subsidies would trigger these mandates and payments against Plaintiffs, who are individuals and businesses residing in states that have opted not to establish Exchanges. The Rule would block the individual Plaintiffs from satisfying the unaffordability exemption, thereby forcing them to purchase comprehensive, costly insurance that they do not want. And the Rule would expose the business Plaintiffs to payments under the employer mandate, thereby requiring them to offer comprehensive, ACA-compliant insurance that they do not want to sponsor. The IRS Rule thus injures all of these Plaintiffs.

8. Accordingly, Plaintiffs seek a declaratory judgment that the IRS Rule is illegal under the Administrative Procedure Act, and injunctive relief barring its enforcement.

I. JURISDICTION AND VENUE

9. Because this action arises under the federal Administrative Procedure Act ("APA"), 5 U.S.C. § 706, this Court has federal question jurisdiction under 28 U.S.C. § 1331.

10. Plaintiffs seek declaratory and injunctive relief under 28 U.S.C. §§ 2201–02, Federal Rule of Civil Procedure 57, and Federal Rule of Civil Procedure 65.

11. Venue is proper in this Court under 28 U.S.C. § 1391(e)(l), because the defendants are officers and agencies of the United States and reside in this district.

II. PARTIES

12. Plaintiff Jacqueline Halbig is a resident of the Commonwealth of Virginia, which has opted not to establish its own insurance Exchange. She derives her income from her one-woman consulting practice. Absent the IRS Rule, Halbig would (based on any realistic estimate of her expected income) fall within the unaffordability exemption to the individual mandate penalty in 2014. But because the Subsidy Expansion Rule makes her eligible for a premium-assistance subsidy, she will be disqualified from that exemption and subject to the individual mandate penalty. As a result, Halbig will be forced to either pay a penalty or purchase more insurance than she wants. She is therefore injured by the IRS Rule, because it has the effect of either subjecting her to monetary sanctions or requiring her to alter her behavior to avoid those sanctions. Further, either way, Halbig's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

13. Plaintiff David Klemencic is a resident of the State of West Virginia, which has opted not to establish its own insurance Exchange. He derives his income from Ellenboro Floors, his sole proprietorship. Absent the IRS Rule, Klemencic would (based on any realistic estimate of his expected income) fall within the unaffordability exemption to the individual mandate penalty in 2014. But because the Subsidy Expansion Rule makes him eligible for a premium-assistance subsidy, he will be disqualified from that exemption and subject to the individual mandate penalty. As a result, Klemencic will be forced to either pay a penalty or purchase more insurance than he wants. He is therefore injured by the IRS Rule, because it has the effect of either subjecting him to monetary sanctions or requiring him to alter his behavior to avoid those sanctions. Further, either way, Klemencic's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

14. Plaintiff Carrie Lowery is a resident of the State of Tennessee, which has opted not to establish its own insurance Exchange. She derives her income as a freelance legal researcher. Absent the IRS Rule, Lowery would (based on any realistic estimate of her expected income) fall within the unaffordability exemption to the individual mandate penalty in 2014. But because the Subsidy Expansion Rule makes her eligible for a premium-assistance subsidy, she will be disqualified from that exemption and subject to the individual mandate penalty. As a result, Lowery will be forced to either pay a penalty or purchase more insurance than she wants. She is therefore injured by the IRS Rule, because it has the effect of either subjecting her to monetary sanctions or requiring her to alter her behavior to avoid those sanctions. Further, either way, Lowery's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

15. Plaintiff Sarah Rumpf is a resident of the State of Texas, which has opted not to establish its own insurance Exchange. She derives her income as a public-relations consultant. Absent the IRS Rule, Rumpf would (based on any realistic estimate of her expected income) fall within the unaffordability exemption to the individual mandate penalty in 2014. But because the Subsidy Expansion Rule makes her eligible for a premium-assistance subsidy, she will be disqualified from that exemption and subject to the individual mandate penalty. As a result, Rumpf will be forced to either pay a penalty or purchase more insurance than she wants. She is therefore injured by the IRS Rule, because it has the effect of either subjecting her to monetary sanctions or requiring her to alter her behavior to avoid those sanctions. Further, either way, Rumpf's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

16. Plaintiff Innovare Health Advocates ("Innovare") is a Missouri professional corporation headquartered in Missouri, which has opted not to establish its own insurance Exchange. Innovare is an internal medicine practice with 55 full-time employees committed to providing both care (to its patients) and insurance (to its employees) that improve health by devolving power and responsibility to individuals. Absent the IRS Rule, Innovare would not be threatened by the employer mandate, because Missouri employees would not be eligible for federal subsidies and businesses in that State would therefore not be subject to assessable payments under the employer mandate. Were it not subject to such payments, Innovare would be preparing to expand its consumer-driven health insurance plan to cover all full-time employees, which would very likely not comply with the ACA. Innovare is therefore injured by the IRS Rule, because it has the effect of either exposing it to monetary sanctions or requiring it to alter its behavior in order to avoid those sanctions. Innovare intends to avoid the sanctions by complying with the employer mandate. Further, either way, Innovare's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

17. Plaintiffs GC Restaurants SA, LLC, Olde England's Lion & Rose, LTD, Olde England's Lion & Rose at Castle Hills, LTD, Olde England's Lion & Rose Forum, LLC, Olde England's Lion & Rose at Sonterra, LTD, and Olde England's Lion & Rose at Westlake, LLC, are Texas limited liability companies or limited partnerships headquartered in Texas, which has opted not to establish its own insurance Exchange. These businesses ("the Restaurants") are under the common control of a single individual, J. Allen Tharp, so for purposes of the ACA they are treated (together with another corporation under Tharp's control) as a single employer with over 350 full-time employees. Absent the IRS Rule, the Restaurants would not be threatened by the employer mandate, because Texas employees would not be eligible for federal subsidies and

businesses in that State would therefore not be subject to assessable payments under the employer mandate. The Restaurants do not offer health insurance to many full-time employees and do not want to offer it to them in 2014, but that choice will expose the Restaurants to assessable payments under the employer mandate, given the IRS Rule. The Restaurants are therefore injured by the IRS Rule, because it has the effect of either subjecting them to monetary sanctions or requiring them to alter their behavior to avoid those sanctions. The Restaurants intend to avoid the sanctions by complying with the employer mandate. Further, either way, the Restaurants' financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

18. Plaintiff Community National Bank ("the Bank") is an association headquartered in Kansas, which has opted not to establish its own insurance Exchange. The Bank employs approximately 80 full-time employees. Absent the IRS Rule, the Bank would not be threatened by the employer mandate, because Kansas employees would not be eligible for federal subsidies and businesses in that State would therefore not be subject to assessable payments under the employer mandate. The Bank's directors object to certain morally offensive provisions of the ACA (such as its definition of contraceptive and abortifacient drugs as "preventive services") and have determined that the Bank would rather drop the health insurance it offers to its full-time employees than comply with those provisions. However, such action would expose the Bank to assessable payments under the employer mandate, given the IRS Rule. The Bank is therefore injured by the IRS Rule, because it has the effect of either subjecting it to monetary sanctions or requiring it to alter its behavior to avoid those sanctions. The Bank intends to avoid the sanctions by complying with the employer mandate. Further, either way, the Bank's financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

19. Defendant Kathleen Sebelius is the Secretary of the U.S. Department of Health and Human Services. She is sued in her official capacity.

20. Defendant Jacob Lew is the Secretary of the U.S. Department of the Treasury. He is sued in his official capacity.

21. Defendant Steven Miller is the Acting Commissioner of Internal Revenue. He is sued in his official capacity.

22. Defendant U.S. Department of Health and Human Services ("HHS") is an executive agency of the United States within the meaning of the APA.

23. Defendant U.S. Department of the Treasury is an executive agency of the United States within the meaning of the APA.

24. Defendant Internal Revenue Service is an executive agency of the United States within the meaning of the APA.

25. Absent a declaration resolving the validity of the IRS Rule, Plaintiffs will be forced to either purchase or sponsor specific insurance that they otherwise would not purchase or sponsor, or expose themselves to financial penalties. The decision to purchase or sponsor ACA-compliant insurance for 2014 must be made this year, and so Plaintiffs' injuries are impending.

III. STATUTORY AND REGULATORY BACKGROUND

A. The ACA Offers Subsidies Through State-Run Insurance Exchanges

26. The ACA regulates the individual market for health insurance primarily through insurance Exchanges organized along state lines. HHS describes an Exchange as "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality." *Initial Guidance to States on Exchanges*, http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html (last visited May 1, 2013).

Participation in Exchanges also facilitates federal regulation of both insurers (who are subjected to numerous rules and requirements in order to sell their products on Exchanges) and individuals (who are required by the individual mandate to purchase comprehensive insurance policies).

27. The Act provides that, by January 1, 2014, "[e]ach State shall . . . establish" an insurance exchange to "facilitate[] the purchase of qualified health plans." ACA § 1311(b)(1). But, under the Constitution's core federalism commands, the federal government cannot *compel* sovereign states to create Exchanges. The Act therefore also recognizes that some states may not be "electing State[s]," because they may not "elec[t] . . . to apply" HHS regulations for the "establishment and operation of Exchanges"; or they might otherwise "fai[l] to establish [an] exchange," ACA § 1321(a)–(c). It provides that if a state is "not an electing State" or if the HHS Secretary determines, "on or before January 1, 2013," that an "electing State . . . will not have any required Exchange operational by January 1, 2014," then the Secretary "shall . . . establish and operate such Exchange within the State." *Id.* § 1321(c). The federal government is therefore responsible for establishing and operating Exchanges in states that decline to do so.

28. The Act encourages states to establish Exchanges with a variety of incentives, chiefly the premium-assistance subsidy for state residents purchasing individual health insurance through State-established Exchanges. The subsidy takes the form of a refundable tax credit paid directly by the Federal Treasury to the taxpayer's insurer as an offset against his premiums. *See* ACA §§ 1401, 1412. Targeted at low- and moderate-income individuals and families, the subsidy is available to households with incomes between 100 percent and 400 percent of the federal poverty line. *See* ACA § 1401(c)(1)(a). Under the 2013 federal poverty guidelines published by HHS, a single person with annual income between $11,490 and $45,960 would qualify for the subsidy. *See* Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182 (Jan. 24, 2013).

29. The payment of the subsidy is conditioned on the individual purchasing insurance through an Exchange established by a state. The Act provides that a tax credit "shall be allowed" in a particular "amount," 26 U.S.C. § 36B(a), with that amount based on the monthly premiums for a "qualified health pla[n] offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent . . . of the taxpayer *and which were enrolled in through an Exchange established by the State under [§] 1311 of the Patient Protection and Affordable Care Act*," *id.* § 36B(b)(2)(A) (emphasis added). Therefore there is no premium-assistance subsidy under the Act unless the citizen pays for insurance obtained through a State-established Exchange. Confirming the point, the statute calculates the subsidy by looking to "coverage months," defined as months in which the taxpayer "is covered by a qualified health plan described in subsection (b)(2)(A) *that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act*." 26 U.S.C. § 36B(c)(2)(A)(i) (emphasis added). Again, unless the citizen has enrolled in a plan through a State-created Exchange established under § 1311 of the ACA, he gets no subsidy.

B. Federal Subsidies Trigger the Individual and Employer Mandate Payments

30. The availability of the subsidy triggers the Act's individual mandate penalty for many otherwise-exempt individuals. That mandate requires all "applicable" individuals to obtain "minimum essential coverage." ACA § 1501(d); 26 U.S.C. § 5000A(a). Failure to comply with that requirement triggers a penalty. 26 U.S.C. § 5000A(b). But that penalty does not apply to those "who cannot afford coverage." *Id.* § 5000A(e)(1). For an individual to fall within the unaffordability exemption, the annual cost of health insurance must exceed eight percent of his annual household income. *Id.* § 5000A(e)(1)(A). That cost is calculated as the annual premium for the cheapest insurance plan available in the Exchange in that person's state, minus "the credit allowable under section 36B [ACA § 1401(a)]." *Id.* § 5000A(e)(1)(B)(ii). In states that do not

establish their own Exchanges, no tax credit is "allowable." *Id.* Thus, by purporting to make the credit allowable in such states, the IRS Rule increases the number of people in those states subject to the individual mandate's penalty. Those persons would otherwise be free to buy inexpensive, high-deductible, catastrophic insurance (which is otherwise restricted by the Act to individuals under age 30) or to forgo insurance entirely, without being exposed to any penalties.

31. The availability of the subsidy also effectively triggers the assessable payments under the employer mandate. Specifically, the Act provides that any employer with 50 or more full-time employees will be subject to an "assessable payment" if it does not offer them the opportunity to enroll in affordable, employer-sponsored coverage. But the payment is only triggered if at least one full-time employee enrolls in a plan, offered through an Exchange, for which "an applicable premium tax credit … is allowed or paid." 26 U.S.C. § 4980H(a), (b). Thus, if no federal subsidies are available in a state because the state has not established its own Exchange, then employers in that state may offer their employees non-compliant insurance, or no insurance at all, without being exposed to any assessable payments under the Act.

C. Thirty-Three States Decline To Establish Their Own Exchanges

32. Exercising the option granted by the Act (and required by the Constitution), thirty-three states have decided not to establish Exchanges. *See State Decisions For Creating Health Insurance Exchanges*, Kaiser State Health Facts, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17 (last visited May 1, 2013). Twenty-six states—including Kansas, Missouri, Tennessee, Texas, and Virginia—have opted out of the Exchange regime completely, *see id.*, while another seven—including West Virginia—have opted only to assist the federal government with its operation of federally-established Exchanges, *see id.*; *see also* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans;

Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,325 (Mar. 27, 2012) (categorizing "partnership" Exchanges as federally-established).

D. The IRS Promulgates a Regulation Ignoring the ACA's Limitations on Subsidies

33. Under the text of the Act, premium-assistance subsidies are not available in the thirty-three states with federally-established Exchanges. But the IRS has promulgated a rule requiring the Treasury to disburse subsidies in those states regardless. Specifically, the Rule states that subsidies shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then defines "Exchange" to mean "a State Exchange, regional Exchange, subsidiary Exchange, *and Federally-facilitated Exchange*." *See* Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378, 30,387 (May 23, 2012) (emphasis added). (Regional and subsidiary Exchanges are, like ordinary state Exchanges, established by states under § 1311 of the Act.)

34. The IRS justified its regulation with only the following short explanation:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

Id. at 30,378.

35. Under the IRS Rule, premium-assistance subsidies are thus available in the thirty-three states that declined to establish their own Exchanges. In turn, those subsides trigger the employer mandate payment for employers within those states and expand the reach of the individual mandate penalty for individuals residing in those states.

IV. CLAIMS

COUNT I:
Rulemaking in Violation of the Administrative Procedure Act ("APA")

36. Plaintiffs repeat and reallege each of the foregoing allegations in this Complaint.

37. The APA forbids agency action "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(C). It further forbids agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Id.* § 706(2)(A).

38. The ACA unambiguously restricts premium-assistance subsidies to state-established insurance Exchanges. The plain text of the statute makes subsidies available only to individuals who enroll in insurance plans "through an Exchange established by the State under [§] 1311 of the [Act]." 26 U.S.C. § 36B(b)(2)(A). But an exchange established by the federal government under the authority of § *1321* of the Act is not "an Exchange established by the State under [§] *1311* of the [Act]." The IRS's reading is contrary to the Act's plain language.

39. Congress understood the distinction between Exchanges established by a state under § 1311 of the Act and Exchanges established under other authority in the Act, and consciously distinguished between the two. For example, ACA § 1312(d)(3)(D) provides that

> after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—(I) created under this Act (or an amendment made by this Act); or (II) offered through *an Exchange established under this Act* (or an amendment made by this Act). (Emphasis added.)

40. By authorizing federal premium-assistance subsidies to individuals who do not qualify under the statute, the IRS Rule exceeds the agency's statutory authority and is arbitrary, capricious, and contrary to law.

41. Even assuming *arguendo* that the Act grants the IRS the discretion to authorize federal subsidies for individuals enrolled in plans from Exchanges not established by a state, the

statutory interpretation offered by the IRS in support of the Rule is arbitrary, capricious, unsupported by a reasoned basis, and contrary to law.

42. Plaintiffs have no adequate or available administrative remedy; in the alternative, any effort to obtain an administrative remedy would be futile.

43. Plaintiffs have no adequate remedy at law.

44. Defendants' action in promulgating the Subsidy Expansion Rule imposes a certainly impending harm on Plaintiffs that warrants relief.

V. REQUESTS FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray that this Court:

1. Enter a declaratory judgment that the IRS Rule violates the APA;

2. Enter a preliminary and permanent injunction prohibiting the application or enforcement of the IRS Rule; and

3. Award all other relief as the Court may deem just and proper, including any costs or fees to which Plaintiffs may be entitled by law.

Dated: May 2, 2013
Washington, District of Columbia

Respectfully submitted,
/s/ Michael A. Carvin
Michael A. Carvin (D.C. Bar No. 366784)
macarvin@jonesday.com
Jacob M. Roth (D.C. Bar No. 995090)
yroth@jonesday.com
Jonathan Berry (*application for admission pending*)
jberry@jonesday.com

JONES DAY
51 Louisiana Avenue NW
Washington, DC 20001
Phone: (202) 879-3939
Fax: (202) 626-1700

Attorneys for Plaintiffs

Exhibit A

Declaration of David Klemencic,
Florida v. U.S. Dep't of Health & Human Servs.,
No. 3:10-cv-00091 (N.D. Fla. Nov. 4, 2010)

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

STATE OF FLORIDA, by and through BILL McCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, *et al.*,

Plaintiffs,

vs. Case No. 3:10-cv-91-RV/EMT

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DECLARATION OF DAVID KLEMENCIC
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, David Klemencic, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 50 years old, a citizen of the United States, and a citizen and resident of the State of West Virginia. I am personally familiar with the facts contained in this declaration, and I am competent to testify thereto.

2. I am a member of the National Federation of Independent Business ("NFIB") in good standing.

3. I am the sole proprietor of Ellenboro Floors, located at 108 W. Washington Street, Ellenboro, West Virginia 26346. My business sells flooring. I have no employees.

4. I am married and have no children under the age of 26.

5. My business and personal funds are not kept separate, and I use my personal funds to pay my business expenses when necessary.

6. I do not have health insurance. My wife has insurance through her employer, Tim

Horton's Restaurant, but I am not covered under it. I last had health insurance over 12 years ago. I have looked into purchasing health insurance within the past year but have determined that it is too expensive.

7. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. I am subject to the ACA's individual insurance mandate. I object to the ACA's unconstitutional overreaching and to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance. I do not wish to have such insurance and do not believe that the cost of health insurance is a wise or acceptable use of my financial resources.

9. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources from my own priorities, and particularly from supporting and running my business as I consider to be best and most advantageous. I believe that the added costs of ACA compliant insurance will threaten my ability to maintain my own, independent business.

10. To comply with the individual mandate, I would be forced to reorder my personal and business affairs. Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and to make it grow.

11. In particular, I must investigate what impact the costs of compliance with the individual insurance mandate will have on my priorities, and especially whether, in light of those costs, my independent business can continue to be a viable going concern, or whether to comply I must close my business and seek employment that provides qualifying health insurance as a benefit.

12. In order to comply with the ACA's individual insurance mandate, I believe that I would also have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

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

Executed this 22 day of October, 2010 at 8:00 Am.

David Klemencic

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, *Plaintiffs,* *v.* KATHLEEN SEBELIUS, *et al.*, *Defendants.*	Civ. No. 13-623 Judge Richard W. Roberts

DECLARATION OF DAVID KLEMENCIC

I, David Klemencic, do hereby declare:

1. I will be 54 years old on January 1, 2014.

2. I am not married and have no dependents.

3. I am a citizen of the United States and a resident of the State of West Virginia. I live at 1780 Long Run Road, Cairo, West Virginia 26337.

4. I am self-employed as a flooring retailer by my sole proprietorship, Ellenboro Floors. My 2012 modified adjusted gross income was approximately $11,000. That figure included $8,000 in depreciation on gas leases I own. In 2014, I will take no further depreciation. I project that my modified adjusted gross income for 2014 will be $20,000.

5. I am not eligible for health insurance from the government or any employer.

6. The annual premium for the lowest-cost bronze plan available to me in the individual market in the federally-established Exchange in West Virginia in 2014 will exceed eight percent of my projected household income in 2014. Accordingly, absent any eligibility for federal subsidies, I would be exempt in 2014 from the individual mandate penalty and I would

be entitled to obtain, before January 1, 2014, a "certificate of exemption" so certifying. That certificate of exemption would entitle me to purchase catastrophic insurance coverage, or forgo all coverage without any fear of incurring a penalty under the Affordable Care Act.

7. However, if I am eligible for a federal subsidy in 2014, that would reduce my "required contribution" under the Affordable Care Act to the point that I will be disqualified from the unaffordability exemption to the individual mandate penalty and unable to obtain a certificate of exemption. Thus, if I am eligible for a federal subsidy in 2014, I will be forced either to pay a tax penalty or to buy comprehensive health coverage for 2014, and I will be prohibited from purchasing catastrophic coverage for 2014.

8. I do not want to purchase comprehensive health coverage in 2014. Even if the government would subsidize it or pay for it completely, I oppose government handouts and therefore do not want to buy that coverage.

9. Moreover, because eligibility for the subsidy obligates me to spend money in the near future (on either comprehensive coverage or a penalty), I am forced to immediately engage in financial planning to set aside funds sufficient for those purposes. My financial strength and fiscal planning are immediately and directly affected by this exposure to costs and/or liabilities.

I declare under penalty of perjury that the foregoing is true and correct.
Executed on this day, August 5, 2013.

David Klemencic

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, *Plaintiffs,* *v.* KATHLEEN SEBELIUS, *et al.*, *Defendants.*	Civ. No. 13-623 Judge Richard W. Roberts

DECLARATION OF J. ALLEN THARP

I, J. Allen Tharp, do hereby declare:

1. I own and control GC Restaurants SA, LLC, Olde England's Lion & Rose, LTD, Olde England's Lion & Rose at Castle Hills, LTD, Olde England's Lion & Rose Forum, LLC, Olde England's Lion & Rose at Sonterra, LTD, and Olde England's Lion & Rose at Westlake, LLC, all of which are Texas limited liability companies or limited partnerships headquartered in Texas (collectively, "the Restaurants"). For purposes of the employer mandate under the Affordable Care Act ("ACA"), all of these entities—being under my common control—are treated (together with one other corporation under my control) as a single employer with over 350 full-time employees.

2. Because Texas has elected not to establish its own health insurance Exchange, none of the Restaurants' employees should be eligible for premium assistance subsidies under the ACA. Accordingly, the Restaurants should not be subject to the employer mandate penalty.

3. But because the IRS Rule makes subsidies available in Texas, many of the Restaurants' full-time employees would be eligible for subsidies if the Restaurants do not offer them health insurance coverage that meets the ACA's requirements. For example, based on the

projected payroll for my Golden Chick quick-service restaurants (incorporated as GC Restaurants SA, LLC), approximately 18 full-time Golden Chick employees will be paid wages at a level between 100 and 400 percent of the federal poverty line, which is the income range that qualifies for subsidies. (Eleven of those employees are not married.) Accordingly, many full-time Golden Chick employees would qualify for subsidies if not offered ACA-compliant health coverage. If even a single such full-time employee receives a federal subsidy, the Restaurants will be subjected to penalties under the employer mandate.

4. In order to offer low prices, the Restaurants do not currently offer health coverage to many of their full-time employees (including all Golden Chick employees) and do not want to offer it to them in 2014 or 2015. Were we not at risk of incurring penalties under the employer mandate, the Restaurants would continue not to offer health coverage to these employees.

5. Instead, however, because of the IRS Rule, the Restaurants will be at risk of incurring penalties under the employer mandate. Indeed, it is virtually certain that they would incur those penalties. Accordingly, the Restaurants intend to avoid any penalty by complying with the employer mandate, including by sponsoring coverage for some full-time employees and reducing the hours of other full-time employees. Reducing hours is costly as well, because it requires the Restaurants to hire and train additional employees. The Restaurants simply cannot take the risk of incurring massive penalties under the ACA.

6. Moreover, because the Restaurant employees' eligibility for the subsidy obligates the Restaurants to spend money in the near future (on either ACA-compliant health coverage or a penalty under the employer mandate), the Restaurants must immediately engage in financial planning to set aside funds sufficient for those purposes. Their financial strength and fiscal planning are thus immediately and directly affected by this exposure to costs and/or liabilities.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this day, August 6th, 2013.

J. Allen Tharp

Exhibit A

Subsidy Calculator

Premium Assistance for Coverage in Exchanges

about this tool

()

This tool illustrates health insurance premiums and subsidies for people purchasing insurance on their own in new health insurance exchanges (or "Marketplaces") created by the Affordable Care Act (ACA). Beginning in October 2013, middle-income people under age 65, who are not eligible for coverage through their employer, Medicaid, or Medicare, can apply for tax credit subsidies available through state-based exchanges.

Additionally, states have the option to expand their Medicaid programs to cover all people making up to 138% of the federal poverty level (which is about $33,000 for a family of four). In states that opt out of expanding Medicaid, some people making below this amount will still be eligible for Medicaid, some will be eligible for subsidized coverage through Marketplaces, and others will not be eligible for subsidies.

With this calculator, you can enter different income levels, ages, and family sizes to get an estimate of your eligibility for subsidies and how much you could spend on health insurance. As premiums and eligibility requirements may vary, contact your state's Medicaid office or exchange with enrollment questions.

The Foundation encourages other organizations to feature the calculator on their websites using the embed instructions (subsidy-calculator-embed-instructions/).

Enter Information About Your Household

1. Enter income as: 2014 Dollars
2. Enter annual income (dollars): 20000 ?
3. Is employer coverage available? No ?
4. Number of people in family: 1 ?
5. Number of adults (21 and older) enrolling in exchange coverage: 1 Adult
   Age 54 Uses Tobacco? No ?
6. Number of children (20 and younger) enrolling in exchange coverage: No Children

Clear Submit

notes

()

Frequently Asked Questions

()

Subsidy Calculator

Premium Assistance for Coverage in Exchanges

about this tool

0

Enter Information About Your Household

1. Enter income as: 2014 Dollars
2. Enter annual income (dollars): 20000 ?
3. Is employer coverage available? No ?
4. Number of people in family: 1 ?
5. Number of adults (21 and older) enrolling in exchange coverage: 1 Adult
   Age 54 Uses Tobacco? No ?
6. Number of children (20 and younger) enrolling in exchange coverage: No Children

Clear Submit

results

The information below is about subsidized exchange coverage. Note that subsidies are only available for people purchasing coverage on their own in the exchange (not through an employer). Depending on your state's eligibility criteria, you or some members of your family may qualify for Medicaid.

Household income in 2014:	**174% of poverty level**
Unsubsidized annual health insurance premium in 2014:	**$6,444**
Maximum % of income you have to pay for the non-tobacco premium, if eligible for a subsidy:	**5.11%**
Amount you pay for the premium:	**$1,021** per year (which equals 5.11% of your household income and covers 16% of the overall premium)
You could receive a government tax credit subsidy of up to:	**$5,422** (which covers 84% of the overall premium)

BRONZE PLAN

The premium and subsidy amounts above are based on a Silver plan. You have the option to apply the subsidy toward the purchase of other levels of coverage, such as a Gold plan (which would be more comprehensive) or a Bronze plan (which would be less comprehensive).

For example, you could enroll in a Bronze plan for about **$0** per year (which is **0%** of your household income). By enrolling in a Bronze plan, you would receive $5,341 in subsidies, which would cover the entire amount of your Bronze premium. For most people, the Bronze plan represents the minimum level of coverage required under health reform. Although you would pay less in premiums by enrolling in a Bronze plan, you will face higher out-of-pocket costs than if you enrolled in a Silver plan.

OUT OF POCKET COSTS

Your out-of-pocket maximum for a Silver plan (not including the premium) can be no more than **$2,250**. Whether you reach this maximum level will depend on the amount of health care services you use. Currently, about one in four people use no health care services in any given year.

You are guaranteed access to a Silver plan with an actuarial value of **87%**. This means that for all enrollees in a typical population, the plan will pay for 87% of expenses in total for covered benefits, with enrollees responsible for the rest. If you choose to enroll in a Bronze plan, the actuarial value will be **60%**, meaning your out-of-pocket costs when you use services will likely be higher. Regardless of which level of coverage you choose, deductibles and copayments will vary from plan to plan, and out-of-pocket costs will depend on your health care expenses. Preventive services will be covered with no cost sharing required.

notes

0

Frequently Asked Questions

0

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, Plaintiffs, v. **KATHLEEN SEBELIUS,** in her official capacity as U.S. Secretary of Health and Human Services, *et al.*, Defendants.	Case No. 1:13-cv-00623-RWR

DECLARATION OF DONALD B. MOULDS

I, Donald B. Moulds, declare as follows:

1. I am the Acting Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services (HHS). I have held this position since August 2012. In this position, I am responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis, including analysis of Health Insurance Marketplace premiums. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. On September 25, 2013, my office, the Office of the Assistant Secretary for Planning and Evaluation of HHS (ASPE), issued a databook that contains information, current as of September 18, 2013, regarding Health Insurance Marketplace premiums for 2014 of qualified health plans in the 36 states in which HHS will support or fully run the Health Insurance Marketplace in 2014 ("2014 Marketplace premiums"). That databook is publicly available at http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm. These 2014 Marketplace premiums vary by state, rating area, and the age of the covered individual. This data is still under review and may be revised in HHS systems before being displayed for consumers on October 1, 2013.

3. I understand that, according to the August 5, 2013 declaration filed by plaintiff David Klemencic in the above-captioned matter, Mr. Klemencic resides in Cairo, West Virginia, will be 54 years on January 1, 2014, is not married, and has no dependents. *See* August 5, 2013 Klemencic Decl., No. 24-1. I also understand from this declaration that Mr. Klemencic projects his modified adjusted gross income for 2014 to be $20,000. *See id.*

4. As a resident of Cairo, West Virginia in Ritchie County, Mr. Klemencic is in rating area 10 of West Virginia for purposes of calculating his 2014 Marketplace premiums. *See* CMS-CCIIO, State Specific Geographic Rating Areas, *available at* http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html (last visited Sept. 26, 2013). Assuming the facts as set forth above in paragraph 3 and using the 2014 Marketplace premium data, Mr. Klemencic would pay – before the application of any premium tax credits – a monthly premium of $339.76 for the lowest-cost catastrophic qualified health plan (QHP), $371.28 for the lowest-cost bronze QHP, and $438.44 for the second-lowest-cost silver QHP.

5. Assuming the facts as set forth above in paragraph 3 and based on the information currently available, because Mr. Klemencic's household income in 2014 will be $20,000 and the monthly premiums for the second-lowest-cost silver QHP will be $438.44, under 26 U.S.C. § 36B, he will be eligible for a § 36B premium tax credit of at least $353.32 per month. After applying this tax credit to the cost of the lowest cost bronze QHP, that plan would cost Mr. Klemencic $17.96/month or less.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed this 27th day of September, 2013, in Washington, District of Columbia.

Donald B. Moulds

Exhibit 2

FOCUS - 2 of 59 DOCUMENTS

REP. LOUISE M. SLAUGHTER HOLDS A MEETING ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

March 20, 2010 Saturday

EVENT DATE: March 20, 2010

TYPE: COMMITTEE HEARING

LOCATION: WASHINGTON, D.C.

COMMITTEE: HOUSE COMMITTEE ON RULES

SPEAKER: REP. LOUISE M. SLAUGHTER, CHAIRWOMAN

WITNESSES:
REP. LOUISE M. SLAUGHTER, D-N.Y., CHAIR REP. JIM MCGOVERN, D-MASS. REP. ALCEE L. HASTINGS, D-FLA. REP. DORIS MATSUI, D-CALIF. REP. DENNIS CARDOZA, D-CALIF. REP. MICHAEL ARCURI, D-N.Y. REP. ED PERLMUTTER, D-COLO. REP. CHELLIE PINGREE, D-MAINE REP. JARED POLIS, D-COLO. REP. HENRY A. WAXMAN, D-CALIF. REP. SANDER M. LEVIN, D-MICH. REP. GEORGE MILLER, D-CALIF. REP. XAVIER BECERRA, D-CALIF. REP. ROBERT E. ANDREWS, D-N.J. REP. FRANK PALLONE JR., D-N.J. REP. ROBERT A. BRADY, D-PA. REP. ANTHONY WEINER, D-N.Y. REP. GWEN MOORE, D-WIS.
REP. PAUL D. RYAN, R-WIS. REP. JOE L. BARTON, R-TEXAS REP. DAVE CAMP, R-MICH. REP. JOHN KLINE, R-MINN. REP. JEB HENSARLING, R-TEXAS REP. JOHN SHIMKUS, R-ILL. REP. LEE TERRY, R-NEB. REP. PHIL GINGREY, R-GA. REP. MARSHA BLACKBURN, R-TENN. REP. MICHAEL C. BURGESS, R-TEXAS REP. STEVE SCALISE, R-LA. REP. WALLY HERGER, R-CALIF. REP. TRENT FRANKS, R-ARIZ. REP. CHARLIE DENT, R-PA. REP. ERIK PAULSEN, R-MINN. REP. BILL CASSIDY, R-LA. REP. PHIL ROE, R-TENN. REP. STEVE BUYER, R-IND.
REP. DAVID DREIER, R-CALIF. RANKING MEMBER REP. PETE SESSIONS, R-TEXAS REP. LINCOLN DIAZ-BALART, R-FLA. REP. VIRGINIA FOXX, R-N.C.
REP. HENRY A. WAXMAN, D-CALIF. REP. SANDER M. LEVIN, D-MICH. REP. GEORGE MILLER, D-CALIF. REP. XAVIER BECERRA, D-CALIF. REP. ROBERT E. ANDREWS, D-N.J. REP. FRANK PALLONE JR., D-N.J.

We've addressed a lot of these things, and that is why it's a complicated system. So I think that it is something where we have looked at -- we want to make sure it's affordable for all middle-class Americans, because they're being challenged the most. We know the insurance companies have been given a free ride, so we want to hold them accountable, and we want to, you know, have accessibility for those who don't have it right now.

And those are the principles that we've built this upon. Now, I can't see us pulling this thing apart right now. We've gotten this far. I know there are challenges ahead here. But anything this big is going to have been taken this long.

And when we make policy and we try to get it to the floor, we know it's not the most simple way at all, but this is not a simple situation at all. This is almost the last thing we can do right now for all Americans. We'd like to do it.

Now, I'd like to see probably Mr. Pallone or Mr. Miller or Mr. Andrews, why it is so important to have the three legs, the comprehensive aspect of this bill.

PALLONE: Can I...

MATSUI: Yes.

PALLONE: You know, I'll try to be brief, because I know that time is running out. You talked about the system and how the system be changed and how you sat through so many of our -- our subcommittee hearings.

And I know that so much of the emphasis today is on the money. And I don't want to take away from the debt and the -- and the money and all that.

But I think that what we're talking about here -- and so much of our hearing in Energy and Commerce was devoted to this -- is the change in the way we do things.

And, you know, I'm not trying to be critical, Mr. Hensarling, but you said that -- talk about the people that are outside the system, you know, who are not covered. The fact of the matter is, they're in the system. They're going to the emergency room. You know, they are getting care, but they're getting the wrong kind of care at the wrong time.

Everyone's in the system. Everybody gets health care. Nobody can be denied care if they go to an emergency room or a clinic or whatever. But we're trying to change the way we do things, and there hasn't been that much attention to the fact that the whole way we deliver health care is going to be changed, not in the money or the insurance so much, but the fact that it will be preventative.

People will go to see a doctor on a regular basis. They'll get the primary care and that -- you know, different innovative ways of trying to look at care so that it's not just one doctor here, one doctor there, but the whole system, the concept of the medical home.

There are so many things like this that change the way we deliver health care that will not only save a lot of money, as I've said many times today, but also make for better quality care. And -- and that's why I think -- you know, when you say change the system, I think that's what President Obama was talking about, not so much the -- the dollars, but the fact that we need to do things differently, and this turns the system very much away from this.

And, you know, looking at when you get sick, when you go to the emergency, and back towards trying to prevent bad things from happening.

MATSUI: Well, that's why we have a lot of prevention in here, too.

PALLONE: And when people see that, they're going to love this, because it's such a change in the way we do things, in terms of the quality and the delivery of care.

MATSUI: I think we...

(CROSSTALK)

ANDREWS: If the gentlelady will yield, we've heard almost universally across the House that people say they want to avoid discrimination based on pre-existing conditions. It's hard to find a member who says he or she is not for that.

In order to accomplish that and not spike premiums for insured people, you have to have a larger pool of people that are covered eventually. You can transition into that, but eventually that's what you have to do.

So then people say, well, why do you have the exchanges? Well, because when you're bringing in the larger pool of people to make the pre-existing condition work, you want to have a competitive marketplace, unlike the existing marketplaces in this country, that gets the best deal for people.

And then people say, well, why do you have to have the subsidies? Well, to get people into this marketplace, if somebody's making $25,000, $35,000, $40,000 a year, you can have all the marketplace you want, but they can't buy in without the subsidies.

And people say, why do you have to have the spending restraints and the revenue? Well, you can't have the subsidies without the spending restraint and the revenue.

So I would say to you, gentlelady, that this easy answer, which is so glibly stated by people, "Let's just take care of the pre- existing condition problem," it doesn't fit together if you don't take the next step and the next step and the next step and make it work.

The people in the country deserve more than a half-baked solution that won't work. And that's what this bill does.

DREIER: Would the gentlewoman yield?

MATSUI: Certainly I'll yield.

DREIER: I thank my friend for yielding. And I appreciate this exchange, but I just wanted to share with our colleagues and see if there's any response to a story that has just come out from the Washington Post in the last few minutes.

It says House Democratic leaders say -- let's see here -- House Democratic leaders say that they will take a separate vote on the Senate health care bill, rejecting an earlier, much criticized strategy that would have permitted them to deem the measure passed without an explicit vote. And I just wondered if this is a decision that has been made by the House Democratic leadership. I know that Mr. Cardoza raised concern about it earlier.

MCGOVERN: Let me -- if the gentleman would yield to me, as you know, we're having this hearing, and we have not put a rule together, and that's the whole point of this. And at the end of the -- at the end of this hearing, we will meet and try to...

DREIER: It sounds like it has happened, basically...

(CROSSTALK)

DREIER: ... Washington Post...

(CROSSTALK)

MATSUI: Reclaiming my time here...

CARDOZA: Would the gentlelady yield?

DREIER: "Dems drop the deem and pass plan," is what it says.

CARDOZA: I believe that there has been significant discussion. I want to thank the House leadership for, in fact, indicating to a number of us that that is, in fact, what's going to happen.

And I think that we've had sanity prevail here, and I'm very pleased about that. It's not -- as I said before, it's not that it wasn't unconstitutional or illegal, but it was something that we should have just done in the light of day, straight up. And I want to praise the House leadership...

DREIER: This is something that never has been done before on an issue of this magnitude.

MATSUI: Well, reclaiming my time here, Mr. Miller, did you want to say something?

MILLER: Just to build on what Congressman Andrews said, we have been incrementally tinkering with this system for 50 years at a minimum. And so then when you want to make the kind of -- the kind of change that brings about the efficiencies in the system, the expansion of the system, and controls the utilization in terms of getting value as opposed to activity, if you don't, as Mr. Andrews said, put everybody in, it doesn't work.

You know, that's from the insurance companies. That's from the medical practitioners, the providers who say to you over and over again -- not necessarily agreeing with this bill, but this is what you're going to have to do. You're moving the right pieces around, whether you're talking to the providers or whether you're talking to the insurance industry. And, again, they will argue over bits and pieces of this.

What we have to date is a history where all of the adverse indicators are just tumbling downhill. Businesses large and small are shedding the coverage. Small businesses are shedding the coverage. One of the -- one of the premier insurance providers, employers in our state, is now putting a surcharge on spouses, a surcharge on children. They're offloading, and they've been offloading for a decade the cost to the enterprise onto the employees. That is going on all the time.

If you're in -- if you're in an organized union, what you see is more and more is going to -- is going to health care and less and less is going to discretionary income and people's pockets.

So the trends are all in the wrong direction, and they're accelerating. They're absolutely accelerating, in terms of dramatically increasing the uninsured. In our state today, the L.A. Times tells us it's 1 in 4. They tell us there's a $1,000 cost premium on every Californian.

So you've got to bring the people into the system. You've got to drive the efficiencies. You've got to drive the savings. You've got to drive the value of the engagements that take place.

And the fact of the matter is, with medical I.T., with these changes, you get a dramatic change in behavior. At Kaiser hospitals, one of the -- one of -- -- one of the most successful enterprises, now patients are able, without getting a doctor office visit, can ask their doctors questions and get immediate replies within a few minutes of what's bothering them.

They can check their blood pressure, their cholesterol all at home, and it can monitored back and forth. And studies can go on because of the data systems about what works for people under 45, over 45, with different prescriptions and how do generics match up, and all of that is taking place.

And there are employers in our state that say, if Kaiser wasn't available, they could not provide health

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, *Plaintiffs,* *v.* KATHLEEN SEBELIUS, *et al.*, *Defendants.*	Civ. No. 13-623 Judge Paul L. Friedman

SUPPLEMENTAL DECLARATION
OF DAVID KLEMENCIC

I, David Klemencic, do hereby declare:

1. In my declaration of August 5, 2013, I attested that I did not wish to purchase comprehensive health coverage for 2014. The actual insurance premium costs were not then available and so I could not determine with certainty at that time whether I wanted to forgo all coverage or purchase catastrophic coverage.

2. On September 25, 2013, the U.S. Department of Health and Human Services publicly released premium rates for the federally established Exchange in West Virginia.

3. Based on the published rates, I wish to forgo health coverage entirely in 2014, rather than purchase catastrophic coverage.

4. However, if I am eligible for a federal subsidy in 2014, that would disqualify me from the unaffordability exemption to the individual mandate penalty and render me unable to obtain a certificate of exemption from that penalty. Thus, if I am eligible for a federal subsidy in 2014 but forgo purchasing health coverage, I will be forced to pay a penalty.

I declare under penalty of perjury that the foregoing is true and correct.
Executed on this day, October 2, 2013.

David Klemencic

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 1:13-cv-00623-PLF
	)	
KATHLEEN SEBELIUS, in her official capacity as U.S. Secretary of Health and Human Services, *et al.*,	)	
	)	
Defendants.	)	
_____	)	

DEFENDANTS' NOTICE OF FILING
OF SUPPLEMENTAL DECLARATION

The defendants hereby respectfully submit the Supplemental Declaration of Donald B. Moulds. This supplemental declaration addresses the calculation of premiums for health insurance plans available to the plaintiff, David Klemencic, based on data that has become available after the filing of Mr. Mould's original declaration, ECF 38-1.

Dated: October 18, 2013

Respectfully submitted,

STUART F. DELERY
Assistant Attorney General

RONALD C. MACHEN, JR.
United States Attorney

SHEILA LIEBER
Deputy Branch Director

/s/ Joel McElvain
JOEL McELVAIN
Senior Trial Counsel
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, NW
Washington, D.C. 20530
(202) 514-2988
Joel.McElvain@usdoj.gov

ATTACHMENT

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, Plaintiffs, v. **KATHLEEN SEBELIUS,** in her official capacity as U.S. Secretary of Health and Human Services, *et al.*, Defendants.	Case No. 1:13-cv-00623-RWR

SUPLEMENTAL DECLARATION OF DONALD B. MOULDS

I, Donald B. Moulds, declare as follows:

1. I am the Acting Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services (HHS). I have held this position since August 2012. In this position, I am responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis, including analysis of Health Insurance Marketplace premiums. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. On September 27, 2013, I submitted a declaration in the above-captioned matter. *See* ECF 38-1. That declaration relied on data, current as of September 18, 2013, regarding Health Insurance Marketplace premiums for 2014 of qualified health plans in the 36 states in which HHS will run the Health Insurance Marketplace in 2014 (in some cases, with support from the state). As noted in that declaration, those premium data were "still under review and may be revised in HHS systems before being displayed for consumers on October 1, 2013." *Id.* ¶ 2; *see also* http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.

3. Those premium data were subsequently revised in HHS systems before being displayed for consumers on October 1, 2013, on HealthCare.gov. As pertinent here, using the facts as set forth in paragraph 3 of my previous declaration, the monthly premium for the second-lowest-cost silver qualified health plan (QHP) increased from $438.44 to $463.81. This revision in turn increased the amount of 26 U.S.C. § 36B premium tax credit available to Mr. Klemencic from $353.32 per month to $378.69 per month. After applying this revised premium tax credit to the monthly premium for the lowest-cost bronze QHP, which remains $371.28, Mr. Klemencic would now pay nothing ($0/month) for the lowest-cost bronze QHP.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed this 18th day of October, 2013, in Washington, District of Columbia.

Donald B. Moulds

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, Plaintiffs, v. **KATHLEEN SEBELIUS,** in her official capacity as U.S. Secretary of Health and Human Services, *et al.*, Defendants.	Case No. 1:13-cv-00623-PLF

THIRD DECLARATION OF DONALD B. MOULDS

I, Donald B. Moulds, declare as follows:

1. I am the Acting Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services (HHS). I have held this position since August 2012. In this position, I am responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis, including analysis of health insurance marketplace premiums. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties. I have previously submitted two declarations in this matter.

2. I understand that, according to the August 5, 2013 declaration filed by plaintiff David Klemencic in the above-captioned matter, Mr. Klemencic resides in Cairo, West Virginia (zip code 26337), will be 54 years on January 1, 2014, is not married, and has no dependents. *See* August 5, 2013 Klemencic Decl., No. 24-1. I also understand from this declaration that Mr. Klemencic projects his modified gross income for 2014 to be $20,000. *See id.*

3. On September 27, 2013, I submitted a declaration in the above-captioned matter. *See* Moulds Decl., ECF 38-1. That declaration relied on data, current as of September 18, 2013, regarding health insurance marketplace premiums for 2014 of qualified health plans (QHPs or plans) in the 36 states in which HHS will operate the health insurance exchange in 2014 (in some cases, with support from the state). *Id.* These premium data were published in a publicly available databook, which has not been revised since September 18, 2013. *See* http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm. As noted in this databook and in my September 27, 2013 declaration, those premium data were "still under review" and remained subject to revision. *See id.*; Moulds Decl. ¶ 2. Using that tentative premium data and using the facts as set forth in paragraph 2 above, I reported that Mr. Klemencic would pay – before the application of premium tax credits – a monthly premium of $371.28 for the lowest-cost bronze qualified health plan (QHP). *See* Moulds Decl. ¶ 4. I also reported, using the premium data available at that time, that the second-lowest-cost silver QHP would cost Mr. Klemencic $438.44 per month, which, pursuant to 26 U.S.C. § 36B(b)(2), resulted in his eligibility for a premium tax credit of "at least $353.32 per month." *See id.* at ¶ 5. Accordingly, I reported that the lowest-cost bronze QHP "would cost Mr. Klemencic $17.96/month or less" after application of this premium tax credit. *See id.*

4. On October 18, 2013, I submitted a supplemental declaration in the above-captioned matter. *See* ECF 41. That declaration discussed the subsequent revision of the premium data. *See id.* at ¶ 3. Using then-current premium data and using the facts as set forth in paragraph 2 above, I reported that Mr. Klemencic would still pay – before the application of any premium tax credits – a monthly premium of $371.28 for the lowest-cost bronze QHP. *See id.* I also reported that because the monthly premium for the second-lowest-cost silver QHP increased to $463.81, Mr. Klemencic was in turn eligible for an increased premium tax credit of $378.69 under 26 U.S.C. § 36B(b)(2). *See id.* As a

result, I reported that after applying this revised premium tax credit ($378.69) to the monthly premium for the lowest-cost bronze QHP ($371.28), Mr. Klemencic would pay nothing ($0/month) for the lowest-cost bronze QHP in 2014. *See id.*

5. The amount of the premium tax credit for which Mr. Klemencic is eligible increased from what was reported in my September 27, 2013 declaration because the databook referenced in paragraph 3 had tentatively reported a second-lowest-cost silver plan amount in Mr. Klemencic's rating area that was too low, which in turn resulted in a premium tax credit that was too low. *See http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/longdesc/wv.cfm.* Specifically, in Mr. Klemencic's rating area, the two lowest cost silver plans are priced the same ($438.44/month), and the databook referenced in paragraph 3 used the monthly premium of one of those plans as the second-lowest-cost silver plan amount. This erroneously resulted in the use of the monthly premium amount of the *lowest* cost silver plan – not the monthly premium amount of the "second lowest cost silver plan" as provided by Section 36B(b)(2). In such situations, IRS policy is to treat the silver plan with the next lowest monthly premium as the "second lowest cost silver plan," which, in this case, is the silver plan with a monthly premium of $463.82. We have advised states operating a state-based Exchange of this same IRS policy in response to inquiries pre-dating the open enrollment period for the health insurance Exchanges.

6. My October 18, 2013 declaration accurately reported the cost of the lowest-cost bronze plan available to Mr. Klemencic and the amount of premium tax credits for which he would be eligible.[1] However, further review of the lowest-cost bronze plan available to Mr. Klemencic revealed that this plan offered some non-Essential Health Benefits. As a result, my October 18, 2013 declaration did not account for 45 C.F.R. § 156.470, which prohibits the application of premium tax credits to benefits that

[1] The monthly premium for the second-lowest-cost silver plan and the resulting premium tax credit available to Mr. Klemencic each have subsequently been rounded up by one cent to $463.82 and $378.70 respectively.

are non-Essential Health Benefits. The cost of the non-Essential Health Benefits in the lowest-cost bronze plan in Mr. Klemencic's rating area is $1.70/month. As a result, Mr. Klemencic would have to pay $1.70/month for the lowest-cost bronze plan in his rating area.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. Executed this 12th day of November, 2013, in Washington, District of Columbia.

Donald B. Moulds

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 1:13-cv-00623-PLF
	)	
KATHLEEN SEBELIUS, in her official capacity as U.S. Secretary of Health and Human Services, *et al.*,	)	
	)	
Defendants.	)	

EXHIBITS IN SUPPORT OF
DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

Index

Exhibit 1

111TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
111–443

THE RECONCILIATION ACT OF 2010

REPORT

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4872

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 202 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010

together with

MINORITY VIEWS

VOLUME I
DIVISION I

MARCH 17, 2010.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

vide for the participation of non-physician providers. Non-physician providers would only be allowed to participate if they accepted the established rates as payment in full.

Reason for Change

This provision ensures that the Secretary has the tools to establish the terms and conditions for providers to participate in the public option. The provision also defines two levels of physician participation and, in order to protect consumers, establishes rules on permissible cost sharing and payment to non-participating providers who treat enrollees in the public option.

Effective Date

January 1, 2013.

Sec. 226. Application of Fraud and Abuse Provisions

Current Law

Title XVIII of the SSA, the Medicare statutes, requires activities that prevent, detect, investigate and prosecute health care fraud and abuse. In general, initiatives designed to fight fraud, waste, and abuse are considered program integrity activities. Program integrity is considered a component of the effective and efficient administration of government programs, which are entrusted with ensuring that taxpayer dollars are spent wisely. Efforts to ensure Medicare program integrity encompass a wide range of activities and require coordination among multiple private and public entities. This includes processes directed at reducing payment errors to Medicare providers, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse.

Proposed Law

The provisions of law (other than criminal law) identified by the Secretary by regulation, in consultation with the Inspector General, that impose sanctions with respect to waste, fraud, and abuse under Medicare would also apply to the public health insurance option.

Reason for Change

Applies Medicare waste, fraud and abuse requirements in a similar manner to the public option.

Effective Date

January 1, 2013.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability Through Health Insurance Exchange

Current Law

No provision.

Proposed Law

This provision would provide premium and cost-sharing credits to "affordable credit eligible individuals" (defined in Section 242) for certain individuals enrolled in coverage through the Exchange.

The Commissioner would pay each QHBP participating in the Exchange the aggregate amount of credits for all eligible individuals enrolled in that plan.

An Exchange-eligible individual could apply to the Commissioner, through the Exchange or another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner, through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner, would make a determination as to eligibility of an individual for affordability credits. The Commissioner would establish a process whereby, on the basis of information otherwise available, individuals may be deemed eligible for credits. The Commissioner would also establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

If the Commissioner determines that a state Medicaid agency has the capacity to make a determination of eligibility for affordability credits under the same standards as used by the Commissioner under the Medicaid memorandum of understanding (described above in Section 205), the state Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination, and the Commissioner would reimburse the state Medicaid agency for the costs of conducting such determinations.

In addition, there would be a Medicaid screen-and-enroll obligation, which would ensure that individuals applying for affordability credits, may be screened for Medicaid eligibility. If they are determined eligible for Medicaid, the Commissioner, through the Medicaid memorandum of understanding, would provide for their enrollment under the state Medicaid plan, and the state would provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply.

During the first two years of implementation, credits would be allowed for coverage under a Basic plan only. Beginning in the third year, credits would be allowed for coverage under Enhanced or Premium plans by a process established by the Commissioner. Credits would continue to be based on the basic plan, the individual would be responsible for any difference between the premium for an Enhanced or Premium plan and the credit amount based on a Basic plan applicable to that enrollee.

The Commissioner would be authorized to request from the Treasury Secretary information that may be required to carry out this subtitle (regarding individual affordability credits), consistent with existing rules regarding confidentiality and disclosure of tax return information. Individuals who are eligible to receive credits would not receive them in the form of cash payments.

Reason for Change

Establishes affordability credits for those without other coverage—or an offer of affordable coverage—to assist individuals and families with the purchase of health insurance coverage. These credits are key to ensuring people affordable health coverage. It also provides for the Exchange to coordinate with state Medicaid programs to ensure people are enrolled in the appropriate program.

111TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
111–443

THE RECONCILIATION ACT OF 2010

REPORT

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4872

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 202 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010

together with

MINORITY VIEWS

VOLUME II
DIVISION II–III

MARCH 17, 2010.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

The amendment offered by Representative McKeon (R–CA) would have created a new title at the end of Division A titled Title IV—Small Business Health Fairness. This title would include rules governing association health plans; clarification of treatment of single employer arrangements; enforcement provisions related to association health plans; and other provisions related to association health plans. The amendment was defeated by a roll call vote of 21–27.

The amendment offered by Representative Castle (R–DE) would have allowed variation in cost-sharing and premiums charged by the qualified health benefits plans dependent upon participant participation in employer prevention and wellness programs. The amendment was withdrawn and no further action was taken on it.

The second amendment offered by Representative Wilson (R–SC) would add to H.R. 3200 a Sense of the House of Representatives that any members who vote in support of the public health insurance option are urged to forgo their right to participate in the FEHBP and enroll under the public option. The amendment was passed by voice vote.

The third amendment offered by Representative Price (R–GA) would have established provisions for defined contribution health plans. The amendment was defeated by a roll call vote of 19–29.

The fourth amendment offered by Representative Price (R–GA) would have struck the physician billing language in Section 225(c). The amendment was defeated by a roll call vote of 19–29.

The second amendment offered by Representative McMorris Rodgers (R–WA) would have exempted plans established and maintained by Indian tribal governments. The amendment was defeated by voice vote.

Committee on Ways & Means Mark-up of H.R. 3200

On July 16, 2009, the Committee on Ways and Means met to mark-up H.R. 3200, America's Affordable Health Choices Act and reported the bill as amended by a vote of 23–18.

Committee on Energy & Commerce Mark-up of H.R. 3200

Beginning on July 16, 2009, the Committee on Energy and Commerce met to mark-up H.R. 3200, America's Affordable Health Choices Act. In addition to July 16, 2009, the Committee considered H.R. 3200 on July 17, 20, 30 and 31. The Committee reported the bill as amended by a vote of 31–28.

SENATE CONSIDERATION OF THE AFFORDABLE HEALTH CHOICES ACT

Beginning on June 17, 2009 the HELP Committee met to mark-up the Affordable Health Choices Act. The Committee reported the bill as amended on July 15, 2009 by a vote of 13–10.

III. SUMMARY OF THE BILL

America's Affordable Health Choices Act makes critical reforms to this nation's broken health care system. It will lower costs, preserve choice, and expand access to quality, affordable care. To protect families struggling with health care costs and inadequate coverage, the bill ensures that health insurance companies can no

longer compete based on risk selection. By prohibiting rate increases based on pre-existing conditions, gender and occupation, the bill requires that insurance companies instead compete based on quality and efficiency. In addition, H.R. 3200 will lower the cost of health care by eliminating co-pays and deductibles for preventive care, capping annual out-of-pocket expenses, prohibiting lifetime limits, and allowing the uninsured, part-time workers, and employees of some small businesses to obtain group rates by purchasing health care through the HIE.

H.R. 3200 will expand choice of health insurance, especially in many parts of the country where families have very limited choices because of the nature of the insurance market. The HIE will serve as an organized and transparent "marketplace for the purchase of health insurance"[7] where individuals and employees (phased-in over time) can shop and compare health insurance options. To participate in the HIE, insurers will be required to meet the insurance market reforms and consumer protections and offer the essential benefits package established by the new independent benefits advisory committee. Individuals and families under 400 percent of poverty who qualify for affordability credits will be able to use that money in the HIE to help offset the costs of their health care coverage.

One health insurance choice within the HIE will be the public health insurance option. The public option will be required to operate on the same level as private insurance companies, adhering to the same market reforms and consumer protections, and it will be required to be financed from its premiums. Rates will vary geographically just as private insurers do. The public plan option will be able to utilize payment rates similar to Medicare with provider rates at Medicare plus 5 percent. However, beginning in Y4 the Secretary will have the authority to use an administrative process to set rates (at levels that do not increase costs) in order to promote payment accuracy and the delivery of affordable and efficient care.

The inclusion of a public option in the HIE will help to rein in the costs of health insurance while preserving access. At all times, the Secretary retains the authority to utilize innovative payment mechanisms and policies to improve health outcomes, reduce health disparities, and promote quality and integrated care. Furthermore, the public option will represent choice in many communities where one insurer dominates the market. Consequently, the public health insurance option has the ability to increase competition and control costs. However, no one, including employers who put their employees into the HIE, can place or force anyone into the public option. The decision to enroll in a private plan or the public option is always left to individuals and families to decide for themselves.

H.R. 3200 is built upon the premise of shared responsibility among individuals, employers and the government, so that everyone contributes and has access to affordable, quality health care. America's Affordable Health Choices Act gives employers the choice

[7] Linda Blumberg and Karen Pollitz, Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals, the Urban Institute & Robert Wood Johnson Foundation (April 2009).

to either offer health insurance or pay a percentage of payroll for their employees to go into the HIE.

Beginning in 2013, employers "playing" will be required to offer health coverage to all of their full-time employees and contribute 72.5 percent of the premium for an individual and 65 percent for a family premium. For part-time workers, employers will have the choice to either offer health coverage on a pro rata basis or pay the required penalty. There will be no minimum benefit requirement for existing employer-sponsored health plans until the end of 2018. At that time, employers who "play" will be required to offer coverage that is no less than the minimum benefit level within the Exchange and must include the insurance market reforms.

Employers may also choose to "pay" instead of play. A "pay" employer would be required to make a contribution equal to 8 percent of their payroll to the HIE. However, recognizing the difficulties small businesses face, the bill includes a number of provisions to help small employers. For example, H.R. 3200 exempts employers with payrolls of $250,000 or less from the pay or play requirements. For employers with payroll between $250,000 and $400,000 the contribution amount phases-up from 2 to 8 percent so that only employers with payrolls greater than $400,000 will pay the full 8 percent.

Whether obtaining coverage through an employer, a spouse or the HIE, H.R. 3200 requires that individuals either enroll in health care coverage or pay 2.5 percent of their adjusted gross income capped at the total cost of the average cost premium offered in the HIE. Recognizing that high health care costs prevent many Americans from securing health care coverage, H.R. 3200 provides for affordability credits to help eligible low- and middle-income individuals and families purchase coverage in the HIE. In addition, for those who can demonstrate that they are unable to afford health insurance, the Health Choices Commissioner (Commissioner) retains the authority to develop and grant hardship waivers.

The affordability credits provided for under the bill will be available to individuals and families with incomes between 133 to 400 percent of the federal poverty level. Medicaid will be expanded so that anyone below 133 percent of poverty will be Medicaid eligible and that expansion will be fully federally financed. Employees who are offered health insurance through an employer will be unable to go into the HIE and receive affordability credits unless that employer coverage is deemed unaffordable. An unaffordable employer offer is one where the employees' share of the premium and cost sharing are more than 11 percent of family income.

Finally, as millions of Americans gain coverage, investments in the health care workforce are critical to ensuring all Americans have access to needed care. H.R. 3200 includes significant investments to help train more primary care and public health physicians as well as nurses. It puts into place incentives to encourage more people to become doctors and nurses (particularly in rural areas). Some of the workforce provisions include: (1) increased funding for the National Health Service Corp.; (2) expanded scholarships and loans for health professionals who work in shortage professions and areas; (3) steps to increase physician training outside of the hospital and redistribute unfilled graduate medical edu-

cation residency slots so that more primary care physicians can be trained; and (4) grants through the Department of Labor to help train and retain nurses.

IV. Committee Views

The Committee on Education and Labor of the 111th Congress is committed to containing the cost of health care and ensuring that every American has access to affordable, quality health care coverage. H.R. 3200 includes critical reforms to the health care system that are needed to reduce surging premium and health care costs that families, businesses and governments are struggling to afford. The bill cuts over a half trillion dollars from the health care system, ensures that no one is ever one illness away from bankruptcy and creates a system where 97 percent of Americans will have health care coverage by 2015.

Overview

Health care reform is a critical issue in this country. There are 47 million people in the United States without health care coverage and almost nine million of them are children.[8] Meanwhile, health care costs are rising for nearly everyone. The United States spends over $2.4 trillion—more than 18 percent of GDP—on health care services and products—far more than other industrialized countries.[9] In addition, health care costs continue to grow faster than the economy as a whole, and individuals and families are burdened by the weight of these escalating expenses. Yet, for all this spending, the United States' scores are average or worse on many key indicators of health care quality. Health care reform is critical to restoring prosperity for our nation's families and H.R. 3200 will ensure that coverage is truly affordable and dependable for hard-working Americans.

The Uninsured

The number of uninsured persons in the United States continues to grow, from 44.8 million in 2005 to 47.0 million in 2006. The percentage of uninsured is also rising, from 15.3 percent of the total population in 2005 to 15.8 percent in 2006.[10]

More than two-thirds of the uninsured live in a household with one full-time worker. These increasing numbers can be attributed to the rising cost of health care, a decline in manufacturing jobs and an increase in workers employed in the service industries and small businesses, which are less likely to provide insurance.[11] Roughly two-thirds of Americans without health insurance have incomes 200 percent below the federal poverty level—or approximately $44,000 for a family of four.[12] Not surprisingly, those in households with annual incomes below $25,000 are even less likely

[8] Supra note 2.
[9] National Coalition on Health Care, "Facts on the Cost of Health Insurance and Health Care," (2007), available at: *http:www.nchc.org/facts/cost.shtml*
[10] U.S. Census Bureau, "Health Insurance Coverage: 2006—Highlights." (Aug. 27, 2007), available at: *http:www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html*
[11] Robert Pear. "Without Health Benefits, a Good Life Turns Fragile," N.Y. Times (Mar. 5, 2007).
[12] Kaiser Family Foundation, "The Uninsured: A Primer," (Oct. 2008). *http:www.kff.org/uninsured/upload/7451–04.pdf.*

to be insured. In 2006, twenty-five percent of these Americans were uninsured in comparison to 16 percent of the total population.[13]

Approximately 162 million non-elderly workers and their dependents received health coverage through their employment-based health plans.[14] However, millions of other working Americans are unable to participate in an employer-sponsored plan, either because the employer does not offer coverage or the employee is not eligible under the plan. In 2005, 20 percent of "wage and salary" workers had an employer that did not offer any coverage to their workers. And 18 percent were not eligible for the health plan that was offered by their employer.[15] For example, some firms do not offer coverage to part-time employees and some do not offer coverage to workers who have been employed for less than a specific amount of time.

While employer-sponsored plans still remain the dominant source of health coverage for most Americans, the percentage of people obtaining health coverage through these plans has been steadily shrinking. For example, 60 percent of employers offered benefits in 2007, compared with 69 percent in 2000. Most of this decline can be attributed to the decline in small businesses (less than 200 workers) offering coverage.[16] Among firms with less than 10 workers, the offer rate dropped from 57 percent in 2000 to 45 percent in 2007.[17] For employers who have stopped offering coverage, almost three out of four say that premiums are too expensive.[18]

Unaffordable Health Care Coverage

Employers and workers alike are increasingly concerned about the rising costs of health care and insurance. Premiums for employer-sponsored health coverage are rising much faster than workers' earnings and inflation. Between spring 2006 and spring 2007, premiums for coverage offered by employers across the United States increased by 6.1 percent—more than twice the growth in the Consumer Price Index (CPI). The average annual cost of employer-sponsored health insurance was nearing $13,000 in 2008. In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 12 percent more for their coverage in 2007 than in 2006. Premiums for a family of four paid by workers increased by 10 percent from 2006 to 2007.[19]

These increases are of great concern, and more and more workers believe that they may not be able to afford their share of the cost

[13] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006" Current Population Reports (2006) at 60–233. See also, U.S. Department of Commerce, Economics and Statistics Administration, August 2007.

[14] Elise Gould, "The Erosion of Employer-Sponsored Health Insurance," Economic Policy Institute (Oct. 8, 2008).

[15] Supra note 9.

[16] Kaiser Commission on Medicaid and the Uninsured, "2007 Employer Health Benefits Survey—Summary of Findings," (Sept. 2007) at 29, available at: *http:www.kff.org/insurance/7672/index.cfm*

[17] Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey." Employee Benefit Research Institute, October 2007.

[18] Kaiser Family Foundation/HRET, "Employer Health Benefits 2007 Annual Survey." (Sept. 2007).

[19] Id.

of coverage. In a recent poll by the Pew Research Center,[20] forty-four percent of workers surveyed say that affording health insurance is difficult or very difficult. In addition, almost three out of four uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly. Workers also know that if they lose their job, they are likely to lose access to affordable health care coverage.

In addition, among those employers that offer benefits, a large percentage of firms report that in the next year not only are they very or somewhat likely to increase the amount workers contribute to premiums (45 percent), but they will also increase deductible amounts (37 percent), office visit cost sharing (42 percent) or the amount that employees have to pay for prescription drugs (41 percent).[21]

The problem of being "underinsured" has also become increasingly relevant. One recent study estimated that 29 percent of individuals who have insurance are "underinsured" and have coverage that is inadequate to secure them access to needed care or protect again catastrophic medical bills.[22]

The Commonwealth Fund found that 25 million adults who had health coverage in 2007 were underinsured[23]—a 60 percent increase from the 16 million Americans who were underinsured in 2003.[24] Another study found that while 16 percent of adults spent more than 10 percent of their family income on health care service in 1996. By 2003 the proportion of adults bearing these health-related "catastrophic financial burdens" had increased to 19 percent to about 49 million individuals.[25] Another study found that financial burdens had increased to the point that private health insurance coverage no longer provided adequate financial protection for low-income families.[26]

In addition, many families have little room within their family budgets for large or unexpected out-of-pocket health care expenses. In 2003, an estimated 77 million Americans—nearly two out of five adults—had difficulty paying medical bills.[27] Even working age adults who were continually insured had problems paying their medical bills and carried medical debt as a result. Nearly half of all bankruptcies in the United States are related, in part, to health care expenses. And of those facing medical bankruptcies, roughly

[20] Pew Research Center for the People and the Press poll, conducted January 9–13, 2008, available at: *http:people-press.org/reports/dispaly.php3?ReportID=* 395.

[21] Supra note 16.

[22] Consumer Reports, "Health Insurance: CR Investigates Health Care," September 2007, available at: *http:www.consumerreports.org/cro/health-fitness/health-care/health-insurance–9–07/overview/0709__[illegible]__[illegible]*

[23] According to the Commonwealth Fund study, families are identified as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or for low-income adults (200 percent below the federal poverty level), medical spending consumed at least 5 percent of family income.

[24] Cathy Schoen et al, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Health Affairs 27 no. 4 (2008).

[25] J. Banthin and D. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," JAMA (2006).

[26] J. Banthin, P. Cunningham and D. Bernard. "Financial Burdens of Health Care, 2001–2004," Health Affairs 27, no.1 (2008) at 188–195.

[27] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," The Commonwealth Fund (Aug. 2005).

three-quarters had health insurance at the onset of their bankrupting illness.[28]

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income, but also by health status. According to Judy Feder, Senior Fellow at the Center for American Progress, "health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care."[29] Individuals who are older and have chronic conditions such as diabetes, heart disease, or arthritis, or have experienced a stroke, are more likely to spend a high proportion of their income on health expenses. If these individuals do not have an employer-sponsored health plan, or if they lose this coverage, their ability to purchase coverage in the non-group market is limited at best. The non-group market systematically denies coverage, limits benefits, and charges excessive premiums to individuals with pre-existing conditions or those who are perceived to be at high-risk. Ironically, the people who are more likely to become sick—the very population that insurance is supposed to protect—are also more likely to be underinsured and face grave financial problems.

The Consequences of being Uninsured or Underinsured

Being uninsured makes it more likely that a person will not receive adequate medical care. Individuals without insurance often go without or delay care, and the care they do receive is likely to be lower quality than the care received by insured individuals. An estimated 18,000 to 22,000 Americans die each year because they do not have health coverage.[30] The length of time a person goes without health insurance also makes a difference—people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time.[31] Finally, lack of coverage and coverage stability is particularly burdensome on the seriously and chronically ill, whose care is often delayed or denied when they cannot pay.[32]

HEALTH CARE COSTS AND SPENDING: THE COST OF DOING NOTHING

H.R. 3200 ensures quality and affordable health care choices for all Americans while also controlling costs in a system in which costs have spiraled out of control. The United States spends over $2.4 trillion on health care each year.[33] As noted earlier, health care expenditures in the United States constitute approximately 18 percent of the current Gross Domestic Product (GDP).[34] If health care costs continue to grow at historical rates, the share of GDP

[28] David Himmelstein, Elizabeth Warren, D. Thorne, and S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," Health Affairs (2005).
[29] Judy Feder, Testimony before the Committee on Energy and Commerce Committee (hereinafter Feder) (Mar. 17, 2009).
[30] "Insuring America's Health: Principles and Recommendations," Institute of Medicine (Jan. 14, 2004).
[31] Id.
[32] Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (May 2002), available at: *http:www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf*
[33] Supra note 9.
[34] Executive Office of the President, Council of Economic Advisors, "The Economic Case for Health Care Reform," available at *http:www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/ (June 2009).*

devoted to health care in the United States is projected to reach 34 percent by 2040.[35]

International Comparisons

The United States devotes a far larger share of GDP to health care spending more than two times per person on health care than any other OECD (Organization for Economic Co-operation and Development) country.[36] While health care expenditures in the United States are about 18 percent of GDP[37] the OECD reports that the next highest country was Switzerland—with 11.3 percent—and in most other high-income countries, the share was less than 10 percent.[38]

Despite outpacing other countries with investments in health care, the U.S. fails to produce better health outcomes in fundamental ways. OECD data shows that life expectancy in the United States is lower than in any other high-income country, as well as in many middle-income countries.[39] Similarly, the infant mortality rate in the United States is substantially higher than that of other developed countries. While many factors other than health care expenditures may affect life expectancy and infant mortality rates—for example, demographics, lifestyle behaviors, income inequality, non-health disparities, and measurement differences across countries[40]—the Council of Economic Advisors (CEA) has concluded that "the fact that the United States lags behind lower spending countries is strongly suggestive of substantial inefficiency in our current system."[41] Indeed, according to estimates by the CEA based on the spending and outcomes in other countries, efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP.[42]

Analyzing health care spending over time, the CEA also notes that while health care spending has increased in other countries as well, the spending by the U.S. has not yielded the same outcomes as other countries. In 1970, the United States devoted only a moderately higher fraction of GDP to health care than other high-income countries, whereas in 2009 the United States spends dramatically more.[43] Yet, during that same period, life expectancy has actually risen less in the United States than in other countries.[44] This data suggests that much of the increased U.S. spending is inefficient.[45]

---

[35] Id.
[36] Marcia Angell Testimony before the Committee on Education and Labor Committee (hereinafter Angell) (Jun. 10, 2009).
[37] Supra note 34.
[38] Id.
[39] Id.
[40] Robert Wood Johnson Foundation, Commission to Build a Healthier America, "Beyond Health Care: New Directions to a Healthier America" (Apr. 2009).
[41] Supra note 34.
[42] Id.
[43] Id.
[44] Garber, Alan M., and J. Skinner, "Is American Health Care Uniquely Inefficient?" Journal of Economic Perspectives (2008) at 27–50.
[45] Supra note 34.

Cost of the Uninsured

While the U.S. health care system currently leaves 47 million Americans uninsured[46] and approximately 25 million underinsured,[47] the CEA projects that the number of uninsured could increase to 72 million by 2040.[48] Such increases in the numbers of uninsured people will create additional uncompensated care costs, which include costs incurred by hospitals and physicians for the charity care they provide to the uninsured as well as bad debt such as unpaid bills.[49] Both the federal government and state governments use tax revenues to pay health care providers for a portion of these costs through programs such as Disproportionate Share Hospital (DSH) payments and grants to Community Health Centers.[50] In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.[51] The CEA projects that if the U.S. does not slow the real growth rate of health spending and a subsequent rise in the uninsured, the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.[52]

Costs to Individuals and Families

As the cost of health care skyrockets, families and employers offering health insurance struggle to absorb the increased costs. In 2008, employer-based premiums increased by 5 percent. That growth was even greater for small firms. On average, they incurred a premium increase of 5.5 percent, and, for those with 24 or fewer workers, their respective increase was 6.8 percent.[53] Much of the increase in health care costs has been shifted onto workers. In 2008, the average annual premium for a family of four was $12,700, and workers contributed approximately $3,400 of that total which was 12 percent more than the year before. Workers are now paying $1,600 more for family coverage than they did 10 years ago.[54] Over the last decade, health care costs have risen on average four times faster than workers' earnings.[55]

These dramatic increases in health care costs have serious implications for American households. Some economists believe that, over the long run, workers pay for the rising cost of health insurance through lower wages.[56] To illustrate this relationship, the CEA has analyzed historical and projected average annual total compensation (measured in 2008 dollars), which includes wages as

[46] National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml (2009).*
[47] "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Commonwealth Fund (2008)
[48] Supra note 34.
[49] American Hospital Association, "Uncompensated Hospital Care Fact Sheet" (Nov. 2005), available at *http:www.aha.org/aha/content/2005/pdf/0511 UncompensatedCareFactSheet.pdf.*
[50] Hadley, Jack, J. Holahan, T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs (2008).
[51] Id.
[52] Supra note 34.
[53] The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2008 Annual Survey, (Sept. 2008).
[54] Angell.
[55] See, National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml* (2009).
[56] Pauly, Mark V., "Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance" (1998).

well as non-wage benefits such as health insurance.[57] Their analysis indicates that health insurance premiums are growing more rapidly than total compensation in percentage terms, and as a result, an increasing share of total compensation that a worker receives goes to cover health insurance premiums.[58] Moreover, the CEA notes that households with employer-sponsored health insurance could also be affected by rapid cost growth as employers shift to less generous plans with higher annual deductibles.[59] It is important to note, however, that the wage stagnation experienced by workers over recent decades cannot be attributed solely to rising health care costs. For example, low-wage workers have experienced real wage declines in recent years despite few such workers having access to or participating in employment-based health insurance coverage.[60] More economic dynamics are at work in the wage squeeze on workers, but rising health costs contribute to the downward pressure.

H.R. 3200 Will Increase Standards of Living and Create New Jobs

By slowing the growth in health care costs, standards of living will improve and resources will be freed to improve and expand the health care system. The CEA projects that slowing growth by 1.5 percentage points per year will save a family $2,600 by 2020.[61] By 2030 that savings would be increased to nearly $10,000.[62]

Furthermore, the CEA estimates that the coverage expansions that will result from health reform will produce a net benefit of approximately $100 billion a year, or about two-thirds of a percent of GDP.[63] According to its analysis, health care reform will lower the unemployment rate in the United States and could add as many as 500,000 jobs on an annual basis.[64] By producing a more healthy and productive workforce, health care reform will improve standards of living and help strengthen the U.S. economy.

Shared Responsibility & Employment-Based Health Care Insurance

In order to control costs and expand access to quality affordable health care, everyone must be covered and employers, individuals and the government must share in this responsibility. Consistent with the minimum wage and overtime laws, H.R. 3200 creates a fundamental right to a minimum level of health care contribution and/or coverage through an employer. As noted earlier, two-thirds of Americans receive health coverage through an employer, and H.R. 3200 builds upon the current employer-based system by implementing a 'pay or play' requirement.

The employer responsibility to provide and/or contribute to the health care of its workers will stabilize the employer-based health care system. Because the Employee Retirement Income Security Act of 1974 (ERISA) currently contains no requirement that an em-

[57] Supra note 34 (relying on the 1996 to 2006 Medical Expenditure Panel Survey-Insurance Component).
[58] Id.
[59] Id.
[60] Economic Policy Institute, "Increasing Health Costs Can't Explain Earnings Dip for Low-Wage Workers," Economic Snapshot (April 12, 2006).
[61] Supra note 34.
[62] Id.
[63] Id.
[64] Id.

ployer offer employee benefits, employers who do not offer health insurance to their workers gain an unfair economic advantage relative to those employers who do provide coverage, and millions of hard-working Americans and their families are left without health insurance. It is a vicious cycle because these uninsured workers turn to emergency rooms for health care which in turn increases costs for employers and families with health insurance. It is estimated that in 2008 premiums were about 8 percent or $1,100 higher due to this hidden cost shift.[65]

Strengthening the Employer-Based System

Millions of employers voluntarily decide to offer health benefits because it is in their economic interest. Employers are not taxed on their contributions to employees' health care, and these costs are deductible as a business expense.[66] In addition, large employers can offer health care coverage at a much lower cost because they can negotiate with insurers and have a larger pool of employees to spread the risk. Furthermore, employers recognize that investments in health care can produce gains in employee health which means fewer missed days, higher productivity and better overall job satisfaction.

Despite the incentives to offer health coverage, skyrocketing health care costs make it difficult for employers, particularly small businesses, to offer comprehensive health insurance. As noted earlier, while approximately 63 percent of the under–65 population and their dependents have insurance through employment,[67] the number of employers offering health care coverage has been declining over the last decade. The number of people getting health coverage through an employer dropped by 3 million between 2000 and 2007,[68] largely due to increasing costs. In addition, the Center for American Progress projects that as a result of layoffs, approximately 14,000 Americans lose their employer-sponsored coverage each day.[69] Overall, since 1999 premiums have increased 120 percent and at a rate that is on average four times faster than workers' earnings.[70]

However, even without an employer shared responsibility requirement, 86 percent of employers surveyed report that they will continue offering health care despite increasing costs.[71] Many of these employers are large ones who use health care benefits as a means to recruit and retain employees. Health care benefits are "highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage" even though they can currently do so.[72]

---

[65] Ben Furnas and Peter Harbage, "The Cost Shift from the Uninsured," The Center for American Progress (Mar. 2009).
[66] Paul Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," Health Affairs (May/June 2008) at 675.
[67] Supra note 10.
[68] Id.
[69] Center for American Progress (Feb. 2009), available at: *http:www.americanprogressaction.org/issues/2009/03/health—losses.html.*
[70] National Coalition on Health Care, "Health Insurance Costs," (2009), available at: *www.nchc.org/facts/cost.shtml*
[71] Supra note 61.
[72] Hacker at 10.

H.R. 3200 generally will not change what many employers are already doing. Beginning in 2013, the bill requires employers already offering health insurance to make an offer to all full-time employees and contribute 72.5 percent of the cost toward an individual policy and 65 percent toward a family policy. Today, employers on average contribute 83 percent toward the coverage of individual premiums and 71 percent toward the coverage of family premiums.[73]

The second phase of requirements under H.R. 3200 for existing employer health plans does not take effect until the end of 2018. At that time, in addition to making the required contribution amount, every employer-sponsored health plan will have to, at a minimum meet the essential benefit standards defined by the benefits committee, as well as satisfy the insurance reform standards specified in the bill. Employer health insurance plans will be required to be equivalent to no less than 70 percent of the actuarial value minus the cost sharing components of the essential benefit package. The majority of employers already meet this standard. According to the Congressional Research Service, the typical employer-sponsored PPO has an estimated actuarial value between 80–84 percent, while the typical employer-sponsored health savings account (HSA) and a qualified high deductible health plan (HDHP) has an estimated actuarial value of 76 percent, excluding contributions by an employer.[74]

While many employer plans already meet the bill's requirements, there are some notable omissions. For example, 10 percent of employer plans do not offer mental health and substance use disorder benefits and many include caps on lifetime limits and out of pocket expenses. In these cases, employers will have over 8 years to modify their plans and meet the requirements. Finally, H.R. 3200 extends the same benefit and insurance reform standards in all new employer and HIE plans, so that individuals and families have access in either case to affordable quality health coverage.

Protecting Small Business

For small business, health reform "is their number one need." [75] Forty-percent report that high costs have a "negative effect on other parts of their business, such as high employee turnover or preventing business growth." [76] According to the Small Business Majority, a non-profit independent group representing 27 million small businesses, small businesses spend 18 percent more than large employers for health care coverage.[77] The result is that in 2008, the percent of firms offering health insurance with three to nine employees dropped from 57 percent to 49 percent.[78]

---

[73] "Employee Benefits in the United States, March 2008," Bureau of Labor Statistics (Aug. 7, 2008).
[74] Chris Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service (May 29, 2009) at 3–4.
[75] John Arensmeyer, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Arensmeyer)(Jun. 23, 2009) at 1.
[76] Taking the Pulse on Main Street, "Small Businesses, Health Insurance and Priorities for Reform (Jan. 2009).
[77] Arensmeyer at 2.
[78] Id.

Small businesses have small purchasing pools and one of the biggest obstacles they face in securing affordable health coverage is the lack of bargaining power they have against the insurance companies. In addition, the administrative costs paid by small businesses can be up to 27 percent of premiums to pay for marketing and paperwork costs and underwriting.[79]

LaShonda Young, a small business owner, testified to the Committee about the problems she has had in seeking coverage for her forty employees. She received eight bids and each was from the same insurance company. She testified her experience isn't unique, as there are only one or two health insurers in her area.[80] She went on to testify that, "it's been years since we've been able to afford group health insurance . . . we got quotes from a couple of different places, [the] quotes came in at about 13 percent of payroll. [We're] willing to pay our fair share but we just couldn't afford 13 percent . . . "[81] Even if she was able to afford the coverage, she knew that it wouldn't cover the pre-existing conditions of her employees for up to 18 months and there was no guarantee the costs would remain stable.[82] As a result, small employers like Young are looking to other ways to help their employees find coverage on their own. Young testified that her company offers small stipends to employees to buy insurance on their own.

High health care costs also present an enormous obstacle for those trying to start or maintain a new business. While small businesses have traditionally played an essential role during prior economic recoveries, the high cost of health care is deterring entrepreneurs from starting a business in the first place. Louise Hardaway started her own business near Nashville, Tennessee. When attempting to get health care insurance she was quoted $12,800 a month to cover herself, her husband, business partner, and her business partner's spouse and child. Due to her inability to find affordable health care coverage Ms. Hardaway went out of business and went to work for another company where she could get health care.[83]

Recognizing the economic reality for many small businesses, in addition to driving down health care costs overall, H.R. 3200 contains numerous provisions such as tax credits and access to the HIE to help these employers provide coverage and alleviate their costs. In addition, the bill exempts employers from the pay or play requirement if they have payrolls of $250,000 or less. For employers with payrolls above $250,000 who choose not to offer coverage and would rather pay a penalty, that penalty is phased-up so that only employers with payrolls over $400,000 must pay the 8 percent penalty.

The Small Business Majority reports that small businesses, workers and the economy stand to save billions of dollars with the

[79] "The Economic Impact of Healthcare Reform on Small Business," Small Business Majority (Jun. 11, 2009) .
[80] LaShonda Young, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Young)(Jun. 23, 2009) at 2.
[81] Young at 2.
[82] Id.
[83] Simona Covel, "Sick and Getting Sicker," Wall St. Journal (Jul. 23, 2009).

enactment of health care reform.[84] Absent health care reform small businesses will spend $2.4 trillion in health care costs over the next ten years. With health reform, small businesses will save 36 percent of those costs, as much as $855 billion. Without health reform, small businesses stand to lose $52.1 billion in profits due to high health care costs over the next ten years. Health reform will decrease these losses and save $29.2 billion. Reduced health care costs will allow employers to reinvest in their business and their workers. Without health reform, individuals working for small businesses could lose up to $834 billion in lost wages as employers pass increased health care costs onto their employees over the next ten years. Health reform could save workers over $300 billion over the next ten years.[85] Reduced health care costs will allow employers to reinvest in their business and their workers.

THE HEALTH INSURANCE EXCHANGE WILL HELP SMALL EMPLOYERS

H.R. 3200 creates a health insurance exchange (HIE) for the uninsured and employees of small businesses to purchase health insurance in the initial years after enactment. Due to the disadvantages small businesses face when trying to purchase health care coverage on their own, both proponents and opponents of the bill believe that a health insurance exchange is essential for small business: "a broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed."[86] Furthermore, it "can be a vehicle that facilitates and monitors the movement of the system toward achievements of many national health care reform goals." Eighty-percent of small business owners in a recent state survey stated they favor a health insurance pool that they can put their employees into to buy coverage.[87]

A health insurance exchange is an organized marketplace where individuals and some employers can go to purchase health insurance. The HIE is advantageous to those looking to purchase insurance because it provides transparency when individuals and families shop for their health insurance. Currently, insurers are regulated by a patchwork of state laws. Beyond licensing requirements to sell insurance, private health insurance companies and health maintenance organizations (HMO) operate with considerable autonomy. The result is that policies can vary greatly and many policies leave people underinsured.

The robust HIE will not only organize the marketplace but also include insurance reforms and consumer protections, administer affordability credits, and provide people with choice of plans. The HIE will require that insurers, both private and public, adhere to the same rules. To help consumers make educated decisions the Commissioner will conduct outreach and provide assistance to consumers. The Commissioner will ensure that information is readily available in plain language and is provided in a culturally and linguistically appropriate manner. Furthermore, qualified health ben-

[84] Supra note 76.
[85] Id.
[86] Arensmeyer at 4.
[87] Id.

efits plans (QHBP) including those participating in the HIE will be required to comply with transparency requirements established by the Commissioner, including the accurate and timely disclosure of plan documents, plan terms and conditions, as well as information on cost-sharing and payments with respect to out-of-network coverage, claims denials and other information to help educate consumers.

In addition to monitoring and streamlining the insurance industry, the HIE will play a significant role in containing health care costs. Health care costs are comprised of both the underlying costs of providing health care services as well as the administrative costs related to the provisions of coverage.[88] The HIE will require participating plans to offer standardized benefit packages which will increase the ability to compare plans and "reinforce incentives for insurers to price premiums as competitively as possible."[89] Lower cost plans in the HIE will help those employers who "play" by putting their employees into HIE because they will be responsible for a set contribution amount regardless of the plan an employee choose.[90] Furthermore, the affordability credits available to individuals in the HIE who do not enter the exchange with an employer contribution are tied to the average of the lowest three plans which will then incentivize individuals to choose low-cost plans. By the same token, insurers will be incentivized to offer low-cost plans in order to get more business.[91]

Access & Cost Containment Through A Public Health Insurance Option

The inclusion of a strong public health insurance option in the HIE will save over one hundred billion dollars and provide choice to millions of consumers who currently have little or no choice when looking for a health plan. Its inclusion in the HIE will promote value and innovation in the private health insurance industry by increasing competition. The result is that the public option will lower costs for consumers across the private market.

The public health insurance option will provide access to meaningful choice, something many Americans have never had when searching for a health plan. Many areas only have one or two dominant insurance options that control the market and thus have no downward pressure on costs.[92] Furthermore, "it is often in [these insurers'] interest to pay higher rates to key doctors and hospitals because they can pass on these costs to individuals and employers."[93] For insurers trying to enter a market, this practice makes it difficult for them to compete and reduce costs.

While the public option will be subject to the same standards as private plans, the public option can use administrative efficiencies to control costs. On average, private insurance overhead was about 11.7 percent of premiums which is significantly higher when com-

[88] Linda Bloomberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals" (Apr. 2009).
[89] *Id.*
[90] However, an employer is always permitted to contribute an amount greater than the minimum should it choose.
[91] *Id.*
[92] Hacker at 5.
[93] *Id.*

pared to public insurers (Medicare is estimated at 3.6 percent and Medicaid at 6.8 percent).[94] In addition, because the public option is a health plan available nationwide it will have a broad reach and be able to obtain larger volume discounts and will not operate for profit.[95] Accordingly, the public option in H.R. 3200 will serve as a "benchmark for private plans, a backup to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control backstop."[96]

Ultimately, it will be up to consumers in the HIE to decide whether to enroll in the public option or a private plan. H.R. 3200 intends to create a level playing field for both to compete. Consumers will be able to compare what each plan offers—private plans or the public option—and decide which plan serves them and their families best.[97]

Ensuring Access to Health Care Through Insurance Market Reforms

Comprehensive insurance reforms are another critical element of health reform. Guaranteeing access to health care and protecting against medical debt largely depends on implementing comprehensive insurance reforms. About "20 percent of the population accounts for 80 percent of health spending;" the "sickest one-percent accounting for nearly one-quarter of health expenditures."[98] This uneven distribution of medical care creates incentives for insurance companies to avoid risk altogether rather than trying to spread it among the insured population.[99] As a result, health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy.[100] These practices include: denying health coverage based on pre-existing conditions or medical history,[101] even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender;[102] and rescinding policies after claims are made based on an assertion that an insured's original application was incomplete.[103] In addition, while "state and federal laws give individuals the right

[94] John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform," Urban Institute (2009).
[95] Hacker at 7.
[96] *Id.*
[97] *Id.*
[98] Karen Pollitz, testimony before the Committee on Energy and Commerce, Subcommittee on Health (hereinafter Pollitz) (Mar. 17, 2009).
[99] Linda Blumberg, testimony before the Committee on Ways And Means (April 22, 2009).
[100] Mila Kofman, testimony before the Committee on Energy and Commerce, Subcommittee on ealth (hereinafter Koffman)(Mar. 17, 2009); Blumberg, *supra* 94.
[101] *See* Fran Visco, testimony before the Committee on Education and Labor (June 22, 2009). Ms Visco testifying on behalf of the National Breast Coalition, stressed how no insurance or inadequate insurance has had a devastating effect on women diagnosed with breast cancer.
[102] A 2008 report by the National Women's Law Center examined individual insurance policies in 47 states and the District of Columbia and found that most of the states engage in a practice called "gender rating" where insurance companies arbitrarily charge women and men different rates for individual insurance premiums. Specifically, they found that women under 55 are charged more for health insurance than men (at age 25, 4% to 45% more; at age 40, 4 to 48% more). In addition, the report discovered that the vast majority of individual policies do not cover maternity leave, and in 9 states and the District of Columbia, insurers can reject survivors of domestic violence and those who have had C-sections. *See: Nowhere to Turn: How the Individual Insurance Market Fails Women*, National Women's Law Center (2008).
[103] *Id*, Pollitz, supra 98.

to renew their health insurance coverage, guaranteed renewability provides no protection against rate increases."[104]

Discrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured.[105] As noted earlier, these practices have resulted in about 57 million Americans having debt because of medical bills,[106] and over 42 million of that number has some sort of medical coverage.[107] Medical debt is now the leading cause of personal bankruptcy.[108]

A key element to health reform is to prohibit risk selection practices and to support those factors based on quality and efficiency. Where states have prohibited these discriminatory practices, consumers have benefitted. For example, since 1993, Maine requires insurers to provide health insurance to individuals or small businesses on a "guarantee issue" basis. In addition, it also has an "adjusted community rating" so that prices for policies are set based on "the collective claims experience of anyone with a policy" and not on any one individual's medical history.[109]

H.R. 3200 includes insurance market reforms ending discriminatory practices conducted by insurance companies. These reforms will apply both inside and outside the HIE to end the discriminatory practices currently practiced by insurance companies. The bill requires that all policies be sold on a guaranteed issue basis; prohibits insurers from excluding coverage based on pre-existing conditions; and prohibits insurers from charging higher rates based on health status, gender, or other factors. It would allow premiums to vary based only on age (no more than 2:1),[110] geography and family size. In addition, the bill prohibits lifetime and annual limits on benefits so that families no longer face bankruptcy as a result of a serious medical illness.

STRENGTHENING THE HEALTH CARE WORKFORCE

As millions of new people gain access to health care coverage, H.R. 3200 recognizes that significant investments in the health care workforce are needed. There is mounting evidence that the nationwide healthcare workforce shortage is accelerating. The Health Resources and Services Administration, within the Department of Health and Human Services, reported in January of this year that twenty states were experiencing scarcities of physicians and

---

[104] *Id.*

[105] *Id*; Pollitz, *supra* 98. While 47 million Americans have no health insurance at all, almost as many are underinsured.

[106] Pollitz, *supra* 98, testified that "when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5% of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills."

[107] Pollitz, *supra* 98.

[108] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007*, The American Journal of Medicine (2009) at 3, finding that in 2007, 62.1% of all bankruptcies in the United States were medical, compared with 8 percent in 2001. *See also:* Pollitz, *supra* 98; Kofman, *supra* 100, both of whom testified that most medical bankruptcies are filed by insured people.

[109] Kofman, *supra* 100.

[110] Pollitz, *supra* 98, testified that age is "a strong proxy for health status."

Exhibit 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

200 Independence Ave SW
Washington, DC 20201

Date: January 3, 2013

From: Center for Consumer Information and Insurance Oversight

Title: Affordable Insurance Exchanges Guidance

Subject: Guidance on the State Partnership Exchange

I. Purpose

Through a hybrid model called a State Partnership Exchange, States may assume primary responsibility for many of the functions of the Federally-facilitated Exchange permanently or as they work towards running a State-based Exchange. For example, states may carry out many plan management functions through what is referred to throughout this guidance as a State Plan Management Partnership Exchange. In addition, states can choose to assume responsibility for in-person consumer assistance and outreach, through what is referred to throughout this guidance as a State Consumer Partnership Exchange. States also have the option to assume responsibility for a combination of these main Exchange activities.

With a State Partnership Exchange, states can continue to serve as the primary points of contact for issuers and consumers, and will work with HHS to establish an Exchange that best meets the needs of state residents. This guidance provides a framework and basic roadmap for states considering a State Partnership Exchange. This guidance also describes how the Department of Health and Human Services (HHS) will work with states independent of State Partnership Exchange.

Contents

Working with States to Implement Exchanges

The Affordable Care Act directs HHS to establish a Federally-facilitated Exchange (FFE) in any state that does not elect to establish a State-based Exchange and in any state where the Secretary determines (by January 1, 2013) that there will not be an operational State-based Exchange by January 1, 2014. HHS continues to work with states establishing State-based Exchanges. For other states, HHS will structure the FFE so that state knowledge and expertise can be integrated into the FFE to the greatest extent possible. This guidance outlines the various options that states have to provide input and guidance, and take ownership over significant components of the operation of an FFE, primarily through a State Partnership Exchange. The State Partnership Exchange options provide states with a high level of participation in plan management and consumer assistance/outreach either on a permanent basis or as a stepping stone to a State-based Exchange in the future. For states with neither a State-based nor State Partnership Exchange, we describe how HHS can integrate traditional state regulatory functions and activities into FFE operations.

I. State Partnership Exchange Overview

On May 16, 2012, HHS released General Guidance on the FFE[1] that provided basic information regarding State Partnership Exchanges. A State Partnership Exchange enables a state to be actively involved in Exchange operations, continue to play a primary role in interacting with issuers and consumers in the state, and make recommendations as to how local market factors should inform the implementation of Exchange standards. The overall goal of a State Partnership Exchange is to enable the Exchange to benefit from efficiencies when states have existing regulatory authority and capability, and to provide a framework for tailoring aspects of the FFE to state markets and residents while maintaining a positive and seamless experience for consumers. The State Partnership Exchange can also serve as a path for states toward future implementation of a State-based Exchange.

A State Partnership Exchange enables states to assume primary responsibility for carrying out certain activities related to plan management, consumer assistance and outreach, or both. We welcome states' ideas on how best to make this hybrid model work. In areas where the law prohibits HHS from completely delegating responsibility to a state, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS. This guidance provides states and other stakeholders with details regarding the State Partnership Exchange option for the 2014 benefit year. HHS intends to provide further details throughout Exchange establishment and may refine the policies included here in future years of operation.

[1] http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf

II. State Plan Management Partnership Exchange

HHS recognizes that State Departments of Insurance (DOIs) have a longstanding regulatory role with the health insurance issuers that will participate in the FFE. HHS believes that preserving the DOI's traditional roles and responsibilities in the insurance market generally by having a state role in the operation of the Exchange is important to ensure market parity inside and outside the Exchange, and to guard against adverse risk selection within the Exchange.

In addition, HHS recognizes that even where a state with an FFE does not participate in a State Partnership Exchange, states will continue to perform regulatory activities such as reviews of health plan rates, benefits, and provider networks with respect to all plans offered in the state, both inside and outside the Exchange. Therefore, even where a State Partnership Exchange is not operating, HHS will work with states to integrate state reviews into the FFE's process for certifying QHPs.

Overview of the State Plan Management Partnership Exchange

In a State Plan Management Partnership Exchange, the scope of state responsibilities includes: recommending plans for QHP certification, recertification and decertification; QHP issuer account management; and day-to-day administration and oversight of QHP issuers. States in a State Partnership Exchange will carry out similar plan management activities for stand-alone dental plans certified by the Exchange.

The chart below summarizes the functions, activities, and responsibilities that a state and HHS will perform for a State Plan Management Partnership Exchange in 2013 and 2014. State Partnership Exchange recommendations and activities must be consistent with applicable law (statutes and regulations), FFE guidance and timelines, standard operating procedures (SOPs), and policies.

Chart 1: State and HHS Activities under a State Plan Management Partnership Exchange (2013-2014)

State Activities	HHS Activities
QHP Certification Process	
• Issue QHP application • Collect issuer and plan data to support QHP certification and Exchange operations[2] • Submit rate review determinations to HIOS[3] • Verify issuer compliance with actuarial value (AV) and cost-sharing reduction plan variation standards in support of the QHP certification process[4] • Submit recommendations to HHS regarding QHP certification and recertification (including for stand-alone dental plans and CO-OPs) • Transmit timely and standardized issuer and plan data to HHS to populate the Exchange website and to support ongoing Exchange operations in an HHS-approved system (i.e., SERFF, HIOS)	• Develop data standards in conjunction with states for QHP data collection and ongoing data reporting • Receive, approve (as appropriate), implement and oversee a state's certification and recertification recommendations
QHP Issuer Account Management	
Day-to-day issuer account management activities specifically related to plan management, including: • Serve as point of contact for issuer questions and issues related to QHP certification and other QHP responsibilities • Manage communications with QHP issuers and the FFE related to Exchange issues and monitoring • Resolve, track, and coordinate consumer complaints as necessary with HHS	• Coordinate responses to issuer questions and issues related to other FFE functions, including eligibility, enrollment and financial management received by the state • Provide technical assistance to issuers as needed related to Exchange operational requirements that are not traditional state functions • Ensure receipt of updated issuer information • Respond to consumer complaints received via the federal customer service channels for the State Partnership Exchange or refer to the state entity, as appropriate, for tracking and resolution of complaints
QHP Issuer Oversight and Monitoring	
• Ensure continued compliance with QHP certification standards • Take compliance actions under state law against QHP issuers due to violation of state insurance laws and regulations, and inform HHS accordingly for Exchange records and Exchange action as well, if	• Oversee QHP issuers related to Exchange operations outside of the scope of traditional state insurance oversight and QHP certification, including compliance with: • Enrollment transaction requirements, enrollment reconciliation

[2] The state will be allowed to utilize the HHS Health Insurance Oversight System (HIOS) for issuer and plan data collection or another system approved by HHS in connection with participation in a State Partnership Exchange.
[3] HIOS refers to the HHS Health Insurance Oversight System. SERFF refers to NAIC's System for Electronic Rate and Form Filing.
[4] The state will have access to the actuarial value (AV) calculator and will be responsible for verifying issuers' compliance with AV standards, including applicable cost-sharing reduction plan variations. Rules concerning issuer compliance with AV standards are proposed at 77 FR 70643.

appropriate • Recommend Exchange compliance actions for QHPs to HHS and coordinate state law enforcement with Exchange enforcement where appropriate • Coordinate with HHS on Exchange operational oversight, i.e. compliance with Exchange standards	• Eligibility and enrollment standards for eligibility determinations made by the Exchange (see 45 CFR 155.302 for options provided to an Exchange with respect to eligibility determinations) • Financial management operations as applicable • Other operational requirements related to the FFE website, call center, customer service, etc. • Coordinate with the state on oversight findings • Receive and review state enforcement recommendations in connection with Exchange operations, make Exchange enforcement decisions, and take enforcement actions, as appropriate
Quality	
• Coordinate with HHS on data collection requirements related to quality, such as accreditation, including those that will be specified in future rulemaking • Conduct other quality or performance monitoring, at the discretion of the state, under state law or to inform QHP certification recommendations • Provide a web link to additional quality data that will display on the Exchange Internet website that connects to the state DOI or other state agency websites [*optional*]	• Develop quality rating, quality improvement strategy, enrollee satisfaction survey, phase two process for recognizing accrediting entities and other data standards for quality data collection and ongoing data reporting

Plan Management Function: QHP Certification Process

With a State Plan Management Partnership Exchange, states will have flexibility in how they carry out their role in QHP certification while applying the QHP certification standards in a manner consistent with FFE policies. A state could perform an alternate review if it meets or exceeds the FFE standards in connection with how QHP certification standards are applied; such flexibility is intended to address insurance market conditions unique to the state. Commenters to the General Guidance on the FFE suggested that some standardization should exist across states served by FFEs, while encouraging some ability for states to tailor interpretation and application of FFE standards to state-specific markets. To assist states in developing processes and procedures for the state role in QHP certification, HHS is publishing its planned approach to QHP certification reviews.

Appendix A describes how HHS will evaluate potential QHPs against all QHP certification standards in the FFE. HHS believes that articulating a reasonable interpretation for each standard will improve the state-federal relationship, streamline HHS' process for reviewing state work, and offer issuers additional consistency in complying with state and federal standards.

HHS will work closely with states operating a State Plan Management Partnership Exchange to negotiate a state-specific MOU based on the state's approved Blueprint for a State Partnership Exchange. In addition to describing how HHS and the state will work together to implement plan management functions, the MOU will include some description of how the state will review QHPs for certification.

While the law does not allow HHS to completely delegate QHP certification to states with an FFE, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS. Specifically, HHS will accept or respond to state QHP recommendations within 14 business days of receipt, on the condition that the state has followed processes previously outlined in the Blueprint application and MOU agreement. HHS does not intend to re-review QHP data or otherwise duplicate work performed by the state. HHS will notify the state in writing of any concerns that preclude HHS approval of its recommendations; the state will have nine business days following this notification to respond to HHS' concerns and request reconsideration of HHS' decisions. HHS will notify the state of its final decision and basis for the decisions within five business days of receipt of the state's response.

The final rule[5] outlining standards for the Consumer Operated and Oriented Plan Program (CO-OP) states that CO-OP QHPs that meet the program standards, Exchange-specific standards, and federal standards may be deemed as QHPs by HHS or an entity designated by HHS. In a State Plan Management Partnership Exchange, the participating state's responsibilities will include providing recommendations to HHS to assist in the determination of whether or not the CO-OP meets the requirements for a QHP, with the final determination to deem the CO-OP left to HHS.

Plan Management Function: Issuer Account Management

States in a State Plan Management Partnership Exchange will coordinate with HHS with regard to issuer account management and ongoing monitoring of QHP issuers. To facilitate this relationship, HHS anticipates that QHP issuers operating in a State Partnership Exchange will have a designated Federal Account Manager, who will serve as a point of contact between the QHP issuer and HHS for questions and issues related to federal activities, such as administration of advance payments of the premium tax credit. The Federal Account Manager will assist QHP issuers by providing policy clarifications and other assistance with the program on an as-needed basis.

We expect that states will develop their own mechanisms to support and monitor QHP issuers on an ongoing basis in order to have a primary role in overseeing QHP issuers on day-to-day matters. Specific roles and responsibilities for the states and for the Federal Account Manager in

[5] http://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf

this area will be outlined in guidance and procedures to be developed by HHS with input from states participating in a State Partnership Exchange.

Plan Management Function: Issuer Oversight

States that participate in a State Plan Management Partnership Exchange will assume the first line of responsibility with respect to QHP issuer oversight. Consistent with the state's regulatory authority and state law, HHS expects that the state will have primary responsibility for investigating QHP performance. This will include responsibilities such as managing certain types of consumer complaints about issuers, examining potential QHP issuer non-compliance with applicable laws, and ensuring ongoing compliance with the QHP agreement and certification standards.

Specifically, the state will work with HHS and existing consumer assistance programs to ensure the resolution of consumer complaints in the State Partnership Exchange. We expect that the state will continue to oversee the successful resolution of complaints received through channels that exist today, prior to the existence of the Exchange and outside of the Exchange, such as issuer customer service channels or other existing state-based resources.

States will maintain their responsibility for enforcing state law, including those relevant to QHP certification and decertification. The state will also be responsible for developing and implementing a process to make recommendations to HHS for decertification (based on violations of federal law or regulations, or other reasons). HHS will monitor and address matters that directly relate to other areas of FFE or federal operations, including instances in which federal funds such as cost-sharing reductions, advance payments of the premium tax credit, and risk corridor payments, may be directly implicated.

Plan Management Function: Quality

States that participate in a State Plan Management Partnership Exchange will coordinate with HHS on quality reporting and display requirements. As indicated in the General Guidance on the FFE, HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification beginning in 2016 based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act sections 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h). States may collect additional quality data (and collect data prior to 2016) directly from issuers or third party entities (such as accrediting entities) for use in applying the consumer interest standard of QHP certification under 45 CFR 155.1000, making QHP certification determinations, conducting QHP performance monitoring, and providing consumer education and outreach.

States will apply accreditation requirements proposed in 45 CFR 155.1045 as part of recommending QHP certification when a state participates in a State Plan Management Partnership Exchange. This role will also include requiring issuers with existing accreditation to

authorize the release of data from the accrediting entity to the Exchange as part of the application for QHP certification. Under the current regulatory proposal,[6] each FFE will collect accreditation information from all health plans and issuers seeking QHP certification. An FFE Internet website will display accreditation status for QHP issuers based on QHP issuers' existing commercial, Medicaid or Exchange accreditation from recognized accrediting entities.

Until QHP-specific quality ratings are available, each FFE Internet website will display Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results from accredited commercial product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations.[7] If applicable CAHPS commercial data are not available, the FFE Internet website will display CAHPS data available from accredited Medicaid product line results if these data are available for the same QHP product types and adult/child populations. Each FFE will collect these data from the recognized accrediting entity and display them for the applicable QHP issuers. States participating in a State Partnership Exchange will collect and transmit to HHS this accreditation-related data on QHP issuers and ensure that QHP issuers understand that the Exchange Internet website will display data from existing accreditation, if applicable, as part of the QHP certification process developed by the state for the State Partnership Exchange.

Issuer and Plan Data Collection

One key to operating a successful State Plan Management Partnership Exchange is the collection of data from issuers (either as part of the QHP certification process or during management of QHP issuers) and the transfer of that information to HHS for use in overall Exchange administration. Issuer and plan-level data are integral to many portions of Exchange operations.

Issuer-level information will include administrative data, including high-level identifying information and contacts. This information will be used to identify issuers in the plan management system and by other FFE business areas as they develop points of contact with the issuers and facilitate operational activities. Issuer-level information also includes information related to issuer compliance with QHP certification standards.

Plan-level data will include information on rates and benefits. Such information is key for Exchange and HHS functions in the administration of advance payments of cost-sharing reductions and advance payments of the premium tax credit.[8] The collection of rate and benefit

[6] The CMS Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule, CMS-9980-P, was proposed at 77 FR 70643 (Nov. 26, 2012); includes a proposal concerning the accreditation timeline for QHPs seeking certification by all FFEs, including State Partnership Exchanges.
[7] HHS intends to propose rules for QHP quality rating subject to section 1311(c)(3); our intent is that such ratings will be available for display beginning in the 2016 open enrollment period for the 2017 coverage year.
[8] Rules concerning the administration of cost-sharing reductions are proposed at 77 FR 73117 and advanced payments of the premium tax credit at 77 FR 70643.

data will also be used for oversight and transparency purposes, as well as monitoring market trends.

Due to the integral role that plan management data plays in overall FFE operations, states participating in a State Partnership Exchange will use a data collection tool that aligns with the overall FFE infrastructure. Therefore, states that choose a State Plan Management Partnership Exchange will have the option to use the Health Insurance Oversight System (HIOS) or an HHS-approved State system for data collection. HHS is aware that some states are hoping to leverage their existing data collection systems to support a State Plan Management Partnership Exchange, and HHS encourages states to begin discussions with CCIIO staff to explore how they can use existing resources to facilitate this.

In this spirit, HHS is working with the National Association of Insurance Commissioners (NAIC) to enable states to use the System for Electronic Rate and Form Filing (SERFF) as part of the QHP submission and certification process in a State Plan Management Partnership Exchange. HHS and the NAIC are developing QHP submission interfaces to ensure that SERFF collects the full list of data elements necessary for QHP certification, and to enable seamless data transmissions between SERFF and HHS.

States participating in a State Plan Management Partnership Exchange will complete their part of the QHP certification process and remit the specified plan data and recommendations via SERFF or HIOS to HHS by July 31, 2013. Issuers will verify the accuracy of the data that has been submitted to HHS in a number of ways, including the upload and verification of plan data on the FFE Internet website, verification of premiums quoted by the premium calculator, and issuer system trainings.

Recommended State Plan Management Exchange Timeline

The chart below serves as a guideline for states participating in a State Partnership Exchange to implement all necessary plan management activities before open enrollment begins.

	State Activities Connected to Participation in State Plan Management Exchange
Through Feb. 2013	• Participate in design reviews under section 1311(a) cooperative agreements, if applicable.[9] Such reviews may include amendments to existing cooperative agreement terms or state applications for new cooperative agreements containing terms and activities the state performs in connection with the State Partnership Exchange.

[9]Grants Funding Opportunity Announcement released on June 29, 2012, page 57-60. http://www07.grants.gov/search/search.do;jsessionid=YvVZPtbTL5Hy4Tgw7g4MdBGQtHdhycbgLRHvKdNhlQ5zQ2gnMYxc!-1618278613?oppId=180734&mode=VIEW

Early 2013	• Begin to identify the entity performing plan management functions and governance structure. • Begin to submit evidence of legal authority to perform plan management functions. • Begin to: o Develop procedures for day-to-day oversight and monitoring of QHPs. o Develop plan for supporting QHP issuers and providing technical assistance. o Develop approach for QHP issuer recertification, decertification, and appeal of decertification recommendations.
Feb. 15, 2013	• Last date to submit a declaration letter indicating that the state plans to pursue a State Partnership Exchange and the Blueprint Application. • Last date for a state to submit an initial application for a section 1311 cooperative agreement to establish a grant relationship with CMS that will allow the state to become an operational State Partnership Exchange for plan year 2014. A state can continue to seek additional funding through 2014 to continue building functions for a State Partnership Exchange, to create linkages to the FFE and to build State-based Exchange functions if the state intends to transition to a State-based Exchange in later years.
April 2013	• Suggested start to the QHP certification submission process.
May-June 2013	• Participate in consultations with HHS to ensure successful operation of the QHP certification process.
July 31, 2013	• Complete the QHP certification process and send final recommendations and QHP data to HHS.
August 2013	• Plan-preview period on FFE website to address any QHP issuer data errors.

Working with States Outside of a State Plan Management Partnership Exchange

HHS recognizes that determination of whether issuers and health plans meet QHP certification standards outlined in 45 CFR 156.200 involves activities that oftentimes are already or will be performed by state regulators under state law, including state laws that address 2014 market reforms. For example, we know that many states will conduct reviews for: coverage of essential health benefits (EHB), including formulary reviews for EHB purposes; compliance with actuarial value and market rating reforms; and rate increases, consistent with state authority and federal law.

Additionally, HHS recognizes that determination of whether plans meet several other QHP certification standards – including, for example, network adequacy – are closely related to market-wide standards, and may rely upon the same data and state authority, such as in the case of marketing standards. Therefore, HHS anticipates integrating state regulatory activities into its decision-making for QHP certification determinations in the FFE, provided that states make these determinations and provide information to HHS consistent with federal standards and FFE timelines. Unlike in states where there is a State Plan Management Partnership Exchange, in which the state will recommend QHP certification decisions to HHS, in this context, a state will evaluate whether a health plan or issuer meets particular certification standards as a part of its established state regulatory role.

HHS will consult with states to provide technical assistance and consultation on market-wide standards and other QHP certification standards, as needed. That consult will determine how HHS should prepare to conduct QHP certification for an FFE in the state in a manner that leverages the state's approach to reviewing health plans under state law and in connection with market reform standards. As with State Plan Management Partnership Exchange activities, state reviews that follow HHS' planned approach will be relied upon by HHS in making QHP certification decisions. HHS will be responsible for ensuring that QHPs meet all QHP certification standards that the state does not review. To the extent possible under applicable law, HHS will use the same process to review state recommendations and state findings, as described previously in this document in connection with State Partnership Exchanges. We note that states will not be asked to undertake reviews or analyses beyond those that would be conducted as a matter of state law.

HHS will also work with states to determine the format and delivery date for information and analyses that the states wish to share with HHS in this context.

III. State Consumer Partnership Exchange

A State Consumer Partnership Exchange draws on the state's knowledge and experience regarding the needs of consumers in the state to support a simplified, seamless consumer experience. In a State Consumer Partnership Exchange, a state is responsible for the day-to-day management of the Exchange Navigators and the development and management of a separate and distinct in-person assistance program, and can choose to be responsible for outreach and educational activities. HHS will operate the call center and website for the State Partnership Exchange, and be responsible for the funding and award of Navigator grants.

Navigators

Section 1311(i) of the Affordable Care Act directs that Navigators conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of QHPs and information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities. Navigators will engage in locally-focused work. Navigator grantees could include individuals and organizations that often target their outreach to specific ethnic, geographic, or other communities.

States that choose to operate a State Consumer Partnership Exchange will conduct the day-to-day management of the Navigator program, including ongoing monitoring of Navigator activities and providing technical assistance to Navigators. Consistent with the Exchange final rule,[10] HHS

[10] Exchanges Final Rule: 45 CFR 155.210

will establish conflict of interest, cultural and linguistic competency, and training standards that will apply to Navigators in FFEs and State Consumer Partnership Exchanges. The state will ensure that Navigators are adhering to those FFE standards, as well as to the State Consumer Partnership Exchange's privacy and security standards developed by HHS in operation of the State Partnership Exchange.[11] HHS will develop and operate the Navigator training program, which will culminate in an assessment that all grantees are required to pass in order to operate as Navigators. The state will be able to develop additional training modules, if they choose to do so, that Navigators would take. HHS and the state will also work together on an ongoing basis to ensure that both parties remain appropriately informed about Navigators and the work they are performing. We anticipate that the state with a State Consumer Partnership Exchange will notify HHS of any concerns or problems about Navigators.

Additionally, states participating in the State Consumer Partnership Exchange can use section 1311(a) cooperative agreement funds to: (1) build the infrastructure necessary to manage the network of Navigators in their state and (2) if the state is transitioning to a State-based Exchange, build and test Navigator programs to be used by the State-based Exchange. However, monies authorized under section 1311(a) of the Affordable Care Act cannot be used to fund Navigator grants.

In a State Consumer Partnership Exchange, Navigators will be funded through federal grants. It is legally required that HHS retain ultimate authority over the Navigator grant process, including selecting Navigator grantees and awarding Navigator grants, and the approval of grantee activities and budgets.

In-Person Assistance Programs

HHS anticipates that not all communities or eligible individuals will have easy access to a Navigator. Some communities may not have entities that apply to be Navigators, while other entities intending to serve specific communities may not be selected to receive a Navigator grant. To help ensure that consumers who need in-person assistance have access to such assistance from a State Consumer Partnership Exchange, the participating states will build additional programs, distinct and apart from the Navigator program, that will be available to help consumers in those states. The same training standards and training program that apply to Navigators will also apply to in-person assistance programs. As with Navigator training, states with a State Consumer Partnership Exchange will be able to supplement the HHS-developed training with state-specific modules for their in-person assistance programs.

The state will be responsible for developing, implementing, and managing a program consistent with 45 CFR 155.205 (d) and (e); for the State Consumer Partnership Exchange, such programs

[11] Exchanges Final Rule: 45 CFR 155.210 and 155.260

should also be consistent with guidance in the General Guidance on the FFE released earlier this year. HHS anticipates that states with a State Consumer Partnership Exchange could provide this assistance with state employees as well as through contracts or grants, funded by federal 1311 grants, made under state law. This will allow states (as applicable) to adjust the number of personnel as necessary during the course of the year to respond to consumer demand (for example: providing additional resources during initial or annual enrollment periods).

In a State Consumer Partnership Exchange, states will have broad authority to develop in-person assistance programs subject to guidance provided by HHS. In-person assistance programs are distinct from the Navigator program, and the state must support them in a manner that ensures coordination with the Navigator program in order to avoid duplication of effort.

States operating a State Consumer Partnership Exchange can use section 1311 funds to set up and fund first year costs for in-person assistance programs and are permitted, but not required, to contract with state consumer assistance programs[12] – such as those established under section 2793 of the Public Health Service Act – to perform these services. We note that these programs may not replace Exchange Navigator grant programs. Establishment and operation of a Navigator grant program is a minimum Exchange function for all Exchanges, including all State-based and Federally-facilitated Exchanges. In-person assistance programs and personnel may supplement Navigator programs and serve different distinct consumer assistance requirements of Exchanges.[13]

Interaction with Agents and Brokers

All states, regardless of what type of Exchange is in operation, can determine whether to permit agents and brokers to enroll consumers in QHPs through the Exchange. In addition, all states will continue to set standards for the agent and broker industry and to play their traditional role in licensing and overseeing agents and brokers.

Agents and brokers in all FFE states, including in states where a State Consumer Partnership Exchange is operating, will use the FFE agent and broker web portal, which will allow agents and brokers to sign an agreement with the Exchange[14] and complete Exchange training and registration. Agents and brokers are also eligible to serve as Navigators for a State Partnership Exchange. However, agents and brokers who choose to work as Navigators cannot be compensated for enrolling individuals into either QHPs or other non-QHP health insurance or health plans, consistent with 45 CFR 155.210(d)(4). HHS plans to issue further guidance on the role of agents and brokers in the Exchange.

---

[12] Exchange establishment cooperative Agreement Funding FAQ released June 29, 2012: http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html

[13] Exchange final rule 155.205(d): http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

[14] Exchange final rule 155.220(d): http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

Interaction with Consumer Assistance Programs (CAPs)

Through grants from HHS, over the past two years, CAPs have assisted consumers with private health insurance issues. This assistance ranges from helping consumers find appropriate health insurance to helping them file appeals with their issuers. Just as consumers today need help and have questions about their health plans, consumers in QHPs and in other private health plans will continue to need assistance with post-enrollment issues such as claim denials, billing issues, and incorrect cost sharing. Navigators are statutorily required to refer consumers with these types of concerns to programs, such as CAPs, for additional assistance.

Timing of Consumer Assistance

Although open enrollment for Exchanges begins on October 1, 2013, Exchange-related in-person outreach and education will ideally begin prior to that. Having a baseline understanding of health insurance will help consumers make plan selections in an Exchange. Consumers will also benefit from a basic understanding of Exchanges, QHPs, and affordability provisions prior to open enrollment so they can make informed choices about their health insurance options.

In order to conduct necessary outreach activities and help improve the health insurance literacy of consumers, it is recommended that in-person activities in State Consumer Partnership Exchanges begin in the summer of 2013. Once open enrollment begins, in-person consumer assistance will become a combination of both public education and enrollment assistance.

Consumer Partnership: Outreach and Education

The State Consumer Partnership Exchange allows states the opportunity to conduct outreach and education. States may develop and execute, with HHS approval, activities to promote the FFE as well as brand and promote in-person assistance programs, including Navigators.

To the extent permissible under applicable law, HHS will share consumer research with states via the Collaborative Application Lifecycle Tool (CALT), including branding and message testing among various audiences. States are encouraged to use this research in their outreach and education efforts, to test their outreach and education materials, to develop branding and messaging, and to conduct further testing.

Outreach and Education

We strongly encourage states participating in a State Consumer Partnership Exchange to engage local stakeholders in the role of information intermediaries, including coordination with other health and human service programs within the state to extend and broaden outreach. This might include providing referral information on applicant or enrollee notices, emails, websites, and through call center assistance.

States are encouraged to develop their own outreach and education materials and activities but can use materials developed by HHS as well. Such materials could include information regarding

eligibility and enrollment options, program information, benefits, and services available through the Exchange and other insurance affordability programs available within the state. The materials should be culturally and linguistically appropriate based upon the state's expertise with such populations. This includes making materials accessible to persons with limited English proficiency and disabilities.

HHS will work closely with states participating in the State Consumer Partnership Exchange to provide updates on its outreach and education plans as they are developed, to avoid duplication of efforts for planning and outreach purposes within the state. States can increase the intensity of consumer outreach efforts at the local level, taking into consideration the best strategies to reach the public and encourage enrollment in the Exchange. As a state starts transition to a State-based Exchange and receives conditional approval of its Exchange Blueprint, it may expand its online consumer presence to include broader education information beyond what is on the FFE website.

Branding

States participating in a State Consumer Partnership Exchange are encouraged to brand consumer assistance programs, including CAPs and Navigators, within their state and use these programs as a primary outreach channel in motivating consumers to seek in-person assistance. States may promote and brand the Navigator and in-person assistance programs within their states through various mechanisms, including state-branded in-person assistance websites, earned and paid media, and outreach to eligible consumers.

States may also develop strategies to promote the FFE website. While the name of the FFE program and the FFE website (URL) will not change state to state because all the FFEs (and State Partnership Exchanges) will share administrative infrastructure, there will be opportunities to include state-specific icons (such as a flag or seal) on state-specific sections of the FFE website. Additionally, while states may not alter the search engine optimization (SEO) on the FFE website, they could provide tailored search capabilities on any branded in-person assistance websites.

Timing and Deliverables

The following provides guidance on deliverables and the timeline for states participating in a State Consumer Partnership Exchange.

Deliverable from State to HHS in connection with a State Consumer Partnership Exchange	**Timeline**
Outreach and Education Plan with high-level timeline of strategies and execution dates	March 29, 2013
Paid and Earned Media Plan	June 15, 2013

Minimum Standards for State Activities and Deliverables for a State Consumer Partnership Exchange.

The Outreach and Education Plan should include a plan for developing:

- Consumer-focused content that clearly explains all consumer eligibility and enrollment options, program information, benefits, and services available.
- Content written in plain language, free of jargon and using active task-based labels whenever possible.
- Culturally and linguistically appropriate outreach methods
    a. If paid media is utilized, an overview including timing and channels (for example, television, radio, print, out-of-home, and online)
    b. A clear call to action referencing the FFE website.
- Education about :
    a. Eligibility and enrollment
    b. Program information
    c. Benefits and services available through the Exchange and other insurance affordability options
- Outreach and education targeted to various stakeholders.
- Performance metrics for tracking results
- Content development plans should include consumer testing, including testing among persons with limited English proficiency and persons with disabilities, to make sure content and language resonate with target audiences and should identify the types of auxiliary aids and services available and any language assistance services.

IV. HHS Role in a State Partnership Exchange

HHS will carry out all minimum Exchange functions not performed by states in the State Partnership Exchange, such as enrollment, establishment and maintenance of the Exchange Internet website, and the call center. In addition, HHS remains responsible for overall operation of the State Partnership Exchange and, as described in this document, will review the activities of the state. In response to the State Partnership Exchange options proposed earlier this year in the General Guidance on the FFE, a number of stakeholders requested a State Partnership Exchange option for a state to carry out activities for eligibility determinations. The Exchange final rule[15] establishes additional flexibility for Exchanges and states that is independent from a State Partnership Exchange regarding eligibility determinations; State-based Exchanges are encouraged to review those options. We also note that states can elect to perform, or use federal

[15] 45 CFR 155.302 of the Exchange final rule, available online at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

government services for, the reinsurance program. The risk adjustment program will be operated by HHS for any state without an approved State-based Exchange (*see* 45 CFR 153.310(a)(2)).

The federal government will be responsible for conducting stakeholder as well as regular and meaningful Tribal consultations consistent with the HHS Tribal Consultation Policy, in states with a State Partnership Exchange. It is expected that states will participate in stakeholder and Tribal consultations, and engage in discussions with stakeholders and federally recognized tribes regarding State Partnership Exchange functions that pertain to their plan management and consumer assistance activities. After each Tribal consultation and on an ongoing basis, it is expected that states and HHS will discuss feedback provided during the consultation sessions and how to address the comments in the context of the applicable State Partnership Exchange.

Initial Approval of a State Partnership Exchange

To operate a State Partnership Exchange in 2014, a state must complete the relevant portions of the Exchange Blueprint[16] and be approved or conditionally approved by HHS for the functions and activities the state will perform. State Partnership Exchange approval standards mirror State-based Exchange approval standards for plan management and the relevant consumer activities, and include standards related to sharing data and coordinating processes between the state and the Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange for the 2014 coverage year.

Federal Support of a State Partnership Exchange

The June 29, 2012 Frequently Asked Questions described how a state may receive funding for its start-up year expenses for activities related to establishing a State Partnership Exchange, as well as costs associated with transition to and establishment of a State-based Exchange[17]. After section 1311 grant funds to states are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed for a State Partnership Exchange on behalf of the FFE. Additionally, to the extent permissible under applicable law, HHS intends to make HHS-developed tools and other resources available to states participating in either a State Partnership Exchange or State-based Exchange.

Transition from a State Partnership Exchange to an State-based Exchange in Future Years

States that seek HHS approval to operate a State-based Exchange for coverage years beginning after January 1, 2014 (for example, January 1, 2015) should follow the same process and similar timeframes for states seeking to operate an Exchange beginning in January 1, 2014. For example, a state operating a State Partnership Exchange for plan year 2014 that intends to transition to a State-based Exchange for plan year 2015 will submit a Declaration Letter and a Blueprint Application to HHS by November 18, 2013.

---

[16] http://cciio.cms.gov/resources/files/hie-blueprint-11162012.pdf

[17] http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012 html.

States are encouraged to notify HHS of their intent to transition between Exchange models as early as possible to ensure a seamless transition process, which will likely include developing appropriate transitional procedures and processes. When approved as a State-based Exchange, the state would assume the flexibility and responsibilities of that model under the Affordable Care Act and associated regulations.

Conclusion

A State Partnership Exchange provides opportunities for states to shape the implementation of Exchanges for their residents. Because the statute does not provide for divided authority or responsibility between states and the federal government, HHS developed the State Partnership Exchange options to maximize state participation and responsibility within this legal framework. In areas for which HHS cannot completely delegate responsibility to a state that participates in a State Partnership Exchange, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS.

We look forward to working with states and other stakeholders, including consumers, healthcare providers, issuers, tribes, and other groups to implement State Partnership Exchanges in a manner that achieves our shared goal of increasing access to affordable, high-quality coverage. We welcome public comment on the State Partnership Exchange described in this document.

Appendix A: HHS Approach for Certification of FFE QHPs for the 2014 Coverage Year

Note: with regard to market-wide reforms, HHS will defer to state approvals that are done consistently with federal regulations and guidance (in the table, such deferrals are summarized as "confirm"). Otherwise, HHS will perform the review for the FFE.

	Statutory/Regulatory Standard	HHS Approach for Certification of QHPs
Standards that Apply to All Non-grandfathered Individual and Small Group Plans		
EHB standards*	Issuer offers coverage that is substantially equal to the coverage offered by the benchmark plan (45 CFR 156.115).	• Confirm that issuer offers coverage that is substantially equal to benchmark plan**; • If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits**; and • Collect issuer attestation of compliance with all EHB standards.
EHB Formulary review*	Plan covers at least the greater of: 1. One drug in every USP category and class; OR 2. The same number of drugs in each category and class as benchmark plan. (45 CFR 156.120)	• Confirm the number of drugs per category and class**; and • Collect issuer attestation of compliance with EHB formulary standards.
Prohibition on Discrimination	An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125).	• Confirm review for non-discrimination. If state has not reviewed, conduct outlier test to identify potentially discriminatory benefit designs**. • Collect issuer attestation of compliance with non-discrimination standards.
AV standards*	Offers plans at metal levels specified in statute (45 CFR 156.135).	Confirm that the AV for each QHP meets specified levels (or falls within allowable variation): • Bronze plan: 60% (58 to 62%) • Silver plan: 70% (68 to 72%) • Gold plan: 80% (78 to 82%) • Platinum plan: 90% (88 to 92%) Review for unique plan designs, if applicable.
Standards that Apply to QHPs Seeking Exchange Certification		
Licensure and solvency	Licensed by and in good standing with the state (45 CFR 156.200(b)(4)).	• Confirm that state has licensed the issuer and determined that the issuer is in good standing; or • Collect issuer attestation to meeting state licensure and solvency requirements.
Network adequacy	Network includes sufficient number and types of providers (including providers that treat substance abuse and mental health conditions) to ensure that all services are available without unreasonable delay (45 CFR 156.230). Note: also applies to stand-	Collect attestation that issuer meets standard **plus** one of the following: • If HHS determines that state has an effective network adequacy review***, HHS will confirm that the state has approved the issuer's network; • If HHS determines that a state does not have

	alone dental plans.	an effective network adequacy review, HHS will accept the issuer's attestation alone if the issuer is accredited for an existing line of business (commercial or Medicaid) by an HHS-recognized accrediting entity; or • If HHS determines that a state does not have an effective network adequacy review and the issuer is not accredited, HHS will collect an access plan for the QHP. HHS will also collect provider network data from a sampling of selected issuers following certification, and will also monitor accessibility complaints. Obtain link to issuer's provider directory for display on the Exchange website.
Inclusion of ECPs	Network includes sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs (45 CFR 156.235). Note: also applies to stand-alone dental plans.	Based on HHS-developed ECP list, verify one of the following: • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers****; • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by CMS. The above standard is a transitional policy to accommodate first year timeframes.
	Issuer that provides a majority of covered services through employed physicians or a single contracted medical group complies with the alternate standard established by the Exchange (45 CFR 156.235(b)).	Verify one of the following: • Issuer has at least the same number of providers located in designated low-income areas[18] as the equivalent of at least 20% of available ECPs in the service area; • Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification

[18] HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

		as part of its Issuer Application; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. The above standard is a transitional policy to accommodate first year timeframes.
Marketing	Complies with state marketing laws and regulations (45 CFR 156.225(a)).	• Collect issuer attestation to meeting state marketing standards.
Accreditation*	Be accredited based on local performance by an accrediting entity recognized by HHS on the timeline established for an FFE (45 CFR 155.1045). Issuers must authorize the release of their accreditation survey data.	• Verify that issuer meets FFE accreditation timeline requirements. • Collect and verify information on issuers' existing accreditation (if applicable). • Verify that issuer has authorized release of accreditation data.
Service area	The service area of a QHP must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations (45 CFR 155.1055).	Conduct automated check to identify partial-county requests. If a partial county request is identified, conduct case-by-case manual review of justification**.
Rate increases for QHPs	Exchange must review all rate increases and justifications, along with recommendations provided under Public Health Service Act section 2794(b) and rate increase trends inside and outside the Exchange, and take such information into consideration when making QHP certification determinations (45 CFR 155.1020(b)).	Confirm the results of Effective Rate Review programs.
Non-discrimination	Issuer does not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation (45 CFR 156.200(e)).	Collect issuer attestation to meeting regulatory standards.
Non-discrimination	QHP issuer does not employ benefit designs that will discourage the enrollment of individuals with significant health needs (45 CFR 156.225(b)).	• Conduct outlier analysis or other automated test to identify possible discriminatory benefits**. • Review benefit designs identified outliers and/or results of automated test.

		• Collect issuer attestation to meeting regulatory standards.
Plan Variations for Individuals Eligible for Cost-Sharing Reductions and for American Indian/Alaska Native Populations*	Issuer must offer three silver plan variations for each silver QHP, and one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation.	Conduct automated review via rate and benefit templates. Review AV for non-standard plan designs using approach described above.

*These standards are currently the subject of regulatory proposals and their inclusion here is subject to adoption of final rules that are consistent with the proposals.

**To the extent permissible under applicable law, HHS will make available an analytic tool, analytic parameters, or other resources (e.g., scenarios) to support states.

***HHS would determine whether a state has an effective network adequacy review based upon whether the state has statutory authority to review issuers' networks, and whether the authority allows the state to determine whether the issuer/health plan maintains a network sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay.

****Contracts offered must reflect the generally applicable payment rates of the issuer, and must account for the payments to FQHCs under 1902(bb), unless the FQHC and issuer mutually agree on other rates. Contracts offered to Indian providers are encouraged include the QHP Addendum for Indian providers.

Exhibit 3

STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000

EARL RAY TOMBLIN
GOVERNOR

February 15, 2013

The Honorable Kathleen Sebelius, Secretary
United States Department of Health and Human Services
200 Independence Avenue SW, Suite 739H
Washington DC, 20201

Dear Secretary Sebelius:

Please accept this letter as acknowledgement that the State of West Virginia has the intent to participate in a State Partnership Exchange (SPE) in Plan Management and for components of Consumer Assistance for plan year 2014. West Virginia does not intend to develop a large scale marketing campaign promoting the health benefit exchange. Additionally, West Virginia does not intend to manage the day to day activities of federal Navigators. Finally, West Virginia does not intend to operate the reinsurance program for plan year 2014.

West Virginia retains the ability to modify the stated intent to proceed in a State Partnership Exchange until appropriate State analysis of forthcoming federal rules and guidance occurs. In addition, the State will only proceed with SPE operations as long as sufficient federal funding is available to cover all SPE costs. Furthermore, West Virginia will continue to evaluate all available options concerning the Health Benefit Exchange so as to ensure that the most fiscally prudent and consumer-conscious approach is adopted in West Virginia.

The Health Benefit Exchange and other provisions of the Patient Protection and Affordable Care Act will have significant implications for West Virginia. My administration is committed to maintaining the sound fiscal stewardship that has been the hallmark of our State for 25 years. We are also committed to improving population health so as to enhance the quality of life of our citizens and to reduce the cost from poor health felt by families, businesses, and taxpayers.

OFFICE OF THE GOVERNOR

The West Virginia Offices of the Insurance Commissioner, headed by Commissioner Mike Riley, will be the primary agency in charge of Exchange activities in West Virginia. Jeremiah Samples, Director of Health Policy for the Insurance Commission, will be the point of contact with HHS regarding our application and other Exchange implementation issues. Ms. Nancy Atkins will be the point of contact for Medicaid eligibility determination issues. Ms. Sharon Carte will be the point of contact for CHIP related issues.

Thank you,

Earl Ray Tomblin

Earl Ray Tomblin
Governor of West Virginia

ERT: ko

Exhibit 4

Table 1. CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage

EFFECTS ON INSURANCE COVERAGE[a]		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
(Millions of nonelderly people, by calendar year)												
Prior-Law Coverage[b]	Medicaid and CHIP	35	34	34	33	33	33	33	34	34	34	34
	Employment-Based	156	157	159	161	164	165	166	167	167	168	169
	Nongroup and Other[c]	25	25	26	26	27	27	27	27	28	28	28
	Uninsured[d]	57	57	57	56	56	55	55	56	56	56	56
	TOTAL	272	274	276	277	279	281	282	284	285	286	288
Change	Medicaid and CHIP	1	9	12	12	12	12	12	13	13	13	13
	Employment-Based[e]	2	*	-2	-6	-6	-7	-7	-7	-7	-7	-7
	Nongroup and Other[c]	*	-2	-3	-4	-5	-5	-5	-5	-5	-5	-5
	Insurance Exchanges	0	7	13	22	24	25	25	24	25	24	24
	Uninsured[d]	-2	-14	-20	-25	-25	-25	-25	-25	-25	-25	-25
Uninsured Under the Affordable Care Act												
Number of Uninsured Nonelderly People[d]		55	44	37	31	30	30	30	30	31	31	31
Insured Share of the Nonelderly Population[a]												
Including All Residents		80%	84%	86%	89%	89%	89%	89%	89%	89%	89%	89%
Excluding Unauthorized Immigrants		82%	86%	89%	91%	92%	92%	92%	92%	92%	92%	92%
Memo: Exchange Enrollees and Subsidies												
Number with Unaffordable Offer from Employer[f]			*	*	*	1	1	1	1	1	1	1
Number of Unsubsidized Exchange Enrollees			1	2	4	4	5	5	5	5	5	5
Average Exchange Subsidy per Subsidized Enrollee			$5,290	$5,330	$5,350	$5,590	$5,990	$6,240	$6,720	$7,060	$7,460	$7,900

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) and, in the case of this document, the effects of subsequent related judicial decisions, statutory changes, and administrative actions.

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; * = between 500,000 and -500,000 people.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia who are younger than 65.

b. Figures reflect average enrollment over the course of a year; individuals reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of the Affordable Care Act, which is now current law, changes in coverage are shown compared with coverage projections in the absence of that legislation, or "prior law."

c. The effects are almost entirely for nongroup coverage; "other" includes Medicare.

d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for but not enrolled in Medicaid.

e. The change in employment-based coverage is the net result of projected increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and another 3 million people will have an offer of employment-based coverage but will enroll in health insurance from another source instead. These flows out of employment-based coverage will be partially offset by an estimated 7 million people who will newly enroll in employment-based coverage under the Affordable Care Act.

f. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

Table 2. CBO's May 2013 Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act

(Billions of dollars, by fiscal year)

EFFECTS ON THE FEDERAL DEFICIT[a,b]	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total, 2014-2023
Medicaid and CHIP Outlays[c]	1	21	41	62	70	76	80	83	87	92	98	710
Exchange Subsidies and Related Spending[d]	4	26	51	87	108	118	123	129	137	143	151	1,075
Small-Employer Tax Credits[e]	1	1	2	1	1	1	1	1	2	2	2	14
Gross Cost of Coverage Provisions	6	48	94	151	179	195	205	214	226	237	250	1,798
Penalty Payments by Uninsured Individuals	0	0	-2	-4	-5	-5	-5	-5	-6	-6	-6	-45
Penalty Payments by Employers[e]	0	0	-10	-11	-14	-15	-16	-17	-18	-19	-20	-140
Excise Tax on High-Premium Insurance Plans[e]	0	0	0	0	0	-5	-9	-11	-14	-18	-22	-80
Other Effects on Tax Revenues and Outlays[f]	*	1	1	-6	-14	-20	-23	-24	-26	-28	-31	-171
NET COST OF COVERAGE PROVISIONS	**6**	**49**	**83**	**130**	**146**	**151**	**151**	**156**	**161**	**166**	**170**	**1,363**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) and, in the case of this document, the effects of subsequent related judicial decisions, statutory changes, and administrative actions.

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; * = between zero and -$500 million.

a. Excludes effects on the deficit of other provisions of the act that are not related to coverage, which in the aggregate reduce deficits. Also excludes federal administrative costs subject to appropriation. CBO has previously estimated that the Internal Revenue Service will need to spend between $5 billion and $10 billion over 10 years to implement the Affordable Care Act and that the Department of Health and Human Services and other federal agencies also will have to spend $5 billion to $10 billion over that period. In addition, the Affordable Care Act included explicit authorizations for spending on a variety of grant and other programs; that funding is also subject to future appropriation action.

b. Negative numbers indicate a decrease in the deficit; positive numbers indicate an increase in the deficit.

c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2014-2023 period would increase by about $65 billion as a result of the coverage provisions of the Affordable Care Act.

d. Includes spending for high-risk pools, premium review activities, loans to consumer-operated and -oriented plans, and grants to states for the establishment of exchanges.

e. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

f. The effects are almost entirely on revenues. CBO estimates that outlays for Social Security benefits would increase by about $7 billion over the 2014-2023 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

Table 3. Health Insurance Exchanges: CBO's May 2013 Baseline

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total, 2014-2023
EXCHANGE ENROLLMENT[a]	Millions of People, by Calendar Year											
Individually Purchased Coverage												
Subsidized	0	6	11	19	20	20	20	20	20	19	19	
Unsubsidized[b]	0	1	2	4	4	5	5	5	5	5	5	
TOTAL	0	7	13	22	24	25	25	24	25	24	24	
Employment-Based Coverage												
Purchased Through Exchanges[b]	0	2	2	3	4	4	4	4	4	4	4	
DIRECT SPENDING	Billions of Dollars, by Fiscal Year											
Premium Credit Outlays	0	16	35	63	79	88	92	97	103	109	115	796
Cost-Sharing Subsidies	0	4	8	13	15	16	17	17	18	19	21	149
Related Spending[c]	4	3	2	*	*	*	*	*	*	*	*	5
TOTAL	4	23	44	76	95	104	108	115	122	128	135	950
ADDITIONAL INFORMATION												
Premium Credit Revenue Reductions (Billions of dollars)	0	3	7	11	13	14	15	15	15	15	16	124
Total, Exchange Subsidies and Related Spending	4	26	51	87	108	118	123	129	137	143	151	1,075
Total Exchange Subsidies by Calendar Year (Billions of dollars)	0	33	57	100	112	121	124	132	139	145	153	1,115
Average Exchange Subsidy per Subsidized Enrollee (Dollars)	$0	$5,290	$5,330	$5,350	$5,590	$5,990	$6,240	$6,720	$7,060	$7,460	$7,900	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Numbers may not add up to totals because of rounding; * = between zero and $500 million.

a. Figures reflect the average enrollment over the course of a year and include spouses and dependents covered by family policies.

b. Does not include coverage purchased directly from insurers outside of the exchange system.

c. Includes spending for grants to states for the establishment of exchanges. Also includes spending for high-risk pools, premium review activities, and loans to consumer-operated and -oriented plans -- none of those items are included in "Health insurance subsidies and related spending" in Table 2 of *Updated Budget Projections: Fiscal Years 2013 to 2023, May 2013.*

Exhibit 5

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 30, 2009

Honorable Evan Bayh
United States Senate
Washington, DC 20510

Dear Senator:

The attachment to this letter responds to your request—and the interest expressed by many other Members—for an analysis of how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Specifically, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation have analyzed how health insurance premiums might be affected by enactment of the Patient Protection and Affordable Care Act, as proposed by Senator Reid on November 18, 2009.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

Douglas W. Elmendorf

Attachment

cc: Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Congressional Budget Office

An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act

November 30, 2009

There is great interest in how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Consequently, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have analyzed how those premiums might be affected by the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590, as proposed by Senator Reid on November 18, 2009. The analysis looks separately at the effects on premiums for coverage purchased individually, coverage purchased by small employers, and coverage provided by large employers.

Key Elements of the Proposed Legislation

The proposal includes many provisions that would affect insurance premiums:

- New policies purchased from insurers individually (in the "nongroup" market) or purchased by small employers would have to meet several new requirements starting in 2014. Policies would have to cover a specified set of services and to have an "actuarial value" of at least 60 percent (meaning that the plan would, on average, pay that share of the costs of providing covered services to a representative set of enrollees). In addition, insurers would have to accept all applicants during an annual open-enrollment period, and insurers could not limit coverage for preexisting medical conditions. Moreover, premiums could not vary to reflect differences in enrollees' health or use of services and could vary on the basis of an enrollee's age only to a limited degree.

- A less extensive set of changes would be implemented more quickly and would continue in effect after 2013. Among other changes, health insurance plans: could not impose lifetime limits on the total amount of services covered; could rescind coverage only for certain reasons; would have to cover certain preventive services with no cost sharing; and would have to allow unmarried dependents to be covered under their parents' policies up to age 26. Those changes would also apply to new coverage provided by large employers, including firms that "self-insure"—meaning that the firm, rather than an insurer, bears the financial risk of providing coverage.

However, current policies that had been purchased in any of those markets or that were offered by self-insured firms would be exempt from all of those changes if they were maintained continuously—that is, policies held since the date of enactment of the legislation would be "grandfathered."

In addition, the proposal would: establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance "exchanges" through which certain individuals and families could receive federal subsidies to substantially reduce the amount they would pay to purchase that coverage; make a public insurance plan available through those exchanges in certain states; penalize certain individuals if they did not obtain insurance coverage and penalize certain employers if their workers received subsidies through the exchanges; provide tax credits to certain small employers that offer coverage to their workers; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); levy an excise tax on insurance plans with relatively high premiums; impose fees on insurers and on manufacturers and importers of certain drugs and medical devices; and make various other changes to the federal tax code and to Medicare, Medicaid, and other federal programs. Each of those components of the legislation has the potential to affect the premiums that are charged for insurance, directly or indirectly; some would increase premiums, and others would decrease them.

Overview of the Analysis

In general, the premium for a health insurance policy equals the average amount that an insurer expects to pay for services covered under the plan plus a loading factor that reflects the insurer's administrative expenses and overhead (including any taxes or fees paid to the government) and profits (for private plans). An insurer's costs for covered services reflect the scope of benefits that are covered, the plan's cost-sharing requirements, the enrollees' health status and tendency to use medical services, the rates at which providers are paid, and the degree of benefit management the insurer uses to restrain spending. Although the factors affecting premiums are complex and interrelated—and thus can be difficult to disentangle—this analysis groups the effects of the proposal on premiums into three broad categories:

- Differences in the amount of insurance coverage purchased,
- Differences in the price of a given amount of insurance coverage for a given group of enrollees, and
- Differences in the types of people who obtain coverage in each insurance market.

CBO and JCT estimated the effect of the legislation on premiums in three broad insurance markets—nongroup, small group, and large group—as well as the

contributions to the changes in premiums from each of those three sources of change. Several aspects of the analysis bear emphasis:

- The analysis focuses on the effects of the legislation on the average premium *per person*—that is, per covered life, including dependents covered by family policies. That approach provides an integrated measure of the impact on premiums for single coverage and family coverage, and those effects are expressed as percentage changes in average premiums. The analysis also summarizes the effects of the proposal on the dollar cost of the average premium *per policy* (rather than per insured person) and presents those effects separately for individual and family policies in each market.[1]

- Many individuals and families would experience changes in premiums that differed from the changes in average premiums in their insurance market.[2] As explained below, some provisions of the legislation would tend to decrease or increase the premiums paid by all insurance enrollees, while other provisions would tend to increase the premiums paid by healthier enrollees relative to those paid by less healthy enrollees or would tend to increase the premiums paid by younger enrollees relative to those paid by older enrollees. As a result, some individuals and families within each market would see changes in premiums that would be larger or smaller than, or be in the opposite direction of, the estimated average changes.

- The analysis examines the effects of the proposal in 2016 in order to indicate the impact that it would have once its provisions were fully implemented. To focus on permanent elements of the legislation, however, the estimates exclude the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only (which would be funded by an assessment on insurers).

- The analysis focuses on the effects of the legislation on total health insurance premiums that would be charged to individuals or employers before accounting for premium subsidies or the small business tax credit. The analysis also reports the effects of the legislation on the amounts the purchasers would ultimately have to pay, after accounting for those two forms of assistance. However, even when examining unsubsidized

[1] In some cases, the translation from premiums per person to premiums per policy is complex. To the extent that proposals change the average number of enrollees in a family policy, the premium per person in family coverage could increase even as the premium per policy decreased (for example, if fewer children were covered); conversely, the average premium per person could decrease even as the premium per policy increased (for example, if more children were covered).

[2] Consistent with CBO and JCT's earlier estimate of the coverage and budgetary effects of the insurance coverage provisions in this proposal, this analysis addresses coverage of the nonelderly resident population.

premiums, the analysis incorporates the effects of those subsidies (as well as existing tax preferences) on the number and types of people who would obtain coverage in each market, because those effects would have an important impact on the total premiums charged.

- The analysis does not incorporate potential effects of the proposal on the level or growth rate of spending for health care that might stem from increased demand for services brought about by the insurance expansion or from the development and dissemination of less costly ways to deliver care that would be encouraged by the proposal. The impact of such "spillover" effects on health care spending and health insurance premiums is difficult to quantify precisely, but the effect on premiums in 2016 would probably be small.

This analysis contains several sections. The next section summarizes the findings. The following three sections describe the estimated effects of the legislation on total premiums paid to insurers through its effects on the amount of insurance coverage obtained, the price of a given amount of insurance coverage for a given group of enrollees, and the type of people who obtain coverage. A subsequent section analyzes the effect of the proposal on the net cost of obtaining insurance, taking into account both the subsidies that would be available to individuals for insurance purchased through the exchanges and the tax credits that would be provided to small businesses. The penultimate section discusses the effects of the excise tax on insurance policies with relatively high premiums (the effects of which are accounted for separately because they would apply only to a portion of the market for employment-based insurance in 2016). A final section briefly discusses some potential effects of the proposal that are not included in the quantitative analysis.

Summary of Findings

The effects of the proposal on premiums would differ across insurance markets (see Table 1). The largest effects would be seen in the nongroup market, which would grow in size under the proposal but would still account for only 17 percent of the overall insurance market in 2016. The effects on premiums would be much smaller in the small group and large group markets, which would make up 13 percent and 70 percent of the total insurance market, respectively.

Nongroup Policies

CBO and JCT estimate that the average premium per person covered (including dependents) for new nongroup policies would be about 10 percent to 13 percent higher in 2016 than the average premium for nongroup coverage in that same year under current law. About half of those enrollees would receive government subsidies that would reduce their costs well below the premiums that would be charged for such policies under current law.

Table 1.

Effect of Senate Proposal on Average Premiums for Health Insurance in 2016

	Percentage, by Market		
	Nongroup[a]	Small Group[b]	Large Group[c]
Distribution of Nonelderly Population Insured in These Markets Under Proposal	17	13	70
Differences in Average Premiums Relative to Current Law Due to:			
Difference in Amount of Insurance Coverage	+27 to +30	0 to +3	Negligible
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	-7 to -10	-1 to -4	Negligible
Difference in Types of People with Insurance Coverage	-7 to -10	-1 to +2	0 to -3
Total Difference Before Accounting for Subsidies	+10 to +13	+1 to -2	0 to -3
Effect of Subsidies in Nongroup and Small Group Markets			
Share of People Receiving Subsidies[d]	57	12	n.a.
For People Receiving Subsidies, Difference in Average Premiums Paid After Accounting for Subsidies	-56 to -59	-8 to -11	n.a.
Effect of Excise Tax on High-Premium Plans Sponsored by Employers			
Share of People Who Would Have High-Premium Plans Under Current Law	n.a.	19	
For People Who Would Have High-Premium Plans Under Current Law, Difference in Average Premiums Paid[e]	n.a.	-9 to -12	
Memorandum			
Number of People Covered Under Proposal (Millions)	32	25	134

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: n.a. = not applicable.

a. The nongroup market includes people purchasing coverage individually either in the proposed insurance exchanges or in the individual insurance market outside the insurance exchanges.

b. The small group market includes people covered in plans sponsored by firms with 50 or fewer employees.

c. The large group market includes people covered in plans sponsored by firms with more than 50 employees.

d. Premium subsidies in the nongroup market are those available through the exchanges. Premium subsidies in the small group market are those stemming from the small business tax credit.

e. The effect of the tax includes both the increase in premiums for policies with premiums remaining above the excise tax threshold and the reduction in premiums for those choosing plans with lower premiums.

That difference in unsubsidized premiums is the net effect of three changes:

- Average premiums would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained. In particular, the average insurance policy in this market would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits. Those expansions would reflect both the minimum level of coverage (and related requirements) specified in the proposal and people's decisions to purchase more extensive coverage in response to the structure of subsidies.

- Average premiums would be 7 percent to 10 percent lower because of a net reduction in costs that insurers incurred to deliver the same amount of insurance coverage to the same group of enrollees. Most of that net reduction would stem from the changes in the rules governing the nongroup market.

- Average premiums would be 7 percent to 10 percent lower because of a shift in the types of people obtaining coverage. Most of that change would stem from an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed.[3]

Average premiums per policy in the nongroup market in 2016 would be roughly $5,800 for single policies and $15,200 for family policies under the proposal, compared with roughly $5,500 for single policies and $13,100 for family policies under current law.[4] The weighted average of the differences in those amounts equals the change of 10 percent to 13 percent in the average premium *per person* summarized above, but the percentage increase in the average premium *per policy* for family policies is larger and that for single policies is smaller because the average number of people covered per family policy is estimated to increase under the proposal. The effects on the premiums paid by some individuals and families could vary significantly from the average effects on premiums.

Those figures indicate what enrollees would pay, on average, not accounting for the new federal subsidies. The majority of nongroup enrollees (about 57 percent) would receive subsidies via the new insurance exchanges, and those subsidies, on average, would cover nearly two-thirds of the total premium, CBO and JCT

[3] Although the effects of each factor should be multiplied rather than added in order to generate the total effect on premiums, there are also interactions among the three factors that make the sum of the individual effects roughly equal to the total effect. The ranges shown for the likely effects of each factor and for the likely overall effect on premiums were chosen to reflect the uncertainties involved in the estimates; however, the actual effects could fall outside of those ranges.

[4] Because of an error, the figures for average nongroup premiums in 2016 under current law that were reported in CBO's September 22, 2009, letter to Senator Baucus on this subject (which had been reported as being about $6,000 for single coverage and about $11,000 for family coverage) were not correct.

estimate. Thus, the amount that subsidized enrollees would pay for nongroup coverage would be roughly 56 percent to 59 percent lower, on average, than the nongroup premiums charged under current law. Among nongroup enrollees who would *not* receive new subsidies, average premiums would increase by somewhat less than the 10 percent to 13 percent difference for the nongroup market as a whole because some factors discussed below would have different effects for those enrollees than for those receiving subsidies.

The amount of subsidy received would depend on the enrollee's income relative to the federal poverty level (FPL) according to a specified schedule (see Table 2, appended).[5] Under the proposal, the subsidy levels in each market would be tied to the premium of the second cheapest plan providing the "silver" level of coverage (that is, paying 70 percent of enrollees' covered health care costs, on average). CBO and JCT have estimated that, in 2016, the average premium nationwide for those "reference plans" would be about $5,200 for single coverage and about $14,100 for family coverage. The difference between those figures and the average nongroup premiums under the proposal that are cited above ($5,800 and $15,200, respectively) reflects the expectation that many people would opt for a plan that was more expensive than the reference plan, to obtain either a higher amount of coverage or other valued features (such as a broader network of providers or less tightly managed benefits).

Employment-Based Coverage

The legislation would have much smaller effects on premiums for employment-based coverage, which would account for about five-sixths of the total health insurance market. In the small group market, which is defined in this analysis as consisting of employers with 50 or fewer workers, CBO and JCT estimate that the change in the average premium per person resulting from the legislation could range from an increase of 1 percent to a reduction of 2 percent in 2016 (relative to current law).[6] In the large group market, which is defined here as consisting of employers with more than 50 workers, the legislation would yield an average premium per person that is zero to 3 percent lower in 2016 (relative to current law). Those overall effects reflect the net impact of many relatively small changes, some of which would tend to increase premiums and some of which would tend to reduce them (as shown in Table 1).[7]

---

[5] Table 2 reproduces the table included in Congressional Budget Office, letter to the Honorable Harry Reid providing an analysis of subsidies and payments at different income levels under the Patient Protection and Affordable Care Act (November 20, 2009).

[6] Under the proposal, the small group market in 2016 would be defined to include firms with 100 or fewer employees, but the threshold for the exemption from the penalties imposed on employers would be set at 50 full-time employees. Because the proposal would have similar effects on premiums for large and small employers, reclassifying firms with 51 to 100 workers as small employers for purposes of this analysis would probably have little effect on the overall results, though the factors affecting premiums for those firms would be somewhat different.

[7] Because the aggregate amount of premiums for employment-based plans is large, even small percentage changes can have noticeable effects on the federal budget through their effects on the amount of compensation excluded from taxation because of the tax preference that applies to those premiums.

By CBO and JCT's estimate, the average premium per policy in the small group market would be in the vicinity of $7,800 for single policies and $19,200 for family policies under the proposal, compared with about $7,800 and $19,300 under current law. In the large group market, average premiums would be roughly $7,300 for single policies and $20,100 for family policies under the proposal, compared with about $7,400 and $20,300 under current law.[8] As in the nongroup market, the effects on the premiums paid by some people for coverage provided through their employer could vary significantly from the average effects on premiums, particularly in the small group market.

Those figures do not include the effects of the small business tax credit on the cost of purchasing insurance. A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016. For those people, the cost of insurance under the proposal would be about 8 percent to 11 percent lower, on average, compared with that cost under current law.

The reductions in premiums described above also exclude the effects of the excise tax on high-premium insurance policies offered through employers, which would have a significant impact on premiums for the affected workers but which would affect only a portion of the market in 2016.[9] Specifically, an estimated 19 percent of workers with employment-based coverage would be affected by the excise tax in that year. Those individuals who kept their high-premium policies would pay a higher premium than under current law, with the difference in premiums roughly equal to the amount of the tax. However, CBO and JCT estimate that most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums; those reductions would result from choosing plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services.[10] On balance, the average premium among the affected workers would be about 9 percent to 12 percent less than under current law. Those figures incorporate the other effects on premiums for employment-based plans that were summarized above.

---

[8] Those calculations also reflect an expectation that a large share of enrollees in employment-based plans would be in grandfathered plans throughout the 2010–2019 period.

[9] Beginning in 2013, insurance policies with relatively high premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. That threshold would be set initially at $8,500 for single policies and $23,000 for family policies (with certain exceptions); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

[10] CBO and JCT assume that, if employers reduce the amount of compensation they provide in the form of health insurance (relative to current-law projections), offsetting changes will occur in other forms of compensation, which are generally taxable.

Uncertainty Surrounding These Estimates

The analysis presented here reflects the cost estimate for the legislation that CBO and JCT provided on November 18. The same substantial degree of uncertainty that surrounds CBO and JCT's estimates of the impact that the proposal would have on insurance coverage rates and the federal budget also accompanies this analysis of the proposal's effects on premiums. Some components of those effects are relatively straightforward to estimate, such as the effect of imposing specific fees or the effect of a change in the amount of coverage purchased because of requirements for minimum coverage; however, estimating effects that depend heavily on how enrollees, insurers, employers, or other key actors would respond—to such things as the changes in the market rules for nongroup policies or the excise tax on high-premium policies—involve greater uncertainty. The projections of average premiums in each market under current law are also uncertain.

Differences in the Amount of Coverage Purchased

One key factor contributing to the differences in average insurance premiums under the proposal is differences in the average amount of coverage purchased. Those differences reflect differences in both the *scope* of insurance coverage—the benefits or services that are included—and in the *share of costs* for covered services paid by the insurer—known as the actuarial value. With other factors held equal, insurance policies that cover more benefits or services or have a higher actuarial value (by requiring smaller copayments or deductibles) have higher premiums, while policies that cover fewer benefits or services or specify larger copayments or deductibles have lower premiums.

The main elements of the legislation that would affect the amount of coverage purchased are the requirement that all new policies in the nongroup and small group markets cover at least a minimum specified set of benefits; the requirement that such policies have a certain minimum actuarial value; and the design of the federal subsidies, which would encourage many enrollees in the exchanges to join plans with an actuarial value above the required minimum. (The excise tax on high-premium plans would also affect the amount of coverage purchased; the impact of that tax is discussed in a separate section of this analysis.) Those provisions would have a much greater effect on premiums in the nongroup market than in the small group market, and they would have no measurable effect on premiums in the large group market.

Specifically, because of the greater actuarial value and broader scope of benefits that would be covered by new nongroup policies sold under the legislation, the average premium per person for those policies would be an estimated 27 percent to 30 percent higher than the average premium for nongroup policies under current law (with other factors held constant). The increase in actuarial value would push the average premium per person about 18 percent to 21 percent above its level under current law, before the increase in enrollees' use of medical care resulting from lower cost sharing is considered; that induced increase, along with

the greater scope of benefits, would account for the remainder of the overall difference.

In the small group market, the greater actuarial value and broader scope of benefits provided for in the legislation would increase the average premium per person by about zero to 3 percent (leaving aside the effect of the excise tax on high premium plans, which is discussed separately, and holding other factors constant). Those requirements would have no noticeable effect on premiums in the large group market (again, excluding the effect of the high-premium excise tax).

A Broader Scope of Benefits Would Increase Nongroup Premiums

Under the legislation, new nongroup policies would cover a broader scope of benefits than are projected to be covered by such policies, on average, under current law. In particular, the legislation would require all new nongroup policies to cover a specified set of "essential health benefits," which would be further delineated by the Secretary of Health and Human Services (HHS) and would be required to match the scope of benefits provided by typical employment-based plans. As a result, new nongroup policies would cover certain services that are often not covered by nongroup policies under current law, such as maternity care, prescription drugs, and mental health and substance abuse treatment. Moreover, nongroup insurers would be prohibited from denying coverage for preexisting conditions, so premiums would have to increase to cover the resulting costs.

An additional consideration relates to state-mandated benefits. Under the proposal, states that mandated coverage of benefits beyond those required by the new federal rules would have to pay any costs of subsidizing those additional benefits. CBO and JCT assumed that, to the extent that states continued to mandate such benefits, they would make the resulting payments directly to insurers—so those costs would not be reflected in the premiums that enrollees observed when shopping for insurance in the exchanges. The reduction in premiums (relative to those under current law) resulting from this provision would be relatively small because many benefits that states mandate are already provided by typical employment-based plans and thus would be included in the "essential health benefits" that the proposal would require nongroup policies to cover.[11]

The legislation would further require that policies sold in the small group market cover the same minimum set of benefits as those sold in the nongroup market. That requirement would have relatively little effect on premiums in the small group market, however, because most policies sold in that market already cover those services and would continue to cover them under current law. Further, small group policies that are maintained continuously would be grandfathered under the proposal.

[11] For an additional discussion of the average incremental cost of state-mandated benefits, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), p. 61.

A Greater Actuarial Value Would Increase Nongroup Premiums

Under the legislation, new nongroup policies purchased after 2013 would have a substantially greater actuarial value, on average, than nongroup policies purchased under current law. Policies sold in the nongroup market are expected to have an average actuarial value of about 60 percent under current law, and new nongroup policies would be required to have an actuarial value of at least 60 percent (the level specified for the "bronze" plan) under the proposal. However, federal premium subsidies would be tied to a "reference premium" equal to the premium of the second lowest cost "silver" plan, which would have an actuarial value of 70 percent, and plans would also be available with actuarial values of 80 percent ("gold" plan) and 90 percent ("platinum" plan).[12]

People who received premium subsidies would be able to buy a plan whose premium exceeded the reference premium, although they would have to pay the entire additional cost of that more expensive plan. With the expected enrollment choices of people with subsidies and people without subsidies taken into account, the average actuarial value of nongroup policies purchased is estimated to be roughly 72 percent. The increases in actuarial value relative to that under current law would increase the premiums for those policies, because the policies would cover a greater proportion of their enrollees' spending on medical care. Of course, the increases in actuarial value would also reduce enrollees' expected out-of-pocket spending on copayments and deductibles, particularly for enrollees who used more medical services than average. The reduced cost sharing would lead to greater use of medical services, which would tend to push premiums up further.[13]

Among nongroup enrollees who would not receive new subsidies, the average actuarial value of their coverage would not differ as sharply from the average for the nongroup market under current law. Some would choose to enroll in a "young invincibles" plan to be offered under the proposal; that plan would have relatively high deductibles and a relatively low actuarial value (estimated to be less than 50 percent), and the premium would be correspondingly low. (That plan would generally not be attractive to individuals who could receive premium subsidies for more extensive coverage.) Moreover, if they wanted to, current policyholders in the nongroup market would be allowed to keep their policy with no changes, and the premiums for those policies would probably not differ substantially from current-law levels. But because of relatively high turnover in that market (as well as the incentives for many enrollees to purchase a new policy in order to obtain

[12] Enrollees with income below 200 percent of the FPL would receive subsidies for cost sharing to increase the overall actuarial value of their coverage to either 80 percent or 90 percent. However, the plan in which they enrolled would have a premium that reflects an actuarial value of 70 percent, and that premium was used in the calculation of the average premium under the proposal.

[13] The increase in spending for health care that would arise when uninsured people gained coverage is accounted for separately; see the discussion below. For a discussion of the impact that cost sharing has on spending for health care and related considerations, see Congressional Budget Office, *Key Issues*, pp. 61–62, 71–76, and 110–112.

subsidies), CBO and JCT estimate that relatively few nongroup policies would remain grandfathered by 2016.

Effects on Premiums for Employment-Based Plans Would be Much Smaller
The legislation would impose the same minimum actuarial value for new policies in the small group market as in the nongroup market. That requirement would have a much smaller effect on premiums in the small group market, however, because the great majority of policies sold in that market under current law have an actuarial value of more than 60 percent. Essentially all large group plans have an actuarial value above 60 percent, so the effect on premiums in that market would be negligible. In sum, the greater actuarial value and broader scope of benefits in the legislation would increase the average premium per person in the small group market by about zero to 3 percent (with other factors held constant). Those requirements would have no significant effect on premiums in the large group market.

Differences in the Price of a Given Amount of Coverage for a Given Population

A second broad category of differences in premiums encompasses factors that reflect an "apples-to-apples" comparison of the average price of providing equivalent insurance coverage for an equivalent population under the legislation and under current law.[14] The main provisions of the legislation that fall into this category are the new rules for the insurance market, including the establishment of exchanges and availability of a public plan through those exchanges, which would reduce insurers' administrative costs and increase slightly the degree of competition among insurers, and several new fees that would be imposed on the health sector, which would tend to raise insurance premiums.[15]

Some observers have argued that private insurance premiums would also be affected by changes in the extent of "cost shifting"—a process in which lower rates paid to providers for some patients (such as uninsured people or enrollees in government insurance programs) lead to higher payments for others (such as privately insured individuals). However, the effect of the proposal on premiums through changes in cost shifting seems likely to be quite small because the proposal has opposing effects on different potential sources of cost shifting, and

[14] In this description, "equivalent coverage" means policies that have the same scope of benefits and cost-sharing requirements. The benefits received by enrollees in plans with equivalent coverage also depend on factors such as the benefit management being used and the size and composition of the provider network.

[15] The effect of the excise tax on health insurance plans with relatively high premiums is discussed separately, below. Also, to focus on permanent elements of the legislation, this analysis does not include the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only. Those payments would be financed by a fee levied on all private insurers, so the effects would differ by market but the overall impact on premiums would be modest.

the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance.

CBO and JCT estimate that the elements of the legislation that would change the price of providing a given amount of coverage for a given population would, on net, reduce the average premium per person for nongroup coverage in 2016 by about 7 percent to 10 percent relative to the amount under current law. Those elements of the legislation would reduce the average premium per person in the small group market by about 1 percent to 4 percent and would not have a measurable impact on premiums in the large group market.

New Market Rules Would Reduce Administrative Costs

Compared with plans that would be available in the nongroup market under current law, nongroup policies under the proposal would have lower administrative costs, largely because of the new market rules:[16]

- The influx of new enrollees in response to the individual mandate and new subsidies—combined with the creation of new insurance exchanges—would create larger purchasing pools that would achieve some economies of scale.

- Administrative costs would be reduced by provisions that require some standardization of benefits—for example, by limiting variation in the types of policies that could be offered and prohibiting "riders" to insurance policies (which are amendments to a policy's terms, such as coverage exclusions for preexisting conditions); insurers incur administrative costs to implement those exclusions.

- Administrative costs would be reduced slightly by the general prohibition on medical underwriting, which is the practice of varying premiums or coverage terms to reflect the applicant's health status; nongroup insurers incur some administrative costs to implement underwriting.

- Partly offsetting those reductions in administrative costs would be a surcharge that exchange plans would have to pay under the proposal to cover the operating costs of the exchanges.

In the small group market, some employers would purchase coverage for their workers through the exchanges.[17] Such policies would have lower administrative costs, on average, than the policies those firms would buy under current law,

[16] Those market rules would also affect premiums by changing the scope of coverage provided and the types of people who obtain coverage, as discussed in other sections.

[17] In 2016, states would have to give all employers with 100 or fewer employees the option to purchase coverage through the exchanges. States could give larger employers that option starting in 2017. However, CBO and JCT expect that few large firms would take that option if offered because their administrative costs would generally be lower than those of nongroup policies that would be available in the exchanges.

particularly for very small firms.[18] The primary sources of administrative cost savings for small employers would be the economies of scale and relative standardization of benefits in the exchanges noted above; currently, the use of exclusions for preexisting conditions is rare in the small group market, so the rules affecting coverage of those conditions would have only a small effect on administrative costs in that market.

In addition, the administrative simplification provisions of the legislation would require the Secretary of HHS to adopt and regularly update standards for electronic administrative transactions such as electronic funds transfers, claims management processes, and eligibility verification. In CBO and JCT's estimation, those provisions would reduce administrative costs for insurers and providers, which would result in a modest reduction in premiums in all three broad insurance markets.

Increased Competition Would Slightly Reduce Premiums in the Nongroup Market

The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees. In particular, insurers probably would adopt slightly stronger benefit management procedures to restrain spending or would slightly reduce the rates they pay providers. Those small employers that purchased coverage through the exchanges would see similar reductions in premiums because of the increased competition among plans.

One other feature of the proposal would also put a modicum of downward pressure on average premiums in the exchanges—namely, the provisions allowing exchange administrators to act as "prudent purchasers" when reviewing and approving the proposed premiums of potential insurers.[19] Although the administrators' authority would be limited, evidence from the implementation of an exchange system in Massachusetts suggests that the existence of such authority would tend to reduce premiums slightly.

CBO and JCT's analysis of exchange premiums has also taken into account the availability of a public plan through those exchanges in some states. Premiums for the public plan as structured under the proposal would typically be somewhat

[18] Among small employers, administrative costs decline as a share of premiums as the size of the firm increases. Thus, the smallest employers would be most likely to see lower administrative costs for policies in the exchanges than what they would be charged under current law.

[19] Specifically, the legislation would require insurers seeking to participate in the exchanges to submit a justification for any premium increase prior to implementing it; the legislation also would give exchanges the authority to take that information into consideration when determining whether to make a plan available through the exchanges.

higher than the average premiums of private plans offered in the exchanges.[20] By itself, that development would tend to increase average premiums in the exchanges—but a public plan would probably tend to reduce slightly the premiums of the private plans against which it is competing, for two reasons:

- A public plan as structured in the proposal would probably attract a substantial number of enrollees, in part because it would include a broad network of providers and would be likely to engage in only limited management of its health care benefits. (CBO and JCT estimate that total enrollment in the public plan would be about 3 million to 4 million in 2016.) As a result, it would add some competitive pressure in the exchanges in areas that are currently served by a limited number of private insurers, thereby lowering private premiums to a small degree.

- A public plan is also apt to attract enrollees who are less healthy than average (again, because it would include a broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

Those factors would reduce the premiums of private plans in the exchanges to a small degree, but the effect on the average premium in the exchanges would be offset by the higher premium of the public plan itself. On balance, therefore, the provisions regarding a public plan would not have a substantial effect on the average premiums paid in the exchanges.[21]

New Fees Would Increase Premiums Slightly

The legislation would impose several new fees on firms in the health sector. New fees would be imposed on providers of health insurance and on manufacturers and importers of medical devices. Both of those fees would be largely passed through

[20] Under the proposal, the public plan would negotiate payment rates with providers. CBO and JCT anticipate that those rates would be similar to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than private plans, on average, but would probably engage in less benefit management and attract a less healthy pool of enrollees (the effects of which would be offset only partially by the risk adjustment procedures that would apply to all plans operating in the exchanges). On net, those factors would result in the public plan's premiums being somewhat higher than the average premiums of private plans in the exchanges.

[21] The presence of the public plan would have a more noticeable effect on federal subsidies because it would exert some downward pressure on the premiums of the lower-cost plans to which those subsidies are tied.

to consumers in the form of higher premiums for private coverage. Self-insured plans would be mostly exempt from the fee on health insurance providers, and since large firms are more likely to self-insure, that fee would result in smaller percentage increases in average premiums for large firms than it would for small firms and for nongroup coverage.[22]

The legislation also would impose a fee on manufacturers and importers of brand-name prescription drugs, which would be allocated among firms on the basis of drug sales to government programs. Because that fee would not impose an additional cost for drugs sold in the private market, CBO and JCT estimate that it would not result in measurably higher premiums for private coverage. (The legislation would also impose an excise tax on high-premium insurance policies provided by employers; that tax is discussed separately below because it would affect only a portion of the insurance market.)

Effects Related to Cost Shifting Would Be Minimal

Some observers have predicted that the proposal (and similar initiatives) would affect premiums for private insurance plans by changing the extent of cost shifting. The legislation would have opposing effects on the pressures for cost shifting:

- On the one hand, the legislation would reduce payments to hospitals and certain other providers under Medicare.[23] In addition, it would significantly increase enrollment in Medicaid, which pays providers appreciably lower rates than private insurers do. Those changes could cause premiums for private coverage to increase.

- On the other hand, the legislation would ultimately reduce the uninsured population by more than half, which would sharply reduce the amount of uncompensated or undercompensated care provided to people who lack health insurance. One recent estimate indicates that hospitals provided about $35 billion in such care in 2008—an amount that would grow under current law but would be expected to decline considerably under the legislation.[24] That change could cause premiums for private coverage to decrease.

---

[22] The fee would be levied on third-party administrators of self-insured plans in proportion to twice their administrative spending, which is substantially less than the total premiums that would be the base for the levy on plans purchased from insurers. Government health insurance plans such as Medicare and Medicaid would be exempt from that fee, but any public plan offered in the exchanges would be subject to it.

[23] The legislation would reduce Medicare payment updates for most services in the fee-for-service sector (other than physicians' services) and reduce Medicare and Medicaid payments to hospitals that serve large numbers of low-income patients, known as "disproportionate share" (DSH) hospitals.

[24] Recent evidence indicates that physicians collectively provide much smaller amounts of uncompensated or undercompensated care than hospitals. See Jonathan Gruber and David Rodriguez, "How Much Uncompensated care Do Doctors Provide?" *Journal of Health Economics*, vol. 26 (2007), pp. 1151–1169.

The net effect of those opposing pressures would depend on their relative magnitude and also on the degree to which costs are shifted. CBO expects that the magnitude of those opposing pressures would be about the same. Moreover, CBO's assessment of the evidence is that a small amount of cost shifting occurs but that it is not as widespread or extensive as is commonly assumed. The fact that private insurers pay providers higher rates, on average, than Medicare and Medicaid is not evidence that cost shifting occurs. For cost shifting to occur, a *decline* in the rates paid by some payers would have to lead to an *increase* in the rates paid by others; thus, for cost shifting from reductions in rates paid by Medicare to occur, providers would have to have initially been charging private insurers lower rates than they could have. Well-designed studies have found that a relatively small share of the changes in payment rates for government programs is passed on to private payment rates, and the impact of changes in uncompensated care is likely to be similar.[25] Overall, therefore, CBO's assessment is that the legislation would have minimal effects on private-sector premiums via cost shifting.

Differences in the Types of People Who Obtain Coverage in Different Insurance Markets

The third broad factor that would affect average insurance premiums is differences in the types of people who obtain coverage in different insurance markets. If more people who are relatively healthy or relatively disinclined to use medical care participate in a given insurance market, then the average spending on medical services provided in that market will be lower, and the average premium in that market will be lower, with other factors held equal; conversely, if more people who are relatively unhealthy or are relatively inclined to use medical care participate in a given insurance market, the average spending on medical services and the average premium for that market will be higher, all else equal. Thus, a shift of less healthy people from one insurance market to another will tend to lower premiums in the "source" market and raise them in the "destination" market. Likewise, the number and types of people who would be uninsured under current law but would become insured under the proposal—and the effects of gaining coverage on their use of health care—would affect the average premiums charged in the markets in which they buy insurance.

Overall, CBO and JCT estimate that an influx of new enrollees into the nongroup market would yield an average premium per person in that market that is 7 percent to 10 percent lower than the average premium projected under current law. Changes in the types of people covered in the small group and large group markets would have much smaller effects on premiums, yielding a change in the small group market that could range from a decrease of 1 percent to an increase of 2 percent, and a decrease in the large group market of zero to 3 percent.

[25] For a more extensive discussion of cost shifting, see Congressional Budget Office, *Key Issues*, pp. 112–116.

Key Characteristics of the Insured and Uninsured Under Current Law

To assess the likely medical spending of prospective new enrollees in different insurance markets, it is useful to review some key characteristics of the insured and uninsured populations under current law. CBO and JCT's assessment of those characteristics is based on data from representative surveys of the U.S. population that examine people's health insurance coverage, health status, and use of health care.[26] This discussion addresses the projected distribution of the population in 2016, using as a reference point the 162 million people expected to be covered by employment-based insurance in that year under current law.

About 14 million people are expected to be covered by nongroup policies in 2016 under current law. Enrollees in nongroup coverage would be about 3 years older, on average, than enrollees in employment-based insurance—which would tend to raise their use of medical care—but would be slightly healthier, on average, at any given age—which would tend to lower their use of care. On balance, the average spending on medical care of nongroup enrollees would be somewhat greater than that of enrollees in employment-based insurance if they were enrolled in insurance plans with the same amount and structure of coverage.

By contrast, the 52 million people who are expected to be uninsured under current law in 2016 would be about 2 years younger, on average, than the population covered by employment-based plans and thus would be about 5 years younger than nongroup enrollees, on average. At any given age, the average health of the uninsured population would be somewhat worse than the average health of people with nongroup insurance. A large share of the uninsured population, however, would not be eligible to obtain subsidized coverage via the exchanges; instead, those with income below 133 percent of the FPL would generally be eligible for free coverage through Medicaid. That low-income group is relatively unhealthy, and once they are removed from the comparison, the disparity in health between the remaining uninsured population and current-law enrollees in the nongroup market essentially disappears. Therefore, considering only their age and their health status and holding other factors constant, the expected use of medical care by uninsured people who would be eligible for subsidized coverage in the exchanges would be less than that of current nongroup enrollees.

One other factor that would not be the same—and that would tend to accentuate this projected difference in utilization—is how much medical care the uninsured would use once they did gain coverage: They would tend to consume less medical care than current nongroup enrollees, even after adjusting for their age and health. CBO's review of relevant studies concluded that insuring the currently uninsured under a typical employment-based plan would generate an increase of 25 percent to 60 percent in their average utilization of care. (That average increase in utilization and spending would arise even though some newly insured people

[26] For additional information on the data sources used and the methodology involved, see Congressional Budget Office, *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

would avoid expensive treatments by getting care sooner, before their illness progressed, or would receive services in a less expensive setting.) Despite that substantial increase in utilization, their use of care would still be below that of people with similar characteristics who are currently insured.[27] That remaining difference in average utilization probably reflects various differences between the insured and uninsured aside from differences in their age and health status, and the effect of obtaining insurance could be much larger for some people and much smaller for others.

A Limited Amount of Adverse Selection Would Occur in New Nongroup Plans

The preceding discussion examined the types of people who would receive coverage in different markets under current law or would be eligible to receive coverage in different markets under the proposal. However, the effects of the proposal on the types of enrollees in each market would depend ultimately on who *chose* to receive coverage in those markets—with the most significant changes coming in the nongroup market.

Under current laws governing the nongroup market, insurers in most states do not have to accept all applicants, may vary premiums widely to reflect differences in enrollees' health status and age, and may exclude coverage of preexisting medical conditions. By themselves, the proposal's provisions changing those rules would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care. Therefore, in the absence of other changes to the insurance market, people who are older and more likely to use medical care would be more likely to enroll in nongroup plans—a phenomenon known as adverse selection. Such selection would tend to increase premiums in the exchanges relative to nongroup premiums under current law.

However, several other provisions of the proposal would tend to mitigate that adverse selection:

- The legislation would establish an annual open enrollment period for new nongroup policies similar to that typically used by employers, which would limit opportunities for people who are healthy to wait until an illness or other health problem arose before enrolling.

- The substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people. For people whose

[27] CBO estimates that the uninsured currently use about 60 percent as much medical care as insured people, taking into account differences between the groups in their average age and health status. Providing all of the uninsured with health insurance coverage equivalent to a typical employment-based plan would thus be estimated to increase their demand for medical services to a level that is between 75 percent and 95 percent of the level of similar people who are currently insured (corresponding to an increase of 25 percent and 60 percent, respectively). For additional discussion of these estimates, see Congressional Budget Office, *Key Issues,* pp. 71–76.

income was below 200 percent of the FPL, those subsidies would average around 80 percent.

- The requirement that people have insurance would also encourage a broad range of people to take up coverage in the exchanges. CBO and JCT expect that some people would obtain coverage because of the penalties that would be levied for not complying with the mandate (which would be $750 per adult and $375 per child in 2016) and that others would obtain coverage simply because of the existence of a mandate; those expectations are based in part on people's compliance with other types of mandates.[28]

- The premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees (though federal subsidy payments would have to rise to make up the difference). That arrangement would dampen the chances that a cycle of rising premiums and declining enrollment would ensue.

- During the 2014–2016 period, as the mandate penalties were being phased in and other provisions were in the initial stages of implementation, the legislation would provide reinsurance payments to insurers that ended up with particularly high-cost enrollees. That reinsurance system (funded by an assessment on all insurers) would also limit the impact of adverse selection on insurance premiums.

On balance, CBO and JCT expect that some adverse selection into nongroup plans would arise, especially among people who received relatively small subsidies. However, the extent of such adverse selection is likely to be limited, and many nongroup enrollees would be in fairly good health.

The Characteristics of Enrollees in Nongroup Plans Would Be Substantially Different Than Those Under Current Law

CBO and JCT estimate that about 32 million people would obtain coverage in the nongroup market in 2016 under the proposal, consisting of about 23 million who would obtain coverage through the insurance exchanges and about 9 million who would obtain coverage outside the exchanges. Relative to the situation under current law, with about 14 million people buying nongroup coverage, the different mix of enrollees would yield average premiums per person in that market that are about 7 percent to 10 percent lower. Some people who would enroll in nongroup coverage under the proposal would be uninsured under current law, some would have employment-based coverage, and some would have nongroup coverage under current law as well. To estimate how the different mix of enrollees in the nongroup market would affect premiums, it is useful to examine enrollment patterns and expected medical costs for each of those three groups.

[28] For a discussion of compliance with mandates, see Congressional Budget Office, *Key Issues*, pp. 48–54.

First, CBO and JCT estimate that about a third of the nongroup enrollees estimated under the proposal in 2016 would be uninsured under current law. As discussed above, the pool of people who would be eligible for the exchanges and would otherwise be uninsured would be—relative to those who have nongroup coverage under current law—younger, roughly as healthy at any given age, and likely to use less medical care (given their age and health status). At the same time, the adverse selection discussed above means that the members of that pool who would choose to purchase coverage would be less healthy, on average, than all of the members of the pool together, particularly among those who would receive limited subsidies. On balance, CBO and JCT estimate that the enrollees who would be uninsured under current law would use significantly less medical care, on average, than individuals enrolled in nongroup coverage under current law (with other factors held constant).[29]

Second, CBO and JCT estimate that about a fifth of nongroup enrollees under the proposal in 2016 would have employment-based coverage under current law. Most of those people would not have an offer of employment-based coverage under the proposal; others would have such an offer but it would be deemed unaffordable, so they would be eligible to obtain subsidies through the exchanges. On average, those enrollees would be older and in poorer health than nongroup enrollees under current law, because the proposal's changes in the nongroup market would make that market more appealing to those types of people. The inflow of those people into the nongroup market would thus tend to increase average medical spending and average premiums per person in that market to some degree.

Third, CBO and JCT estimate that nearly half of the people enrolling in nongroup coverage under the proposal would have nongroup coverage under current law as well. Holding other factors constant, those enrollees would obviously not change average medical spending or premiums in the nongroup market relative to the levels under current law.

In the comparison of nongroup premiums under the proposal with those under current law, the differences discussed in this section would vary considerably among people. In general, the proposal would tend to increase premiums for people who are young and relatively healthy and decrease premiums for those who are older and relatively unhealthy. However, to fully evaluate the implications of the proposal for different types of people, it is necessary to include the effects of the subsidies that are discussed below.

[29] People who report that they are in either fair or poor health tend to use much more health care than the average person, and otherwise uninsured people in fair or poor health would be more likely to enroll in nongroup coverage. Even so, they would constitute less than 10 percent of the otherwise uninsured group enrolling in nongroup coverage.

The Characteristics of Enrollees in Employment-Based Plans Would Be Slightly Different Under the Proposal

CBO and JCT estimate that changes in the characteristics of people with insurance in the small group market would yield a change in the average premiums per person in that market that could range from a decrease of 1 percent to an increase of 2 percent. That difference would be the net effect of three principal factors:

- Under the legislation, new insurance policies sold in the small group market would be subject to the same rating rules as policies sold in the nongroup market. In particular, insurers in the small group market could not vary premiums to reflect the health of firms' workers. That change would reduce premiums for small firms whose employees are in relatively poor health—leading some of those firms that would not offer insurance under current law to do so under the proposal—and increase premiums for small firms whose employees are in relatively good health—leading some of those firms who would offer coverage under current law not to do so under the proposal. Consequently, the people covered in the small group market would be in somewhat worse health, on average, under the proposal than under current law, which would tend to increase average premiums in that market.[30]

- The individual mandate included in the proposal would induce some uninsured workers who would decline the coverage offered by their employers under current law to purchase such coverage. That change would reduce average premiums by a modest amount, because the people who would become insured would be in better health, on average, than their coworkers who would purchase insurance under current law.

- The individual mandate (and the small business tax credit) would also increase slightly the percentage of small firms that offer coverage. Those firms are likely to have healthier workers, on average, than small firms that would offer coverage under current law, largely reflecting the relative youth of workers at firms that would not offer coverage under current law compared with workers at firms that would. Consequently, their inclusion in the small group market would reduce average premiums in that market by a small amount.

[30] That effect would be muted by the proposal's grandfathering provisions, which would allow insurers to continue to set premiums according to current rules as long as an employer's policy was continuously maintained; however, that option would also be most attractive to employers with relatively healthy workers and least attractive to employers with relatively unhealthy workers. The increased attractiveness of the nongroup market for older and less healthy workers would also temper the effect of the new rating rules on average premiums in the small group market, because some of those workers would shift from employment-based to nongroup coverage.

In contrast, CBO and JCT estimate that changes in the characteristics of people with insurance in the large group market would reduce average premiums per person in that market by about zero to 3 percent. One factor that would contribute to that difference is the shift of some less healthy workers to the nongroup market, as noted above. Another factor is the individual mandate, which would encourage younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so. Other factors that would slightly increase coverage of relatively healthy individuals under large group plans are the provisions of the legislation that would require large employers to automatically enroll new employees in an insurance plan and to offer coverage for unmarried dependents up to age 26. The proposal's restrictions on variation in premiums would have minimal effect on premiums in the large group market; many large firms self-insure and thus would not be affected by those changes, and firms that might be adversely affected could be grandfathered and thus avoid the restrictions.

Effects of the Proposed Exchange Subsidies and Small Business Tax Credit

Under the proposal, the government would subsidize the purchase of nongroup insurance through the exchanges for individuals and families with income between 133 percent and 400 percent of the FPL, and it would provide tax credits to certain small businesses that obtained health insurance for their employees. Although the preceding analysis accounted for the effects of those subsidies on the number and types of people who would obtain coverage and on the amount of coverage that enrollees would obtain, the direct effect of the subsidies on enrollees' payments for coverage were not included in the figures presented above because the objective there was to assess the impact of the legislation on the average premiums *paid to insurers*. This section builds on the earlier calculations by quantifying how the exchange subsidies and tax credits would directly affect the average premiums *paid by individuals and families* who would receive that government assistance.

Premium subsidies in the exchanges would be tied to the premium of the second cheapest silver plan (which would have an actuarial value of 70 percent). The national average premium for that reference plan in 2016 is estimated to be about $5,200 for single coverage and about $14,100 for family coverage (see Table 2). The national average premium for all nongroup plans would be higher—about $5,800 for single coverage and about $15,200 for family coverage—because many people would buy more expensive plans.

Under the proposal, the maximum share of income that enrollees would have to pay for the reference plan would vary depending on their income relative to the FPL, as follows:

- For enrollees with income below 133 percent of the FPL, the maximum share of income paid for that plan would be 2.0 percent in 2014; for enrollees with income between 133 percent and 300 percent of the FPL,

that maximum share of income would vary linearly from about 4 percent of income to 9.8 percent of income in 2014; and for enrollees with income between 300 percent and 400 percent of the FPL, that maximum share of income would equal 9.8 percent.

- After 2014, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for 2016, they are estimated to range from about 2.1 percent to about 10.2 percent.

- Enrollees with income below 200 percent of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels: 90 percent for those with income below 150 percent of the FPL, and 80 percent for those with income between 150 percent and 200 percent of the FPL.

- Enrollees with income above 400 percent of the FPL would not be eligible for exchange subsidies, and enrollees with income below that level whose premiums for the reference plan turned out to be less than their income-based cap also would not receive subsidies.

CBO and JCT estimated that roughly 23 million people would purchase their own coverage through the exchanges in 2016 and that roughly 5 million of those people would not receive exchange subsidies.[31] Therefore, of the 32 million people who would have nongroup coverage in 2016 under the proposal (including those purchased inside and outside the exchanges), about 18 million, or 57 percent, would receive exchange subsidies. For the people who received subsidies, those subsidies would, on average, cover nearly two-thirds of the premiums for their policies in 2016. Putting together the subsidies and the higher level of premiums paid to insurers yields a net reduction in average premiums paid by individuals and families in the nongroup market—for those receiving subsidies—of 56 percent to 59 percent relative to the amounts paid under current law. People in lower income ranges would generally experience greater reductions in premiums paid, and people in higher income ranges who receive subsidies would experience smaller reductions or net increases in premiums paid.

The government would also provide some subsidies for the purchase of health insurance in the form of tax credits to small firms. Under certain circumstances, firms with relatively few employees and relatively low average wages would be eligible for tax credits to cover up to half of their contributions toward insurance premiums. Of the people who would receive small group coverage in 2016 under the proposal, roughly 12 percent would benefit from those credits, CBO and JCT estimate. For the people who would benefit from those credits, the credits would

[31] See Congressional Budget Office, cost estimate for the amendment in the nature of a substitute to H.R. 3590, the Patient Protection and Affordable Care Act (November 18, 2009), Table 3.

tend to reduce the net cost of insurance to workers relative to the premiums paid to insurers by a little less than 10 percent, on average, in 2016. In the small group market, the other factors that were the focus of earlier sections of this analysis would cause premiums paid to insurers to change by an amount that could range from an increase of 1 percent to a reduction of 2 percent (compared to current law). Putting together the tax credits and the change in premiums paid to insurers yields a net reduction in the cost of insurance to workers in the small group market—for those benefiting from tax credits—of 8 percent to 11 percent relative to that under current law.

Effects of the Excise Tax on High-Premium Insurance Plans

The legislation would impose an excise tax on employment-based policies whose total premium (including the amounts paid by both the employer and the employee) exceeded a specified threshold. The tax on such policies would be 40 percent of the amount by which the premium exceeded the threshold. In general, that threshold would be set at $8,500 for single policies and $23,000 for family policies in 2013 (the first year in which the tax would be levied), although a number of temporary and permanent exceptions would apply. After 2013, those dollar amounts would be indexed to overall inflation plus 1 percentage point.

CBO and JCT estimate that, under current law, about 19 percent of employment-based policies would have premiums that exceeded the threshold in 2016. (Because health insurance premiums under current law are projected to increase more rapidly than the threshold, the percentage of policies with premiums under current law that would exceed the threshold would increase over time.) For policies whose premiums remained above the threshold, the tax would probably be passed through as a roughly corresponding increase in premiums. However, most employers would probably respond to the tax by offering policies with premiums at or below the threshold; CBO and JCT expect that the majority of the affected workers would enroll in one of those plans with lower premiums. Plans could achieve lower premiums through some combination of greater cost sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medical services), more stringent benefit management, or coverage of fewer services.

Thus, people who remained in high-premium plans would pay higher premiums under the excise tax than under current law, and people who shifted to lower-premium plans would pay lower premiums under the excise tax than under current law—with other factors held constant. On net, CBO and JCT estimate that the excise tax and the resulting behavioral changes, incorporating the changes in premiums for employer-sponsored insurance that were discussed earlier in this analysis, would reduce average premiums among the 19 percent of policies affected by the tax by about 9 percent to 12 percent in 2016.

Other Potential Effects on Premiums

The proposal could have some broader or longer-term effects on the level or growth rate of health care spending and health insurance premiums. Such effects could arise from several sources, some of which would tend to raise premiums relative to the figures cited above, and others of which would tend to lower them. The uncertainties involved in assessing the magnitude of those effects are especially great. However, in CBO and JCT's judgment, those effects are unlikely to be large—especially by 2016, which is the focus of this analysis.

On the one hand, research by Amy Finkelstein suggests that expanded insurance coverage could have broader effects on the use of health care services than are captured by focusing on changes for the previously uninsured.[32] Examining trends in hospital spending, she found that the substantial increase in demand for medical services generated by the introduction of Medicare in 1965 accelerated the dissemination of new medical procedures more broadly and could account for about half of the overall increase in hospital spending for the population as a whole that occurred in subsequent years.

By that logic, the expansion of insurance coverage to millions of nonelderly people under this proposal could generate a larger increase in health care spending—and thereby health insurance premiums—than estimated here. However, several factors temper that conclusion. For one, the quantitative effect would presumably be smaller than that caused by Medicare because nonelderly people use less health care, on average, than elderly people. Moreover, Medicare initially paid hospitals on the basis of their incurred costs—an approach that gave hospitals little incentive to control those costs. The increase in hospital spending that resulted from Medicare's creation could well have been smaller under a less generous payment system or in an era of more tightly managed care. In particular, roughly half of the increase in insurance coverage generated by this proposal would come from expanded enrollment in Medicaid, which pays relatively low rates to providers. Incentives for cost control would also be greater in the proposed exchanges, because exchange enrollees would have to pay the full additional cost of joining a more expensive insurance plan. Regardless, any effects of expanded insurance coverage on the dissemination of new medical procedures would unfold slowly and would have little effect on health care and health insurance premiums by 2016.

On the other hand, the proposal includes numerous provisions that would encourage the development and dissemination of less costly ways to deliver appropriate medical services, either directly or indirectly. Examples of those provisions include the excise tax on high-premium insurance plans; the creation of a new Medicare advisory board that might limit the growth rate of Medicare

[32] See Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics*, vol. 122, no. 1 (February 2007), pp. 1–37. For additional discussion of this study, see Congressional Budget Office, *Key Issues*, p. 111.

spending; and certain changes in Medicare's payment methods as well as new pilot and demonstration projects regarding other changes in payment methods (such as penalties for hospital readmissions that are deemed avoidable and incentives to coordinate patients' care). The changes in Medicare's payment methods could "spill over" to the private sector and decrease spending for health care relative to currently projected levels. However, the effects of those initiatives on Medicare's spending are uncertain and would probably be small in 2016 relative to the program's total spending, so any spillover to private insurance at that point would probably be small as well. In addition, the excise tax on high-premium plans would apply to a small share of plans in 2016, so its effects on the cost and efficiency of health care would also probably be small at that point.

All of those considerations serve to emphasize the considerable uncertainty that surrounds any estimate of the impact of any proposal that would make substantial changes in the health insurance or health care sectors, given the size and the complexity of those sectors. That uncertainty applies to the estimated effects of proposals on the federal budget and insurance coverage rates, as well as to their impact on premiums.

TABLE 2. Analysis of Exchange Subsidies and Enrollee Payments in 2016 11/20/2009

Under the Patient Protection and Affordable Care Act

Estimate for "Reference Plan" in 2016 -- 2nd Lowest-Cost "Silver" Plan

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	$5,200	$1,900
Family Policy	70%	$14,100	$5,000

Single Person

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 14,700	$ 300	94%	$ 1,100	$ 800	$ 1,100	7%
150-200%	4.7% - 6.5%	$ 20,600	$ 1,200	77%	$ 600	$ 1,300	$ 2,500	12%
200-250%	6.5% - 8.4%	$ 26,500	$ 2,000	62%	$ -	$ 1,900	$ 3,900	15%
250-300%	8.4% - 10.2%	$ 32,400	$ 3,000	42%	$ -	$ 1,900	$ 4,900	15%
300-350%	10.2%	$ 38,300	$ 3,900	25%	$ -	$ 1,900	$ 5,800	15%
350-400%	10.2%	$ 44,200	$ 4,500	13%	$ -	$ 1,900	$ 6,400	14%
400-450%	n.a.	$ 50,100	$ 5,200	0%	$ -	$ 1,900	$ 7,100	14%

Family of Four

Income Relative to the FPL	*Premium Cap as a Share of Income /a*	*Middle of Income Range /b,c*	*Enrollee Premium for Low-Cost "Silver" Plan*	*Premium Subsidy (share of premium)*	*Average Cost-Sharing Subsidy*	*Average Net Cost Sharing*	*Enrollee Premium + Avg. Cost Sharing*	
							Dollars	*Percent of Income*
100-150% /d	2.1% - 4.7%	$ 30,000	$ 600	96%	$ 3,300	$ 1,700	$ 2,300	8%
150-200%	4.7% - 6.5%	$ 42,000	$ 2,400	83%	$ 1,800	$ 3,200	$ 5,600	13%
200-250%	6.5% - 8.4%	$ 54,000	$ 4,000	72%	$ -	$ 5,000	$ 9,000	17%
250-300%	8.4% - 10.2%	$ 66,000	$ 6,100	57%	$ -	$ 5,000	$ 11,100	17%
300-350%	10.2%	$ 78,000	$ 7,900	44%	$ -	$ 5,000	$ 12,900	17%
350-400%	10.2%	$ 90,100	$ 9,200	35%	$ -	$ 5,000	$ 14,200	16%
400-450%	n.a.	$ 102,100	$ 14,100	0%	$ -	$ 5,000	$ 19,100	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

Notes: All dollars figures have been rounded to the nearest $100; n.a. = not applicable; FPL = federal poverty level.

a) In 2014, the income-based caps would range from about 4% at 133% of the FPL to 9.8% at 300% of the FPL, and that 9.8% cap would extend to 400% of the FPL; in subsequent years, those caps would be indexed.

b) In 2016, the FPL is projected to equal about $11,800 for a single person and about $24,000 for a family of four.

c) Subsidies would be based on enrollees' household income, as defined in the bill.

d) Under the bill, people with income below 133% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cap in 2014 for those with income below 133% of the FPL would be 2% of income.

Exhibit 6

ASPE
ISSUE BRIEF

Health Insurance Marketplace Premiums for 2014

On October 1, 2013, a Health Insurance Marketplace will open in each state, providing a new, simplified way to compare individual market health insurance plans. Americans will be able to use the Health Insurance Marketplace to shop for and purchase health insurance coverage, which will begin January 1, 2014.[1] In addition, individuals and families with household incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL) who are not eligible for certain other types of coverage may qualify for tax credits to make premiums more affordable.[2]

This report summarizes the health plan choices and premiums that will be available in the Health Insurance Marketplace. It contains new information, current as of September 18, 2013, on qualified health plans[3] in the 36 states in which the Department of Health and Human Services (HHS) will support or fully run the Health Insurance Marketplace in 2014. Plan data is in final stages but is still under review as of September 18 and may be revised in HHS systems before being displayed for consumers, so this information is subject to change. This analysis also includes similar information that is publicly available from 11 states and the District of Columbia that are implementing their own Marketplace.[4] This report focuses on the plans with the lowest premiums in each state, as consumers are expected to shop for low-cost plans.

Nearly all consumers (about 95%) will have a choice of 2 or more health insurance issuers (often many more) and nearly all consumers (about 95%) live in states with average premiums below earlier estimates.[5] Other key findings include:

[1] To be eligible to purchase coverage in a Marketplace, you must be a US citizen or legal resident and not be incarcerated.
[2] Tax credit eligibility is dependent on several factors in addition to income, including whether an individual is eligible for Minimum Essential Coverage through their employer, Medicaid, or CHIP.
[3] A qualified health plan is a plan certified to be offered in a Marketplace. A health insurance issuer may offer multiple qualified health plans. For example, a silver plan and a bronze plan from Blue Cross and Blue Shield would be considered two qualified health plans.
[4] The three states missing from this analysis, Massachusetts, Hawaii, and Kentucky, had not released premium information as of September 16, 2013. Idaho and New Mexico, while State-Based Marketplaces, will be using federal systems to display plans, and are therefore included in the 36 states with data submitted to CMS.
[5] See http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.cfm for a description of the earlier estimates from the Congressional Budget Office.

Individuals will have an average of 53 qualified health plan choices in states where HHS will fully or partially run the Marketplace[6]

- Individuals and families will be able to choose from a variety of bronze, silver, gold, and platinum plans in the Health Insurance Marketplace, as well as catastrophic plans for young adults and those without affordable options.[7] Health insurance issuers can offer multiple qualified health plans, including multiple qualified health plan choices within a single metal level. In the 36 states in this analysis, the number of qualified health plan choices available in a rating area ranges from a low of 6 to a high of 169 plans.[8] On average, individuals and families will have 53 qualified health plans to choose from in their rating area. Young adults will have an average of 57 qualified health plans to choose from, including catastrophic plans. The average number of choices will likely increase after including final data from state-based Marketplaces, which tend to have greater issuer participation.

- On average, there are 8 different health insurance issuers[9] participating in each of the 36 Marketplaces included in this analysis. This ranges from a low of 1 issuer to a high of 13 issuers within a state. About 95 percent of the non-elderly population in these 36 states lives in rating areas with 2 or more issuers. Roughly one in four issuers is offering health plans in the individual market for the first time in 2014.[10]

Premiums <u>before</u> tax credits will be more than 16 percent lower than projected

- The weighted average second lowest cost silver plan for 48 states (including DC) is 16 percent below projections based on the ASPE-derived Congressional Budget Office

[6] This total excludes catastrophic plans, which are not available to all enrollees. This analysis includes only the 36 states that submitted data directly to CMS, as that data contains a complete accounting of the number of qualified health plans offered in each rating area in each state.
[7] The Affordable Care Act requires that qualified health plans offered on the Marketplace must be one of four tiers, or "metal levels," based on actuarial value (catastrophic plans are exempt from this requirement). Actuarial value is a measure of health plan generosity. A bronze plan has an actuarial value of approximately 60 percent, a silver plan has an actuarial value of approximately 70 percent, a gold plan has an actuarial value of approximately 80 percent, and a platinum plan has an actuarial value of approximately 90 percent.
[8] Rating areas are state-defined pricing regions for issuers. They overlap with the issuer service areas in many, but not all, cases. In general, the number of issuers or plans available in a rating area will be the number of choices available to all individuals and families living in that rating area. Issuers are not required to offer a qualified health plan in every rating area within a state, however, so the number of available issuers and qualified health plans varies by rating area. These totals exclude catastrophic plans, which are not available to all enrollees.
[9] A health insurance issuer is a company that may offer multiple qualified health plans. For example, a hypothetical Blue Cross and Blue Shield licensed company would be a health insurance issuer, while its $2000 deductible silver plan would be a qualified health plan. An enrollee may have fewer issuers participating in his or her rating area than the total number participating in that state, because issuers are not required to offer a qualified health plan in every rating area.
[10] McKinsey & Company. Emerging exchange dynamics: Temporary turbulence or sustainable market disruption? September 2013.

premiums.[11] In 15 states, the second lowest cost silver plan will be less than $300 per month – a savings of $1,100 a year per enrollee compared to expectations. Overall, 95% of the uninsured potentially eligible for the Marketplaces live in states with average premiums below ASPE-derived CBO projected premiums (see Figure 1).[12]

- Young adults will pay lower premiums and also have the option of a catastrophic plan that covers prevention, some primary care, and high costs in cases of major accident or illness.[13] The weighted average lowest monthly premiums for a 27-year-old in 36 states[14] will be (*before* tax credits): $129 for a catastrophic plan, $163 for a bronze plan, and $203 for a silver plan. More than half of the uninsured potentially eligible for the Marketplaces live in a state where a 27-year-old can purchase a bronze plan for less than $165 per month *before* tax credits. There are an estimated 6.4 million uninsured Americans between the ages of 25 and 30 who may be eligible for coverage through Medicaid or the Marketplaces in 2014.[15]

Premiums <u>after</u> tax credits

- Tax credits will make premiums even more affordable for individuals and families. For example, in Texas, an average 27-year-old with income of $25,000 could pay $145 per month for the second lowest cost silver plan, $133 for the lowest cost silver plan, and $83 for the lowest cost bronze plan *after* tax credits.[16] For a family of four in Texas with income of $50,000, they could pay $282 per month for the second lowest cost silver plan, $239 for the lowest silver plan, and $57 per month for the lowest bronze plan *after* tax credits.[17]

---

[11] For a discussion of methodology, see http://aspe hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.cfm.

[12] Based on analysis of the the 2011 American Community Survey (ACS), available at http://cms.gov/Outreach-and-Education/Outreach/HIMarketplace/Census-Data-.html?no_redirect=true. Eligible uninsured is defined as uninsured Americans who are citizens or legal residents under the age of 65 and therefore eligible for coverage either in the Marketplace or through Medicaid. We define Marketplace eligible as the eligible uninsured with incomes above 138% of the Federal Poverty Level in Medicaid expansion states or above 100% of the Federal Poverty Level in non-expansion states. These estimates do not take into account the eligibility requirements relating to other minimum essential coverage.

[13] Tax credits are not available for catastrophic plans.

[14] This analysis includes only the 36 states that submitted data directly to CMS, as not all 12 of the State-based Marketplaces with available premium data have released catastrophic premiums.

[15] Estimated using the 2011 American Community Survey (ACS) Public Use Microdata Sample. This estimate includes US citizens and legal residents between the ages of 25 and 30 who are uninsured and may be eligible for the Marketplace or Medicaid in 2014. The estimates do not take into account whether an individual may have access to Minimum Essential Coverage through an employer.

[16] This analysis concerns only tax credits and premium costs, but we note that cost sharing reductions are not available in bronze plans except for American Indians and Alaska Natives. Cost sharing reductions are available to individuals and families with incomes below 250 percent of the FPL who enroll in silver plans, and to American Indians and Alaska Natives enrolled in metal level. These cost sharing reductions reduce consumer costs (such as out-of-pocket maximums, copays, and coinsurance) at the point of service, whereas tax credits reduce only premiums.

[17] Because the tax credit is calculated as the difference between the cost of the second lowest cost silver plan premium and the maximum payment amount determined by income, those with higher premiums get larger tax

- After taking tax credits into account, fifty-six percent of uninsured Americans (nearly 6 in 10) may qualify for health coverage in the Marketplace for less than $100 per person per month, including Medicaid and CHIP in states expanding Medicaid.[18]

Premiums tend to be lower in states where there is more competition and transparency

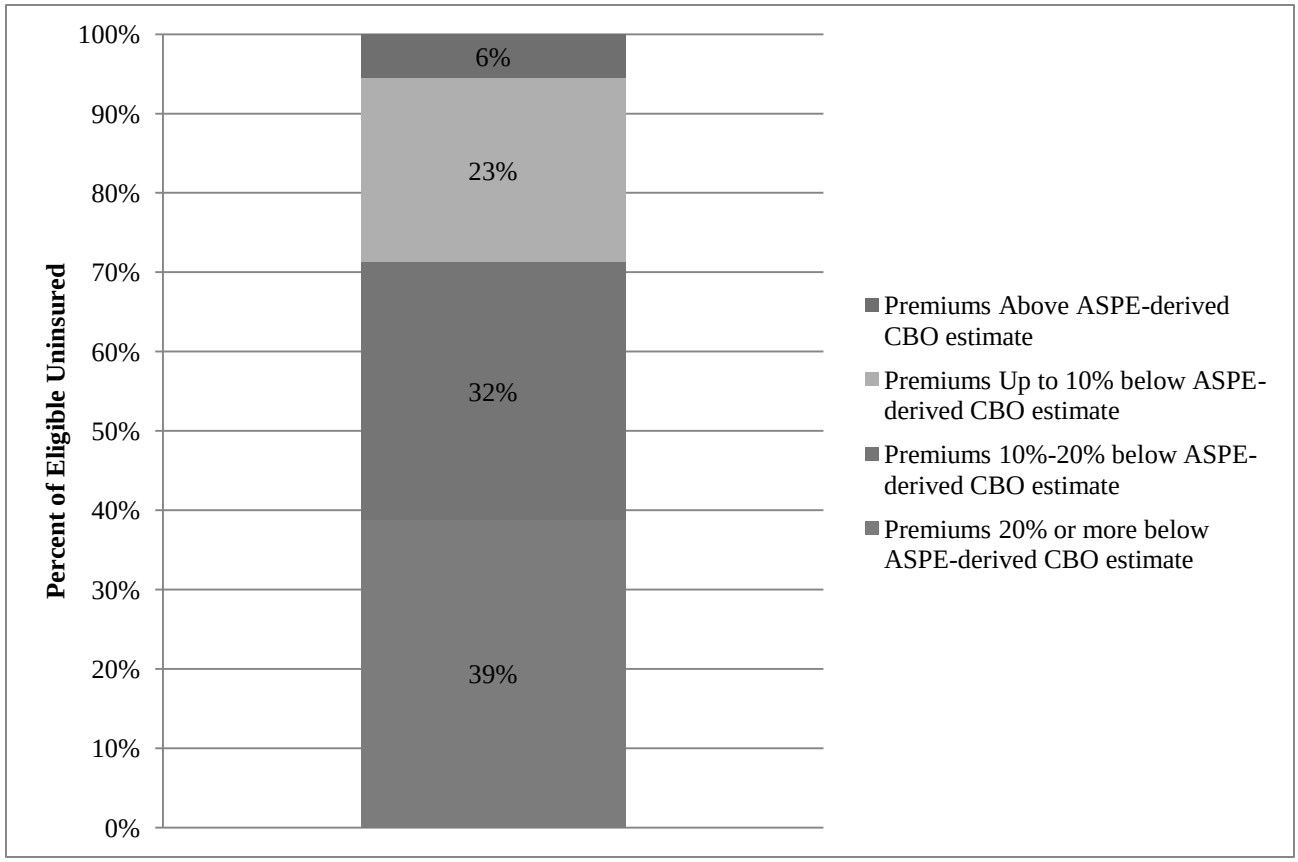
- In the 36 states included in this analysis, states with the lowest average premium tend to have a higher average number of issuers offering qualified health plans. There are, on average, 8 issuers participating in the Marketplace in the states with average premiums in the lowest quartile, compared to an average of 3 issuers in states with average premiums in the highest quartile.

credits. Therefore, using tax credits to purchase a bronze plan may yield lower net bronze premiums in higher-cost states or for older individuals and families.

[18] See http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm.

Figure 1: Percent of Uninsured Potentially Eligible for the Marketplaces by Second Lowest Cost Silver Premium Relative to ASPE-Derived CBO Estimate, 48 States

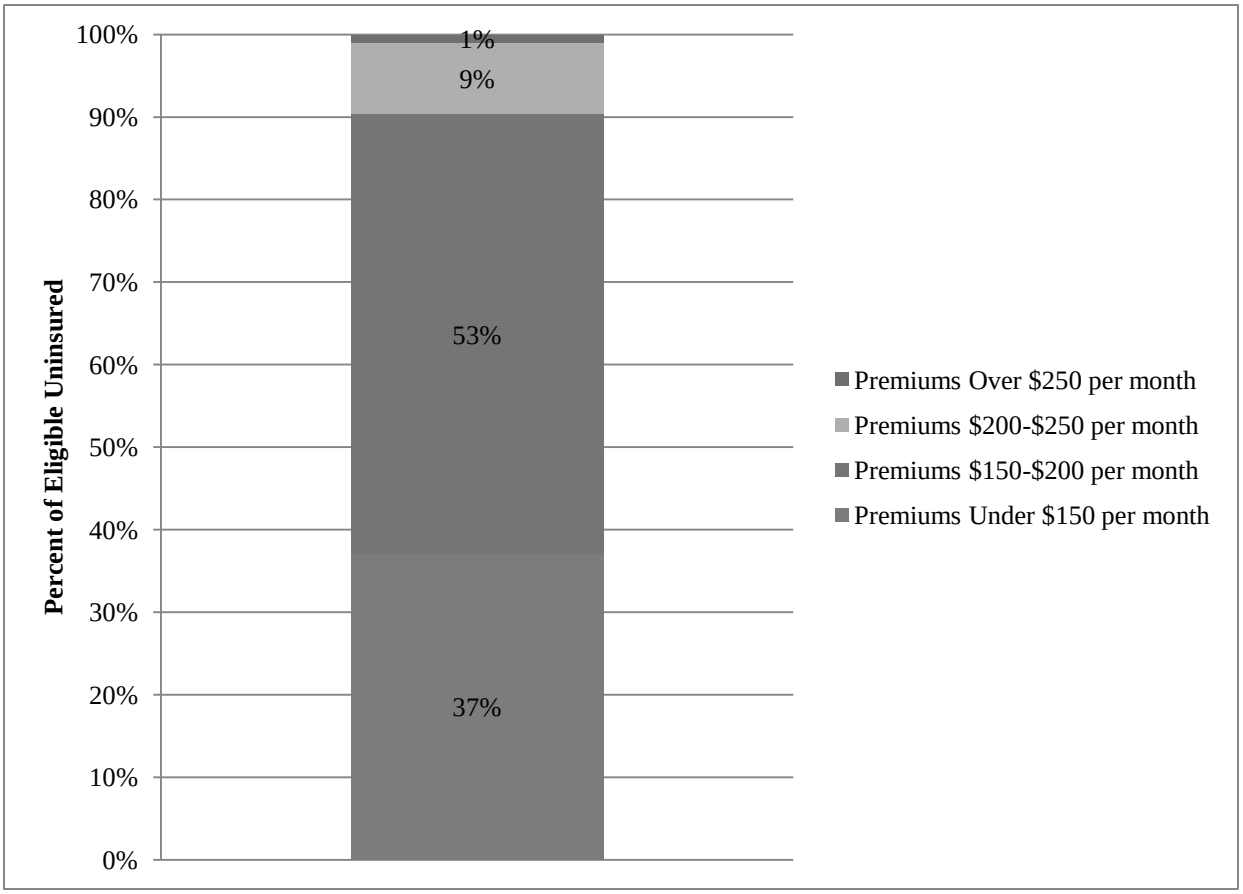
The following figure shows the distribution of uninsured Americans potentially eligible to enroll in the Marketplaces in the 48 states with available premium information, as compared to the ASPE-derived CBO premium estimate of $392 per month.



NOTE: This figure uses weighted average second lowest cost silver premiums as depicted in Table 4, before tax credits. States are weighted by the number of uninsured potentially eligible for the Marketplaces.

Figure 2: Percent of Uninsured Potentially Eligible for the Marketplaces by Lowest Cost Bronze Premium for a 27 Year Old, 36 States[19]

The following figure shows the distribution of uninsured Americans potentially eligible to enroll in the Marketplaces by bronze premiums for a 27-year-old.



NOTE: This figure uses weighted average lowest cost bronze premiums for a 27-year-old as depicted in Table 1, before tax credits. States are weighted by the number of uninsured potentially eligible for the Marketplaces.

[19] The 36 states included in this analysis are the Supported State-based Marketplaces, State Partnership Marketplaces, and Federally-facilitated Marketplaces, for which ASPE has complete data. We do not include State-based Marketplace data here.

Table 1: Premiums and Qualified Health Plan Choices, 36 States (Weighted average across entire state)

State	Average Number of QHPs[20]	27-Year-Old, Before Tax Credits				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[21]		
		Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[22]
AK[23]	34	$254	$312	$401	$236	$312	$107	$48	$1,131	$205	$0
AL	7	$162	$200	$248	$138	$209	$145	$98	$757	$282	$112
AR	28	$181	$231	$263	$135	$241	$145	$85	$873	$282	$64
AZ	106	$141	$164	$187	$107	$166	$145	$120	$600	$282	$192
DE	19	$203	$234	$282	$137	$237	$145	$111	$859	$282	$158
FL	102	$169	$200	$229	$132	$218	$145	$96	$789	$282	$104
GA	50	$179	$208	$242	$142	$221	$145	$103	$800	$282	$132
IA	39	$139	$175	$203	$95	$189	$145	$96	$683	$282	$103
ID	42	$150	$182	$211	$134	$188	$145	$107	$680	$282	$144
IL	58	$134	$180	$210	$134	$188	$145	$90	$682	$282	$84
IN	34	$200	$258	$332	$168	$265	$145	$80	$961	$282	$46
KS	37	$130	$171	$192	$87	$171	$145	$104	$619	$282	$133
LA	40	$175	$235	$253	$142	$249	$145	$71	$902	$282	$15
ME	20	$216	$255	$336	$182	$265	$145	$96	$961	$282	$104
MI	43	$146	$178	$218	$118	$202	$145	$89	$731	$282	$80
MO	17	$162	$211	$242	$110	$220	$145	$87	$798	$282	$72
MS	22	$225	$265	$321	N/A	$295	$145	$75	$1,069	$282	$28

[20] Not including catastrophic plans.
[21] For the purposes of this analysis, a family of four is defined as one 40-year-old adult, one 38-year-old adult, and two children under the age of 18.
[22] After tax credits, bronze premiums for a family of four may be below those for a single individual. This occurs because the tax credit is calculated as the difference between the cost of the second lowest cost silver plan premium and the maximum payment amount determined by income. Because premiums for older individuals and families are higher than those for younger individuals, tax credits are larger for older individuals and families. Therefore, using tax credits to purchase a bronze plan may yield lower bronze premiums for older individuals and families than for younger individuals.
[23] Alaska has an alternate Federal Poverty Level, which is used to calculate tax credits here.

State	Average Number of QHPs[20]	27-Year-Old, Before Tax Credits				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[21]		
		Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[22]
MT	26	$165	$204	$222	$149	$208	$145	$102	$753	$282	$126
NC	22	$186	$237	$283	$123	$243	$145	$88	$880	$282	$74
ND	24	$185	$230	$259	$142	$232	$145	$98	$841	$282	$111
NE	40	$159	$196	$232	$122	$206	$145	$98	$744	$282	$113
NH	12	$186	$236	$281	$157	$237	$145	$94	$859	$282	$96
NJ	29	$219	$253	$303	$186	$260	$145	$103	$943	$282	$131
NM	52	$143	$181	$204	$120	$186	$145	$102	$672	$282	$128
OH	46	$177	$200	$243	$131	$212	$145	$110	$768	$282	$156
OK	53	$114	$169	$203	$105	$175	$145	$84	$634	$282	$63
PA	56	$151	$170	$205	$125	$187	$145	$109	$675	$282	$152
SC	26	$176	$219	$259	$146	$223	$145	$97	$809	$282	$109
SD	32	$196	$225	$272	$169	$235	$145	$106	$852	$282	$141
TN	59	$119	$155	$205	N/A	$161	$145	$103	$584	$282	$128
TX	54	$139	$189	$225	$139	$201	$145	$83	$727	$282	$57
UT	82	$153	$183	$212	$116	$203	$145	$95	$656	$282	$122
VA	47	$156	$213	$253	$118	$221	$145	$80	$799	$282	$48
WI	97	$189	$227	$280	$150	$238	$145	$96	$861	$282	$106
WV	12	$185	$218	$266	$169	$218	$145	$112	$789	$282	$161
WY	16	$286	$324	$365	$259	$342	$145	$90	$1,237	$282	$81
Average, 36 States	53	$163	$203	$240	$129	$214	$145	$93	$774	$282	$95

NOTE: Premiums shown above are a weighted average of the lowest cost plans in each rating area within a state. Weights are derived from county-level population under the age of 65, projected by the Census Bureau. The average across all 36 states is based on the number of uninsured eligible for the Marketplaces.

Table 2: Premiums and Qualified Health Plan Choices, 36 States (Largest City in State)

State	City Name	Number of QHPs[24]	27-Year-Old, Before Tax Credits				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[25]		
			Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[26]
AK[27]	Anchorage	34	$254	$312	$402	$236	$312	$107	$48	$1,131	$205	$0
AL	Birmingham	10	$170	$209	$239	$140	$211	$145	$104	$765	$282	$134
AR	Little Rock	38	$190	$241	$276	$124	$251	$145	$84	$909	$282	$60
AZ	Phoenix	111	$139	$159	$181	$105	$161	$145	$123	$584	$282	$202
DE	Entire State	19	$203	$234	$282	$137	$237	$145	$111	$859	$282	$158
FL	Miami	137	$163	$202	$239	$109	$221	$145	$87	$799	$282	$72
GA	Atlanta	68	$166	$188	$214	$127	$205	$145	$105	$744	$282	$138
IA	Cedar Rapids	45	$132	$171	$193	$90	$189	$145	$88	$683	$282	$77
ID	Boise	46	$145	$179	$208	$128	$189	$145	$101	$685	$282	$122
IL	Chicago	73	$125	$172	$202	$141	$174	$145	$96	$628	$282	$106
IN	Indianapolis	31	$204	$278	$348	$170	$279	$145	$70	$1,011	$282	$11
KS	Wichita	36	$121	$162	$179	$81	$162	$145	$104	$587	$282	$134
LA	New Orleans	52	$170	$209	$238	$139	$242	$145	$74	$875	$282	$23
ME	Portland	17	$192	$233	$306	$162	$242	$145	$96	$876	$282	$103

[24] Not including catastrophic plans.
[25] For the purposes of this analysis, a family of four is defined as one 40-year-old adult, one 38-year-old adult, and two children under the age of 18.
[26] After tax credits, bronze premiums for a family of four may be below those for a single individual. This occurs because the tax credit is calculated as the difference between the cost of the second lowest cost silver plan premium and the maximum payment amount determined by income. Because premiums for older individuals and families are higher than those for younger individuals, tax credits are larger for older individuals and families. Therefore, using tax credits to purchase a bronze plan may yield lower bronze premiums for older individuals and families than for younger individuals.
[27] Alaska has an alternate Federal Poverty Level, which is used to calculate tax credits here.

State	City Name	Number of QHPs[24]	27-Year-Old, Before Tax Credits				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[25]		
			Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[26]
MI	Detroit	50	$138	$156	$181	$105	$184	$145	$99	$665	$282	$115
MO	St. Louis	20	$147	$196	$213	$100	$216	$145	$76	$782	$282	$32
MS	Jackson	22	$199	$226	$258	$150	$336	$145	$8	$1,216	$282	$0
MT	Bozeman	26	$163	$201	$219	$147	$206	$145	$102	$744	$282	$126
NC	Charlotte	28	$183	$247	$285	$115	$251	$145	$77	$910	$282	$36
ND	Fargo	24	$175	$217	$242	$128	$222	$145	$98	$805	$282	$110
NE	Omaha	50	$162	$210	$252	$114	$222	$145	$84	$805	$282	$62
NH	Entire State	12	$186	$236	$281	$157	$237	$145	$94	$859	$282	$96
NJ	Entire State	29	$219	$253	$303	$186	$260	$145	$103	$943	$282	$131
NM	Albuquerque	55	$126	$155	$186	$110	$159	$145	$112	$577	$282	$162
OH	Columbus	29	$205	$196	$245	$151	$207	$145	$142	$751	$282	$273
OK	Oklahoma City	61	$105	$158	$204	$107	$165	$145	$85	$597	$282	$66
PA	Philadelphia	42	$195	$210	$250	$171	$246	$145	$94	$891	$282	$96
SC	Columbia	28	$166	$218	$244	$113	$220	$145	$90	$798	$282	$84
SD	Sioux Falls	32	$196	$207	$251	$164	$217	$145	$124	$785	$282	$207
TN	Nashville	72	$114	$148	$197	$131	$154	$145	$104	$559	$282	$135
TX	Houston	46	$138	$195	$233	$132	$201	$145	$81	$728	$282	$52
UT	Salt Lake	85	$143	$162	$188	$110	$197	$145	$91	$635	$282	$109
VA	Fairfax County	56	$144	$213	$258	$124	$223	$145	$66	$807	$282	$0
WI	Milwaukee	84	$200	$247	$300	$169	$258	$145	$86	$935	$282	$70
WV	Huntington	12	$176	$208	$253	$161	$208	$145	$113	$753	$282	$167
WY	Cheyenne	16	$271	$307	$346	$245	$324	$145	$92	$1,171	$282	$92

Table 3: Premiums and Qualified Health Plan Choices, 25 Metropolitan Statistical Areas in 36 States (Largest Rating Area in MSA)

MSA Name	Number of QHPs[28]	27-Year-Old Rates				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[29]		
		Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[30]
Dallas-Fort Worth, TX	43	$153	$217	$266	$173	$223	$145	$74	$808	$282	$26
Houston-Brazoria, TX	46	$138	$195	$233	$132	$201	$145	$81	$728	$282	$52
Atlanta, GA	68	$166	$188	$214	$127	$205	$145	$105	$744	$282	$138
Chicago, IL	73	$125	$172	$202	$141	$174	$145	$96	$628	$282	$106
Miami-Hialeah, FL	137	$163	$202	$239	$109	$221	$145	$87	$799	$282	$72
Tampa-St. Petersburg-Clearwater, FL	102	$167	$189	$218	$129	$199	$145	$113	$721	$282	$165
Phoenix, AZ	111	$139	$159	$181	$105	$161	$145	$123	$584	$282	$202
Philadelphia, PA	42	$195	$210	$250	$171	$246	$145	$94	$891	$282	$96
New York-Northeastern NJ	29	$219	$253	$303	$186	$260	$145	$103	$943	$282	$131
Orlando, FL	98	$182	$207	$238	$141	$225	$145	$102	$816	$282	$126
Detroit, MI	50	$138	$157	$181	$105	$184	$145	$100	$665	$282	$118
San Antonio, TX	58	$138	$168	$192	$109	$196	$145	$87	$710	$282	$73
Fort Lauderdale-Hollywood-Pompano Beach, FL	132	$128	$174	$189	$86	$199	$145	$74	$722	$282	$24

[28] Not including catastrophic plans.
[29] For the purposes of this analysis, a family of four is defined as one 40-year-old adult, one 38-year-old adult, and two children under the age of 18.
[30] After tax credits, bronze premiums for a family of four may be below those for a single individual. This occurs because the tax credit is calculated as the difference between the cost of the second lowest cost silver plan premium and the maximum payment amount determined by income. Because premiums for older individuals and families are higher than those for younger individuals, tax credits are larger for older individuals and families. Therefore, using tax credits to purchase a bronze plan may yield lower bronze premiums for older individuals and families than for younger individuals.

MSA Name	Number of QHPs[28]	27-Year-Old Rates				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[29]		
		Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[30]
St. Louis, MO	20	$147	$196	$213	$100	$216	$145	$76	$782	$282	$32
Indianapolis, IN	31	$204	$278	$348	$170	$279	$145	$70	$1,011	$282	$11
Charlotte-Gastonia-Rock Hill, NC	28	$183	$247	$285	$115	$251	$145	$77	$910	$282	$36
Cleveland, OH	45	$152	$201	$245	$121	$204	$145	$93	$738	$282	$94
Washington DC Metro Area, VA	56	$144	$213	$258	$124	$223	$145	$66	$807	$282	$0
Pittsburgh, PA	36	$119	$134	$169	$104	$139	$139	$119	$505	$282	$209
Austin, TX	76	$144	$169	$193	$109	$205	$145	$85	$741	$282	$64
Salt Lake City-Ogden, UT	85	$143	$162	$188	$110	$197	$145	$91	$635	$282	$109
West Palm Beach-Boca Raton-Delray Beach, FL	132	$147	$167	$193	$109	$220	$145	$72	$797	$282	$18
McAllen-Edinburg-Pharr-Mission, TX	30	$109	$153	$174	$98	$155	$145	$99	$560	$282	$117
Jacksonville, FL	86	$137	$186	$202	$92	$210	$145	$72	$760	$282	$19
Greensboro-Winston Salem-High Point, NC	17	$167	$224	$260	$105	$228	$145	$84	$826	$282	$62

NOTE: For MSAs that include multiple rating areas, this table shows only the largest rating area within that MSA. Rating area population is derived from county-level population under the age of 65, projected by the Census.

Table 4: Weighted Average Premiums, 48 States

State	Lowest Cost Silver	Second Lowest Cost Silver	Lowest Cost Bronze
Alabama	$303	$318	$247
Alaska	$474	$474	$385
Arizona	$248	$252	$214
Arkansas	$351	$366	$275
California	$341	$373	$278
Colorado	$305	$305	$232
Connecticut	$397	$436	$340
Delaware	$356	$360	$308
District of Columbia	$293	$297	$204
Florida	$304	$328	$257
Georgia	$304	$317	$265
Idaho	$276	$285	$227
Illinois	$274	$286	$203
Indiana	$392	$403	$304
Iowa	$266	$287	$212
Kansas	$260	$260	$197
Louisiana	$356	$374	$265
Maine	$388	$403	$328
Maryland	$266	$299	$197
Michigan	$271	$306	$222
Minnesota	$192	$192	$144
Mississippi	$403	$448	$342
Missouri	$318	$334	$245
Montana	$309	$316	$251
Nebraska	$298	$312	$241
Nevada	$295	$297	$227
New Hampshire	$359	$360	$282
New Jersey	$382	$385	$332
New Mexico	$275	$282	$217
New York[31]	$319	$349	$276
North Carolina	$361	$369	$282
North Dakota	$350	$353	$281
Ohio	$304	$321	$263
Oklahoma	$256	$266	$174
Oregon	$241	$250	$205
Pennsylvania	$259	$286	$229
Rhode Island	$341	$366	$264
South Carolina	$333	$339	$267

[31] New York premiums are the same for all ages.

State	Lowest Cost Silver	Second Lowest Cost Silver	Lowest Cost Bronze
South Dakota	$341	$357	$298
Tennessee	$235	$245	$181
Texas	$287	$305	$211
Utah	$239	$266	$201
Vermont[32]	$395	$413	$336
Virginia	$323	$335	$237
Washington	$350	$352	$264
West Virginia	$331	$331	$280
Wisconsin	$344	$361	$287
Wyoming	$489	$516	$425
Weighted Average, 48 States	$310	$328	$249

NOTE: Premiums shown above are a weighted average of the lowest cost silver plan, the second lowest cost silver plan, and the lowest cost bronze plan in each rating area within the 36 Supported State-based Marketplaces, State Partnership Marketplaces, and Federally-Facilitated Marketplaces as of September 18, 2013, as well as 12 State-based Marketplaces. The rating area weights are constructed based on county-level population under the age of 65. For State-based Marketplaces, premiums are a weighted average across all rating areas for California and New York, and are for the entire state in DC, Rhode Island, and Vermont. For the remaining states, premiums are for the following rating areas: Denver, Colorado; Bridgeport, Hartford, and New Haven, Connecticut; Baltimore, Maryland; Minneapolis and St. Paul, Minnesota; Las Vegas, Nevada; Portland, Oregon; Seattle, Washington. Age weighting for all states is based on expected age distribution in the Marketplaces, estimated by the RAND Corporation.

[32] Vermont premiums are the same for all ages.

Methodology

These analyses are based on data submitted to the Centers for Medicare and Medicaid Services (CMS) from 36 states, as well as publicly available premium information from 12 State-based Marketplaces. As Supported State-based Marketplaces, Idaho and New Mexico submitted plan data to CMS for display using Federal web architecture and are included in the 36 state analysis. The data used in this brief are current as of September 18, 2013. At that time, not all issuers' data had been completely verified in CMS systems. In addition, as of that date, three State-based Marketplaces had not yet published any premium information, and other states had published estimates or incomplete information. Therefore, the premiums presented in this paper should be considered illustrative, not final.

Some State-based Marketplaces have not published all premiums for each **issuer**. In Maryland, we display the silver plans from the lowest cost issuer and the second lowest cost issuer rather than for the second lowest cost silver **plan**. For all other states, we display the lowest cost silver plan and the second lowest cost silver plan. The ASPE-derived CBO estimate used for comparison to silver plans is based on the latest CBO premium estimates, adjusted as described in prior ASPE issue briefs.[33]

We use several different types of weighting in these analyses. To develop an age-weighted average premium within a single rating area, we used the expected age distribution of individual market enrollees in 2014 from the RAND COMPARE Microsimulation model. To develop a statewide average premium across rating areas, we weighted each rating area within a state by the total population under age 65 within that rating area. These population weights were developed using Census projections of county-level population for 2012.[34] To develop a nationwide average including all states, we weighted by the number of uninsured potentially eligible for the Marketplace in each state, developed from the 2011 American Community Survey (ACS) Public Use Microdata Sample.[35] These estimates represent non-elderly US citizens and legal residents who are uninsured and have incomes above 138% of the Federal Poverty Level in Medicaid expansion states or above 100% of the Federal Poverty Level in non-expansion states. These estimates do not take into account the eligibility requirements relating to other minimum essential coverage.

All premium tax credits presented in this issue brief are calculated based on the 2013 Federal Poverty Guidelines.[36] These Guidelines represent the Federal Poverty Levels that will be used for the 2014 plan year.

[33] See http://aspe hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.cfm
[34] See http://www.census.gov/popest/data/counties/asrh/2012/CC-EST2012-ALLDATA html.
[35] For data and further methodological details, see http://cms.gov/Outreach-and-Education/Outreach/HIMarketplace/Census-Data-.html?no_redirect=true.
[36] See http://aspe hhs.gov/poverty/13poverty.cfm.

Exhibit 7

Health Status of Exchange Enrollees: Putting Rate Shock in Perspective

Timely Analysis of Immediate Health Policy Issues
July 2013
Linda J. Blumberg and John Holahan

Summary

Recent news reports have focused on the health insurance premiums that will be available to those purchasing nongroup insurance under the Affordable Care Act's (ACA) reforms that will be implemented in 2014. Many stories originally focused on "rate shock"—the concern of insurers and others that some of those with current nongroup coverage will face significantly higher premiums once the nongroup market becomes more accessible and affordable for those with health problems. More recently, however, stories have focused on premiums made public in some states, where several insurers (although not all) are identifying the reforms as a significant expansion opportunity and are setting premiums competitively in order to continue to attract lower-cost enrollees, whose enrollment decisions are the most sensitive to high prices. While some have been surprised at the lower premium bids in light of the pervasive "rate shock" warnings in political circles, these premiums are consistent with the findings of the analysis presented here.

We compare the population most likely to enroll in the ACA's nongroup market exchanges to those who now have employer coverage, focusing on characteristics related to their health risks. This comparison seems apt, since there is widespread agreement that the large population enrolled in employer-based insurance coverage constitutes an actuarially sound, long-term sustainable risk pool. To the extent that the population likely to enroll in the nongroup exchange and nonexchange markets under the ACA is similar in health-related characteristics to the larger employer-based market, unsubsidized premiums in the reformed nongroup market should be set at reasonable levels.

While individuals with higher-than-average health care needs may be somewhat more likely to enroll in the nongroup market in the first year, once past the transition period, the health characteristics of nongroup enrollees can be expected to be quite similar to those with employer-based insurance. The exchange target population is slightly less likely to report excellent, very good or good physical and mental health; less likely to report any of several chronic conditions; more likely to be smokers (although the simulated enrollment population is less likely to smoke); and less likely to be obese than those with employer insurance. Many exchange enrollees will receive subsidies—premiums paid by enrollees will be based on a percentage of income—so the availability of subsidies will reduce any impact of total premiums being somewhat higher in the first year of implementation. If the exchange target population does not participate at the rates predicted given their characteristics, however, premiums could be higher than what we observe in the employer-based market.

Background

Beginning January 1, 2014, the Affordable Care Act (ACA) will bring significant changes to the private nongroup insurance market, including new prohibitions on health status–related discrimination in pricing, enrollment and benefits provided. The law also creates nongroup health insurance exchanges in each state designed to increase competition and transparency in insurance, and provides financial assistance for nongroup insurance purchasers with modest incomes. These reforms constitute significant changes to the currently small and generally exclusive nongroup insurance market. And with major change often comes uncertainty and concern over the implications.

Recent months have seen a mix of news reports, ranging from insurers and others worried that the premiums charged for nongroup exchange enrollees under reform would be very high—sometimes characterized as "rate shock"—to more positive stories of late reported on some lower than expected insurance premium bids in particular states. Generally, concerns center around whether some of those with current nongroup coverage will face significantly higher premiums than they do today once the nongroup market becomes more accessible and affordable for those with health problems. Specifically, many have raised concerns that some young adults with very low cost limited-benefit policies today who are not eligible for subsidies will see significant increases in premiums. Policy-maker and stakeholder worries over premiums also reflect

Robert Wood Johnson Foundation
Urban Institute

carriers' fears of adverse selection—that those with higher medical needs will be overrepresented in particular health plans or markets, or that, in the beginning of implementation, those in worse health, for example, will be the first to enroll in the new exchanges while those in good health will delay enrolling.

For these reasons, some insurers could set premiums at relatively high levels in the first year of health reform implementation. However, within an indeterminate but likely short period, large numbers of more moderate-risk individuals are expected to enroll in the nongroup exchanges because of the existence of a more stable, reliable, and adequate source of coverage outside the workplace; the income-related subsidies to lower the cost of premiums and cost-sharing for many; and the new requirement that most individuals obtain insurance coverage or pay a tax.[1] In fact, the federal subsidies, structured to limit the share of income an eligible enrollee must contribute toward his/her own insurance, will shield most exchange enrollees from transitional turbulence in premiums. We are already seeing that, in some states, several insurers (although not all) are identifying the reforms as a significant expansion opportunity and are setting premiums competitively in order to continue to attract lower-cost enrollees, whose enrollment decisions are the most sensitive to high prices.[2] While some in the media have been surprised at the lower premium bids in light of the pervasive "rate shock" warnings in political circles, these premiums are consistent with the findings of the analysis presented here.

This paper examines the larger picture: what is the post-transition pool of individuals insured in the reformed nongroup market likely to look like? We examine the health-related characteristics of those likely to enroll in exchanges. We focus primarily on those who have nongroup coverage or are uninsured prior to reform. These individuals will make up the bulk of nongroup market enrollment, both inside and outside exchanges. A very small share of those with current employer or Medicaid coverage will obtain nongroup coverage under the ACA, but they are estimated to make up a very small percentage of this market.[3] Consequently, the key analytic question we address here is how those with current nongroup coverage and those currently uninsured compare in health risk to those who now have employer coverage. This comparison seems apt, since there is widespread agreement that the large population enrolled in employer-based insurance coverage constitutes an actuarially sound, long-term sustainable risk pool. (Employer premiums themselves are higher than many would like but this is an overall health system issue; there are many provisions of the ACA that address cost containment.[4]) To the extent that the population likely to enroll in the nongroup exchange and nonexchange markets under the ACA is similar in health-related characteristics to the larger employer-based market, unsubsidized premiums in the reformed nongroup market should be set at reasonable levels.

We also compare the characteristics of those likely to enroll in the ACA's nongroup market to those in public coverage programs. This comparison provides some insight into the risk pool implications of moving significant portions of Medicaid enrollees into the exchange-based risk pools, an idea that is being considered in some states but is not an explicit component of the ACA.[5] As reported in Appendix Table 1, there are some differences in health status measures between those with nongroup coverage and the uninsured in the exchange target population. For example, nongroup enrollees are more likely to report being in excellent, very good or good physical and mental health than the uninsured but are also more likely to have certain chronic conditions such as arthritis, asthma and high blood pressure. However, exchange enrollees will make up one unified risk pool, regardless of pre-reform insurance status, and as such we combine them into one group here.

We conclude that:

- Any "rate shock" that occurs will be a transitional phenomenon; competition will result in average premiums in the nongroup exchanges at reasonable levels;
- The health status of those expected to enroll in the nongroup exchanges is similar to those in the employer market today: they are slightly less likely to report being in excellent, very good or good health (92.3 percent versus 93.8 percent), but they are also less likely to report a number of chronic conditions, including arthritis, high blood pressure, diabetes and heart disease;
- Those expected to enroll in the nongroup exchange are significantly less likely than those with employer coverage to smoke (13.7 percent versus 16.8 percent) and are significantly less likely to be obese (23.7 percent versus 27.2 percent);
- While we focus on individual characteristics related to expected use of health care services and do not estimate premiums explicitly, premiums in the reformed nongroup market will reflect the health status similarities with the employer-based insurance pool while differing in administrative costs, cost-sharing and benefits; and
- Enrolling the Medicaid *expansion* population in nongroup exchanges will have little effect on average health risk, although including the pre-ACA Medicaid eligible population would increase the average risk of exchange enrollees significantly.

Data and Approach

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) data file, including data from the Medical Expenditure Panel Survey–Household Component (MEPS-HC), in our descriptive analyses comparing the characteristics of likely nongroup exchange enrollees and employer-based insurance enrollees. HIPSM is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options. HIPSM simulates the decisions of employers, families and individuals to offer and enroll in health insurance coverage. The model predicts the impact of policy on changes in government and private health care spending, uncompensated care costs, health insurance premiums in employer and nongroup health insurance risk pools, rates of employer offers of coverage, and health insurance coverage.[6]

Table 1: Demographic Characteristics of Adults 19–64 with MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit (HIU)

	Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the HIU				All with Current Employer Sponsored Insurance	
	Current ESI		Current Nongroup/Uninsured			
	N	%	N	%	N	%
Total (19–64)	5,312,200	100.0%	16,197,300	100.0%	110,777,200	100.0%
Age						
19–34	819,900	15.4%*	5,550,700	34.3%	31,517,300	28.5%*
35–54	2,187,100	41.2%*	7,395,100	45.7%	56,597,300	51.1%*
55–64	2,305,200	43.4%*	3,251,500	20.1%	22,662,600	20.5%*
Gender						
Male	2,657,300	50.0%*	9,168,200	56.6%	53,646,300	48.4%*
Female	2,654,900	50.0%*	7,029,100	43.4%	57,131,000	51.6%*
Race/Ethnicity						
Non-Hispanic White	4,494,100	84.6%*	10,612,900	65.5%	80,572,400	72.7%*
Non-Hispanic Black	263,600	5.0%*	1,668,500	10.3%	11,055,400	10.0%
Hispanic	272,900	5.1%*	2,748,100	17.0%	11,574,600	10.4%*
Non-Hispanic Other	281,600	5.3%*	1,167,800	7.2%	7,574,900	6.8%*
Modified Adjusted Gross Income as % of FPL						
Under 138% of FPL	0	0.0%	0	0.0%	7,424,500	6.7%*
138 to 199% of FPL	610,900	11.5%*	4,700,400	29.0%	7,059,300	6.4%*
200 to 299% of FPL	888,600	16.7%*	4,707,000	29.1%	16,237,700	14.7%*
300 to 399% of FPL	740,600	13.9%	2,296,400	14.2%	17,148,800	15.5%*
400% of FPL and Above	3,072,100	57.8%*	4,493,400	27.7%	62,906,900	56.8%*
Employment Status						
Full-Time, Full-Year Worker in HIU	3,204,100	60.3%*	10,422,700	64.3%	95,202,000	85.9%*
Less Than Full-Time, Full-Year Worker in HIU	799,800	15.1%*	4,712,500	29.1%	12,236,100	11.0%*
No Worker in HIU	1,308,300	24.6%*	1,062,100	6.6%	3,339,200	3.0%*
Education Status						
Less Than High School	169,900	3.2%*	1,828,300	11.3%	5,637,100	5.1%*
High School Graduate	1,266,500	23.8%*	5,412,000	33.4%	28,987,500	26.2%*
Some College	1,490,100	28.1%*	5,063,000	31.3%	33,970,100	30.7%*
College Graduate	2,385,700	44.9%*	3,893,900	24.0%	42,182,500	38.1%*

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured is statistically significant at the p <.05 level. This test is not carried out for the exchange target ESI versus all current ESI groups.

Health Insurance Unit (HIU) refers to the family members who can be covered by a single private insurance policy.

HIPSM, which has the Current Population Survey (CPS) as its core, statistically matches data from the MEPS-HC to CPS observations. The current version of HIPSM relies on merged data from the 2009 and 2010 CPS and 2006 to 2008 MEPS-HC, aged to 2011. The MEPS-HC is a longitudinal survey that contains data on insurance coverage, medical expenditures and a large number of health status measures for a large, nationally representative population.[7] The population of central interest for this analysis is made up of those with current nongroup insurance and those currently uninsured, both groups with incomes above 138 percent of the federal poverty level (FPL) (i.e., those who will not qualify for Medicaid under the ACA's public program expansion) and who do not have access to an affordable employer-sponsored insurance (ESI) offer in their household. Those with access to an affordable ESI offer (direct premium cost facing the worker for single coverage being less than 9.5 percent of family income) are not eligible for subsidized coverage in the new nongroup exchanges and are much more likely to obtain coverage through the offering employer as opposed to entering the exchange.

We use HIPSM's ACA simulation results of post-reform premiums and insurance offers in conjunction with family income data to identify the target population for exchange enrollment. The test of access to affordable employer insurance offers eliminates from subsidy eligibility about 95 percent of all workers with employer-sponsored insurance offers and with incomes above 138 percent of FPL. Undocumented immigrants are also excluded from the exchange target population, consistent with provisions of the ACA.

In later results we use HIPSM to assess the health status-related characteristics of the population that the model's full simulation specifically predicts to enroll in the nongroup exchanges under the

Table 2: Health Characteristics of Adults 19–64 with MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit

	Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer-Sponsored Insurance Offer in the Health Insurance Unit				All with Current Employer Sponsored Insurance	
	Current ESI		Current Nongroup/Uninsured			
	N	%	N	%	N	%
Total (19–64)	5,312,200	100.0%	16,197,300	100.0%	110,777,200	100.0%
General Health						
Excellent/Very Good/Good	4,919,600	92.6%*	14,828,700	91.6%	103,940,100	93.8%*
Fair/Poor	392,600	7.4%*	1,368,600	8.4%	6,837,100	6.2%*
Mental Health						
Excellent/Very Good/Good	4,945,300	93.1%*	14,300,700	88.3%	104,886,000	94.7%*
Fair/Poor	366,900	6.9%*	1,896,600	11.7%	5,891,200	5.3%*
Chronic Physical Conditions						
Arthritis	1,209,700	22.8%*	2,283,900	14.1%	17,011,000	15.4%*
Asthma	497,600	9.4%*	1,180,900	7.3%	9,975,700	9.0%*
Diabetes	446,100	8.4%*	909,300	5.6%	6,653,300	6.0%*
Emphysema	39,000	0.7%*	208,500	1.3%	513,500	0.5%*
Heart Disease[1]	505,300	9.5%*	1,005,000	6.2%	7,003,100	6.3%
High Blood Pressure	1,560,000	29.4%*	3,244,400	20.0%	24,905,500	22.5%*
Stroke	94,300	1.8%*	192,200	1.2%	1,080,600	1.0%
Current Smoker						
Yes	858,800	16.2%*	4,382,400	27.1%	18,599,500	16.8%*
No	4,453,400	83.8%*	11,814,900	72.9%	92,177,700	83.2%*
BMI						
Underweight (< 18.5)	45,600	0.9%*	295,300	1.8%	1,482,100	1.3%*
Normal Weight (18.5–24.9)	1,733,600	32.6%*	6,039,400	37.3%	39,916,200	36.0%*
Overweight (25.0–29.9)	2,016,100	38.0%	6,089,700	37.6%	39,204,900	35.4%*
Obese (30.0+)	1,516,800	28.6%*	3,772,800	23.3%	30,174,100	27.2%*
Limitation in Physical Functioning[2]	536,800	10.1%	1,524,800	9.4%	6,615,800	6.0%*

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured is statistically significant at the p <.05 level.

[1] Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

[2] Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

Health Insurance Unit refers to the family members who can be covered by a single private insurance policy.

ACA. The model predicts employer offer decisions and household/individual coverage decisions given the options and incentives available under different policy environments. People can enter exchanges by leaving employer plans, moving from current nongroup coverage to exchange-based nongroup coverage, or by gaining coverage after having been uninsured. If some of the small number of states that have already expanded Medicaid eligibility above ACA levels eliminate Medicaid eligibility for groups with incomes above 138 percent of FPL in response to the reforms, some people will switch from Medicaid to exchange coverage.

HIPSM considers various characteristics, such as age, health status, health expenditures, socioeconomic information, and preferences revealed by pre-reform coverage choices to predict who will enroll in coverage. Thus, this approach provides a more nuanced alternative for predicting the characteristics of those who will enroll in exchange-based coverage post-reform, compared to the first set of results presented in the paper that focus on a larger group of potential enrollees. HIPSM simulates the effects of policy changes in equilibrium, and as such the results presented do not represent short-term effects that may occur during a transition period.

Finally, there has been an interest on the part of several states in potentially enrolling their Medicaid expansion populations—those with incomes below 138 percent of FPL—in private plans in the exchanges rather than through traditional Medicaid programs and exclusive Medicaid managed care plans. One important concern with such an approach is the implication of merging at least a portion of the Medicaid eligible population into the insurance risk pool with the exchange enrollees.[8] Does the Medicaid expansion population tend to be sicker than those with incomes above 138 percent of FPL who are likely to enroll in the exchanges? How would the risk pool differ if all nonelderly Medicaid enrollees are placed into exchange plans? If Medicaid enrollees' health profiles differ significantly from the profile of expected exchange enrollees, merging the pools together could have significant premium implications for the exchange populations, with particularly significant financial implications for those enrolling without federal subsidies. Again, we use HIPSM simulations of Medicaid eligibility and enrollment under the ACA to identify the appropriate populations for analysis.

Table 3: Health Characteristics of Adults 19–64 Simulated to Enroll in Nongroup Exchange Under ACA

	Simulated Nongroup Exchange Enrollment, Above 138% of FPL, Without Affordable Employer Offer[3]		All with Current Employer-Sponsored Insurance	
	N	%	N	%
Total (19–64)	9,186,500	100.0%	110,777,200	100.0%
General Health				
Excellent/Very Good/Good	8,476,300	92.3%	103,940,100	93.8%*
Fair/Poor	710,200	7.7%	6,837,100	6.2%*
Mental Health				
Excellent/Very Good/Good	8,351,700	90.9%	104,886,000	94.7%*
Fair/Poor	834,800	9.1%	5,891,200	5.3%*
Chronic Physical Conditions				
Arthritis	1,255,000	13.7%	17,011,000	15.4%*
Asthma	672,400	7.3%	9,975,700	9.0%*
Diabetes	486,100	5.3%	6,653,300	6.0%
Emphysema	87,100	0.9%	513,500	0.5%*
Heart Disease[1]	481,600	5.2%	7,003,100	6.3%*
High Blood Pressure	1,725,100	18.8%	24,905,500	22.5%*
Stroke	84,500	0.9%	1,080,600	1.0%
Current Smoker				
Yes	1,257,200	13.7%	18,599,500	16.8%*
No	7,929,300	86.3%	92,177,700	83.2%*
BMI				
Underweight (< 18.5)	169,100	1.8%	1,482,100	1.3%*
Normal Weight (18.5–24.9)	3,396,700	37.0%	39,916,200	36.0%
Overweight (25.0–29.9)	3,443,300	37.5%	39,204,900	35.4%*
Obese (30.0+)	2,177,400	23.7%	30,174,100	27.2%*
Limitation in Physical Functioning[2]	**742,100**	**8.1%**	**6,615,800**	**6.0%***

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup Exchange is statistically significant at the p <.05 level.

[1] Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

[2] Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

[3] A small percentage of simulated nongroup exchange enrollees have MAGI below 138% of FPL due to immigration status and length of residence in the US, and a small percentage of enrollees will opt for exchange coverage even though they have affordable offers of employer-sponsored insurance. These small groups are excluded from this table for comparability with the other tables in this analysis.

Throughout the analysis, family income is defined at the health insurance unit (HIU) level[9] using the modified adjusted gross income (MAGI)[10] computation consistent with income eligibility definitions in the ACA. This analysis also focuses exclusively on nonelderly adults, excluding the population age 65 and above as well as children age 18 or under. The vast majority of the elderly population will be excluded from the exchanges due to Medicare eligibility, and the expected health care costs of children do not vary as much as they do for adults across population groups, meaning their inclusion could complicate identifying risk differences central to this analysis.

A number of recent studies have shown that self-reported health status has strong predictive power in identifying individuals at risk for high health expenditures.[11] As a result, assessing differences in such measures across population groups can provide insights into the expected health care costs associated with different pools of insured individuals.

Results

Demographic Characteristics of the Potential Exchange Population. Table 1 allows us to compare the socioeconomic characteristics of those nonelderly adults with current employer-sponsored insurance (the rightmost set of columns) with nonelderly adults who constitute the target population for the new nongroup exchanges. These target populations include those with incomes above 138 percent of FPL (the ACA's Medicaid expansion eligibility level) without affordable offers of coverage through an employer once the ACA is fully implemented. We separate this target population into its two component groups: those with current ESI coverage (many of whom are already paying more on their own than what the ACA deems as its threshold of affordability) and those who have either nongroup coverage today or are uninsured. More than three-quarters of the target population is composed of the nongroup/uninsured (approximately 16.2 million people, compared to about 5.3 million people with current ESI coverage that costs the worker more than 9.5 percent of family income). We separate these two groups since those with current ESI are significantly less likely to leave that coverage and enroll in the exchanges than are their counterparts with current nongroup coverage or who are currently uninsured.

Table 4: Health Characteristics of Adults 19–64, Comparing Current Medicaid Enrollees, Medicaid Expansion Target Population, and the Nongroup Exchange Target Population

	Adults (19-64)					
	Current Medicaid Under 138% of FPL Nondisabled		Medicaid Expansion Target Population: Current Nongroup/Uninsured Under 138% of FPL		Exchange Target Population: Nongroup/Uninsured Above 138% of FPL Without Affordable Employer Offer	
	N	%	N	%	N	%
Total (19–64)	8,836,400	100.0%	20,941,000	100.0%	16,197,300	100.0%
General Health						
Excellent/Very Good/Good	6,135,500	69.4%*	17,480,900	83.5%*	14,828,700	91.6%
Fair/Poor	2,700,900	30.6%*	3,460,100	16.5%*	1,368,600	8.4%
Mental Health						
Excellent/Very Good/Good	7,044,900	79.7%*	19,116,800	91.3%*	14,300,700	88.3%
Fair/Poor	1,791,500	20.3%*	1,824,200	8.7%*	1,896,600	11.7%
Chronic Physical Conditions						
Arthritis	1,510,000	17.1%*	1,994,600	9.5%*	2,283,900	14.1%
Asthma	1,124,500	12.7%*	1,362,300	6.5%*	1,180,900	7.3%
Diabetes	906,900	10.3%*	808,900	3.9%*	909,300	5.6%
Emphysema	92,400	1.0%	127,900	0.6%*	208,500	1.3%
Heart Disease[1]	640,300	7.2%*	786,800	3.8%*	1,005,000	6.2%
High Blood Pressure	1,985,200	22.5%*	2,766,200	13.2%*	3,244,400	20.0%
Stroke	206,600	2.3%*	162,200	0.8%*	192,200	1.2%
Current Smoker						
Yes	2,638,000	29.9%*	5,285,400	25.2%	4,382,400	27.1%
No	6,198,400	70.1%*	15,655,600	74.8%	11,814,900	72.9%
BMI						
Underweight (< 18.5)	237,400	2.7%*	549,600	2.6%*	295,300	1.8%
Normal Weight (18.5–24.9)	2,918,400	33.0%*	7,752,600	37.0%*	6,039,400	37.3%
Overweight (25.0–29.9)	2,450,700	27.7%*	7,543,700	36.0%	6,089,700	37.6%
Obese (30.0+)	3,229,900	36.6%*	5,095,100	24.3%*	3,772,800	23.3%
Limitation in Physical Functioning[2]	**1,410,700**	**16.0%***	**1,248,500**	**6.0%***	**1,524,800**	**9.4%**

Source: HIPSM 2011

Note: An ESI offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from Nongroup/Uninsured Above 138% of FPL is statistically significant at the p <.05 level.

[1] Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

[2] Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

The data in Table 1 show that the current nongroup/uninsured population with income above the ACA's Medicaid eligibility level is younger and more likely to be male than the full employer-sponsored insurance population.[12] For example, 34.3 percent of the nongroup/uninsured population is between the ages of 19 and 34 versus 28.5 percent of the full ESI population. Similarly, 56.6 percent of the nongroup/uninsured population is male versus 48.4 percent of the ESI population. They are also more likely to be Hispanic (17.0 percent versus 10.4 percent) and less likely to be non-Hispanic white. This target group has, on average, significantly lower income; about 57 percent of the full ESI population has family income at 400 percent of FPL or above versus about 28 percent for the nongroup/uninsured target population. The target population of nongroup/uninsured also has lower levels of full-time employment.

The ESI target population—those enrolled in employer coverage but whose premium under the ACA would not be deemed affordable—are considerably older, are much more likely to be non-Hispanic white, have substantially higher incomes, and tend to be significantly more highly educated than their counterparts who are currently nongroup-covered or uninsured.

Health Status of the Potential Exchange Population. We find that the combined nongroup/uninsured target population is slightly less likely to report excellent, very good or good health than the ESI population: 91.6 percent versus 93.8 percent, respectively (Table 2). The target population is also less likely to report excellent, very good or good mental health: 88.3 percent versus 94.7 percent. On the other hand, the nongroup/uninsured are less likely to report chronic conditions. This includes arthritis (14.1 percent versus 15.4 percent), asthma (7.3 percent versus 9.0 percent), diabetes (5.6 percent versus 6.0 percent), and high blood pressure (20.0 percent versus 22.5 percent). These differences in chronic conditions between the groups diminish considerably within age group (data not shown), meaning that the exchange target population has lower rates of prevalence of chronic conditions largely due to the population being younger.

The nongroup/uninsured are, however, far more likely to be smokers than the

full ESI population: 27.1 percent versus 16.8 percent, respectively. The nongroup/uninsured are very similar to the full ESI population in body mass index (BMI), with a lower share of the nongroup uninsured being obese (23.3 percent versus 27.2 percent of the full ESI group). The nongroup/uninsured are more likely to have a limitation in physical functioning (9.4 percent versus 6.0 percent).

The ESI target population reports similar general health and mental health as the full ESI population (92.6 percent versus 93.8 percent, a statistically significant difference, but small in magnitude), but higher rates of some chronic conditions, for example arthritis, diabetes, heart disease, high blood pressure and stroke. They are slightly less likely to be normal weight or underweight compared to the full ESI population, but they have statistically identical smoking rates to that group. Ten percent of the target ESI population has a limitation in physical functioning, compared to 6 percent of the full ESI population.

Thus, we conclude that the population likely to enter the exchange—those with nongroup coverage or who are uninsured without affordable employer offers—look quite similar to those who now have employer-sponsored insurance. (A major reason for this is that those with the most severe health problems are already covered by Medicare or Medicaid—data not shown.) It is also possible that those uninsured today have some characteristics not measured here that make them even less likely to use medical care than is suggested here, characteristics that are associated with their uninsured status. Regardless, the results shown here mean that, all else being equal, average premiums for this population should not differ markedly from the ESI market overall. But not all is equal; administrative costs should be higher in the nongroup exchange, while nongroup plans are likely to have fewer benefits and more cost-sharing than many employer plans, all of which will determine premiums along with the average health status of the populations enrolled.

Simulating Exchange Enrollment. Table 3 represents the results of a full simulation of exchange enrollment using HIPSM. As noted earlier, we used HIPSM to predict who would enroll in nongroup coverage in the exchange, including those moving from existing nongroup coverage to exchange enrollment, those gaining coverage after being uninsured, or those switching from employer coverage into the exchange. This allows us to take advantage of the sophisticated behavioral modeling incorporated in HIPSM to predict more precisely who will enroll, as opposed to the broader population targeted by the policies. For example, the model considers factors such as age and health status—those with greater needs for care would be more likely to sign up as would those qualifying for larger premium tax credits.

When we compare results of the simulated enrollment with the ESI population, we find again that the simulated nongroup exchange enrollees are only slightly less likely to report excellent, very good or good general and mental health—in fact, the simulated enrollment group looks slightly more similar to the ESI group than did the broader target group on these measures. While the differences are statistically significant, they are not substantially different in absolute magnitude.

In contrast, when we look at chronic conditions, the simulated nongroup exchange enrollees remain less likely to have arthritis, asthma, heart disease and high blood pressure than the ESI population. Notably, the simulated exchange enrollees are significantly *less* likely to be smokers than the ESI population, even though the broader target nongroup/uninsured population is considerably *more* likely to smoke. This is the consequence of the ACA's rules allowing insurers to charge tobacco users up to 1.5 times the premium of non-tobacco users of the same age for the same coverage; the higher premiums will dissuade smokers from obtaining coverage. Simulated exchange enrollees are also less likely to be obese than those with ESI coverage but again have higher rates of physical functioning limitations. Thus, again, the results are somewhat mixed but there are strong similarities between the expected exchange enrollees and the population with ESI in characteristics that are likely to be associated with health care costs. Thus, we would expect the average premiums in nongroup exchange plans to be similar to what we observe in the employer market today, other than presumably somewhat higher administrative costs and differences in benefits provided and cost-sharing options chosen.

Merging Medicaid and Exchanges. Table 4 compares the ACA's exchange target population of nongroup/uninsured with the population targeted by the Medicaid expansion, and those currently enrolled in Medicaid and not disabled. This indicates the implications for risk pools of merging the Medicaid expansion population into exchanges. The ACA's exchange target population of nongroup/uninsured report better general health (91.6 percent being in excellent, very good or good health) than those in the Medicaid expansion target population (83.5 percent in excellent, very good or good health). On the other hand, the Medicaid expansion target population is slightly more likely to report excellent, very good or good mental health—91.3 percent versus 88.3 percent—a significant but probably not meaningful difference. In general, the lower income Medicaid expansion target population is less likely to have chronic conditions, including being less likely to suffer from arthritis, asthma, diabetes, emphysema, heart disease, high blood pressure and stroke. Also, there is no significant difference between the two groups in the likelihood of being a smoker, their BMI profiles are very similar, and the Medicaid expansion population is less likely to have a limitation in physical functioning. Again this is a slightly mixed picture, but it suggests that bringing the Medicaid expansion population into the exchanges would not significantly affect the risk pool.

Bringing the entire currently enrolled Medicaid population with incomes below 138 percent of FPL into the exchange is a very different story, even excluding current enrollees with disabilities. The current nonelderly nondisabled Medicaid population is substantially less likely to report being in excellent, very good or good health—69.4 percent versus 91.6 percent in the exchange target population. They are also less likely to report excellent, very good, or good mental health—79.7 percent

versus 88.3 percent. They are more likely to have several chronic conditions, including arthritis, asthma, diabetes, heart disease, high blood pressure or stroke. They are also more likely to be smokers and are substantially more likely to be obese. Thus, bringing in the entire Medicaid population would affect risk pools significantly, increasing federal subsidy costs due to the resulting higher average premiums for all subsidized enrollees and increasing costs for the unsubsidized population within the exchanges, in particular, but also having potential implications for the subsidized enrollees as well.

Conclusion

While individuals with higher than average health care needs may be somewhat more likely to enroll in the nongroup market in the first year, once past the transition period, the health characteristics of nongroup enrollees can be expected to be quite similar to those with employer-based insurance. The exchange target population is slightly less likely to report excellent, very good or good physical and mental health; less likely to report any of several chronic conditions; more likely to be smokers (although the simulated enrolle population is less likely to smoke); and less likely to be obese than those with employer insurance. Many exchange enrollees will receive subsidies; because premiums paid by enrollees will be based on a percentage of income, the availability of subsidies will reduce any impact of total premiums being somewhat higher in the first year of implementation. If the exchange target population does not participate at the rates predicted given their characteristics, however, premiums could be higher than what we observe in the employer-based market.

Analyses using microsimulation models incorporating the best economic research on behavioral responses to health insurance at different prices predict considerable participation in exchanges under the ACA by a diverse group of individuals, with the availability of federal subsidies and the new requirement that most people obtain health insurance coverage being important factors. Well-funded and well-executed efforts at outreach and enrollment are critical to obtaining these predicted enrollment levels, and increased funding for additional subsidies beyond the ACA's schedule would also increase participation by healthy individuals.

Appendix Table 1: Comparison of Health Characteristics of Adults 19–64 in the Nongroup Exchange Target Population with Current Nongroup Insurance or Currently Uninsured

	Nongroup Exchange Target Population: MAGI Above 138% of FPL Without an Affordable Employer Offer in the Health Insurance Unit					
	Current Nongroup		Current Uninsured		Combined	
	N	%	N	%	N	%
Total (19–64)	3,754,800	100.0%	12,442,400	100.0%	16,197,300	100.0%
General Health						
Excellent/Very Good/Good	3,557,000	94.7%*	11,271,700	90.6%	14,828,700	91.6%
Fair/Poor	197,800	5.3%*	1,170,800	9.4%	1,368,600	8.4%
Mental Health						
Excellent/Very Good/Good	3,455,000	92.0%*	10,845,700	87.2%	14,300,700	88.3%
Fair/Poor	299,800	8.0%*	1,596,800	12.8%	1,896,600	11.7%
At Least One Physical Chronic Condition	1,436,100	38.2%*	4,189,600	33.7%	5,625,700	34.7%
Chronic Physical Conditions						
Arthritis	621,100	16.5%*	1,662,800	13.4%	2,283,900	14.1%
Asthma	353,300	9.4%*	827,600	6.7%	1,180,900	7.3%
Diabetes	155,900	4.2%*	753,400	6.1%	909,300	5.6%
Emphysema	31,900	0.9%*	176,600	1.4%	208,500	1.3%
Heart Disease[1]	228,100	6.1%	776,900	6.2%	1,005,000	6.2%
High Blood Pressure	817,500	21.8%*	2,426,900	19.5%	3,244,400	20.0%
Stroke	43,700	1.2%	148,500	1.2%	192,200	1.2%
Current Smoker						
Yes	539,600	14.4%*	3,842,800	30.9%	4,382,400	27.1%
No	3,215,300	85.6%*	8,599,600	69.1%	11,814,900	72.9%
BMI						
Underweight (< 18.5)	54,200	1.4%	241,200	1.9%	295,300	1.8%
Normal Weight (18.5–24.9)	1,555,800	41.4%*	4,483,700	36.0%	6,039,400	37.3%
Overweight (25.0–29.9)	1,447,500	38.6%	4,642,200	37.3%	6,089,700	37.6%
Obese (30.0+)	697,400	18.6%*	3,075,400	24.7%	3,772,800	23.3%
Limitation in Physical Functioning[2]	**329,700**	**8.8%**	**1,195,100**	**9.6%**	**1,524,800**	**9.4%**

Source: HIPSM 2011

Note: An employer-sponsored insurance offer is defined as affordable if the employee share of the premium is 9.5% of family income or less.

* Indicates difference from uninsured is statistically significant at the p <.05 level. This test is not carried out for the combined nongroup/uninsured group.

[1] Heart disease includes heart attack, coronary heart disease, angina and other heart disease as defined in the MEPS-HC.

[2] Includes difficulty lifting 10 pounds, walking up 10 steps, walking 3 blocks, walking a mile, standing for 10 minutes, bending over or stooping, reaching overhead, and using fingers to grasp.

Health Insurance Unit refers to the family members who can be covered by a single private insurance policy.

Endnotes

[1] See, for example, Blavin F, Buettgens M and Roth J. "State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain." Washington: The Urban Institute, 2012. http://www.urban.org/publications/412485.html; and Congressional Budget Office. "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010." Washington: Congressional Budget Office, 2010. http://www.cbo.gov/publication/22077.

[2] Kingsdale J and Aurori J. "Impact of National Health Reform and State-Based Exchanges on the Level of Competition in the Nongroup Market." Princeton: Robert Wood Johnson Foundation, 2013. http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/impact-of-national-health-reform-and-state-based-exchanges-on-th.html; Holahan J, Lucia K, Peters R, et al. "Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States." (Forthcoming 2013).

[3] Unpublished HIPSM results, 2013.

[4] Zuckerman S and Holahan J. "Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs." Washington: The Urban Institute, 2012.

[5] Rovner J. "Arkansas Medicaid Expansion Attracts Other States' Interest." National Public Radio, March 26, 2013. http://www.npr.org/blogs/health/2013/03/26/175301509/arkansas-medicaid-expansion-attracts-other-states-interest.

[6] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[7] For more information on the MEPS-HC, see http://meps.ahrq.gov/mepsweb/survey_comp/household.jsp

[8] Another central issue in the discussion of this option is the relative cost of coverage in private plans relative to current Medicaid plans, since private plans today tend to pay providers at higher rates and are thus more expensive than Medicaid. The expected price differential under reform is difficult to predict for two reasons. First, while the research evidence on the current system is clear that private insurance plans are considerably more expensive than Medicaid holding health status and other characteristics constant, incentives under the ACA mean that exchanges in at least some areas are expected to offer some lower-cost commercial plans that use more limited provider networks and pay lower provider payments than is the commercial norm today. Second, with a larger Medicaid-eligible population that must be served under the ACA, state programs may start to pay somewhat higher reimbursement rates in order to attract a broader network of providers willing to participate in the program. As a result of the unpredictability of these dynamics and how pervasive they are likely to be, we do not address the Medicaid versus exchange cost differential here.

[9] A health insurance unit includes the members of a nuclear family who can be covered under one health insurance policy. A policyholder may cover his or her spouse, all children under 18, and children between 18 and 23 who are full-time students.

[10] Under the ACA, income eligibility is based on the IRS tax definition of modified adjusted gross income, which includes the following types of income for everyone who is not a tax-dependent child: wages, business income, retirement income, investment income, Social Security, alimony, unemployment compensation, and financial and educational assistance.

[11] See, for example, DeSalvo KB, Jones TM, Peabody J, et al. "Health Care Expenditure Prediction with a Single Item, Self-Rated Health Measure." *Medical Care*, 47(4): 440–447, 2009; and Fleishman JA, Cohen JW, Manning WG, et al. "Using the SF-12 Health Status Measure to Improve Predictions of Medical Expenditures." *Medical Care*, 44(5) (Suppl.): 154–163, 2006.

[12] The full ESI population includes those with current ESI that are part of the "target" population in Table 1 due to the premium they pay directly exceeding the ACA's threshold for affordability.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Linda Blumberg is a senior fellow and John Holahan is an institute fellow in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors are grateful for research assistance by Chris Hildebrand and Caitlin Carroll and the comments and suggestions made by Genevieve Kenney, Larry Levitt, Tim Waidmann, and Steve Zuckerman. Matthew Buettgens' contributions to the development of the HIPSM model allowed us produce the estimates in this paper.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit http://www.urban.org. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.

Exhibit 8

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: October 28, 2013

Subject: Shared Responsibility Provision Question and Answer

Q: Will any individual who enrolls in coverage through the Marketplace by the end of the open enrollment period for 2014 have to make a shared responsibility payment in 2015 for the months prior to the effective date of the individual's coverage?

A: Starting in 2014, the individual shared responsibility provision requires each individual to maintain health coverage (known as minimum essential coverage), qualify for an exemption from the requirement to maintain minimum essential coverage, or make a shared responsibility payment when filing a federal income tax return. To help make coverage affordable for millions of individuals and families, the Affordable Care Act provides, among other things, a premium tax credit to eligible individuals and families to help pay for the cost of health insurance coverage purchased through Health Insurance Marketplaces.

The shared responsibility payment generally applies to people who have access to affordable coverage during a taxable year but who choose to spend a substantial portion of that year uninsured. The Affordable Care Act gives the Secretary of the U.S. Department of Health and Human Services (HHS) the authority to establish hardship exemptions from the shared responsibility payment for individuals who "have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan [QHP]."[1] Under this authority, HHS has enumerated several situations that constitute such a hardship.[2]

Furthermore, the Affordable Care Act provides the Secretary of HHS the authority to determine the initial open enrollment period for individuals to enroll in coverage through the Marketplaces for 2014.[3] Pursuant to this authority, the final rule entitled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers" and published on March 27, 2012, at 45 CFR 155.410(b) ("Exchange Final Rule") specifies that the initial open enrollment period for individuals begins on October 1, 2013, and extends into 2014. The Exchange Final Rule

[1] 26 USC § 5000A(e)(5).
[2] "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions", published on June 26, 2013, at 45 CFR 155.605(g).
[3] § 1311(c)(6)(A) of the Affordable Care Act.

also provides the coverage effective dates for individuals enrolling in coverage through the Marketplaces during the initial open enrollment period.[4] For plan selections made between the 1st and the 15th of a given month, the coverage effective date is the first day of the immediately following month, and for plan selections made between the 16th and end of a given month, the coverage effective date is the first day of the second following month.

To ensure that the shared responsibility payment generally applies only to the limited group of people who have access to affordable coverage during a year but who nonetheless choose to spend a substantial portion of that year uninsured, the Affordable Care Act provides nine statutory exemptions relating to the individual shared responsibility provision within the Internal Revenue Code.[5] The short coverage gap exemption specifies that an individual is exempt for "[any] month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months."[6]

The length of the initial open enrollment period and the coverage effective dates, in tandem with the terms of the short coverage gap exemption, created the possibility that an individual who enrolled in coverage through a Marketplace during the initial open enrollment period could nonetheless be liable for a shared responsibility payment for months prior to the effective date of that coverage, if the individual were not otherwise exempt. More specifically, under this structure, an individual who enrolls between February 16, 2014 and the close of the initial open enrollment period will have coverage effective as of April 1 or later. As a result, such an individual would not be eligible for the short coverage gap exemption, which applies only when the coverage gap is less than (but not equal to) 3 months.

HHS recognizes that the duration of the initial open enrollment period implies that individuals have until the end of the initial open enrollment period to enroll in coverage through the new Marketplaces while avoiding liability for the shared responsibility payment. Yet, unless a hardship exemption is established, individuals who purchase insurance through the Marketplaces towards the end of the initial open enrollment period could be required to make a shared responsibility payment when filing their federal income tax returns in 2015. HHS has determined that it would be unfair to require individuals in this situation to make a payment. Accordingly, HHS is exercising its authority to establish an additional hardship exemption in order to provide relief for individuals in this situation.

---

[4] 45 CFR 155.410(c).

[5] 26 USC 5000A(d) and (e). These categories of exemptions are: individuals who do not have access to affordable coverage; individuals with household income below the federal income tax filing threshold; members of federally recognized Indian tribes; individuals who experience a hardship; individuals who experience a short coverage gap; members of certain religious sects; members of a health care sharing ministry; incarcerated individuals; and individuals who are not lawfully present.

[6] 26 USC 5000A(e)(4)(A). This statutory provision is implemented in final Treasury regulations entitled "Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage" and published on August 30, 2013, at 26 CFR 1.5000A-3(j)(2)(i).

Specifically, if an individual enrolls in a plan through the Marketplace prior to the close of the initial open enrollment period, when filing a federal income tax return in 2015 the individual will be able to claim a hardship exemption from the shared responsibility payment for the months prior to the effective date of the individual's coverage, without the need to request an exemption from the Marketplace. Additional detail will be provided in 2014 on how to claim this exemption.

Exhibit 9

Calendar No. 184

111TH CONGRESS *1st Session*	SENATE	REPORT 111–89

AMERICA'S HEALTHY FUTURE ACT OF 2009

R E P O R T

[TO ACCOMPANY S. 1796]

ON

PROVIDING AFFORDABLE, QUALITY HEALTH CARE FOR ALL AMERICANS AND REDUCING THE GROWTH IN HEALTH CARE SPENDING, AND FOR OTHER PURPOSES

together with

ADDITIONAL AND MINORITY VIEWS

COMMITTEE ON FINANCE
UNITED STATES SENATE

OCTOBER 19, 2009.—Ordered to be printed

Calendar No. 184

111TH CONGRESS *1st Session* | SENATE | REPORT 111–89

AMERICA'S HEALTHY FUTURE ACT OF 2009

OCTOBER 19, 2009.—Ordered to be printed

Mr. BAUCUS, from the Committee on Finance, submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany S. 1796]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having considered an original bill, S. 1796, to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, reports favorably thereon and recommends that the bill do pass.

I. BACKGROUND AND NEED FOR LEGISLATION

The U.S. health system is in crisis. In 2008, over 46 million Americans were uninsured and millions more have lost their health coverage as a result of the recent economic downturn. Another 25 million people are underinsured, with coverage that is insufficient to protect against the cost of a major illness. The rising cost of health care outpaces wages by a factor of five to one, placing an ever greater strain on family, business, and government budgets.

Improving the health system is one of the most important challenges we face as a nation, and the inability to achieve comprehensive health reform will undermine any efforts to secure a full and lasting economic recovery. Health reform is an essential part of restoring America's overall economy and maintaining our global competitiveness.

Health care reform is also necessary to protect the finances of working families. Between 2000 and 2009, average family premiums for employer-sponsored health coverage increased by 93 percent—increasing from $6,772 to $13,073—while wages increased by only 19 percent in the same period. Rising health care costs and mounting medical debt account for half of all filed bankruptcies—affecting two million people a year.

Countless studies have shown that those without health coverage generally experience worse health outcomes and poorer health compared to those who are insured. The uninsured are less likely to receive preventive care or even care for traumatic injuries, heart attacks, and chronic diseases. As a result, 23 percent forgo necessary care every year due to cost, while 22,000 uninsured adults die prematurely each year as a result of lacking access to care.

A majority of the uninsured has low or moderate incomes—with two-thirds in families with an annual income less than twice the Federal poverty level (FPL). Eight in ten of the uninsured are in working families in which workers are either not offered coverage by their employer or they do not qualify for employer-offered coverage.

Hospitals and clinics provide an estimated $56 billion annually in uncompensated care to people without health insurance, and those with health coverage pay the bill through higher health care costs and increased premiums. This so-called "hidden health tax" cost the average family over $1,000 in high premiums last year. An estimated ten percent of health care premiums in California are attributable to cost shifting due to the uninsured.

Rising health costs have taken a toll on U.S. businesses as well. An estimated 159 million Americans receive health benefits through an employer, with the average cost of this coverage reaching $4,824 for single coverage and $13,375 for family coverage in 2009. Over the last decade, employer-sponsored coverage has increased by 131 percent, forcing employers—particularly small employers—to make difficult choices among painful options to offset increasing health costs. These choices include raising workers' premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

Federal and state governments have also struggled with health care costs. The Congressional Budget Office has noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance." The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care—a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP, or $4.3 trillion annually. Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years. Over the same period, the GDP will grow by just 64 percent.

Despite high levels of spending on health care, a recent study by the Institute of Medicine concludes that the current health system is not making progress toward improving quality or containing costs for patients or providers. Research documenting poor quality of care received by patients in the U.S. is shocking. A 2003 RAND

Corporation study found that adults received recommended care for many illnesses only 55 percent of the time. Needed care for diabetes was delivered only 45 percent of the time and for pneumonia 39 percent of the time. Patients with breast cancer fared better, but still did not receive recommended care one-quarter of the time.

Compared to other industrialized countries, our quality of care does not reflect the level of our investment. The U.S. ranks last out of 19 industrialized countries in unnecessary deaths and 29th out of 37 countries for infant mortality—tied with Slovakia and Poland, and below Cuba and Hungary. Our rate of infant mortality is double that of France and Germany.

In short, Americans are not getting their money's worth when patients receive services of little or no value—such as hospitalizations that could have been prevented with appropriate outpatient treatment, duplicate tests, or ineffective tests and treatments. Yet the current system does little to steer providers toward the right choices. Even though more care does not necessarily mean better care, Medicare and most other insurers continue to pay for more visits, tests, imaging services, and procedures, regardless of whether the treatment is effective or necessary, and pay even more when treatment results in subsequent injury or illness.

Providers are not consistently encouraged to coordinate patients' care or to supply preventive and primary care services, even though such actions can improve quality of care and reduce costs. Rewarding providers that furnish better quality care, coordinate care, and use resources more judiciously could reduce costs and, most importantly, better meet the health care needs of millions more American patients.

Each of the key challenges facing our health care system—lack of access to care, the cost of care, and the need for better-quality care—must be addressed together in a comprehensive approach. Covering millions of uninsured through a broken health system is fiscally unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will not alleviate the burden of uncompensated care and cost shifting. The time for incremental improvements has passed; health care reform must be comprehensive in scope.

It is in this context that the Finance Committee developed the legislative proposal that would become the "America's Healthy Future Act." The legislation approved by the Finance Committee addresses the challenges facing our health care system by expanding health coverage to 29 million Americans, improving quality of care and transforming the health care delivery system, and reducing Federal health spending and the Federal deficit over the ten year budget window and in the long run.

As a general principle, the bill allows those who like their health insurance to keep what they have today. For the millions of Americans who don't have employer-sponsored coverage, cannot afford to purchase coverage on their own, or who are denied coverage by health insurance companies due to a pre-existing condition, the Chairman's Mark reforms the individual and small-group markets, making health coverage affordable and accessible. These market reforms would require insurance companies to issue coverage to all individuals regardless of health status, prohibit insurers from lim-

iting coverage based on pre-existing conditions and allow only limited variation in premium rates.

The Mark would make purchasing health insurance coverage easier and more understandable by creating state-based web portals, or "exchanges" that would direct consumers to all available health plan options. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges—like the individual market exchanges—would be web portals that make comparing and purchasing health care coverage easier for small businesses.

The Mark standardizes benefits to force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and ensures that every policy offered in the individual and small group market provides meaningful coverage for essential services. Those age 25 or under will also have access to an affordable young invincible plan that would provide catastrophic coverage and first dollar coverage for prevention. Plans would not be allowed to set lifetime or annual coverage limits.

The Chairman's Mark would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults with incomes at or below $30,000 a year for a family of four ($14,400 for an individual), beginning in 2014. Individuals between 100 percent of FPL and 133 percent of FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a health insurance exchange. The federal government would provide significant additional funding to states to cover the cost of providing services to newly eligible Medicaid beneficiaries.

To ensure that health coverage is affordable, the Mark would provide an advanceable, refundable tax credit for low and middle-income individuals (between 100–400 percent of FPL) to help offset the cost of private health insurance premiums. Undocumented immigrants are prohibited from benefiting from the credit. A cost-sharing subsidy would be provided to limit the amount of out-of-pocket costs that individuals and families between 100–200 percent of FPL have to pay. The cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and a higher actuarial value plan.

A tax credit would also be available to small businesses. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution. Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchange can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of $20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over $20,000, with a complete phase-out at 25 employees or average taxable wages of $40,000. Non-profit organizations with 25 or fewer employees would also be eligible to receive tax credits if they meet the same requirements. These organizations would be eligible for a 25 per-

cent credit from 2011–2013 and a 35 percent credit in 2013 and thereafter.

The Mark creates authority for the formation of the Consumer Owned and Oriented Plans (CO–OPs). These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. These plans will offer consumer-focused alternatives to existing insurance plans. Six billion dollars in federal seed money would be provided for start-up costs and to meet state solvency requirements.

To ensure the insurance market reforms function properly, the Mark would create a personal responsibility requirement for health care coverage, with exceptions provided for religious conscience (as defined in Medicare) and undocumented individuals. Those who fail to meet the requirement are subject to a penalty. Appropriate exemptions are made from the penalty.

The Chairman's Mark does not require employers to offer health insurance. However, effective July 1, 2013, all employers with more than 50 employees who do not offer coverage would be required to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to the average national exchange credit and subsidy up to a cap of $400 per total number of employees (whether they are receiving a tax credit and subsidy or not). A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

In addition to provisions that expand health care coverage, the Chairman's Mark would make critical investments in policies to promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease and obesity. Preventive screenings enable doctors to detect diseases earlier, when treatment is most effective, thereby averting more serious, costly health problems later.

The Mark would provide Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan designed to address health risks and chronic health problems and to develop a schedule for regular recommended preventive screenings. It would eliminate out-of-pocket costs for recommended preventive services for Medicare beneficiaries and provide incentives for states to cover recommended services and immunizations in Medicaid. And finally, the Mark establishes an initiative to reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

The legislation makes significant steps to reform the health care delivery system. Medicare currently reimburses health care providers on the basis of the volume of care they provide—regardless of whether the treatment contributes to helping a patient recover. The Chairman's Mark includes various proposals to move the Medicare fee-for-service system towards paying for quality and value. These proposals include hospital value-based purchasing—and

value-based purchasing for other Medicare providers including physicians, home health agencies, nursing homes, long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers.

To encourage greater collaboration among health care providers, the Chairman's Mark would allow high-quality providers that coordinate care across a range of health care settings to share in the savings they achieve for the Medicare program. It would create an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) that would have authority to test new patient-centered payment models designed to encourage evidence-based, coordinated care for Medicare, Medicaid, and CHIP. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program. It would also implement a national pilot program on payment bundling and start to pay hospitals less for avoidable hospital readmissions.

Efforts to reduce costs and improve quality in the health care delivery system will require an investment in the health care infrastructure necessary to support coordinated quality care and create a more effective, efficient delivery system. The legislation would provide additional resources to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. The Mark would also invest in research on what treatments work best for which patients and ensure that information is available and accessible to patients and doctors, such as through the establishment of an independent institute to research the effectiveness of different health care treatments and strategies. These provisions are carefully crafted so that patients would never be denied treatment based on age, disability status or other related factors as a result of the research findings.

To promote primary care and maintain adequate access to health care providers, the Chairman's Mark would provide primary care practitioners and targeted general surgeons with a Medicare payment bonus of ten percent for five years. It would strengthen the health care workforce by increasing graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots, with priority given to increasing training in primary care and general surgery. The provision would also encourage additional training in outpatient settings, including teaching health centers, and ensure communities retain vital training slots if a hospital closes.

The Mark also improves the accuracy of Medicare payments to providers by reducing overpayments to providers. It would cancel a scheduled 21.5 percent reduction to physician payments in 2010 and replace the impending cut with a positive update. The legislation would improve the value of Medicare Advantage by reforming payments so that the program appropriately pays insurers for their costs and promotes plans that offer high quality, efficient health care for seniors. To preserve beneficiary access to certain services they now receive, the legislation would grandfather MA plans in areas where plans currently bid at or below 75 percent of traditional fee-for-service Medicare to deliver benefits, so plans will continue to offer the plans they currently offer and pay what they currently pay to deliver benefits for existing beneficiaries.

For rural providers, the Mark includes important provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities. Specifically, the Mark would extend and improve many rural access protections.

Sharply rising costs throughout the health system threaten Medicare's sustainability in the long term. If costs are not constrained, the Medicare program will be insolvent by 2017. To ensure the fiscal solvency and sustainability of the Medicare program, the Chairman's Mark would create a new independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Commission would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The Mark would also reduce annual market basket updates for hospitals, home health providers, nursing homes, hospice providers, long-term care hospitals and inpatient rehabilitation facilities, including adjustments to reflect expected gains in productivity. Payment updates for Part B providers would be reduced by an estimate of increased productivity, and income-related premiums would be adopted in Part D.

To improve the transparency of insurance products so that individuals know what they are purchasing, the services which are covered and the associated out-of-pocket costs, the Mark would create standards so that individuals receive an outline of coverage presented in a uniform format. The Mark would also require insurance companies to publish the share of their premium revenue that is used for administrative expenses and would impose new requirements on insurers to meet standards for the electronic exchange of payment and other health care information with hospitals, doctors and other providers.

Reducing fraud, waste, and abuse in Medicare, Medicaid and CHIP will reduce costs and improve quality throughout the system. The Medicare improper payment rate for 2008 was 3.6 percent of payments, or $10.4 billion and the National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than $60 billion per year. The Chairman's Mark includes several significant provisions to combat fraud, waste and abuse in our health care system.

The America's Healthy Future Act is fully offset and would reduce the deficit and reduce Federal health spending over the long run. In addition to the Medicare Commission, the other policy that contributes to this goal is the high cost insurance excise tax. Beginning in 2013, this provision would levy a non-deductible excise tax on insurance companies and plan administrators for any health insurance plan that is above the threshold of $8,000 for singles and $21,000 for family plans. The threshold would be higher for workers with high risk jobs or for retirees aged 55 and up. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. A transition

rule would increase the threshold for the 17 highest cost states for the first three years.

Other revenue measures include a limit on the amount of contributions to health Flexible Spending Accounts (FSAs) beginning in 2011, a provision to conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction, an increased penalty for use of HSA funds for non-qualified medical expenses, and an increase in the threshold for claiming the itemized deduction for medical expenses.

The legislation also includes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector, an annual flat fee of $4 billion on the medical device manufacturing sector, and an annual flat fee of $6.7 billion on the health insurance sector. Each of these non-deductible fees would be allocated across the respective industry according to market share. The device fee would not apply to companies with sales of medical devices in the U.S. of $5 million or less and would not apply to sales of Class I products or Class II products that retail for less than $100 under the FDA product classification system.

Taken together, this legislation achieves the goals of expanding health care coverage to the uninsured, reducing health care costs and improving the quality of care by transforming the health care delivery system. This comprehensive legislation represents a significant milestone in our nation's pursuit of quality, affordable health care for all Americans.

LEGISLATIVE HISTORY AND COMMITTEE ACTION

The Finance Committee has spent two years working on health reform, learning about the problem and identifying solutions. In the past two years, the committee held 20 hearings on health care reform. Last June the committee hosted a day-long health care summit at the Library of Congress featuring Federal Reserve Chairman Ben Bernanke and Dr. J. Craig Venter, genomic research pioneer, as keynote speakers.

Leading up to the markup, the committee held three roundtable discussions reflecting the three major areas of reform—access, cost and quality. In connection with each roundtable—the committee hosted experts from around the country with many different perspectives. Finance Committee members asked many questions of these experts and delved into the issues. Along with each roundtable, the committee put out a detailed policy options paper and held three closed-door walk-through sessions to discuss those options.

In sum, the hearings, summit, roundtables and walk-through sessions demonstrated an open and exhaustive consideration of this health care proposal.

In moving forward with the markup, the Finance Committee distributed the Chairman's Mark and posted it on the committee website on September 16, a full week prior to the start of the markups. Members submitted 564 amendments to the Chairman's Mark, all of which were posted on the website—a measure in the name of transparency that has never been taken by the committee before.

The markup of America's Healthy Future Act lasted for eight days. These days were long days, often running past 10:00 p.m. On the last day of considering amendments, the committee worked past 2:00 a.m. All in all, it has been more than 22 years since the Finance Committee met for eight days on a single bill.

During those eight days, the committee considered 135 amendments and conducted 79 roll call votes, adopting 41 amendments. A final amendment was adopted prior to the vote on October 13, 2009 to report the bill. And the final vote to report the bill was 14–9.

The legislation resulting from the committee's effort is a balanced, sensible plan that takes the best ideas from both sides of the aisle. It achieves President Obama's vision to improve America's health care system, and it is a plan designed to get the 60 votes it needs to pass. The Congressional Budget Office confirms that the legislation will reduce the deficit by $81 billion in the first 10 years, and that the legislation will reduce the deficit further in the next 10 years. Coverage is expanded to 29 million Americans, increasing the rate of insurance to 94 percent at a cost of $829 billion.

II. EXPLANATION OF THE BILL

TITLE I—HEALTH CARE COVERAGE

Subtitle A—Insurance Market Reforms

SEC. 1001. INSURANCE MARKET REFORMS IN THE INDIVIDUAL AND SMALL GROUP MARKETS

The Committee Bill would amend the Social Security Act (42 U.S.C. 301 et seq.) by adding a new Title XXII at the end:

"TITLE XXII—HEALTH INSURANCE COVERAGE"

SEC. 2200. ENSURING ESSENTIAL AND AFFORDABLE HEALTH BENEFITS COVERAGE FOR ALL AMERICANS

Present Law

No provision.

Committee Bill

The purpose of Title I would be to ensure that all Americans have access to affordable and essential health benefits coverage (1) by requiring that all new health benefits plans offered to individuals and employers in the individual and small group market are qualified health benefit plans (QHBPs) that meet the insurance rating reforms and essential health benefits coverage requirements under this bill, (2) by establishing State exchanges to provide greater access to and information about QHBPs, (3) by making health benefits coverage more affordable with premium credits and cost-sharing subsidies, and (4) by establishing the CO-OP program to encourage the establishment of nonprofit health care cooperatives.

the case of an employer, to new employees and their dependents. Beginning July 1, 2013, Federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with the approval from the Secretary.

Health insurance coverage in the individual market (in effect before enactment) that is actuarially equivalent to a catastrophic plan for young individuals (as defined in Sec. 2243(c) of the bill), would be treated as grandfathered plans.

"Subpart 4—Continued Role of States"

Present Law

Pertaining to Sec. 2225–2227: Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and includes requirements related to licensing, solvency, the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Such rules vary from state to state. An insurance carrier must be licensed in each state in which it operates, and comply with the applicable laws and regulations of each state.

Committee Bill

SEC. 2225. CONTINUED STATE ENFORCEMENT OF INSURANCE REGULATIONS

No later than 12 months after enactment, the NAIC would develop a Model Regulation to implement the requirements for plans offered in the individual and small group markets within a state. The Secretary would promulgate regulations to implement the Model Regulation developed by the NAIC. If the NAIC does not establish the Model Regulation within the 12 months after enactment, the Secretary would establish Federal standards implementing the applicable requirements. States would have until July 1, 2013 to adopt and have in effect the Model Regulation or Federal standards established by the Secretary, or a state law or regulation that implements the applicable requirements.

If a state fails to adopt or substantially enforce the Model Regulation, Federal standards, or state laws or regulations, the Secretary would be required to enforce those provisions related to the issuance, sale, renewal, and offering of health benefits plans until the state adopts and enforces such provisions. The Secretary would have enforcement authority under Sec. 2722(b) of the Public Health Services Act to impose civil money penalties on plans that fail to meet such provisions. The Model Regulation, Federal standards, or state laws and regulations implemented by a state must include a requirement that adopted standards (including existing standards under state law that offer more protection to consumers than standards set forth in this title) are applied uniformly to all offerors of health benefits plans in the individual or small group market.

By no later than July 1, 2013, a state would be required to establish and have in operation one or more exchanges, including Small Business Health Options Program (SHOP) exchanges, that meet the requirements regarding the offer of QHBPs. If states do not es-

tablish these exchanges within 2 years of enactment (or if the Secretary determines the exchanges will not be operational by July 1, 2013), the Secretary would be required to contract with a nongovernmental entity to establish the exchanges within the state. States would be required to establish interim exchanges for use by state residents as soon as practicable in the period from January 1, 2010 to June 30, 2013. If these interim exchanges are not operational within a reasonable period after enactment, the Secretary would be required to contract with a nongovernmental entity to establish state exchanges during this interim period.

This title would not replace state laws that establish, implement, or continue any standards or requirements relating to health benefits plans that offer more protection to consumers than the protection offered by standards or requirements included in this title. These standards or requirements would refer to consumer protections (e.g. claims grievance procedures, external review of claims determinations, oversight of insurance agent practices, and others); premium rating reviews; solvency and reserve requirements related to health insurance issuers' licensures; and the assessment of sate-based premium taxes on health insurance issuers. The provisions in this title would not affect ERISA provisions with respect to group health plans.

States could institute programs to provide that offerors of qualified health benefit plans, small employers, and exchanges offering plans in the state's individual and small group market could automatically enroll individuals and employees in (or continue enrollment of individuals in) QHBPs. Automatic enrollment programs would be required to allow individuals or employees to opt out of any coverage in which they were automatically enrolled.

Each state would require offerors of QHBPs through an exchange to provide for a claims review process, to notify enrollees in clear language and in the enrollees' primary language of available internal and external appeals processes, and to allow enrollees to review their files, present evidence, and maintain their insurance coverage during the appeals process. States would be required to provide for an external review process that includes consumer protections set forth in the NAIC's Uniform External Review Model Act, and ensure that enrollees can seek judicial review through Federal or state procedures.

SEC. 2226. WAIVER OF HEALTH INSURANCE REFORM REQUIREMENTS

Present Law

No provision.

Committee Bill

A state could apply for a waiver of any and all requirements of Title I and the IRC for plan years beginning on or after July 1, 2015. The waiver application would have to (1) be filed at a time and manner specified by the Secretary, and (2) provide required information, including a comprehensive description of the State legislation or program for implementing a plan meeting the waiver requirements, and a 10-year budget plan that is budget neutral for the Federal Government.

Exhibit 10

Center for American Progress

Health Care Reform Is a "Three-Legged Stool"

The Costs of Partially Repealing the Affordable Care Act

Jonathan Gruber August 2010

The recent ballot measure in Missouri, along with litigation in the federal courts, challenges the Affordable Care Act's requirement that all individuals hold health insurance. Simultaneously, some members of Congress advocate repealing this requirement and other elements of the Affordable Care Act, claiming that some parts of the transformative legislation will work even if other parts are removed. This paper shows that these claims are false by analyzing what would happen to the Affordable Care Act's coverage and affordability effects if some parts of the legislation were repealed. It focuses on these effects in 2019—the end of the budget window that the Congressional Budget Office uses.

The paper's analysis shows that:

- Repeal of the requirement to buy insurance would mean more people would wait until they get sick to buy insurance in the new nongroup exchanges, which would increase the average premium by 27 percent in 2019.

- Retaining the law's insurance reforms, but repealing the subsidies as well as the requirement to purchase insurance, would further discourage people from buying insurance when they're healthy. Premiums in 2019 would cost twice as much as projected under the law as a result.

- Retaining the law but repealing the mandate would newly cover fewer than 7 million people in 2019 rather than the 32 million projected to be newly covered by the law. Federal spending, however, would decline by only about a quarter under this scenario since the sickest and most costly uninsured are the ones most likely to gain coverage.

- Retaining only the insurance reforms in the law—repealing both the mandate and the subsidies—would not increase the number of people with insurance, leaving 55 million people uninsured in 2019.

The "three-legged stool" of health reform

The Affordable Care Act represents the most significant transformation of our health insurance market in more than 40 years. One of the law's key goals is to fix the broken small group and nongroup insurance markets—where small businesses and people not covered through their jobs get their health insurance. Insurance prices are very high and variable in these markets today, and sick individuals who most need coverage are not able to get it.

At the health law's core is a "three-legged stool" approach to reforming these markets: new rules that prevent insurers from denying coverage or raising premiums based on preexisting conditions, requirements that everyone buy insurance, and subsidies to make that insurance affordable. But some confusion exists about how the stool's three parts fit together—confusion that's compounded by claims that some parts will work without others and by efforts to repeal key elements of the new law.

The truth is that all three legs of the stool are necessary to assure affordable coverage. The first "leg" is regulations that require insurance companies to offer insurance to any applicant with premiums based on age (and tobacco use) and not on underlying health status. Insurance companies are also prohibited from excluding coverage due to preexisting illnesses.

This is a highly popular reform, but it doesn't work in a vacuum. If insurance companies must charge the same price to people whether they're sick or healthy many healthy people will view this as a "bad deal" and not buy insurance. This results in higher prices that chase even more people out of the market. The result is a "death spiral" that leads only the sick to purchase insurance at very high prices. Several states tried such community rating reforms—offering health insurance policies within a given territory at the same price to all persons without medical underwriting—in their nongroup markets over the past two decades, and sharp rises in insurance prices ensued along with rapidly shrinking market size.

This fact motivated Massachusetts in 2006 to add a second "leg" to the stool: a requirement that all residents purchase insurance. In this way the state could ensure a broad distribution of health risks in the market and fair "community-rated" pricing to all.

The problem with this solution in a vacuum, however, is that many families cannot afford health insurance at those community-rated prices. Massachusetts therefore added a third "leg" in the form of subsidies that make health insurance affordable for those below three times the poverty line (as well as some targeted exemptions from the mandate for those who were above the subsidized level but could not afford coverage). This reform has shown very encouraging results, with the number of uninsured in the state falling by 60 percent and nongroup premiums falling by 40 percent.

The Affordable Care Act is similarly designed as a three-legged stool. A recent ballot measure in Missouri and litigation in federal courts would repeal the law's coverage requirement and leave other elements unchanged. At the same time, legislation has been introduced in Congress to repeal some parts of the health law while keeping others—most notably the insurance market reforms. Critics who propose to "repeal and replace" the Affordable Care Act don't seem to understand that *all three legs of the stool are critical for reform*. Pulling out any of the legs while leaving one or two intact will critically undercut gains from reform.

The following table illustrates this fact by estimating the impacts of removing various aspects of the law in 2019, the last year of the projected budget window. The Gruber Microsimulation Model, or GMSIM, was used to develop the estimates. It models the reform's effects in the same manner as the Congressional Budget Office, and therefore reproduces fairly closely the CBO estimates of the law as passed. It's used here to compare three scenarios:

- The law as passed
- The law as passed minus the individual mandate requirement to purchase insurance
- The law as passed minus the mandate, tax subsidies for individuals, and the Medicaid expansions—and retaining the small business tax credit, the insurance market reforms, and insurance exchanges

The cost of partial repeal

How repealing certain Affordable Care Act provisions would affect exchange premiums, coverage, and federal spending in 2019

	The Affordable Care Act	The law minus the mandate	The law minus the mandate, Medicaid expansions, and subsidies in the exchange
Exchange premiums (for a 0.7 actuarial value plan)			
Single premium	$7,910	$10,080	$15,910
Family premium	$18,190	$20,440	$22,160
Coverage changes (millions of people)			
Uninsured	-32.1	-6.8	-0.6
Employer coverage	-4.1	-13.5	-1.7
Medicaid and SCHIP	17.4	11.2	-1.9
Nongroup	-8	-8	-7.2
Exchange	26.8	17.2	11.4
Federal spending (billions of dollars)			
Medicaid and SCHIP	$107	$80	-$6
Exchange tax credits	$108	$89	$0
Small business tax credits	$3	$3	$4
Total spending	$218	$172	-$2

The table shows the effect of these three scenarios on 1) singles and family premiums in the new exchange for a plan of a fixed generosity (an "actuarial value" of 0.7, corresponding to the "silver" level in the new exchanges); 2) changes in the number of uninsured covered from what was projected prior to enactment; and 3) federal spending. The partial repeal's impact can be seen by comparing the second column (no mandate) and the third column (no mandate and no subsidies) to the first.

Why repealing certain portions of the law won't work

Both the mandate and subsidies are crucial to keeping exchange premiums low: The simple logic imbedded in the law is that it is potentially destructive to reform insurance markets without mandating purchase because only the sick buy insurance and prices remain high. We have seen examples of this in states such as New York and Massachusetts (before its most recent reform), which both imposed

modified community rating without a mandate and saw prices skyrocket in their nongroup markets. When Massachusetts implemented its comprehensive reform in 2006 it saw a striking decline in nongroup premiums of 40 percent.

Comparing premiums for the silver plan in the exchange under the law (column 1) with premiums for the same plan under the repeal scenarios reveals the mandate's importance for nongroup premiums in the exchange. For singles, removing the mandate (as shown in column 2) raises premiums by 27 percent—in other words, individuals purchasing insurance in the exchange would pay 27 percent more for their coverage without a mandate. Insurance reforms without a mandate and without subsidies (column 3) would have an even more dramatic impact and would double the single premium in the exchange to almost $16,000 per year. (The impact on family premiums is more modest, as the selection effects are much stronger for young healthy singles).

The individual mandate is critical for increasing insurance coverage: Removing the individual mandate cuts the reduction in uninsured by more than three-quarters. Rather than covering almost 60 percent of the 55 million uninsured in 2019, the bill without the mandate would cover only about 12 percent of the uninsured. If the subsidies are removed—as in the last column—the coverage effects fall further so that there is essentially no increase in insurance coverage from simply setting up the exchange with small business credits and insurance market reforms.

Repealing the mandate greatly erodes coverage by employers: The Affordable Care Act leads to a modest erosion of employer coverage of 4.1 million persons, or about 2.5 percent of projected coverage. But repealing the mandate would reduce employer coverage by 13.5 million persons, or over 8 percent of baseline projections. This is because repealing the mandate would eliminate the enrollment that will come from people meeting the requirement to purchase insurance from employers offering insurance to employees who need to meet that requirement.

The mandate means much more "bang for the buck": While removing the mandate cuts the legislation's coverage gains by more than 75 percent, it only reduces the spending under the legislation by less than one quarter. This is because without the mandate the uninsured gaining coverage are the sickest ones taking advantage of the market reforms and subsidies, while the healthy uninsured remain out of the system. Repealing the mandate further increases federal spending by creating a large movement out of employer coverage and into public insurance and the subsidized exchange.

The mandate and the subsidies are critical to building an insurance market that includes the healthy and the sick: The exchange insures far more people under the Affordable Care Act than under either of the other scenarios—26.8 million people compared to 17.2 million without the mandate and 11.4 million people without the mandate and the subsidies. The reason is that the larger exchange under the law includes healthy and sick people. Partial repeal—new rules for insurance but no mandates and no subsidies—means people are far more likely to participate only when they need health care, producing the substantial increase in average premiums, and, ultimately, the "death spiral" in which only the sick purchase insurance at very high prices.

Conclusion

Removing the Affordable Care Act's mandate would eviscerate the law's coverage gains and greatly raise premiums. And going further by only keeping the market reforms and the small business tax credit would virtually wipe out those coverage gains and cause an enormous premium spike. Without all three legs, the stool—and effective health reform—will not stand.

Jonathan Gruber is a professor of economics at the Massachusetts Institute of Technology.

Exhibit 11

Congressional Budget Office

Testimony

Statement of
Douglas W. Elmendorf
Director

Expanding Health Insurance Coverage and Controlling Costs for Health Care

before the
Committee on the Budget
United States Senate

February 10, 2009

This document is embargoed until it is delivered at 10:00 a.m. (EST) on Tuesday, February 10, 2009. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Other Sources of Coverage

Other significant sources of coverage for nonelderly people include the individual insurance market and various public programs. Roughly 10 million people are covered by individually purchased plans, which have some advantages for enrollees; for example, they may be portable from job to job, unlike employment-based insurance. Even so, individually purchased policies generally do not receive favorable tax treatment. In most states, premiums may vary to reflect an applicant's age or health status, and applicants with particularly high expected costs are generally denied coverage.

Another major source of coverage is the federal/state Medicaid program and the related but smaller CHIP. Both programs provide free or low-priced coverage for children in low-income families and (to a more limited degree) their parents; Medicaid also covers poor individuals who are blind or disabled. On average, Medicaid and CHIP are expected to cover about 43 million nonelderly people in 2009 (and there are also many people eligible for those programs who have not enrolled in them).[2] Medicare also covers about 7 million people younger than 65 who are disabled or have severe kidney disease.

About 12 million people have insurance coverage from various other sources, including federal health programs for military personnel. The total number of nonelderly people with health insurance at any given point in 2009 is expected to be about 216 million.

Approaches for Reducing the Number of Uninsured People

Concerns about the large number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or achieve universal or near-universal coverage. Two basic approaches could be used:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible, or
- Establishing a mandate for health insurance, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers.

By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Those approaches could be combined and could be implemented along with provisions to facilitate enrollment in ways that could achieve near-universal coverage. (Many of the issues and trade-offs that arise in designing such

2. That figure represents average enrollment (rather than the number of people enrolled at any time during the year) and excludes nonelderly individuals living in institutions (such as nursing homes), people living in U.S. territories, and people receiving only limited benefits under Medicaid (such as family planning services).

initiatives are also illustrated by the more incremental options to expand insurance coverage that are examined in the *Budget Options* volume.)

Subsidizing Premiums

Whether new subsidies are delivered through the tax system or a spending program, several common issues arise. Trade-offs exist between the share of the premiums that is subsidized, the number of people who enroll in insurance as a result of the subsidies, and the total costs of the subsidies. As the subsidy rate increases, more people will be inclined to take advantage of them, but the higher subsidy payments will also benefit those who would have decided to obtain insurance anyway. Beyond a certain point, therefore, the cost per newly insured person can grow sharply because a large share of the additional subsidy payments is going to otherwise insured individuals.

To hold down the costs of subsidies, the government could limit eligibility for subsidy payments to individuals who are currently uninsured. That restriction, however, would create incentives for insured individuals to drop their coverage. Some proposals might try to distinguish between people who become uninsured in response to subsidies and those who would have been uninsured in the absence of a government program (for example, by imposing waiting periods for individuals who were previously enrolled in an employment-based plan), but such proposals could be very difficult to administer. In addition, providing benefits only to the uninsured might be viewed as unfair by people with similar income and family responsibilities who purchased health insurance and would therefore be ineligible for the subsidies.

Another approach to limiting costs would target subsidies toward the lower-income groups, who are most likely to be uninsured otherwise, but such approaches can also have unintended consequences that affect the costs of a proposal. If eligibility was limited to people with income below a certain level, then those with income just above the threshold would have strong incentives to work less or hide income in order to qualify for the subsidies or maintain their eligibility. Phasing out subsidies gradually as income rises would reduce those incentives, but it would increase the amount of subsidy payments that go to individuals and families who would have had insurance in any event.

Restructuring the Existing Tax Subsidies. Tax subsidies could be restructured to expand coverage in several ways. For example, the current tax exclusion for employment-based health insurance could be replaced with a deduction or tax credit to offset the costs of insurance, and tax subsidies could be extended to include policies purchased in the individual insurance market. That step would sever the link between employment and tax subsidies for private health insurance and could give similar people the same subsidy whether or not they were offered an employment-based health plan.

Deductions and credits differ, however, in their effectiveness at reaching the uninsured. An income tax deduction might provide limited benefits to low-income

individuals because, like the existing exclusion, its value is less for those in lower tax brackets. In contrast, tax credits can be designed to provide lower- and moderate-income taxpayers with larger benefits than they would receive from tax deductions or exclusions. An important question regarding tax credits—particularly for lower-income people who pay relatively little in income taxes and are also more likely to be uninsured—is whether the credits would be refundable and therefore fully available to individuals with little or no income tax liability.

For the same budgetary costs, a refundable tax credit might be more effective at increasing insurance coverage, both because it can be designed to provide a larger benefit to low-income people than they receive under current law and because those recipients might be more responsive to a given subsidy than are people with higher income. Still, the effect on coverage rates might be limited if people do not receive refundable tax credits before their premium payments are due.

Providing Subsidies Through Spending Programs. The government could seek to increase coverage rates by spending funds to subsidize insurance premiums. New subsidies could be provided implicitly by expanding eligibility for Medicare, Medicaid, or CHIP or explicitly by creating a new program. To hold costs down, benefits could be targeted on the basis of income, assets, family responsibilities, and insurance status. Targeting benefits, however, would require program administrators to certify eligibility and enforce the program's rules, which would affect coverage and the program's costs.

The Effects of Subsidy Proposals. Proposals to subsidize insurance coverage would affect decisions by both employers and individuals. Employers' decisions to offer insurance to their workers reflect the preferences of their workers, the cost of the insurance that they can provide, and the costs of alternative sources of coverage that workers would have. Smaller firms appear to be more sensitive to changes in the cost of insurance than are larger employers. Subsidies that reduce the cost of insurance offered outside the workplace would cause some firms to drop coverage or reduce their contributions. When deciding whether to enroll in employment-based plans, workers would consider the share of the premium that they pay as well as the price and attractiveness of alternatives. The available evidence indicates that a small share of the population would be reluctant to purchase insurance even if subsidies covered nearly all of the costs.

Related Budget Options. Several of the alternatives included in CBO's *Budget Options* volume highlight the potential effects of changing the tax treatment of health insurance. For example, Option 10 would replace the current exclusion from income taxes for employment-based health insurance with a tax deduction that phases out at higher income levels. That option would increase federal revenues by approximately $550 billion through 2018 (as estimated by the staff of the Joint Committee on Taxation). Because that option would increase the effective price of health insurance for higher-income taxpayers, it would, by CBO's estimation, increase the number of

uninsured people by about 1.5 million in 2014 (in part because some employers would decide to stop offering coverage). Those estimates are sensitive to the parameters of the deduction and particularly to the range of income over which the deduction is phased out.

Other examples illustrate the effects on federal costs and coverage that stem from targeting different populations. Allowing low-income young adults to enroll in Medicaid, as described in Option 23, would cover about 1.1 million people in 2014, at a federal cost of about $22 billion over the 2010–2019 period, according to CBO's estimates. Allowing low-income parents with children eligible for Medicaid to enroll in the program, as described in Option 24, would cost about $38 billion over the same period and would expand coverage to about 1.4 million parents and 700,000 children in 2014.

Another approach is illustrated by Option 7, which would create a voucher program to subsidize the purchase of health insurance for households with income below 250 percent of the federal poverty level. Specifically, individuals would receive up to $1,500, and families would receive up to $3,000. According to CBO's estimates, that approach would reduce the net number of uninsured people by about 2.2 million in 2014. Overall, approximately 4 million people would use the voucher, but about 1.7 million of those people would have had coverage in the individual health insurance market or through an employer. In addition, about 100,000 people would become newly uninsured as a result of small employers' electing not to offer coverage because of the new voucher program. The total cost to the federal government of such a voucher program would be about $65 billion over the next decade.

Mandating Coverage

In an effort to increase the number of people who have health insurance or to achieve universal or near-universal coverage, the government could require individuals to obtain health insurance or employers to offer insurance plans. Employer mandates could include a requirement that employers contribute a certain percentage of the premium, which would encourage their workers to purchase coverage. To the extent that the required contributions exceeded the amounts that employers would have paid under current law, offsetting reductions would ultimately be made in wages and other forms of compensation.

The impact of a mandate on the number of people covered by insurance would depend on its scope, the extent of enforcement, and the incentives to comply, as well as the benefits that enrollees received. Individual mandates, for example, could be applied broadly to the entire population of the United States or to a specific group, such as children; employer mandates might vary by the size of the firm. (Option 3 in the *Budget Options* volume is a specific requirement for large employers to offer coverage or pay a fee. Under the provisions of that option, the number of newly insured individuals would be relatively small, only about 300,000.)

Penalties would generally increase individuals' incentives to comply with mandates, but when deciding whether to obtain insurance, people would also consider the likelihood of being caught if they did not comply. Data from the tax system and from other government programs, where overall rates of compliance range from roughly 60 percent to 90 percent, indicate that mandates alone would not achieve universal coverage, largely because some people would still be unwilling or unable to purchase insurance.

Facilitating Enrollment

Simplifying the process of enrolling in health insurance plans or applying for subsidies could yield higher coverage rates and could also increase compliance with a mandate to obtain coverage. One approach would be to enroll eligible individuals in health insurance plans automatically, giving them the option to refuse that coverage or to switch to a different plan. Automatic enrollment has been found to increase participation rates in retirement plans and government benefit programs. It requires the government, an employer, or some other entity to determine the specific plan into which people will be enrolled, however, and those choices may not always be appropriate for everyone.

Factors Affecting Insurance Premiums

Premiums for employment-based plans are expected to average about $5,000 per year for single coverage and about $13,000 per year for family coverage in 2009. Premiums for policies purchased in the individual insurance market are, on average, much lower—about one-third lower for single coverage and one-half lower for family policies. Those differences largely reflect the fact that policies purchased in the individual market generally cover a smaller share of enrollees' health care costs, which also encourages enrollees to use fewer services. An offsetting factor is that average administrative costs are much higher for individually purchased policies. The remainder of the difference in premiums probably arises because people who purchase individual coverage have lower expected costs for health care to begin with.

The federal costs of providing premium subsidies, and the effects of those subsidies on the number of people who are insured, would depend heavily on the premiums charged. Premiums reflect the average cost that any insurer—public or private—incurs, and those costs are a function of several factors:

- The scope of benefits the coverage includes and its cost-sharing requirements,
- The degree of benefit management that is conducted,
- The administrative costs the insurer incurs, and
- The health status of the individuals who enroll.

Insurers' costs also depend on the mechanisms and rates used to pay providers and on other forces affecting the supply of health care services. Proposals could affect many of those factors directly or indirectly. For example, the government might specify a minimum level of benefits that the coverage must provide in order to qualify for a subsidy or fulfill a mandate; such a requirement could have substantial effects on the proposal's costs or its impact on coverage rates.

Design of Benefits, Cost Sharing, and Related Budget Options

Health insurance plans purchased in the private market tend to vary only modestly in the scope of their benefits—with virtually all plans covering hospital care, physicians' services, and prescription drugs—but they vary more substantially in their cost-sharing requirements. A useful summary statistic for comparing plans with different designs is their "actuarial value," which essentially measures the share of health care spending for a given population that each plan would cover. Actuarial values for employment-based plans typically range between 65 percent and 95 percent, with an average value between 80 percent and 85 percent. Cost-sharing requirements for enrollees tend to be greater for policies purchased in the individual insurance market, where actuarial values generally range from 40 percent to 80 percent, with an average value between 55 percent and 60 percent.

Public programs also vary in the extent of the coverage they provide. Medicaid requires only limited cost sharing (reflecting the low income of its enrollees); cost sharing under CHIP may be higher but is capped as a share of family income. Medicare's cost sharing varies substantially by the type of service provided; for example, home health care is free to enrollees, but most hospital admissions incur a deductible of about $1,000. In addition, the program does not cap the out-of-pocket costs that enrollees can incur. Overall, the actuarial value of Medicare's benefits for the nonelderly population is about 15 percent lower than that of a typical employment-based plan. Those considerations would affect CBO's analysis of proposals to expand enrollment in public programs.

In general, the more comprehensive the coverage provided by a health plan, the higher the premium or cost per enrollee. Indeed, an increase in a health plan's actuarial value would also lead enrollees to use more health care services. Reflecting the available evidence, CBO estimates that a 10 percent decrease in the out-of-pocket costs that enrollees have to pay would generally cause their use of health care to increase by about 1 percent to 2 percent. The agency would apply a similar analysis to proposals that included subsidies to reduce the cost-sharing requirements that lower-income enrollees face.

Several budget options examine the effects of changing cost-sharing requirements in the Medicare program. Option 81 would replace the program's current requirements with a unified deductible, a uniform coinsurance rate, and a limit on out-of-pocket costs. That option would reduce federal spending by about $26 billion over 10 years—mostly because of the increase in cost sharing for some services and the resulting

reduction in their use. Option 83 would combine those changes in the Medicare program with limits on the extent to which enrollees could purchase supplemental insurance policies (known as medigap plans) that typically cover all of Medicare's cost-sharing requirements. That option would reduce federal spending by about $73 billion over 10 years—with the added savings emerging because enrollees would be more prudent in their use of care once their medigap plans did not cover all of their cost-sharing requirements. Options 84, 85, and 86 would reduce federal outlays by imposing cost sharing for certain Medicare services that are now free to enrollees, and Option 89 would increase federal outlays by eliminating the gap in coverage (commonly called the doughnut hole) in the design of Medicare's drug benefit. Options 95 through 98 would reduce federal spending by introducing or increasing cost-sharing requirements for health care benefits provided to veterans, military retirees and their dependents, and dependents of active-duty personnel.

Management of Benefits

Another factor affecting health insurance premiums and thus the costs or effects of legislative proposals is the degree of benefit and cost management that insurers apply. Nearly all Americans with private health insurance are enrolled in some type of "managed care" plan, but the extent to which specific management techniques are used varies widely. Common techniques to constrain costs include negotiating lower fees with a network of providers, requiring that certain services be authorized in advance, monitoring the care of hospitalized patients, and varying cost-sharing requirements to encourage the use of less expensive prescription drugs. Overall, CBO estimates, premiums for plans that made extensive use of such management techniques would be 5 percent to 10 percent lower than for plans using minimal management. Conversely, proposals that restricted plans' use of those tools would result in higher health care spending than proposals that did not impose such restrictions.

Administrative Costs

Some proposals would affect the price of health insurance by changing insurers' administrative costs. Some types of administrative costs (such as those for customer service and claims processing) vary in proportion to the number of enrollees in a health plan, but others (such as those for sales and marketing efforts) are more fixed; that is, those costs are similar whether a policy covers 100 enrollees or 100,000. As a result of those economies of scale, the average share of the policy premium that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

Some administrative costs would be incurred under any system of health insurance, but proposals that shifted enrollment away from the small-group and individual markets could avoid at least a portion of the added administrative costs per enrollee that are observed in those markets. In general, however, substantial reductions in administrative costs would probably require the role of insurance agents and brokers

in marketing and selling policies to be sharply curtailed and the services they provide to be rendered unnecessary.

Spending by Previously Uninsured People

The impact that the mix of enrollees has on health insurance premiums is also an important consideration, particularly for proposals that would reduce the number of people who are uninsured. The reason is that the use of health care by the previously uninsured will generally increase when they gain coverage. On average, the uninsured currently use about 60 percent as much care as the insured population, CBO estimates, after adjusting for differences in demographic characteristics and health status between the two groups.

On the basis of the research literature and an analysis of survey data, CBO estimates that enrolling all people who are currently uninsured in a typical employment-based plan would increase their use of services by 25 percent to 60 percent; that is, they would use between 75 percent and 95 percent as many services as a similar group of insured people. The remaining gap in the use of services reflects the expectation that, on average, people who are uninsured have a lower propensity to use health care, a tendency that would persist even after they gained coverage. For more incremental increases in coverage rates, CBO would expect that people who chose to enroll in a new program would be more likely to use medical care than those who decided not to enroll.

In addition, recent estimates indicate that about a third of the care that the uninsured receive is either uncompensated or undercompensated—that is, they either pay nothing for it or pay less than the amount that a provider would receive for treating an insured patient. To the extent that such care became compensated under a proposal to expand coverage, health care spending for the uninsured would increase, regardless of whether their use of care also rose.

Proposals Affecting the Choice of an Insurance Plan

The government could affect the options available to individuals when choosing a health insurance plan—and the incentives they face when making that choice—in a number of ways. In particular, proposals could establish or alter regulations governing insurance markets, seek to reveal more fully the relative costs of different health insurance plans, or have the federal government offer new health insurance options.

The effects of proposals on insurance markets would depend on more than the impact they have on the premiums charged or on the share of the premium that enrollees have to pay; those effects would also reflect the market dynamics that arise as individuals shift among coverage options and as policy premiums adjust to those shifts. In particular, the risk that some plans would experience "adverse selection"—that is, that their enrollees will have above-average or higher-than-expected costs for health care—

has important implications for the operation of insurance markets and for proposals that would regulate those markets or introduce new insurance options.

Insurance Market Regulations and Related Budget Options

Proposals could seek to establish or alter regulations governing the range of premiums that insurers may charge or the terms under which individuals and groups purchase coverage. Purchases in the individual insurance market and most policies for small employers are governed primarily by state regulations. Those regulations differ in the extent to which they limit variation in premiums, require insurers to offer coverage to applicants, permit exclusions for preexisting health conditions, or mandate coverage of certain benefits. Roughly 20 percent of applicants for coverage in the individual market have health problems that raise their expected costs for health care substantially, and in most states they may be charged a higher premium or have their application denied; as a result, premiums are correspondingly lower in those states for the majority of applicants.

Proposals might seek to modify the regulation of health insurance markets in order to make insurance more affordable for people with health problems or to give consumers more choices, but those goals might conflict with each other. For example, limiting the extent to which premiums for people in poor health can exceed those for people in better health (as some states currently do) would reduce premiums for those who have higher expected costs for health care, but it would also raise premiums for healthier individuals and thus could reduce their coverage rates. Other proposals might counteract such limits on variations in premiums—for example, by allowing people to buy insurance in other states. That approach would enable younger and relatively healthy individuals living in states with tight limits to purchase a cheaper policy in another state. Older and less healthy residents who continued to purchase individual coverage in the tightly regulated states, however, would probably face higher premiums as a result.

By themselves, changes in the regulation of the small-group and individual insurance markets would generally have modest effects on the federal budget and on the total number of people who are insured. Those budgetary effects would primarily reflect modest shifts into or out of Medicaid, CHIP, or employment-based coverage as those options became more or less attractive relative to coverage in the individual market. Proposals to require insurers to cover all applicants or to guarantee coverage of preexisting health conditions would benefit people whose health care would not be covered otherwise, but insurers would generally raise premiums to reflect the added costs.

Another approach that has attracted attention recently involves so-called high-risk pools. Most states have established such pools to subsidize insurance for people who have high expected medical costs and have either been denied coverage in the individual insurance market or been quoted a very high premium. Overall participation in high-risk pools is limited—there are currently about 200,000 enrollees nationwide—but proposals could seek to expand the use of those pools by providing new federal

subsidies. The costs of such subsidies would depend primarily on the average health care costs of enrollees, the share of those costs covered by the pool, and the number of people who enrolled as a result.

CBO analyzed several specific options related to the regulation of insurance markets in its *Budget Options* volume. For example, Option 2 would allow insurers licensed in one state to sell policies to individuals living in any other state and to be exempt from the regulations of those other states. Under that option, premiums would tend to rise for people with higher expected costs for health care living in states that tightly regulate insurance markets, and premiums would fall correspondingly for low-cost individuals in those states because some of them would find insurance policies with lower premiums sold in other states with looser regulations. As a result, according to CBO's estimates, by 2014 about 600,000 people with relatively low expected health care spending would gain coverage and about 100,000 people with higher expected costs would drop their coverage. In addition, some firms would stop offering health insurance plans altogether, resulting in an additional loss of coverage for about 100,000 employees and their dependents. Those changes in coverage would generate nearly $8 billion in additional federal revenues over 10 years, as some compensation shifted from untaxed health benefits to taxable wages. Among those who were no longer offered employment-based coverage, a small number would enroll in Medicaid causing roughly a $400 million increase in federal outlays over the 2010–2019 period.

Option 6 would require states to use "community rating" of premiums for small employers who purchase coverage from an insurer—meaning that insurers would have to charge all applicants the same per-enrollee premium for a given policy. Under that option, total enrollment in the small-group health insurance market would fall by about 400,000 (or roughly 1 percent of current enrollment) in 2014, reflecting the net effect of both increased enrollment by people with high expected costs and decreased enrollment by people with low expected costs. The budget deficit would be reduced by about $5 billion over the next decade, largely as a result of higher tax revenues. Option 4 would require all states to establish high-risk pools and provide federal subsidies toward enrollees' premiums. Enrollees would be responsible for paying premiums up to 150 percent of the standard rate for people of similar age. That option would increase the deficit by about $16 billion over the 2010–2019 period; on net, about 175,000 individuals who would have been uninsured otherwise would gain insurance coverage in 2014.

Steps to Reveal Relative Costs

Some proposals would seek to restructure the choices that individuals face—and expose more clearly the relative costs of their health insurance options—either by reducing or eliminating the current tax subsidy for employment-based insurance or by encouraging or requiring the establishment of managed competition systems. Both approaches would provide stronger incentives for enrollees to weigh the expected benefits and costs of policies when making decisions about purchasing insurance. As a

result, many enrollees would choose health insurance policies that were less extensive, more tightly managed, or both, compared with the choices made under current law.

The current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent, on average, if both the income and payroll taxes that are avoided are taken into account. Eliminating that exclusion, or replacing it with a fixed-dollar tax credit or deduction, would effectively require employees to pay a larger share of the added costs of joining a more expensive plan; conversely, employees would capture more of the savings from choosing a cheaper plan. As a result, according to CBO's estimates, people would ultimately select plans with premiums that were between 15 percent and 20 percent lower than the premiums they would pay under current law. Less extensive changes, such as capping the amount that may be excluded at a certain dollar value, would have proportionally smaller effects on average premiums.

The key features of a managed competition system involve a sponsor, such as an employer or government agency, offering a structured choice of health plans and making a fixed-dollar contribution toward the cost of that insurance. Enrollees would thus bear the cost of any difference in premiums across plans. In CBO's estimation, a proposal requiring that approach would yield average premiums for health insurance that were about 5 percent lower than those chosen under current law. Proposals that also adopted other features of managed competition, such as standardization of benefits across plans and adjustments of sponsors' payments to those plans to reflect the health risk of each enrollee, might yield more intense competition among plans and help avoid problems of adverse selection.

Federally Administered Options and Related Budget Options

Under some proposals, the federal government would make available additional options for insurance—for example, by providing access to the private health plans that are offered through the Federal Employees Health Benefits (FEHB) program. The effects of that approach would depend critically on how the premiums for nonfederal enrollees were set. If insurers could charge different premiums to different applicants on the basis of their expected costs for health care, the option would resemble the current small-group and individual markets and thus would have little impact. Alternatively, if new enrollees were all charged the same premium, the FEHB plans would be most attractive to people who expected to have above-average costs for health care. If no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today—so the number of new enrollees would probably be limited. Depending on the specific features of such proposals, providing access to FEHB plans might not prove to be financially viable because of adverse selection into those plans.

The government could also design an insurance option based on Medicare that would be made more broadly available, on a voluntary basis, to the nonelderly population. The federal costs per enrollee would depend primarily on the benefits that system pro-

vided; the rates used to pay doctors, hospitals, and other providers of health care; and the extent of any premium subsidies that were offered to enrollees—all of which could differ from Medicare's current design. As for whether such a plan would be more or less costly than a private health insurance plan that provided the same benefits to a representative group of enrollees, the answer would vary geographically. Assuming that Medicare's current rules applied, those costs would be comparable in many urban areas, but in other areas, the cost of the government-run plan would be lower (as is evident in the current program through which Medicare beneficiaries may enroll in a private health plan). At the same time, because Medicare currently provides broad access to doctors and hospitals and employs little benefit management, a Medicare-based option might attract relatively unhealthy enrollees, which could drive up its premiums, federal costs, or both.

Many of the same considerations would arise in designing a single-payer, Medicare-for-all system, but that approach might raise some unique issues as well—and the scale of its impact on federal costs could obviously be much larger if nearly all of the population was covered. Enrollees could be offered a choice of plans under a single-payer system (as happens in Medicare). If, instead, only one design option was offered and all residents were required to enroll in it, then concerns about adverse selection would not arise. That approach could also reduce the administrative costs that doctors and hospitals currently incur when dealing with multiple insurers. The lack of alternatives with which to compare that program, however, could make it more difficult to assess the system's performance. More generally, that approach would raise important questions about the role of the government in managing the delivery of health care.

Under the provisions of Option 27 in the *Budget Options* volume—which would allow individuals and employers to buy into the FEHB program—CBO estimates that about 2.3 million people would enroll in 2014, of whom about 1.3 million would have been uninsured otherwise. The new program would constitute a separate insurance risk pool for nonfederal enrollees, and their premiums would not be the same as those for federal employees. However, premiums would be the same for all nonfederal enrollees within each plan in a particular geographic area and would be structured so that they did not lead to any new outlays by the federal government. The estimate reflects an assessment that the individuals who enrolled in the program would have greater-than-average health risks, which would lead to higher premiums than if the entire eligible population had enrolled in the program. Although considerable uncertainty exists about the financial viability of FEHB plans in such a program, CBO estimated that features such as an annual open-enrollment period, limited exclusions of coverage for preexisting health conditions, and participation by small employers would limit adverse selection and yield a stable pool of enrollees. The buy-in option would increase the deficit by almost $3 billion from 2010 to 2019, reflecting the net effect of reduced revenues (from a shift in employers' compensation to nontaxable health insurance) and reduced outlays from lower enrollment in Medicaid.

Exhibit 12

HEALTH REFORM IN THE 21ST CENTURY: INSURANCE MARKET REFORMS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

APRIL 22, 2009

Serial 111–14

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

52–258 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

Prepared Statement of Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University, Princeton, New Jersey

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. My research work during the past several decades has been focused primarily on health-care economics and policy.

I would like to thank you, Chairman and your colleagues on this Committee for inviting me to present a statement on the problems of structuring a market for individually purchased health insurance in the United States.

After some remarks on the interface between social ethics and health reform, my statement will focus for the most part of ways of reforming the market for health insurance.

I. INTRODUCTION

Any modern health system, regardless of its structure, must perform the following five major functions:

1. **FINANCING** health care, that is, extracting the requisite funds for the health system from individuals and households, who ultimately pay for all of health care. (Government, employers and private insurers are merely pumping stations in the flow of funds from individuals and households to the providers of health care).
2. **POOLING RISKS** for the purpose of protecting individuals and households from the uncertain financial cost of needed health care.
3. **PURCHASING** health care from its providers (doctors, hospitals, and so on), which includes negotiating or setting the prices to be paid for health care and determining the set of goods and services actually needed for the efficient, evidence-based best treatment of given medical conditions (including disease management and chronic care).
4. **PRODUCING** the goods and services required for the proper treatment of given medical conditions, including their diagnosis.
5. **REGULATING** the various clinical and economic activities involved in the operation of the nation's health system so that it works consistently towards socially desired ends.

As I understand it, this hearing is about the allocation of the first three functions between the private and the public sectors. The fifth function, of course, is the natural preserve of government, especially after the financial markets have demonstrated at such great cost to the rest of the world that private markets cannot be trusted to be self-regulating and working in society's interest, a point now grasped even by economists, including libertarian Alan Greenspan.

The allocation of the first three functions between government and the private sector, however, is not so clear-cut. It depends crucially on the social goals society wishes to posit for its health system, including how the financial burden of ill health is to be allocated to members of society and how care is to be distributed among them. I shall therefore offer a few remarks on that facet of a health system.

II. THE SOCIAL GOALS OF HEALTH SYSTEMS

Most industrialized nations in the OECD, along with Taiwan, seek to operate their health systems on the *Principle of Social Solidarity*. It means to them that health care is to be viewed as a so-called "social good," like elementary and secondary education in the United States. That perspective, in turn, implies that the financial burden of health care for the nation as a whole should be allocated to individual members of society roughly in accordance with the individual's ability to pay, and that needed health care should be available to all members of society on toughly equal terms.

If the health system is to operated subject to this distributive social ethic, it requires that government either operate the financing, risk-pooling and purchasing functions directly (as is the case in Canada, Taiwan and the UK, for example) or that government tightly regulate all three functions, even if they are actually performed by private institutions outside of government proper (as is the case in Germany, the Netherlands and Switzerland).

Unfortunately, the United States never has been able to evolve a widely shared consensus on the distributive social ethic that ought to govern the U.S. health system. The bewildering American health system reflects that lack of consensus.

At one end of the ideological spectrum, many Americans appear to believe that health care ought to be treated as a private consumer good that should be distributed on the basis market principles. This means that the financing of health care ought to be viewed primarily as the responsibility of the individual, and only the

poorest members of society ought to be given public assistance in procuring a bare-bones package of health care. In other words, these Americans believe that, for the most part, health care should be rationed among members of American society on the basis of price and ability to pay, like other basic consumer goods, such as housing, clothing and food.

At the other end of the ideological, just as many other Americans share the ethical precepts of other nations in the OECD. These Americans, too, believe that our health system ought to be operated on the *Principle of Social Solidarity*, that is, that health care should be viewed a social good. If rationing of health care there must be, then it ought to be on principles other than price and ability to pay.

In between these distinct but coherent views reigns massive intellectual confusion.

To illustrate, the same citizens and politicians who look askance at "socialized medicine"[1] reserve the purest form of socialized medicine—the VA health system—for the nation's allegedly much admired veterans. A foreigner may be forgiven for finding this cognitive dissonance bizarre.

Similarly, there are many Americans, who believe that government does not have the right to impose on them a mandate to have health insurance, all the while considering it their moral right as Americans to receive even horrendously expensive tertiary health care in case of critical need, even if the recipients have no hope of financing that care with their own resources. Foreigners may be forgiven for shaking their heads at this immature and asocial entitlements mentality, which would be rare in their home countries.

Finally, a good many citizens and politicians who accept with equanimity the rationing of health care by price and ability in this country openly deplore the rationing of health by administrative means in other countries, perhaps not realizing that textbooks in economics explicitly ascribe to market prices the role of rationing scarce resources among unlimited want[2] Why the latter form of rationing is superior to the former is not obvious.

A much mouthed mantra in our debate on health policy is that "we all want the same thing in health care, but merely quibble over the means to get there." Nothing could be further from the truth. That debate has been and continues to be a tenacious ideological fight over the social ethic that ought to govern American health care; but we camouflage it as a technical debate strictly over means.

My plea before this Committee and to the Congress is that any health reform proposal put before the American people be preceded with a preamble that clearly articulates the social goals our health system is supposed to pursue and the social ethic it is to observe. Policy makers in other nations routinely do so and accept the constraints that this preamble imposes on their design of health reform. It would be helpful to have a clearly articulated statement on the social ethics for American health care as well.

With these preliminary remarks, I would now like to turn to the structure of the market for health insurance.

III. THE MARKET FOR PRIVATE HEALTH INSURANCE

The value a health insurance system offers society is the ability to pool the financial risks faced by individuals in order to protect members of that risk pool from uncertainty over the financial inroads of high medical bills in case of illness. In return for receiving that value, individuals make a financial contribution to the risk pool, in the form of taxes (e.g., payroll taxes) or premiums.

Many economists view this risk pooling as the sole proper function of health insurance *per se*. To them, for example, the segmentation of a free market for private health insurance by risk class, with relatively higher insurance premiums charged to patients expected to be relatively sicker over the insured future period, is not only an inevitable outcome of such a market, but is viewed perfectly acceptable. Such

---

[1] The formal definition of "socialism," according to my American Heritage Desk Dictionary, is a system in which *government owns the means of production*. "Socialized medicine" thus is a system in which government owns, operates and finances health care, as in the VA health system. It is not the same as "social insurance," which merely is an arrangement under which individuals transfer financial risks they face to a larger collective body, often the government. The limited liability shareholders of corporations enjoy, for example, is one of the oldest forms of social insurance, as is the Federal Government's assistance to states struck by natural disasters, as is the many guarantees government extends to the financial sector and as is, of course, Medicare and Medicaid.

[2] As two well-known authors put it: "*Bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.*" See Michael L. Katz and Harvey S. Rosen, *Microeconomics*, (1991): 15.

premiums are called "actuarially fair." On this view, if society wants greater equity in the financing of health care, then government should provide risk-adjusted subsidies toward the purchase of actuarially priced private insurance.

As a practical matter, however, most people seem to believe that both private and public insurers should not only protect individuals from the variance of their own health spending likely to be incurred by that individual over time, but also incorporate in its premium structure hidden cross subsidies from chronically healthy to chronically sick members of society. Most health insurance systems in the world actually do that, including the Medicare and Medicaid programs in the United States and the private employment-based health insurance system.

A. Employment-Based Insurance

In the market for employment-based group health-insurance, the insurance premium paid the insurer by the employer typically is "experienced rated" over the group of employees being insured. It means that the premium reflects the *average expected (actuarial) cost* of the health care likely to be used collectively by all of that employer's employees, plus a markup-up for the cost of marketing and administration and profits.

In effect, then, the bulk of the risk pooling for employment-based health insurance actually is performed by the employer, not the insurer. The insurer bears only a small fraction of the total risk, a fraction that varies inversely with the size of the insured group.

This is even clearer when the employer overtly self-insures, as most large employers in the United States now do. In that case, the employer bears all of the financial risk of the employees' illness, and private insurance carriers are engaged by the employer merely perform the purchasing function (the third function above) on behalf of the employer-run risk pool, including claims processing.

Economists are persuaded by both theory and empirical evidence that, over the longer run, the full cost of the employer's contribution to the employees' group health insurance is shifted back somehow to employees in the form of lower take-home pay or a reduction in other fringe benefits. The arrangement typically does force chronically healthier employees to cross-subsidize chronically sicker employees, because the reduction in take-home pay within a given skill level is independent of the individual employee's health status.

In a sense, then, employment-based insurance is a form of "social insurance." One may call it "private social insurance," especially for larger employers, as distinct from government-run social insurance. It is one reason that the employment-based system has such strong support among people who would like to see American health care governed by the *Principle of Social Solidarity*. The feature of employment-based insurance that attracts them is the pooling of risks in that system.

A problem, of course, is that this principle is vastly eroded, the smaller the number of employees is over which premiums are experience-rated. For very small firms, employment-based insurance approximates individually purchased insurance.

B. The Market for Individual Insurance

In the market for individually purchased insurance, risk pooling necessarily must take place at the level of the insurance company.

As is well known from a distinguished literature in economics, a price-competitive market of individually sold health insurance will naturally segment itself by risk class. By economic necessity—and not a mean spirit—insurers in such a market have no choice but to engage in "medical underwriting" if they want to survive.

This means that private insurers must (a) determine as best they can the health status and likely future cost to the risk pool that an individual prospective customer will cause and (b) charge the individual a premium that covers that anticipated cost (the "actuarially fair premium") plus a mark-up for the risk pool's cost of marketing and administration and for desired profits. The size of this mark-up is constrained through price competition. As the Lewin Group estimated in a recent report, this mark-up averages 31.7% for private insurers in the individual market.[3]

The general public and the media that informs the public seem insufficiently cognizant of the horrendously complex product insurers sell. A health insurance policy is a so-called "contingent contract" under which the insurer is obligated to pay the insured a specified amount of money—or, alternatively, to purchase for the insured specified medical benefits—should that contingency arise.

The problem has always been to define that "contingency" so that it does not trigger disputes on whether or not the contingency has occurred—e.g., whether a med-

[3] The Lewin group, *The Cost and Coverage Impacts of a Public Plan: Alternative Design Options,* Staff Working Paper # 44, April 6, 2009.

ical procedure was called for on clinical grounds. Furthermore, it should be clear that *both* sides to the contract—the insured and the insurer—have the opportunity to cheat on the contract, if they are so inclined. It is the reason why these types of contingent contracts typically are subject to penetrating government regulation and oversight.

There is a tendency among the critics on the private health insurance industry to vilify it. I find that unfair and unproductive. The important question is whether that industry, as it is currently structured, can serve the social objectives American society may wish to posit for it and, if not, what regulation of the industry would be required to make it march toward the desired social goal.

C. Marrying a Purely Private Insurance Sector to the Principle of Social Solidarity

If the social objective of our health reform is to make health insurance available to all Americans on equal terms—as President Obama's campaign statements clearly imply—then the current private market for individual insurance has three major shortcomings.

The first is the practice of *medical underwriting,* that is, the practice of inquiring deeply into the personal health status of individual applicants for insurance and basing the quoted premium on the individual's health status. This practice could be eliminated by forcing every insurance company to charge the same premium to every one of its customers, with the possible exception of age. Every insurer would charge so-called *community-rated premiums*, although these could vary competitively among insurers.

A second practice at odds with the President's stated social goal for American health care is the practice of denying health insurance to anyone whose expected future medical bills exceed the premium that can be charged the individual, or to rescind insurance *ex post* when medical claims have piled up and he insurer cancels the policy over some flaw belatedly found in the original application for insurance. This practice can be eliminated by imposing *"guaranteed issue"* on the industry. It means every insurer must accept all applicants seeking to buy coverage at the insurer's quoted community-rated premium and may not cancel policies *ex post*.

But as both the theoretical and the empirical literature on this market clearly demonstrate, imposition of *community-rated premiums* and *guaranteed* issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with a third, highly controversial requirement, namely, a *mandate on individual to be insured* for a at lest a specified minimum package of health benefits.[4]

A mandate upon the individual to be insured, however, is likely to be disobeyed by large numbers of low-income individuals unless the government is willing and able to grant those individuals sufficient public subsidies toward the purchase of health insurance. One way to assess the adequacy of these subsides is to reach a political consensus on the maximum percentage X that the individual's (or family's) total outlay for health insurance premiums and out-of-pocket health-care spending takes out of the unit's discretionary income (disposable income minus outlays for other basic necessities, such as food, housing, clothing, etc.). That maximum percentage X probably would have to rise with income. Its proper size is a political call. It would be helpful if Congress could agree on such a number.

With these four features—*(1) community rating, (2) guaranteed issue, (3) mandated insurance* and *(4) adequate public subsidies*—a private, strictly monitored health insurance market for individually purchased health insurance probably could be made to march fairly closely in step with the distributive social ethic professed by the President and by many Members of Congress. It would require very tight regulations and supervision of the industry, however, most likely through the National Health Insurance Exchange provided for in the President's health-reform proposal. Within their ranks of enrollees, both the Medicare Advantage program and the Medicaid Managed Care program are tightly regulated and supervised in roughly this fashion.

IV. THE POTENTIAL ROLE OF A NEW PUBLIC HEALTH PLAN

During his presidential campaign, President Obama firmly and quite explicitly promised not only to reform the market for private, individually sold health insur-

[4] For a report on how private insurance markets implode when the mandate to be insured is not imposed in a community-rated market with guaranteed issue, see Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "**Community Rating And Sustainable Individual Health Insurance Markets In New Jersey:** Trends in **New Jersey** 's Individual Health Coverage Program reveal troubled times for the program," *Health Affairs*, July/August 2004; 23(4): 167–175.

ance—along the lines outlined above—but to include among the insurance options in this market a new public plan for non-elderly Americans. This public plan would have to compete with private health insurers for enrollees.

A. Why might a Public Plan be attractive to Americans?

One could imagine a sizeable latent demand among the American public for such a public health plan, even in the absence of any significant cost advantage that such a public plan might have.

In recent years, Americans have seen retiree health benefits once promised them by private corporations melt away. They have seen their 401(k) savings in the private sector similarly melt down severely and the value of any other private pension plan vastly eroded. They have lost their employer-based health insurance with their job or, if they have not yet lost it, they fear of losing it. They have seen once revered and seemingly indestructible American corporations stumble toward bankruptcy and extinction, either at the hand of global competition or as a result of mismanagement. Finally, they have seen the once revered leaders of the financial sector behave in so irrational and destructive a manner as to make a mockery of received economic theory, with its instinctive belief in the economic superiority of private markets[5].

After all of this turbulence, destruction and self-immolation in the once hallowed private sector of the economy, many Americans may now seek the comfort of permanence that a fully portable, reliable and permanent government-run health insurance plan would offer them, side by side with the possibility of choosing a private health insurance plan instead. To deny them that opportunity would require a compelling justification.

Advantages of a Public Plan: A public health insurance plan for non-elderly Americans could offer society a number of advantages.

First, it would be likely to have the advantage of large economies of scale. Therefore, it could economically use expensive and powerful health-information technology to simplify claims processing, lower the cost of prudent purchasing ad quality monitoring, and engage in disease management, if it were allowed to do so.

Although a few large private insurers dominate the market in many areas, overall the market for private health insurance remains remarkably splintered, with many insurers carrying on somehow with very small enrollments, often below 20,000 insured[6] It is not clear how such small insurers can harvest the economies of scale of marketing and administration, and especially the benefits of health information technology. One must wonder what features in this market have allowed them to survive to this point. Presumably, the market for private insurance would have to consolidate significantly in a reformed insurance market.

Second, a public plan would not have to include in its premiums an allowance for profits and probably have low or no marketing costs. The previously cited Lewin Group sees that as a significant cost advantage of the public plan, reducing administrative costs as a percent of medical claims to about 13%, relative to 31% for private insurers. That advantage, however, may be exaggerated if private insurers offered their policies through a formal insurance exchange, reducing the cost of commissions to insurance brokers.

A third advantage could be the ability of a public plan to innovate in paying the providers of health care. Medicare already has been remarkably innovative on that front. The case-based DRG system for hospital payment, now being copied around the world, is Medicare's creation, and so is the development of the Resource-Based-Relative-Value Scale (RBRVS) which now forms the basis of negotiations over fees between physicians and private health insurers.

The next step in payment reform has to be a move away from the time-honored but inefficient fee-for-service system that dominates in both the private and public insurance sectors, and round the world, towards bundled, case-based payments for evidence based, clinically integrated care[7] Along with Medicare, a new public plan for non-elderly Americans could play a role in the development of this payment method as, of course, could private insurance plans.

Finally, government has already contributed substantially to the measurement of the quality of health care and websites that disseminate such information to the

---

[5] See, for example, George A. Akerlof and Robert J. Shiller, *How human Psychology Drives the Economy, and Why it Matters for Global Capitalism,* Princeton University Press, 2009.

[6] See, for example, Allan Baumgarten, *Texas Managed Care Review* 2006 (available at http://www.allanbaumgarten.com/images/presentations/TX_ManagedCareReview_2006.pdf) and similar reports by that author for other states.

[7] See, for example, the website of Prometheus Payment® Inc., http://www.prometheuspayment.org/

market place and has fielded demonstration projects for disease management, once again side by side with the private sector.

Problems with a Public Plan: As I see it, the main problems with the addition of a public health insurance plan to a menu of competing private insurance options are political, rather than technical.

There is in the realm of politics the overarching question whether government should perform functions that the private sector could also perform, even if the private-sector would use more resources—be more costly—to achieve the same end. We see that question debated now in connection with student loans[8] which, according to the Congressional Budget Office[9], cost taxpayers considerably more when channeled through the private banking sector than when loans are made directly by government to students. The outcome of the current debate over student loans may be an augury for the course of health reform.

But even if the answer to the previous question were "Yes"—that government may indeed intrude as a competitor on economic turf traditionally held by the private sector—there is the question of what would constitute a level playing field in a proposed competition of private insurers with a new public plan.

Private insurers argue that if they are forced to compete with a public plan that can piggy-back its payment system onto the administratively set Medicare fees, they are forced to play on an uneven playing field tilted unfavorably in their direction. This suggests a scenario in which the private insurance plans would be pushed to the wall until eventually the U.S. ends up with a single-payer system. The long queues in Canada for certain types of health care, the low fees paid doctors and tight budgets for hospitals there, along with and the much sparser endowment of Canada's health system with certain high-tech equipment are cited as the inevitable destination of a single-payer system.

At this stage, this scenario is mere conjecture, and I have some difficulties following it.

In Canada, private insurance for services covered by the government-run system is prohibited. It would not be in the United States. Thus, if a public health insurance plan for non-elderly Americans really began to deprive American patients of what they desire in health care, the private insurance industry offering superior benefits at higher premiums would not melt away or, if it had, it would quickly be reborn, just as we now see providers starting to refuse the allegedly low fees paid by large private insurer and resorting again to the indemnity insurance model. Markets work that way.

There does, however, remain the issue of the level playing field, which I would not brush aside so easily. In what follows, I shall offer some comments on that issue.

V. DEFINING A LEVEL PLAYING FIELD

Two major facets define the evenness of the playing field on which insurance companies compete with one another: (1) the risk pool with which the insurer ends up and (2) the level of fees at which the insurer can procure health care from its providers.

Risk Pool: At this time roughly two thirds of the American population obtains health insurance from private insurance carries; but collectively private insurers account for only slightly more than one third of total national health spending. It is so because through its Medicare and Medicaid programs, government covers much higher risks on average than do private carriers.

It is not clear how the allocation of risks to private carriers and a new public plan would work out in a market for individual insurance. Chances are that a somewhat sicker risk pool would gravitate toward the public plan, which by itself would put it at a competitive disadvantage *vis a vis* the private plans, other things being equal.

Whatever the case may turn out to be, this facet of the playing field should be recognized in the debate on health reform. To mitigate any tilting of the playing field by that factor, one would ultimately have to install a differential-risk compensation mechanism, such as those operated in Germany, the Netherlands and Switzerland.

Payment Levels: The previously cited report by the Lewin Group projects that, if a new public health plan for non-elderly American paid Medicare fees, and if the overhead of such a plan were less than half of that experienced by private competi-

[8] http://www.washington monthly.com/archives/individual/2009_04/017728.php
[9] http://studentlending analytics.typepad.com/student_lending_analytics/2009/03/cbo-significantly-ups-cost-savings-estimate-from-eliminating-ffelp-.html

tors, then the premiums of the public plan would be 21% below those charged by the private plans.

Assuming a premium-elasticity of the demand for health insurance of −2.47 (meaning a 1% decrease in the premium of the public plan vis a vis the premium of private insurers would trigger a 2.47% migration from private to public insurance), the Lewin Group simulates that some 119 million Americans would shift from private insurance to the public plan, a large fraction of whom would be Americans hitherto covered by employment-based insurance in smaller firms. In fact, the Lewin Group estimates that if the public plan were forced to pay at what it calls "private payer levels," enrollment in private insurance would decline only by 12.5 million, rather than 119 million."

Any such simulation, however, is merely the product of a computer algorithm into which researchers feed assumptions that largely drive the predictions. I, for one, believe that the assumed differential of administrative overhead may be too large, if private insurers sold their policies through an organized exchange, rather than through brokers. Furthermore, research based on the Dutch and Swiss experience suggests considerable stickiness of insurance choices, suggesting that the premium-elasticity assumed by the Lewin Group may be too high. In Switzerland, in particular, very large differences in insurance premiums charged by private insurers for the same package in the same Canton exist with only minimal switching by consumers among plans in response to such differentials. A similar experience has been observed in the Netherlands.[10]

Be that as it may, there is the question what the Lewin Group means by "private payment level." Is there actually such a thing? If so, how is it defined and measured?

Table 6.3 below, taken directly from the *Final Report of the New Jersey Commission on Rationalizing Health Care Resources* (2008),[11] illustrates the variance of actual payments made by one large health insurer to different providers for a standard colonoscopy. Table 6.4 exhibits the variation in actual payments made to different New Jersey hospitals for identical hospital services. Finally, table 6.5 below exhibits similar variances for the same procedures paid by a different, large insurer to different hospitals in California.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

[10] See http://www.commonwealthfund.org/~/media/Files/ Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf

[11] http://www.nj.gov/health/rhc/finalreport/index.shtml

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[a]

	Normal Delivery[1]	CABG[2]	Appendectomy[3]	Hip Replacement[4]
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days.
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Cost Shifting: Medicare and Medicaid stand accused of shifting costs to private insurers by paying providers, especially hospitals, low prices, often below costs. In a study commissioned by the insurance industry, published in December of 2008, Milliman Inc. estimated the size of this cost shift for 2007 at $51 billion for hospitals and $37.8 billion for physicians, for a total of $88.8 billion.[12]

Although the phenomenon of the cost shift seems real to hospital—and insurance executives, it is less obvious to many economists who have debated the existence of the cost shift for decades among themselves. Indeed, with appeal to empirical data bearing on the issue, Congress' own Medicare Payment Advisory Commission (MedPAC) has cast doubt on the existence of a cost shift before this very Committee in a *Statement for the Record* dated March 2009.[13]

But even if one agreed that there actually were such a cost shift from the public to the private insurance sectors, Tables 6.3 to 6.5 presented above that there must be an even larger cost shift within the private insurance sector among private insurers. It raises the question whether the playing field is level even within that sector.

[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (December, 2008) http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf

[13] See also MedPAC, Medicare Payment Policy: MedPAC's March 2009 Report to Congress: 57–67 available at www.medpac.gov.

As Michael A. Porter and Elizabeth Olmsted Teisberg rightly observe on this point in their book *Redefining Health Care*:[14]

"Within the private sector, patients enrolled in large health plans are perversely subsidized by members of smaller groups, the uninsured and out-of-network patients. . . . The dysfunctional competition that has been created by price discrimination far outweighs any short term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts."[15]

What, then, is the Private Payer Level?: Any proposal to force a new public health plan for non-elderly Americans to pay providers at "private payer levels"—the words used by the Lewin Group—would immediately run into the problem of the rampant price discrimination within the private sector, that is, and the huge variation in fees this price discrimination begets. Every insurer pays vastly different fees to different providers for the same service, and every provider bills different insurers different fees for the same service.

What in the chaos begotten by this system would the "private payer level" be to which a new public health plan should adjust. Would it be the average or the median of the prices paid by private insurers? Would they be simple or weighted averages and medians? If the latter, weighted by what? Over what geographic areas would these averages or medians be calculated?

Finally, if the public plan would have to pay such average or median fees, would it not by sheer arithmetic endow private insurers below that average or median with playing field tilted in its favor?

VI. MAKING THE PUBLIC PLAN FUNCTION LIKE A PRIVATE PLAN

In a recent position paper, Len Nichols and John A. Bertko of the New America Foundation have gone to some length to design a level playing field for private insurers and a new public plan.[16]

Nichols' and Bertko's proposal is inspired by the thirty or so state governments that offer their employees a choice between (a) traditional private insurance plans and (b) and a self-insured public plan operated by the state. The authors would subject the competing private and the public plans to exactly the same rules, monitored by an entity other than the government itself. The public plan would have to be actuarially independent and not get any public subsidies not also available to the private plans. Like the private plans, the public plan would have to negotiate its own fees with providers.

Presumably, unlike Medicare, it would be allowed to exclude particular providers from its network of providers and would be allowed to engage in disease management and other strategies designed to enhance value for the dollar.

The advantage the authors can claim for that proposal is that it might find bipartisan approval. A drawback, however, would be the high administrative cost of forcing the new public plan to negotiate fees with each and every provider.

Furthermore, this approach would perpetuate the rampant price discrimination that should, at some time in the future, be replaced with a more efficient and fairer payment system—perhaps even an all-payer system, such as those used in Germany and Switzerland. As Michael Porter and Elizabeth Olmsted Teisberg[17] and others have argued, it is hard to detect any social value in the chaotic price-discrimination that now characterizes the private health insurance market in the United States.

VII. A MARKET COMPOSED SOLELY OF PRIVATE INSURERS

In the end, the idea of the promised new public plan may be sacrificed on the altar of bipartisan political horse trading. In that case, if one wanted to offer Americans the stability and permanence they are likely to crave and run the market for health insurance on the *Principle of Social Solidarity*, one might structure the market for individually purchased insurance along the lines now used in Germany[18],

---

[14] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[15] For a proposal to begin to reduce this price discrimination see Uwe E. Reinhardt, "A More Rational Approach to Hospital pricing," http://economix.blogs.nytimes.com/2009/01/30/a-more-rational-approach-to-hospital-pricing/ and Uwe E. Reinhardt, "**The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,**" *Health Affairs*, January/February 2006; 25(1): 57–69.

[16] Len Nichols and John M. Bertko, "A Modest proposal for a Competing Public Health Plan, The New America Foundation, (March 11, 2009) http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf

[17] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[18] See http://www.commonwealthfund.org/~/media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20pdf.pdf and http://content.

the Netherlands and Switzerland [19], all of whom seek to marry the Principle of Social Solidarity with a system of private, non-profit insurance carriers (Germany and Switzerland) or a mixture of non-profit and for-profit insurers (the Netherlands).

As already noted in the introduction, in these systems the first two functions of a health system—financing and risk pooling—is basically under the control of government, either directly or through tight regulation. The purchasing function, however, is delegated to private, competing entities, albeit under tight regulation as well.

In Germany and Switzerland these systems operate on the basis of an all-payer system, in which fees are negotiated, at the regional level of the state (*Land*) between associations of insurers and associations of providers, where after the negotiated fees apply to all payers and providers within the region. In the Netherlands, fees paid can vary among insurers; but the variance across plans is relatively small by American standards.

VIII. CONCLUSION

Even the opponents of a new public health plan for non-elderly Americans will probably concede that the private market for individually purchased health insurance remains underdeveloped and needs a restructuring before it can serve the needs of the American people better than it has heretofore.

As was argued in Sections III and VII above, even if Congress in the end decided not to permit the establishment of a new public health plan, a rather daunting set of new regulations would have to be imposed on that market to meet the social goals posited for our health system by President Obama. It would also require a mandate on individuals to have basic coverage, a proposal eschewed by the President during the election campaign, albeit not by his Democratic rivals.

Chairman RANGEL. Thank you, Doctor.

We would now like to hear from Bill Vaughan. I join with Chairman Stark in congratulating you and Consumers Union for the contribution you have made to our Congress over the years. And we would like to hear you.

STATEMENT OF WILLIAM VAUGHAN, SENIOR POLICY ANALYST, CONSUMERS UNION

Mr. VAUGHAN. Well, thank you very much, sir, and thank you for inviting us to testify. Consumers Union is the independent, nonprofit publisher of Consumer Reports, and we don't just test toasters. We try to help people with health issues, and we are big, big fans of comparative effectiveness research, which we are using to save people, we think, millions of dollars in getting the most effective, safest, best buy drugs out there.

If Dante were alive writing about the independent health insurance market, it would be in the eighth circle just above where the uninsured are stuck. And it is exhibit number one for what is wrong with American health care.

I was going to go into that, but I think the opening statements of Mr. Camp, Mr. Stark, that is coals to Newcastle. Our statement documents why it is all goofed up, and has some very moving,

---

healthaffairs.org/cgi/content/abstract/27/3/771?ijkey=DsTX9syExLZLc&keytype=ref&siteid=healthaff

[19] See http://content.healthaffairs.org/cgi/content/full/27/3/w204) and (http://www.commonwealthfund.org/~E/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swiss dutchhltinssystems_1220%20pdf.pdf and http://www.allhealth.org/BriefingMaterials/JAMA-Uwe-1183.pdfhttp://content.healthaffairs.org/cgi/content/full/27/3/w204) (http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/ The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pd and http://www.allhealth.org/Briefing Materials/JAMA-Uwe-1183.pdf

wait to be called. And that goes for all of you, but especially your organization that has such a wide membership.

Linda Blumberg, Dr. Blumberg, who is a senior fellow at the Urban Institute. Thank you for being with us.

STATEMENT OF LINDA BLUMBERG, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. BLUMBERG. Mr. Chairman and distinguished Members of the Committee, thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its funders, or its trustees.

Current health insurance markets suffer from many shortcomings. I am going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them.

First, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service.

Second, individuals and employers voluntarily participate as purchasers. But too often, those who would like to buy coverage face barriers to doing so, including problems of affordability and discrimination based on health status.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years, fueling the growth in insurance premiums.

Insurance market reforms and subsidies to make coverage affordable for the modest income population within the context of a more organized health insurance market are essential strategies to address these problems.

A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance option available to purchasers can further promote competition in insurance markets, and could be an effective strategy for slowing health care cost growth.

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. Insurance market regulations are required to prevent risk-selecting behavior by insurers. States allow insurers to risk-select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those that are most likely to seek coverage.

However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many who have some type of insurance may not have adequate coverage to meet their health care needs.

In the context of a health care system that is universal, where everyone is insured all of the time, there would no longer be any reason to allow discrimination by health status, and coverage denials, benefit riders, preexisting condition exclusions, and medical

underwriting can be prohibited, with the costs of those with high medical needs spread broadly across the population.

In such a context, an exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations. An exchange can also provide for risk adjustment to account for any uneven distribution of risk across insurers.

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of reform intended to make coverage affordable for all incomes. Centralizing into a single agency, such as an exchange, the subsidy determination and the payments of subsidies to insurers would be a much more efficient approach to administration that under the HCTC experience we are having today. The exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage.

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. An exchange can be given the authority to negotiate with health insurers over premiums.

Other cost-containment strategies would include requiring similar benefit packages be offered within an exchange to make it easier for consumers to compare prices for like policies, providing improved information materials, and incentives to choose lower-cost plan options. An exchange could also reduce administrative costs due to lower churning across insurance plans.

Adding a public plan option to those offered within an exchange would significantly increase the cost containment potential of reform. A public plan could be modeled after the traditional Medicare Program, paying providers based upon the payment systems Medicare uses, but with different cost-sharing rules and possibly some differences in covered benefits. Payment rates could be set between Medicare and private rates.

Medicare payment policies have been shown to reduce cost growth relative to private insurers. A public plan could create competitive pressures necessary to induce private insurers to be tougher negotiators with the providers and their plans.

The public plan could also be an innovator in the development of other cost-containment mechanisms. It would also create a lower-administrative-cost option for purchasers, putting pressure on private insurers to hold down their own costs.

I do not believe that a public plan option would destroy the private insurance market or lead to a government takeover of insurance, as some fear. Those plans that offer high-quality services and good access to providers would survive. Those that innovate and offer limited networks may even be able to offer lower-cost plans than the public option.

I consider the public plan a very promising catalyst for cost containment, and one that I think would be considerably less of a dramatic change than other effective options, such as having the exchange negotiate rates on behalf of all participating plans, or moving to an all-payor rate-setting system.

Exhibit 13

FOCUS - 2 of 59 DOCUMENTS

REP. LOUISE M. SLAUGHTER HOLDS A MEETING ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

March 20, 2010 Saturday

EVENT DATE: March 20, 2010

TYPE: COMMITTEE HEARING

LOCATION: WASHINGTON, D.C.

COMMITTEE: HOUSE COMMITTEE ON RULES

SPEAKER: REP. LOUISE M. SLAUGHTER, CHAIRWOMAN

WITNESSES:
REP. LOUISE M. SLAUGHTER, D-N.Y., CHAIR REP. JIM MCGOVERN, D-MASS. REP. ALCEE L. HASTINGS, D-FLA. REP. DORIS MATSUI, D-CALIF. REP. DENNIS CARDOZA, D-CALIF. REP. MICHAEL ARCURI, D-N.Y. REP. ED PERLMUTTER, D-COLO. REP. CHELLIE PINGREE, D-MAINE REP. JARED POLIS, D-COLO. REP. HENRY A. WAXMAN, D-CALIF. REP. SANDER M. LEVIN, D-MICH. REP. GEORGE MILLER, D-CALIF. REP. XAVIER BECERRA, D-CALIF. REP. ROBERT E. ANDREWS, D-N.J. REP. FRANK PALLONE JR., D-N.J. REP. ROBERT A. BRADY, D-PA. REP. ANTHONY WEINER, D-N.Y. REP. GWEN MOORE, D-WIS.
REP. PAUL D. RYAN, R-WIS. REP. JOE L. BARTON, R-TEXAS REP. DAVE CAMP, R-MICH. REP. JOHN KLINE, R-MINN. REP. JEB HENSARLING, R-TEXAS REP. JOHN SHIMKUS, R-ILL. REP. LEE TERRY, R-NEB. REP. PHIL GINGREY, R-GA. REP. MARSHA BLACKBURN, R-TENN. REP. MICHAEL C. BURGESS, R-TEXAS REP. STEVE SCALISE, R-LA. REP. WALLY HERGER, R-CALIF. REP. TRENT FRANKS, R-ARIZ. REP. CHARLIE DENT, R-PA. REP. ERIK PAULSEN, R-MINN. REP. BILL CASSIDY, R-LA. REP. PHIL ROE, R-TENN. REP. STEVE BUYER, R-IND.
REP. DAVID DREIER, R-CALIF. RANKING MEMBER REP. PETE SESSIONS, R-TEXAS REP. LINCOLN DIAZ-BALART, R-FLA. REP. VIRGINIA FOXX, R-N.C.
REP. HENRY A. WAXMAN, D-CALIF. REP. SANDER M. LEVIN, D-MICH. REP. GEORGE MILLER, D-CALIF. REP. XAVIER BECERRA, D-CALIF. REP. ROBERT E. ANDREWS, D-N.J. REP. FRANK PALLONE JR., D-N.J.

We've addressed a lot of these things, and that is why it's a complicated system. So I think that it is something where we have looked at -- we want to make sure it's affordable for all middle-class Americans, because they're being challenged the most. We know the insurance companies have been given a free ride, so we want to hold them accountable, and we want to, you know, have accessibility for those who don't have it right now.

And those are the principles that we've built this upon. Now, I can't see us pulling this thing apart right now. We've gotten this far. I know there are challenges ahead here. But anything this big is going to have been taken this long.

And when we make policy and we try to get it to the floor, we know it's not the most simple way at all, but this is not a simple situation at all. This is almost the last thing we can do right now for all Americans. We'd like to do it.

Now, I'd like to see probably Mr. Pallone or Mr. Miller or Mr. Andrews, why it is so important to have the three legs, the comprehensive aspect of this bill.

PALLONE: Can I...

MATSUI: Yes.

PALLONE: You know, I'll try to be brief, because I know that time is running out. You talked about the system and how the system be changed and how you sat through so many of our -- our subcommittee hearings.

And I know that so much of the emphasis today is on the money. And I don't want to take away from the debt and the -- and the money and all that.

But I think that what we're talking about here -- and so much of our hearing in Energy and Commerce was devoted to this -- is the change in the way we do things.

And, you know, I'm not trying to be critical, Mr. Hensarling, but you said that -- talk about the people that are outside the system, you know, who are not covered. The fact of the matter is, they're in the system. They're going to the emergency room. You know, they are getting care, but they're getting the wrong kind of care at the wrong time.

Everyone's in the system. Everybody gets health care. Nobody can be denied care if they go to an emergency room or a clinic or whatever. But we're trying to change the way we do things, and there hasn't been that much attention to the fact that the whole way we deliver health care is going to be changed, not in the money or the insurance so much, but the fact that it will be preventative.

People will go to see a doctor on a regular basis. They'll get the primary care and that -- you know, different innovative ways of trying to look at care so that it's not just one doctor here, one doctor there, but the whole system, the concept of the medical home.

There are so many things like this that change the way we deliver health care that will not only save a lot of money, as I've said many times today, but also make for better quality care. And -- and that's why I think -- you know, when you say change the system, I think that's what President Obama was talking about, not so much the -- the dollars, but the fact that we need to do things differently, and this turns the system very much away from this.

And, you know, looking at when you get sick, when you go to the emergency, and back towards trying to prevent bad things from happening.

MATSUI: Well, that's why we have a lot of prevention in here, too.

PALLONE: And when people see that, they're going to love this, because it's such a change in the way we do things, in terms of the quality and the delivery of care.

MATSUI: I think we...

(CROSSTALK)

ANDREWS: If the gentlelady will yield, we've heard almost universally across the House that people say they want to avoid discrimination based on pre-existing conditions. It's hard to find a member who says he or she is not for that.

In order to accomplish that and not spike premiums for insured people, you have to have a larger pool of people that are covered eventually. You can transition into that, but eventually that's what you have to do.

So then people say, well, why do you have the exchanges? Well, because when you're bringing in the larger pool of people to make the pre-existing condition work, you want to have a competitive marketplace, unlike the existing marketplaces in this country, that gets the best deal for people.

And then people say, well, why do you have to have the subsidies? Well, to get people into this marketplace, if somebody's making $25,000, $35,000, $40,000 a year, you can have all the marketplace you want, but they can't buy in without the subsidies.

And people say, why do you have to have the spending restraints and the revenue? Well, you can't have the subsidies without the spending restraint and the revenue.

So I would say to you, gentlelady, that this easy answer, which is so glibly stated by people, "Let's just take care of the pre- existing condition problem," it doesn't fit together if you don't take the next step and the next step and the next step and make it work.

The people in the country deserve more than a half-baked solution that won't work. And that's what this bill does.

DREIER: Would the gentlewoman yield?

MATSUI: Certainly I'll yield.

DREIER: I thank my friend for yielding. And I appreciate this exchange, but I just wanted to share with our colleagues and see if there's any response to a story that has just come out from the Washington Post in the last few minutes.

It says House Democratic leaders say -- let's see here -- House Democratic leaders say that they will take a separate vote on the Senate health care bill, rejecting an earlier, much criticized strategy that would have permitted them to deem the measure passed without an explicit vote. And I just wondered if this is a decision that has been made by the House Democratic leadership. I know that Mr. Cardoza raised concern about it earlier.

MCGOVERN: Let me -- if the gentleman would yield to me, as you know, we're having this hearing, and we have not put a rule together, and that's the whole point of this. And at the end of the -- at the end of this hearing, we will meet and try to...

DREIER: It sounds like it has happened, basically...

(CROSSTALK)

DREIER: ... Washington Post...

(CROSSTALK)

MATSUI: Reclaiming my time here...

CARDOZA: Would the gentlelady yield?

DREIER: "Dems drop the deem and pass plan," is what it says.

CARDOZA: I believe that there has been significant discussion. I want to thank the House leadership for, in fact, indicating to a number of us that that is, in fact, what's going to happen.

And I think that we've had sanity prevail here, and I'm very pleased about that. It's not -- as I said before, it's not that it wasn't unconstitutional or illegal, but it was something that we should have just done in the light of day, straight up. And I want to praise the House leadership...

DREIER: This is something that never has been done before on an issue of this magnitude.

MATSUI: Well, reclaiming my time here, Mr. Miller, did you want to say something?

MILLER: Just to build on what Congressman Andrews said, we have been incrementally tinkering with this system for 50 years at a minimum. And so then when you want to make the kind of -- the kind of change that brings about the efficiencies in the system, the expansion of the system, and controls the utilization in terms of getting value as opposed to activity, if you don't, as Mr. Andrews said, put everybody in, it doesn't work.

You know, that's from the insurance companies. That's from the medical practitioners, the providers who say to you over and over again -- not necessarily agreeing with this bill, but this is what you're going to have to do. You're moving the right pieces around, whether you're talking to the providers or whether you're talking to the insurance industry. And, again, they will argue over bits and pieces of this.

What we have to date is a history where all of the adverse indicators are just tumbling downhill. Businesses large and small are shedding the coverage. Small businesses are shedding the coverage. One of the -- one of the premier insurance providers, employers in our state, is now putting a surcharge on spouses, a surcharge on children. They're offloading, and they've been offloading for a decade the cost to the enterprise onto the employees. That is going on all the time.

If you're in -- if you're in an organized union, what you see is more and more is going to -- is going to health care and less and less is going to discretionary income and people's pockets.

So the trends are all in the wrong direction, and they're accelerating. They're absolutely accelerating, in terms of dramatically increasing the uninsured. In our state today, the L.A. Times tells us it's 1 in 4. They tell us there's a $1,000 cost premium on every Californian.

So you've got to bring the people into the system. You've got to drive the efficiencies. You've got to drive the savings. You've got to drive the value of the engagements that take place.

And the fact of the matter is, with medical I.T., with these changes, you get a dramatic change in behavior. At Kaiser hospitals, one of the -- one of -- -- one of the most successful enterprises, now patients are able, without getting a doctor office visit, can ask their doctors questions and get immediate replies within a few minutes of what's bothering them.

They can check their blood pressure, their cholesterol all at home, and it can monitored back and forth. And studies can go on because of the data systems about what works for people under 45, over 45, with different prescriptions and how do generics match up, and all of that is taking place.

And there are employers in our state that say, if Kaiser wasn't available, they could not provide health

Exhibit 14

Nos. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.,

v.

KATHLEEN SEBELIUS, ET AL.

STATE OF FLORIDA, ET AL.,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF FOR PRIVATE PETITIONERS ON SEVERABILITY

KAREN R. HARNED
NFIB SMALL BUSINESS LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV. LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

2. A cousin to the individual mandate, the employer "responsibility" assessment, encourages certain employers to sponsor health plans for their employees. Specifically, it imposes an exaction on covered employers if one of their employees obtains a federal subsidy to help pay for insurance purchased elsewhere. *Supra* at 21.

This assessment—labeled "shared responsibility for employers regarding health coverage," 26 U.S.C.A. § 4980H—was one plank of a multi-part effort to spread health-care costs across *multiple* actors. For that reason alone, it cannot stand once individuals, insurers, and the Federal Government are all let off the hook. *Pollock*, 158 U.S. at 636-37.

Further, the exaction is inextricably intertwined with the subsidies described above. Indeed, if those subsidies are invalidated, no employee will ever receive one—and so the employer exaction will never be triggered. The employer exaction is thus simply "incapable of functioning independently" of the subsidies. *Alaska Airlines*, 480 U.S. at 684.

3. The Act also creates new health-insurance "exchanges," marketplaces where individuals and small businesses can buy the Act's new insurance products. The Federal Government only subsidizes coverage purchased within an exchange, thus giving insurance companies a reason to sell there despite the distinct regulatory burdens imposed on plans offered through the exchanges. *Supra* at 19-20.

The exchanges cannot be severed from the provisions already addressed. Without the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are

subject to far greater restrictions. Premised on the mandate, the insurance regulations, and the subsidies, the insurance exchanges cannot operate as intended by Congress absent those provisions.

4. Another part of the Act requires that States substantially relax the eligibility criteria for Medicaid. *Supra* at 21-22. But, as the Government explained below, Congress intended for the additional Medicaid spending required of the States to be "offset" by other "cost-saving provisions." RE 1024. For example, Congress believed the insurance regulations would prevent individuals with pre-existing conditions from being driven onto Medicaid rolls, or into state-funded high-risk pools, by the uninsurable cost of their care. *See* RE 1023; 42 U.S.C.A. § 18091(a)(2)(G) (finding that "62 percent of all personal bankruptcies are caused in part by medical expenses"). Congress further believed the States would also, in light of the mandate and premium subsidies, save money on uncompensated care. *See* RE 1023. If the States need no longer worry about picking up the tab for uninsurable sick people (because private insurers will now be forced to), or for cost-shifting by the uninsured (because the mandate will force them to buy insurance), then they can devote more resources to the poor. Absent the mandate, insurance regulations, and subsidies, this premise would no longer be true, and the States would be forced to bear additional costs far greater than those intended by Congress.[29]

[29] Of course, if the Medicaid expansion is independently unconstitutional, as the State Petitioners contend, then the severability analysis must take their invalidity as a given.

Exhibit 15

111TH CONGRESS
1ST SESSION

H. R. 3962

AN ACT

To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

(2) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and

(3) any nonfederal QHBP offering entity that offers an Exchange-participating health benefits plan that includes coverage for abortions for which funding is prohibited under this section also offers an Exchange-participating health benefits plan that is identical in every respect except that it does not cover abortions for which funding is prohibited under this section.

TITLE III—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 301. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE; OUTLINE OF DUTIES; DEFINITIONS.

(a) ESTABLISHMENT.—There is established within the Health Choices Administration and under the direction of the Commissioner a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of

affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 243(b), the Commissioner shall—

(1) under section 304 establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under section 303, and including with respect to oversight and enforcement;

(2) under section 305 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 302; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 306 and consumer protections under subtitle D of title II.

SEC. 302. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

(a) ACCESS TO COVERAGE.—In accordance with this section, all individuals are eligible to obtain coverage

enue Code of 1986 (relating to employers electing to not provide health benefits).

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b) plus such amounts as are necessary reduced by the amounts deposited under paragraph (1).

(d) APPLICATION OF CERTAIN RULES.—Rules similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

SEC. 308. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Com-

missioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange,

then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange if it meets the requirements for approval under subsection (b).

(b) REQUIREMENTS FOR APPROVAL.—

(1) IN GENERAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(A) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(i) negotiating and contracting with QHBP offering entities for the offering of

Exchange-participating health benefits plans, which satisfy the standards and requirements of this title and title II;

(ii) enrolling Exchange-eligible individuals and employers in such State in such plans;

(iii) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(iv) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Government which does exceed the cost to the Federal Government if this section did not apply; and

(v) enforcement activities consistent with Federal requirements.

(B) There is no more than one Health Insurance Exchange operating with respect to any one State.

(C) The State provides assurances satisfactory to the Commissioner that approval of such

an Exchange will not result in any net increase in expenditures to the Federal Government.

(D) The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Commissioner that it will vigorously enforce violations of applicable requirements.

(E) Such other requirements as the Commissioner may specify.

(2) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(A) IN GENERAL.—In the case of a State operating an Exchange prior to January 1, 2010, that seeks to operate the State-based Health Insurance Exchange under this section, the Commissioner shall presume that such Exchange meets the standards under this section unless the Commissioner determines, after completion of the process established under subparagraph (B), that the Exchange does not comply with such standards.

(B) PROCESS.—The Commissioner shall establish a process to work with a State described in subparagraph (A) to provide assistance necessary to assure that the State's Ex-

change comes into compliance with the standards for approval under this section.

(c) CEASING OPERATION.—

(1) IN GENERAL.—A State-based Health Insurance Exchange may, at the option of each State involved, and only after providing timely and reasonable notice to the Commissioner, cease operation as such an Exchange, in which case the Health Insurance Exchange shall operate, instead of such State-based Health Insurance Exchange, with respect to such State (or States).

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Exchange under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such require-

ments of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

(3) EFFECTIVENESS.—The ceasing or termination of a State-based Health Insurance Exchange under this subsection shall be effective in such time and manner as the Commissioner shall specify.

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

(A) may not be performed by a State-based Health Insurance Exchange under this section; or

(B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(e) REFERENCES.—In the case of a State-based Health Insurance Exchange, except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based

Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be assistance provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 309. INTERSTATE HEALTH INSURANCE COMPACTS.

(a) IN GENERAL.—Effective January 1, 2015, 2 or more States may form Health Care Choice Compacts (in this section referred to as ''compacts'') to facilitate the purchase of individual health insurance coverage across State lines.

(b) MODEL GUIDELINES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall consult with the National Association of Insurance Commissioners (in this section referred to as ''NAIC'') to develop not later than January 1, 2014, model guidelines for the creation of compacts. In developing such guidelines, the Secretary shall consult with consumers, health insurance issuers, and other interested parties. Such guidelines shall—

(1) provide for the sale of health insurance coverage to residents of all compacting States subject to

of costs related to non-service-connected care or services provided by the Secretary of Veterans Affairs to an individual covered under the public health insurance option in a manner consistent with recovery of costs related to non-service-connected care from private health insurance plans.

Subtitle C—Individual Affordability Credits

SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, in the case of an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

(A) an affordability premium credit under section 343 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 344 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

(2) the Commissioner shall pay the QHBP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate amount of affordability credits for all affordable credit eligible individuals enrolled in such plan.

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle. The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid

agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding under section 305(e)(2)—

(A) the State Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination; and

(B) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(3) MEDICAID SCREEN AND ENROLL OBLIGATION.—In the case of an application made under paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding under section 305(e)(2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the

individual had directly applied for medical assistance to the State Medicaid agency.

(4) APPLICATION AND VERIFICATION OF REQUIREMENT OF CITIZENSHIP OR LAWFUL PRESENCE IN THE UNITED STATES.—

(A) REQUIREMENT.—No individual shall be an affordable credit eligible individual (as defined in section 342(a)(1)) unless the individual is a citizen or national of the United States or is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act).

(B) DECLARATION OF CITIZENSHIP OR LAWFUL IMMIGRATION STATUS.—No individual shall be an affordable credit eligible individual unless there has been a declaration made, in a form and manner specified by the Health Choices Commissioner similar to the manner required under section 1137(d)(1) of the Social Security Act and under penalty of perjury, that the individual—

(i) is a citizen or national of the United States; or

(ii) is not such a citizen or national but is lawfully present in a State in the United States (other than as a non-immigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act).

Such declaration shall be verified in accordance with subparagraph (C) or (D), as the case may be.

(C) VERIFICATION PROCESS FOR CITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(i), subject to clause (ii), section 1902(ee) of the Social Security Act shall apply to such declaration in the same manner as such section applies to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying section 1902(ee) of such Act under clause (i)—

(I) any reference in such section to a State is deemed a reference to the Commissioner (or other public entity making the eligibility determination);

(II) any reference to medical assistance or enrollment under a State plan is deemed a reference to provision of affordability credits under this subtitle;

(III) a reference to a newly enrolled individual under paragraph (2)(A) of such section is deemed a reference to an individual newly in receipt of an affordability credit under this subtitle;

(IV) approval by the Secretary shall not be required in applying paragraph (2)(B)(ii) of such section;

(V) paragraph (3) of such section shall not apply; and

(VI) before the end of Y2, the Health Choices Commissioner, in consultation with the Commissioner of Social Security, may extend the peri-

ods specified in paragraph (1)(B)(ii) of such section.

(D) VERIFICATION PROCESS FOR NONCITIZENS.—

(i) IN GENERAL.—In the case of an individual making the declaration described in subparagraph (B)(ii), subject to clause (ii), the verification procedures of paragraphs (2) through (5) of section 1137(d) of the Social Security Act shall apply to such declaration in the same manner as such procedures apply to a declaration described in paragraph (1) of such section.

(ii) SPECIAL RULES.—In applying such paragraphs of section 1137(d) of such Act under clause (i)—

(I) any reference in such paragraphs to a State is deemed a reference to the Health Choices Commissioner; and

(II) any reference to benefits under a program is deemed a reference to affordability credits under this subtitle.

(iii) APPLICATION TO STATE-BASED EXCHANGES.—In the case of the application of the verification process under this subparagraph to a State-based Health Insurance Exchange approved under section 308, section 1137(e) of such Act shall apply to the Health Choices Commissioner in relation to the State.

(E) ANNUAL REPORTS.—The Health Choices Commissioner shall report to Congress annually on the number of applicants for affordability credits under this subtitle, their citizenship or immigration status, and the disposition of their applications. Such report shall be made publicly available and shall include information on—

(i) the number of applicants whose declaration of citizenship or immigration status, name, or social security account number was not consistent with records maintained by the Commissioner of Social Security or the Department of Homeland Security and, of such applicants, the number who contested the inconsistency and sought to document their citizenship or im-

migration status, name, or social security account number or to correct the information maintained in such records and, of those, the results of such contestations; and

(ii) the administrative costs of conducting the status verification under this paragraph.

(F) GAO REPORT.—Not later than the end of Y2, the Comptroller General of the United States shall submit to the Committee on Ways and Means, the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on the Judiciary of the House of Representatives and the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on the Judiciary of the Senate a report examining the effectiveness of the citizenship and immigration verification systems applied under this paragraph. Such report shall include an analysis of the following:

(i) The causes of erroneous determinations under such systems.

(ii) The effectiveness of the processes used in remedying such erroneous determinations.

(iii) The impact of such systems on individuals, health care providers, and Federal and State agencies, including the effect of erroneous determinations under such systems.

(iv) The effectiveness of such systems in preventing ineligible individuals from receiving for affordability credits.

(v) The characteristics of applicants described in subparagraph (E)(i).

(G) PROHIBITION OF DATABASE.—Nothing in this paragraph or the amendments made by paragraph (6) shall be construed as authorizing the Health Choices Commissioner or the Commissioner of Social Security to establish a database of information on citizenship or immigration status.

(H) INITIAL FUNDING.—

(i) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Commissioner of Social Security $30,000,000, to be avail-

able without fiscal year limit to carry out this paragraph and section 205(v) of the Social Security Act.

(ii) FUNDING LIMITATION.—In no case shall funds from the Social Security Administration's Limitation on Administrative Expenses be used to carry out activities related to this paragraph or section 205(v) of the Social Security Act.

(5) AGREEMENT WITH SOCIAL SECURITY COMMISSIONER.—

(A) IN GENERAL.—The Health Choices Commissioner shall enter into and maintain an agreement described in section 205(v)(2) of the Social Security Act with the Commissioner of Social Security.

(B) FUNDING.—The agreement entered into under subparagraph (A) shall, for each fiscal year (beginning with fiscal year 2013)—

(i) provide funds to the Commissioner of Social Security for the full costs of the responsibilities of the Commissioner of Social Security under paragraph (4), including—

(I) acquiring, installing, and maintaining technological equipment and systems necessary for the fulfillment of the responsibilities of the Commissioner of Social Security under paragraph (4), but only that portion of such costs that are attributable to such responsibilities; and

(II) responding to individuals who contest with the Commissioner of Social Security a reported inconsistency with records maintained by the Commissioner of Social Security or the Department of Homeland Security relating to citizenship or immigration status, name, or social security account number under paragraph (4);

(ii) based on an estimating methodology agreed to by the Commissioner of Social Security and the Health Choices Commissioner, provide such funds, within 10 calendar days of the beginning of the fiscal year for the first quarter and in advance for all subsequent quarters in that fiscal year; and

(iii) provide for an annual accounting and reconciliation of the actual costs incurred and the funds provided under the agreement.

(C) REVIEW OF ACCOUNTING.—The annual accounting and reconciliation conducted pursuant to subparagraph (B)(iii) shall be reviewed by the Inspectors General of the Social Security Administration and the Health Choices Administration, including an analysis of consistency with the requirements of paragraph (4).

(D) CONTINGENCY.—In any case in which agreement with respect to the provisions required under subparagraph (B) for any fiscal year has not been reached as of the first day of such fiscal year, the latest agreement with respect to such provisions shall be deemed in effect on an interim basis for such fiscal year until such time as an agreement relating to such provisions is subsequently reached. In any case in which an interim agreement applies for any fiscal year under this subparagraph, the Commissioner of Social Security shall, not later than the first day of such fiscal year, notify the appropriate Committees of the Congress of the

failure to reach the agreement with respect to such provisions for such fiscal year. Until such time as the agreement with respect to such provisions has been reached for such fiscal year, the Commissioner of Social Security shall, not later than the end of each 90-day period after October 1 of such fiscal year, notify such Committees of the status of negotiations between such Commissioner and the Health Choices Commissioner in order to reach such an agreement.

(E) APPLICATION TO PUBLIC ENTITIES ADMINISTERING AFFORDABILITY CREDITS.—If the Health Choices Commissioner provides for the conduct of verifications under paragraph (4) through a public entity, the Health Choices Commissioner shall require the public entity to enter into an agreement with the Commissioner of Social Security which provides the same terms as the agreement described in this paragraph (and section 205(v) of the Social Security Act) between the Health Choices Commissioner and the Commissioner of Social Security, except that the Health Choices Commissioner shall be responsible for providing funds for the Commis-

sioner of Social Security in accordance with subparagraphs (B) through (D).

(6) AMENDMENTS TO SOCIAL SECURITY ACT.—

(A) COORDINATION OF INFORMATION BETWEEN SOCIAL SECURITY ADMINISTRATION AND HEALTH CHOICES ADMINISTRATION.—

(i) IN GENERAL.—Section 205 of the Social Security Act (42 U.S.C. 405) is amended by adding at the end the following new subsection:

"Coordination of Information With Health Choices Administration

"(v)(1) The Health Choices Commissioner may collect and use the names and social security account numbers of individuals as required to provide for verification of citizenship under subsection (b)(4)(C) of section 341 of the Affordable Health Care for America Act in connection with determinations of eligibility for affordability credits under such section.

"(2)(A) The Commissioner of Social Security shall enter into and maintain an agreement with the Health Choices Commissioner for the purpose of establishing, in compliance with the requirements of section 1902(ee) as applied pursuant to section 341(b)(4)(C) of the Affordable Health Care for America Act, a program for verifying in-

formation required to be collected by the Health Choices Commissioner under such section 341(b)(4)(C).

''(B) The agreement entered into pursuant to subparagraph (A) shall include such safeguards as are necessary to ensure the maintenance of confidentiality of any information disclosed for purposes of verifying information described in subparagraph (A) and to provide procedures for permitting the Health Choices Commissioner to use the information for purposes of maintaining the records of the Health Choices Administration.

''(C) The agreement entered into pursuant to subparagraph (A) shall provide that information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to the agreement shall be provided at such time, at such place, and in such manner as the Commissioner of Social Security determines appropriate.

''(D) Information provided by the Commissioner of Social Security to the Health Choices Commissioner pursuant to an agreement entered into pursuant to subparagraph (A) shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out such agreement. Any officer or employee or former officer or employee of the Health Choices Commissioner, or any officer or employee or former officer or employee of a contractor of the Health

Choices Commissioner, who, without the written authority of the Commissioner of Social Security, publishes or communicates any information in such individual's possession by reason of such employment or position as such an officer shall be guilty of a felony and, upon conviction thereof, shall be fined or imprisoned, or both, as described in section 208.

''(3) The agreement entered into under paragraph (2) shall provide for funding to the Commissioner of Social Security consistent with section 341(b)(5) of Affordable Health Care for America Act.

''(4) This subsection shall apply in the case of a public entity that conducts verifications under section 341(b)(4) of the Affordable Health Care for America Act and the obligations of this subsection shall apply to such an entity in the same manner as such obligations apply to the Health Choices Commissioner when such Commissioner is conducting such verifications.''.

(ii) CONFORMING AMENDMENT.—Section 205(c)(2)(C) of such Act (42 U.S.C. 405(c)(2)(C)) is amended by adding at the end the following new clause:

''(x) For purposes of the administration of the verification procedures described in section 341(b)(4) of the Affordable Health Care for America Act, the Health

Choices Commissioner may collect and use social security account numbers as provided for in section 205(v)(1).''.

(B) IMPROVING THE INTEGRITY OF DATA AND EFFECTIVENESS OF SAVE PROGRAM.—Section 1137(d) of the Social Security Act (42 U.S.C. 1320b–7(d)) is amended by adding at the end the following new paragraphs:

''(6)(A) With respect to the use by any agency of the system described in subsection (b) by programs specified in subsection (b) or any other use of such system, the United States Citizenship and Immigration Services and any other agency charged with the management of the system shall establish appropriate safeguards necessary to protect and improve the integrity and accuracy of data relating to individuals by—

''(i) establishing a process through which such individuals are provided access to, and the ability to amend, correct, and update, their own personally identifiable information contained within the system;

''(ii) providing a written response, without undue delay, to any individual who has made such a request to amend, correct, or update such individual's own personally identifiable information contained within the system; and

"(iii) developing a written notice for user agencies to provide to individuals who are denied a benefit due to a determination of ineligibility based on a final verification determination under the system.

"(B) The notice described in subparagraph (A)(ii) shall include—

"(i) information about the reason for such notice;

"(ii) a description of the right of the recipient of the notice under subparagraph (A)(i) to contest such notice;

"(iii) a description of the right of the recipient under subparagraph (A)(i) to access and attempt to amend, correct, and update the recipient's own personally identifiable information contained within records of the system described in paragraph (3); and

"(iv) instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies.".

(C) STREAMLINING ADMINISTRATION OF VERIFICATION PROCESS FOR UNITED STATES CITIZENS.—Section 1902(ee)(2) of the Social

Security Act (42 U.S.C. 1396a(ee)(2)) is amended by adding at the end the following:

"(D) In carrying out the verification procedures under this subsection with respect to a State, if the Commissioner of Social Security determines that the records maintained by such Commissioner are not consistent with an individual's allegation of United States citizenship, pursuant to procedures which shall be established by the State in coordination with the Commissioner of Social Security, the Secretary of Homeland Security, and the Secretary of Health and Human Services—

"(i) the Commissioner of Social Security shall inform the State of the inconsistency;

"(ii) upon being so informed of the inconsistency, the State shall submit the information on the individual to the Secretary of Homeland Security for a determination of whether the records of the Department of Homeland Security indicate that the individual is a citizen;

"(iii) upon making such determination, the Department of Homeland Security shall inform the State of such determination; and

"(iv) information provided by the Commissioner of Social Security shall be considered as strictly confidential and shall only be used by the State and the

Secretary of Homeland Security for the purposes of such verification procedures.

''(E) Verification of status eligibility pursuant to the procedures established under this subsection shall be deemed a verification of status eligibility for purposes of this title, title XXI, and affordability credits under section 341(b)(4) of the Affordable Health Care for America Act, regardless of the program in which the individual is applying for benefits.''.

(c) USE OF AFFORDABILITY CREDITS.—

(1) IN GENERAL.—In Y1 and Y2 an affordable credit eligible individual may use an affordability credit only with respect to a basic plan.

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability premium credit under section 343, but not the affordability cost-sharing credit under section 344, to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordability credit amount otherwise applicable if the individual had enrolled in a basic plan.

(d) ACCESS TO DATA.—In carrying out this subtitle, the Commissioner shall request from the Secretary of the Treasury consistent with section 6103 of the Internal Revenue Code of 1986 such information as may be required to carry out this subtitle.

(e) NO CASH REBATES.—In no case shall an affordable credit eligible individual receive any cash payment as a result of the application of this subtitle.

SEC. 342. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term ''affordable credit eligible individual'' means, subject to subsection (b) and section 346, an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 412;

Exhibit 16

AFFORDABLE HEALTH CARE FOR AMERICA

HEALTH INSURANCE REFORM AT A GLANCE

THE HEALTH INSURANCE EXCHANGES

The Senate-passed bill as improved through reconciliation will create state-based health insurance Exchanges, for states that choose to operate their own exchanges, and a multi-state Exchange for the others. The Exchanges will make health insurance more affordable and accessible for small businesses and individuals.

EXCHANGES

- Create Exchanges where individuals and small businesses can compare and purchase health insurance online – among other places – at competitive prices.
- For states that choose not to operate their own Exchange, there will be a multi-state Exchange run by the Department of Health and Human Services.
- State insurance commissioners will continue to provide oversight regarding consumer protections, rate review, and solvency.
- Protects the financial integrity of the Exchanges through annual audits and financial reporting overseen by the Secretary of Health and Human Services, and establishes procedures and protections to guard against fraud and abuse.

ONE-STOP SHOPPING THAT PROMOTES CHOICE AND COMPETITION

- Health coverage options available in a zip code will be listed on state-based web portals and elsewhere.
- Using the Internet and other means to present consumers with available plans will make purchasing health insurance easier and more understandable.
- Individuals will be able to choose coverage among several benefit packages all including an essential set of benefits that provide comprehensive health care services with different levels of cost sharing.
- To ensure competition, state Exchanges will have a national plan supervised by Office of Personnel and Management and may include state-based non-profit co-ops and multi-state insurance plans.

PROVIDE INFORMATION AND PROMOTE TRANSPARENCY

- Requires standardized format, definitions, enrollment applications, consumer satisfaction, and marketing requirements to allow easy comparison of the prices, benefits, and performance of health plans.
- Establishes a toll-free telephone hotline to respond to consumer requests for assistance.
- Creates online eligibility determinations with regard to health care premium tax credits or public programs, and consumers without access to the Internet will be able to enroll through the mail or in person in a variety of locations.
- Health coverage Navigators in states will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance.
- Awards grants to states to establish, expand, or support health insurance consumer assistance.

ENSURE AFFORDABLE COVERAGE

- Provides premium tax credits to limit the amount individuals and families up to 400% poverty spend on health insurance premiums.
- Provides cost-sharing credits for individuals and families up to 250% of poverty to help ensure affordable coverage.
- Sliding scale tax credits are available to small employers with fewer than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees.

Exhibit 17

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

December 6, 2012

Honorable Darrell E. Issa
Chairman
Committee on Oversight
and Government Reform
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter responds to your request for information about CBO's March 20, 2010, cost estimate for H.R. 4872, the Health Care and Education Reconciliation Act of 2010, in combination with H.R. 3590, the Patient Protection and Affordable Care Act. Specifically, you asked for a description and explanation of CBO's assumption that the premium assistance tax credits established by that legislation would be available in every state, including states where the insurance exchanges would be established by the federal government.

To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered. Nor was the issue raised during consideration of earlier versions of the legislation in 2009 and 2010, when CBO had anticipated, in its analyses, that the credits would be available in every state. CBO's analysts reviewed H.R. 4872 and H.R. 3590 to try to ensure that the agency's estimate accurately reflected the legislative language, as they do for all legislation that they analyze, but that question did not arise in the course of that review, and CBO did not perform a separate legal analysis of that issue.

I hope this information is helpful to the committee.

Sincerely,

Douglas W. Elmendorf

cc: Honorable Elijah E. Cummings
Ranking Member

Exhibit 18

While we are at it, we might as well get the next chart.

There are some who are saying this legislation will result in increased taxes for higher income people; that is, people whose income is, say, around $200,000. There is something to that argument, but that is not the whole story. Let's look at the whole story.

This legislation as portrayed by this chart shows:

High-cost insurance excise tax leads to increased wages.

Why increased wages? Because the Congressional Budget Office or maybe it is the Joint Committee on Taxation—the Joint Committee on Taxation concludes that because of that provision of the bill; that is, the excise tax on companies that provide more expensive policies, in effect those policies will be modified or changed, and in effect the premiums for those policies, the so-called Cadillac plans, will actually go down, according to the Congressional Budget Office, between 7 and 12 percent. But that is premiums. The discussion right now is on taxes. Those folks will be paying a little more taxes. That is true under this legislation. But, again, what is the whole story? Why are they going to be paying more taxes? They are going to be paying more taxes because they will get more income. Their wages and salaries will increase tremendously.

Look at the bar on the left. In the year 2013, the percent of the total tax revenue due to increased wages will be about 90 percent, but that person will also pay a 10-percent increase in taxes. The wage increase, salary increase is far greater than the tax increase. That is true for every year—2013, 2014, 2015, all the way up to 2019. It is proportionately basically the same—roughly around an 80-percent increase in wages and roughly maybe about less than a 20-percent increase in taxes. So on a net basis, those persons are going to be doing pretty well.

Consider the example of Joe who works for ACME Company. He is married and has two children. Together, he and his spouse earn $100,000 a year in taxable wages.

In 2012, ACME Company provides family health coverage to Joe at a cost of $25,000. Because of the high cost insurance excise tax, ACME Company finds different coverage that costs only $21,000 in 2013. Thus, ACME Company can afford to pay Joe an extra $4,000 each year.

Now, even though Joe has to pay income and payroll taxes, he will still have an extra $2,076 in his pocket. That is $4,000 −$1,000 in Federal tax −$612 FICA tax −$312 in State tax.

I don't believe Joe would refuse a pay increase just because he has to pay taxes on that raise.

Or consider Sally, a single mother of two working for XYZ Company. She makes $50,000 in 2013 and receives family health insurance coverage costing $27,000.

When XYZ Company restructures their plan to $22,000 as a result of the high-cost insurance tax, Sally will get an extra $5,000 in wages. That is $3,095 in take-home pay after taxes. That is $5,000 −$750 in Federal income tax −$765 FICA tax −$390 State tax.

I have no doubt that Sally will be able to put that extra money to good use.

Also, I would like to remind everyone about this legislation on premiums. Earlier, I discussed what the Congressional Budget Office said about premiums under our bill. Let me repeat, this is what the Congressional Budget Office says: In summary, the Congressional Budget Office concludes that 93 percent of Americans receive decreases in premiums. About 93 percent of Americans net will see a decrease in premiums.

That is not from these charts; that is from the CBO letter. Of that 93 percent, 10 percent will see decreases of 56 percent to 59 percent because of new tax credits. We are talking about on the individual market. About 60 percent of those who are getting insurance in the individual market on the exchange will get tax credits which will result in roughly a 60-percent reduction in premiums. It is between 56 and 59, which is pretty close to 60 percent. The remaining 7 percent will pay slightly higher—100 less 93. Seven percent will pay slightly higher, but they also get much better insurance for that same dollar. When you have a choice between buying a used car or a new car, you probably expect to pay a little bit more when you buy the new car. Hopefully, it is a little better, higher quality, drives faster, safer, all those things. You expect to pay a little more for a new car, but you get more. The same thing here. You are going to pay a little more. But only 7 percent will see their premiums go up according to the CBO. Those 7 percent are people who do not get tax credits because their incomes are a little higher, but they will get much better insurance, higher quality insurance. CBO says that, much higher quality insurance.

So, in effect, they will probably get at least the same, maybe no increase at all, maybe a reduction in premium, if we calculate in the higher quality insurance they will have.

In addition to CBO, MIT's Jon Gruber has also done a study on premiums. And what does he conclude? He concludes, using Congressional Budget Office data, the Senate bill could mean people purchasing individual insurance would save every year $200 for single coverage and $500 for family coverage in 2009 dollars. Most people think he is one of the best outside experts. He has big computer models. He takes the CBO data and, in some respects, he has helped CBO by giving some information to CBO that it otherwise does not have.

Mr. Gruber also points out that people with low incomes would receive premium tax credits that will reduce the price they pay for health insurance by as much as $2,500 to $7,500.

We have also seen several studies funded by the insurance industry. I don't want to be disparaging but to some degree you have to consider the source. I have been citing CBO. I think most people think they are a highly professional outfit, no axe to grind. Sometimes they upset those against health insurance reform. Sometimes they upset those for health insurance reform. They are a very professional group of people. But I have also seen studies paid for by the private sector, by the insurance industry. Those studies find that premiums will increase under the bill before us for all Americans. These studies are flawed and, frankly, some of them, the authors of these studies admitted they are flawed. They were just looking at selective parts of the legislation, not all parts, and they were pushed by the industry to issue a report quickly. They have admitted that. Each of them failed to take into account all aspects of the proposal. They selectively chose the provisions that will increase premiums, and they ignored those provisions that will lower premiums.

Why do they do that? Basically, the insurance industry wants to kill this bill. I can understand it. If I were the insurance industry, I wouldn't want my apple cart upset either. They do just fine under the status quo, thank you very much. They don't want to see any changes. Some insurance companies want to continue their current practices of denying coverage if you have a preexisting condition. That is how they made their money in the past. They made most of their money by denying coverage, by underwriting insurance rather than making money on conventional insurance. Anyway these companies want to continue their current practice of denying you coverage if you have a preexisting condition. Some want to continue charging unaffordable premiums if you have been sick in the past, and some want to be able to rescind your coverage once you get sick. That is their MO, and they have done pretty well under the status quo.

The Congressional Budget Office and Professor Gruber are both credible and unbiased sources that are not bought and sold by the insurance industry. The Congressional Budget Office and MIT's Gruber have confirmed what many of us have known: that the bill before us will lower premiums and provide a great many options for more comprehensive coverage. That is very important. With the exchange set up and with other provisions that will be in this bill, there are many more options for individuals to buy insurance with. It creates a lot of competition. With health insurance market reform, insurance companies will be competing more on price than they are on quality of coverage.

This legislation provides much needed assistance as well to lower middle-income Americans struggling to pay their health insurance premiums.

The Senator from Nevada, Mr. ENSIGN, a few moments ago said people

Exhibit 19

weeks and four Republican amendments—only four were offered. There never was a Republican substitute, no Republican proposal for health care reform. We have been told this might exist. We have never seen it. Of the four amendments they offered, not one was this substitute that was going to deal with the health care system. It is a promise that has not been kept. They kept saying: It is coming. Pretty soon we are just going to put this thing right in the RECORD. Well, it never happened. In 3 weeks, it never happened.

It is hard work to prepare a substitute. The reason this took so long and has dragged on for so long is we had to take every page of this and turn it over to the Congressional Budget Office. They sit there with their economists, pore over it and say: Well, is it going to add to the deficit or reduce the deficit? Is it going to reduce health care costs? What is the impact? It takes them some time to do that. The Republicans know if they are going to have a substitute, it will have to go through the same rigorous appraisal, and they have not done that, I think because it is hard. In fact, from their political point of view, it might be impossible to try to solve the problems facing health care in America without taking the path we have taken.

What does this bill do? The basics are obvious. First,—and this is all backed up by the Congressional Budget Office—it will reduce the cost of health care. It will make it more affordable. A health care policy for a family of four offered by an employer, on average, cost $6,000 10 years ago. Today, it costs $12,000 a year. It has doubled in 10 years, and in 8 years it will double again to $24,000. We have to slow this down or it will reach a point where more and more people will be uninsured, fewer businesses will offer health insurance, and more individuals will find themselves unable to afford the basic protections they need for themselves and their families.

So the Congressional Budget Office tells us we reduce the growth in the cost of health care, and that is a good thing. They came through with a dramatic revelation yesterday when they said this bill will reduce our deficit as well. If the cost of health care goes down, the cost of health care programs offered by government goes down. They tell us in 10 years we will save $130 billion from the deficit. That is a dramatic savings—the largest in history. But then the news got better. They said, in the second 10 years, instead of saving $650 billion from our debt and deficit, it could reach double that amount: $1.3 trillion in savings in the second 10 years.

I would say to those who give speeches day after day about our deficit, I invite you—in fact, I challenge you to come up with a bill that does this, that gives us actual savings of $130 billion in 10 years and $1.3 trillion in the next 10 years. It is hard to do. It may be impossible for some to come up with such a bill.

This bill also will extend the coverage of health insurance so 94 percent of Americans will have coverage. Madam President, 30 million Americans today who have no health insurance will have health insurance under this bill. Half of them are poor enough that they will receive Medicaid; the other half will qualify for the insurance exchanges and other tax credits to help them pay their premiums so they can have and afford health insurance.

Ninety-four percent of Americans—we have never, ever achieved a level of insured Americans that reached that number. Thirty million Americans will be receiving health insurance at the end of the day.

This bill will start giving consumers across America protections they need against abuses from health insurance companies. One of the things near and dear to my heart about this amendment, which has been criticized by some, is this amendment, which was offered yesterday, has been on the Internet, for those who are interested to read it, for 24 hours, and will continue to be available.

This amendment says that as soon as this is signed, health insurance companies across America cannot deny coverage to children, those under the age of 18, because of a preexisting condition. That means if your son or daughter is diagnosed with diabetes, juvenile diabetes, and you find it difficult to get health insurance today because of that preexisting condition, they will no longer be able to discriminate against your child and your family because of this bill. That is one thing. There are many others.

This whole notion of health insurance companies waiting until you get sick and cut you off when you need them the most, that comes to an end, under this amendment, in 6 months. So over and over again, we give consumers across America a chance to have the coverage they paid for when they need it the most. We used to call it the Patients' Bill of Rights, and it used to be bipartisan. It was Senator Kennedy and Senator MCCAIN who brought it to us, and it failed because the health insurance companies were so politically powerful. But we have got them this time. If we can pass this bill, we finally have the protections the American people so desperately need.

There are other provisions in the bill. Right from the beginning, we provide more help to small businesses. These are businesses with 50, 25 employees and an average payroll of $50,000 an employee to $25,000 an employee or less. For each of those businesses, we say: We are going to help you buy health insurance for the owners of the business as well as for the employees. Those are the folks who are struggling and losing coverage, people such as the realtors in your hometown. Did you know one out of four realtors in America has no health insurance. I did not know it until they came to see me. Well, this gives them a hand. It gives them a tax break as a small business to provide health insurance for their people.

I am going to reserve the remainder of my time. I will tell you, we are here today. We are burning the hours off the clock to vote at 1 a.m. in the morning. It would be more humane to the people who work here, to the Members of the Senate and their families, for us to reach a gentlemanly and gentlewomanly agreement that we will have this vote at a more reasonable time. If we have the 60 votes, which I think we have the commitments for, then we can decide how to move forward.

We have had a long, arduous, and sometimes taxing debate leading to this moment. I think it is time for a vote. The sooner we can reach that vote, the sooner the American people will know that we will either succeed or fail in bringing stability and security when it comes to their health insurance, making that health insurance more affordable, extending the reach and protection of health insurance to record levels of Americans, making sure we have health insurance reform as part of this, and at the same time, at the very same time reducing our deficit.

I reserve the remainder of our time.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. DURBIN. Madam President, how much time do I have remaining?

The ACTING PRESIDENT pro tempore. There is 1 minute 50 seconds.

Mr. DURBIN. Madam President, I wish to suggest the absence of a quorum and ask unanimous consent that the time under the quorum be allotted equally to both sides.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The clerk will call the roll.

The assistant bill clerk (Sara Schwartzman) proceeded to call the roll.

Mr. CHAMBLISS. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. CHAMBLISS. Is it correct, Madam President, the minority side has the hour from 1:30 to 2:30?

The ACTING PRESIDENT pro tempore. That is correct. Under the previous order, the time until 11:30 p.m. shall be controlled in alternative 1-hour blocks with the Republicans controlling the first hour.

Mr. CHAMBLISS. I, then, Madam President, ask unanimous consent Senators CORNYN, GRAHAM, ISAKSON, and myself be allowed to have a colloquy during this first hour, from 1:30 to 2:30.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. CHAMBLISS. Madam President, here we are on our 21st legislative day, less than 4 weeks, on the most major piece of health care legislation ever

Exhibit 20

2 weeks. This hasn't sprung up in the last 2 months.

Millions of Americans went to the polls, understanding, in large measure, what we needed to do to change the system. Despite the rhetoric from the other side, that is the reality, and the record will reflect that. Instead of coming to the table and working with Democrats to write a bipartisan bill, Republicans chose to put partisan party politics first. I listened to my friend, MAX BAUCUS, this morning. I, myself, who thought I had followed carefully the work of the Senate Finance Committee, was actually moved to hear the number of meetings—dozens and dozens, maybe hundreds and hundreds of meetings—he attempted to have in a bipartisan way months ago, years ago, with Republicans. Then, at some point, they decided they thought that politics was more important than policy. I think they made the wrong choice.

They fabricated death panels, distorted Medicare cuts, and undermined and disrespected the role of government in protecting its citizens. They have engaged in a relentless misinformation campaign, aimed solely at using fear to sway public opinion against this bill.

Recently—just yesterday—Senator JOHN MCCAIN, our colleague from Arizona, claimed that the American people are opposed to reform, and he speaks about the will of the majority. I remind my colleague from Arizona that the will of the majority spoke loud and clear last year when they elected President Obama to be President and decided not to elect him. The President is carrying out the will of the majority of the people by trying to provide for them hope and opportunity in an area that has eluded us for 87 years.

This is a good effort, a strong effort, and I most certainly believe that the will of the American people is being heard. The other side has tried to paint a picture of a nation opposed to health care reform. Recent polls show otherwise. When we cut through the misinformation and scare tactics, when Americans hear what is in the bill, they overwhelmingly support it.

According to a recent CNN poll, 73 percent of Americans support expanding Medicaid for the poor. Americans know what most of us know: Most people on Medicaid are the working poor. These are people who wake up early in the morning, work hard all day, and they go back home at night, often by taking public transportation because they don't have an automobile. They work hard. They are American citizens. But they don't have enough money to spend 60 percent or 80 percent of their income on health insurance in a broken, unbridled, unfixed private market. So we join together with our States to provide them access to care through the Medicaid system. I support that. And in this bill, the Federal Government will pick up a large share of the cost of expanding coverage.

That same poll showed that providing subsidies for families that make up to $88,000 a year is favored by 67 percent of Americans. Additional regulations on insurance companies, such as banning denial of coverage for those with preexisting conditions are favored by 60 percent of the American people.

I am one of the Democrats who didn't want to eliminate insurance companies. I believe in private markets. But there have to be certain rules and regulations in order for the private market to work for everyone, and not just for those with wealth or those with the inside scoop on how private markets work.

So we are incentivizing a healthier insurance industry—not coddling it but encouraging it to be competitive and to provide services and coverage for more people in our country.

A recent poll by the Mellman Group shows that support for this bill exists in all States. In my home State of Louisiana, when the provisions of the bill were actually read to voters, 57 percent of Louisianians supported the bill, with 43 percent strongly supporting the reform effort. And most importantly, 62 percent of Louisianians oppose using the filibuster to stop health care reform.

I will read the language used in the poll because people say you can say anything in polls, which is true. If pollsters are not reputable, they can twist and distort. I will read the language used by the poll to describe the plan:

> The plan would require every American citizen to have health insurance and require large employers to provide coverage to their employees. It would require insurance companies to cover those with pre-existing conditions and prevent them from dropping coverage for people who get sick, while providing incentives for affordable preventive care. Individuals and small businesses that do not have coverage would be able to select a private insurance plan from a range of options sold on a National Insurance Exchange. Lower and middle income people would receive subsidies to help them afford this insurance, while those individuals who like the coverage they already have will be able to keep their current plan.

This is a very accurate description of this bill before us—the Patient Protection and Affordable Care Act. It is not a government takeover. There is no public option. There is a national plan available now to every American, just like the Members of Congress and the Federal employees have. There will be exchanges—similar to shopping centers—and Americans will be go to the exchanges and choose from a number of insurance options. The prices will be more transparent. Administrative costs will be lowered. You will not need a Ph.D. to be able to read these policies—they will be written in plain English.

Again, this is not a government takeover, as the other side claims. That is why 57 percent of people in Louisiana, when given the right information, without the rhetoric, without the railing, without the distortions, say: Absolutely, I am for a public-private partnership.

The American people elected President Obama to bring about change. A big part of the change President Obama and Democrats promised during the campaign was improving health care for all Americans. Thanks to the President's leadership and the leadership of Senator REID and many others, we are taking several meaningful steps toward fulfilling that promise.

With the exception of two colleagues, Republicans have failed to negotiate in good faith. I want to say how much I respect our two colleagues from Maine, Senator SNOWE and Senator COLLINS. I have been in dozens of meetings with both of them and know that they struggled mightily to find a way to work with us and to support this bill. I have not spoken with them in the last few days, so I will not discuss their reasons for withholding their support. I am sure they will express those on the floor. But I can say that they are the exception to the rule. I know Senator GRASSLEY, Senator GRAHAM, Senator BENNETT, and a few others engaged early on. I want to acknowledge them and I appreciate their good will. But, unfortunately, the leadership of the Republican Party chose politics over policy. I am disappointed that not a single Republican could support an end to the filibuster. I suppose it is easy to stay unified when the only word in your vocabulary is NO. Although Democrats did not initially agree on exactly how to get there, we were united in saying yes to the common goal of delivering meaningful health care reform to America's families and small businesses. It has been difficult. Some of us come from very conservative States. Some of us come from liberal States. We have diverse populations in our States that have different needs and different views. It has not been pretty, but it has been a practical and hopefully a positive exercise that will bring comfort, support, and strength to the American people and to our economy.

I do hold out hope that when we take our vote on final passage, Republicans will recognize this historic opportunity and vote in favor of this bill that will reduce costs and increase access to health care for millions of Americans.

Last month, I stood here on the floor of the Senate to announce my intention to vote in favor of bringing Senator REID's melded bill to the floor. At the time, I was very clear that my vote was not an indication that I supported that particular version of the bill. My vote was to bring that bill to the floor so that we could do the legislative work the American people sent us here to do.

After weeks of floor debate and amendments and round-the-clock negotiations, that work has been completed. We produced a health care bill that is significantly improved from the one that came to the floor. I would like to share a few thoughts about why, in my view, it is improved.

Exhibit 21

This Congress is irresponsible in our spending. We have increased the debt the likes of which this Nation has never seen, and we are spending as if it is going out of style.

I would point out one matter here about the interest we pay on the debt. In 2008, the annual deficit was $450 billion—at that time, the largest ever. This past year, the deficit for the fiscal year ending September 30 was $1,400 billion, $1.4 trillion. This puts us on the map, according to the Congressional Budget Office, to double the entire debt of America in 5 years, and triple it in 10. Unbelievable.

This is a kind of gimmick—attaching unpaid for, nonbudgeted items to the defense bill, then trying to force it through, so we cannot do anything about it. They snicker, I am sure, in their self-confident way that: We got 'em. If they object to the bill, we will say they don't love our soldiers, they don't support America's defense.

I am getting tired of it. I think the American people are getting tired of it. I saw a poll where the most popular party in America today is the tea party—more than Republicans or Democrats.

Somebody said: Well, $18 billion, Sessions, that is not too much money. But it is done on bill after bill. This is not the only bill that has these kinds of gimmicks in it. Let me show you. I figured this out one day. I put together a chart here a little bit hastily: Baseline Increases: A Destructive Pattern.

When we increase funding in these bills above the budgeted amount and increase the debt, people like to think: Well, it is just $18 billion. That is not much.

Look how that works when you do it over a period of ten years. So let's say next year, we go over $18 billion. This adds another $18 billion to the national debt. Well, that is not so much. But wait, it is a lot. The State of Alabama's general fund budget is $2 billion. Do not tell me $18 billion in one bill, on top of this defense bill, is not a lot of money. It is a huge amount of money.

But it does not work that way. This $18 billion tends to go into the baseline, so the next year, when they talk about increasing the budget, they pad it by another $18 billion. It is not just $18 billion the next year, you see. It is $18 billion on top of what was pumped into the baseline the year before, and that totals out to $36 billion. Then the next year, it is $36 billion, plus $18 billion more. And the next year, it is $54 billion, plus $18 billion more. The next year it is $72 billion, plus $18 billion. The next year, it is $90 billion, plus $18 billion. And the next years, it is $108 billion, $126 billion, $144 billion, and $162 billion if you pad the budget. And this bill is just 1 of 13 accounts: Defense. We have 13 different spending bills. How much is that? It is $900 billion in additional deficits, just because of our inability, our unwillingness, to stay by the numbers that we voted on as our budget limit.

The budget itself, as presented by the President and passed by the Democratic majority, put us on a road to having $1.4 trillion in deficit last year, and it looks as though this year we are going to have a another $1.4 trillion deficit. But just this one little gimmick, if it is replicated each year, can add almost $1 trillion more to the debt of America over ten years. That is why we are concerned about it.

By the way, when we talk about the scheme that puts us on the road, according to the Congressional Budget Office, to tripling the debt of America by 2019, that does not include the health care bill. The health care bill has not passed. This outlook only includes the things that are in law now. So how much more would those figures be if the debt goes up?

I will point to one last thing about the overall financial status of this country: the interest we pay on that debt. This chart shows it.

Last year, this Nation paid $170 billion in interest on the borrowings we have as a nation. In that 1 year it was $170 billion. That is a lot of money. As I said, not counting the State education budget, for all the other matters of our State of 4.6 million people—which is almost one-fiftieth of the Nation's population, an average-sized State—our general fund is $2 billion. However, $170 billion is how much we paid in interest last year. According to the Congressional Budget Office, those numbers will increase to where in 2019, as a result of surging debt, $799 billion will be added to our debt because of interest we must pay; $799 billion just in that 1 year. That is more than the whole defense budget. That is more than the whole U.S. discretionary budget from not too long ago. That is a huge amount of money. It is going to crowd out spending for schools, for highways, for health care, and for other projects.

I am very upset about it. We cannot continue. The President has said this is an unsustainable course. Every economist we talk to says it is an unsustainable course.

But how do we get there? We get there by taking a Defense bill and tacking on $18 billion worth of unfunded spending. Every penny of that gets added to the debt.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SESSIONS. I thank the Chair.

I urge my colleagues to send this bill back and reform it so we can have a clean Defense bill. We need to take these unpaid matters out and make sure they are paid for.

I thank the Chair and yield the floor.

Mr. JOHNSON. Madam President, I rise today to recognize this incredible opportunity to dramatically improve the health of our Nation. Americans face out-of-control health care costs, great inequalities in access to care, eroding benefits, and the ever-increasing threat of losing their health insurance. While it is no easy task to fix a system that is both very complex and very troubled, we cannot fail to act.

I wish today to highlight the challenges faced by approximately 12 million Americans who buy health insurance in the individual market. Many farming and ranching families in South Dakota are forced to purchase from this market, where they all too often wind up underinsured with coverage that costs too much and provides too little.

South Dakotans have contacted me directly to report health insurance discrimination that results in increased premiums, refusal of coverage for necessary treatments, and denial of coverage. I have even heard complaints from people who work in the insurance industry, like Pam from Sioux Falls, SD. She shared with me the serious barriers people encounter when looking for health insurance on the individual market. ''There are huge loopholes in the individual market. People who are not healthy cannot get insurance. We turn people away every day and they want to buy health insurance.''

Insurance companies increase their profits by selling to individuals who will pay premiums but rarely use their benefits, and by avoiding individuals who have health issues. This cherry-picking leaves millions of Americans without access to affordable health insurance coverage. And when families go without health insurance, they receive less preventive care and often must undergo more costly medical treatment when illness progresses undetected. This uncompensated care for the uninsured drives health care costs up for all of us.

Those who buy insurance on the individual market pay top dollar for very limited coverage. They will benefit immensely from health reform. The Patient Protection and Affordable Care Act will increase the insurance options in the individual market and address injurious insurance industry practices that limit access to care. Immediately after enactment, a new program will be created to provide affordable coverage to Americans with preexisting conditions until insurance industry reforms are fully implemented. The legislation will also form health insurance exchanges in every State through which those limited to the individual market will have access to affordable and meaningful coverage. The exchange will provide easy-to-understand information on various health insurance plans, help people find the right coverage to meet their needs, and provide tax credits to significantly reduce the cost of purchasing that coverage.

Pam says, ''People who want to buy individual insurance should be able to, regardless of their health status.'' I couldn't agree more. The Patient Protection and Affordable Care Act will ensure that no American is denied coverage because of their medical history, and it will provide the security of meaningful, affordable health care coverage for all.

Exhibit 22

of this morning be printed in the RECORD following my remarks.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. BINGAMAN. As this chart demonstrates, according to the Congressional Budget Office, if we don't act to deal with the growth in health care costs, Federal spending on Medicare and Medicaid combined will grow from 5 percent of GDP today to almost 10 percent by 2035. By 2080, the government would be spending almost as much as a share of the economy on just its two major health care programs as it has spent on all of its programs and services in recent years.

Let me put up another chart that demonstrates that most of this increase in cost is not the result of our aging population. We do have an aging population; that does add to the cost of health care because as people get older they tend to need more health care. The dark blue shows the increase expected in health care costs by virtue of aging. But the lighter blue talks about the effect of excess cost growth that is not related to aging; that is, the growth in health care cost is out of control in our current system. Such spending is unsustainable. It has led the Congressional Budget Office to say:

Slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for fiscal policy.

Moreover, across the country, premiums continue to increase. They are becoming more and more unaffordable for individuals and for businesses. I hear on a regular basis when I go around New Mexico—and I am sure all my colleagues hear from their constituents as they travel in their States—that people cannot continue to pay more and more each year for their health care coverage. According to an August report by the Commonwealth Fund, nationally, family premiums for employer-sponsored health insurance increased 119 percent between 1999 and 2008. If cost growth continues on its current course, those premiums could increase another 94 percent to an average of $23,842 per family by 2020. I am not sure what the circumstance is in many States, but I know in New Mexico there are many families who cannot afford to pay $23,800 in health care premiums.

Nowhere is the unsustainable growth felt more acutely than in my home State. Without health reform, in my State we are projected to experience the greatest increase in health insurance premiums of any State in the Union. For example, the average employer-sponsored insurance premium for a family in New Mexico was about $6,000 in the year 2000. By 2006, this rate had almost doubled, or the cost had almost doubled to $11,000. By 2016, the amount is expected to rise to an astonishing $28,000. In addition, health insurance premiums in New Mexico make up a larger percentage of New Mexico's income, the income of the average New Mexico family, than almost all other States. We are paying 31.18 percent. Over 31 percent of the average income of a family in New Mexico is going to pay for health care. This is expected to grow to 56 percent if we do not reform our health care system.

It is important to highlight that the higher spending on health care in the United States does not necessarily prolong lives. I hear a lot of speeches about how we have the greatest health care system in the world. We are the envy of the world. People would just love to have access to our health care system. This chart illustrates that in 2000, the United States spent more on health care than any other country in the world, an average of $4,500 per person. That was in 2000. Switzerland was the second highest at $3,300, substantially less. Essentially, its cost per person was 71 percent of what it was in the United States during that year. Nevertheless, the average U.S. life expectancy comes out at 27th in the world. Our life expectancy average is 77 years. Many countries, 26 to be exact, achieve higher life expectancy rates with significantly lower spending on health care.

Data from the McKinsey Global Institute clearly indicates there is a considerable level of waste in our current system. McKinsey estimates that the United States spends nearly $½ trillion annually in excess of other similarly situated nations. Of this, about $224 billion in excess costs are found in hospital care. About $178 billion are found in outpatient care. Together these account for more than 80 percent of U.S. spending above the levels of other nations.

Here is one other chart. This is one I have used before on the Senate floor. Not surprisingly, as costs and inefficiencies continue to build, access to health care is becoming more and more difficult for middle- and lower-income Americans. This chart indicates the rate of uninsurance throughout the country. First, on the left-hand side is the year 2000; on the right-hand side is 2008. We can see the dark blue States are States where 23 percent or more of the population ages 18 to 64 are uninsured. Back in the year 2000, New Mexico and Texas were the only two States where the rate of uninsurance exceeded 23 percent. Now we can see the rate of uninsurance exceeds 23 percent for many of the States, particularly across the southern part of the country.

We have a very serious problem that needs addressing. It is clear that the U.S. health care system is failing many Americans. The situation is becoming more and more urgent. According to a study published by the Harvard Medical School in August, medical costs have led to almost two-thirds of the bankruptcies in this country. More than 26 percent of bankruptcies are attributable to health care problems. The study found that most medical debtors were well educated, owned their own homes, had middle-class occupations and, shockingly, three quarters had health insurance. So these were people who had coverage, but the coverage was not adequate to meet the needs. Unfortunately, for many individuals, the very high cost of medical care leads them to delay or to avoid receiving medical care altogether.

The Urban Institute reports that 137,000 people in this country died between 2000 and 2006 because they lacked health insurance. That includes 22,000 people in 2006. Clearly, the need for national health reform has never been so great.

The Patient Protection and Affordable Care Act, the legislation we are debating, introduced by Senator REID and others a few weeks ago, includes the key reforms we have come up with and that the experts have come up with, aimed at addressing these very serious problems, while protecting the aspects of our health system that are working today.

First, this bill includes long-overdue reforms to increase the efficiency and quality of the health care system while reducing overall cost. For example, the legislation includes payment reforms that I have championed to shift from a fee-for-service payment system to a bundled payment system. This will reshape our health care reimbursement system to reward better care and not simply more care as it currently does today.

Second, it includes a broad new framework to ensure that all Americans have access to quality and affordable health care. This includes creation of a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable tax credits to ensure that coverage is affordable.

Finally, these new health insurance exchanges will help improve choices by allowing families and businesses to compare insurance plans on the basis of price and performance. This puts families, rather than the insurance companies or the government bureaucrats, in charge of health care. It helps people to decide which quality, affordable insurance option is right for them.

The Congressional Budget Office, which is cited here—quite frankly, I notice that the Congressional Budget Office is cited by both Democrats and the Republicans in this debate, and that is a credit to the CBO. They are seen as nonpartisan, and they are nonpartisan. I congratulate Doug Elmendorf for the good work CBO has been doing in support of our efforts to come to the right answer on health care reform—the CBO forecasts that this legislation would not add to the deficit.

As the chart Senator BAUCUS had a few minutes ago clearly indicates, the deficit would be reduced in the first 10 years by $130 billion. It would be reduced in the second 10 years, going up to 2029, by something over $600 billion.

Let me also point out the contrast. We are talking about a bill which the

Exhibit 23

Health Lobby Takes Fight to the States

By DAVID D. KIRKPATRICK
Published: December 28, 2009

TWITTER
LINKEDIN
E-MAIL
PRINT
REPRINTS
SHARE

WASHINGTON — Like about a dozen other states, Florida is debating a proposed amendment to its state constitution that would try to block, at least symbolically, much of the proposed federal health care overhaul on the grounds that it tramples individual liberty.

Enlarge This Image

Steve Cannon/Associated Press

Carey Baker, a Florida state senator, wants his state to opt out of parts of a health bill.

But what unites the proposal's legislative backers is more than ideology. Its 42 co-sponsors, all Republicans, were almost all recipients of outsized campaign contributions from major health care interests, a total of about $765,000 in 2008, according to a new study by the National Institute on Money in State Politics, a nonpartisan group based in Helena, Mont.

It is just one example of how insurance companies, hospitals and other health care interests have been positioning themselves in statehouses around the country to influence the outcome of the proposed health care overhaul. Around the 2008 election, the groups that provide health care contributed about $102 million to state political campaigns across the country, surpassing the $89 million the same donors spent at the federal level, according to the institute.

Any federal legislation is likely to supersede state constitutional amendments. But backers of the state measures say they want to send a message to Congress and also lay groundwork for fights about elements of the health care package that are expected to be left up to the states.

Some proposals floated around Capitol Hill, for example, would allow individual states to "opt in" or "opt out" of regional health insurance markets or government-sponsored insurers.

"We would be essentially telegraphing our intentions," said State Senator Carey Baker, a Florida Republican and lead sponsor of the state's proposal. "If there was an opt-in, we are essentially stating now that we are not going to opt in."

Health Care Conversations
Share your thoughts about the health care debate.

Top Discussions: The Public Option | Medicare and the Elderly | The Senate Bill

Living Story

Health Care Reform
Recent developments on the struggle over health care with background, analysis, timelines and earlier events from NYTimes.com and Google.

Go to the Prescriptions Blog »
Times Topics: Health Care Reform

Think Like a Doctor: Gut Feeling
November 7, 2013, 8:00 AM

Baby's Gaze May Signal Autism, a Study Finds
November 6, 2013

Children Eat More After Sleeping Less
November 6, 2013

Keep Telling Yourself, 'This Workout Feels Good'
November 6, 2013

Ethnic Variations in Fertility Treatment
November 5, 2013

Health & Fitness Tools

BMI Calculator
What's your score? »

MOST POPULAR - HEALTH

E-MAILED | BLOGGED | VIEWED

1. Well: Baby's Gaze May Signal Autism, a Study Finds
2. Well: Keep Telling Yourself, 'This Workout Feels Good'
3. Hepatitis C, a Silent Killer, Meets Its Match
4. Herbal Supplements Are Often Not What They Seem
5. F.D.A. Ruling Would All but Eliminate Trans Fats
6. Well: What's Your 'Fitness Age'?
7. Well: Concerns About Jerky Pet Treats
8. Recipes for Health: Gluten-Free Raisin Pistachio Biscotti
9. Well: Think Like a Doctor: Gut Feeling
10. Well: Children Eat More After Sleeping Less

Go to Complete List Â»

Advocates of a sweeping overhaul by the federal government, on the other hand, say the magnitude of the health care industry's contributions shows the dangers of leaving such a question up to individual states, where campaign finance and ethics rules vary from strict to negligible.

"The states are the next battle," said Richard Kirsch, national campaign manager for the liberal advocacy group Health Care for America Now, "and the insurers and health care industry are primed up and ready to go. The industry has enormous power at the state level, and very few states have state-level consumer groups that are able to lobby effectively against them."

Last year, for example, the drug industry poured more than $20 million into political contributions in states around the country. In California alone, the industry spent an additional $80 million on advertising to beat back a California ballot measure intended to push down drug prices.

Now, speaking on condition of anonymity because the pharmaceutical trade group is officially backing the federal overhaul, industry lobbyists say they are eyeing Congressional proposals that would expand a state's Medicaid obligations, and are preparing to fight efforts to make some of it up by paying less for drugs. (A spokeswoman for the National Conference of State Legislatures said many states were contemplating just that.)

The idea of amending state constitutions to block the core of the federal health care legislation, including the requirement that individuals and businesses buy insurance, began at the conservative Goldwater Institute in Arizona, the state where the first such measure will appear on the ballot next year.

"The measures are an opportunity for people to make their views known in a tangible way, to generate some rumble at the grass roots," said Clint Bolick, a lawyer at the Goldwater Institute who helped devise the idea.

From there, though, the concept was picked up by the American Legislative Exchange Council, a business-friendly conservative group that coordinates activity among statehouses. Five of the 24 members of its "free enterprise board" are executives of drug companies and its health care "task force" is overseen in part by a four-member panel composed of government-relations officials for the Blue Cross and Blue Shield Association of insurers, the medical company Johnson & Johnson and the drug makers Bayer and Hoffmann-La Roche.

The group adopted Arizona's proposed amendment as a model, and it was introduced in 14 state legislatures around the country. Lawmakers in several others are reportedly considering it as well.

"We are trying to prepare, and trying to send a message that there is no reason for those decisions to get made at the federal level," said Representative Linda L. Upmeyer, a Republican who is leading the council's efforts in Iowa.

The states where the amendment has been introduced are also places where the health care industry has spent heavily on political contributions in recent years, according to figures from the National Institute on Money in State Politics. Over the last six years, health care interests have spent $394 million on contributions in states around the country; about $73 million of that went to those 14 states. Of that, health insurance companies spent $18.2 million, according to the institute.

In Florida, where health interests have given a total of about $32 million over the last six years, the state medical association has become an especially important backer of the proposed amendment. In contrast to the national American Medical Association, the state chapter has come out firmly against the current Congressional proposals, and a spokeswoman said the Florida group had embraced the proposed state amendment "to

protect Florida from being forced into a federal government mandate that would hurt patients."

Dr. Madelyn E. Butler, president elect of the Florida Medical Association, said, "We are trying to ameliorate the effects of national health care reform on the State of Florida."

James Greer, chairman of the Florida Republican Party, said he too supported the proposal, which could be on the ballot in 2010 or more likely in 2012. Whatever its legal weight, Mr. Greer said, its mere presence on the ballot would give it political force.

"It will energize Republicans and independents who want to vote against Democrats and the policies of the Democratic Congress," Mr. Greer said.

A version of this article appeared in print on December 29, 2009, on page A1 of the New York edition.

More Articles in Health »

E-MAIL
PRINT
REPRINTS

Past Coverage

Health Care Overhaul Revives Abortion Debate (November 24, 2009)
In House Record, Many Spoke With One Voice: The Lobbyists' (November 15, 2009)
Fund-Raising Adds to the Competing Health Care Pressures on Pelosi (November 7, 2009)
A Delicate Dance for Two Lobbyists Skirmishing Over Health Legislation (October 28, 2009)

Related Searches

Lobbying and Lobbyists	Get E-Mail Alerts
Health Insurance and Managed Care	Get E-Mail Alerts
State Legislatures	Get E-Mail Alerts
Reform and Reorganization	Get E-Mail Alerts

INSIDE NYTIMES.COM

HOME & GARDEN »

A Radiance All Their Own

FASHION & STYLE »

Sweating Details Is Part of Test at Design Contest

OPINION »
Fairness in College Aid
Room for Debate asks what can be done to make sure the formulas for assessing need are reasonable.

SCIENCE »

Baby's Gaze May Signal Autism, a Study Finds

OPINION »

Private Lives: Pirate Nights

ARTS »

'Humans of New York,' by Brandon Stanton

Home | World | U.S. | N.Y. / Region | Business | Technology | Science | Health | Sports | Opinion | Arts | Style | Travel | Jobs | Real Estate | Automobiles | Back to Top

Exhibit 24

and the White House has sufficiently changed to allow that to happen.

Let me talk a little bit again about the Senate-passed bill. We're not talking about the reconciliation bill. We're not talking about the House-passed bill. Remember the Senate-passed bill in December? There was a Senator from Connecticut who said, I cannot vote for a bill if it's got a public option in it.

□ 2150

Maybe it's because there are a lot of insurance companies in Connecticut, I don't know what the reasoning was, but that Senator was very firm that they would not have his vote, and they needed every vote they could to get to 60, so the public option was very reluctantly stripped out of the Senate bill. But is it really going? And the answer is it might not be.

Now, you have heard that several States around the country are looking at, I believe it's up to 37, was the last count, are looking at either filing a constitutional challenge or somehow exempting their State from participating in this new Federal legislation, and that also means that they may not set up the State-based exchange that the bill, the Senate bill, calls for.

Well, what happens in a State that doesn't set up an exchange? Is there not going to be any exchange, so there won't be any insurance in the exchange available to citizens of those States? You would think so, because States should ultimately have sovereignty, except that there is a little known Federal agency called the Office of Personnel Management that is going to be charged with setting up a State-based exchange or a national exchange that every State that doesn't have a State-based exchange, that their citizens can buy through this national exchange. And the Office of Personnel Management, in the language of the bill, is required to set up one insurance company, one for-profit insurance company, and one not-for-profit.

Does this federally administered, national exchange, not-for-profit, insurance company begin to look a lot like the public option that was discussed in the Democrat's bill in the House? The answer is, of course it does.

The Office of Personnel Management currently administers the Federal employee health benefits plan here for all Federal employees, not just in Congress, but all employees. So they are a relatively small agency. That's a big insurance plan, but still, as Federal agencies go, that's a relatively small agency.

It is going to have to rapidly ramp up with a great number of new employees. Perhaps that's one of the ways we are going to deal with unemployment is to hire more people in the Federal Government. But the Office of Personnel Management will have to get considerably larger, and this Office of Personnel Management will now be the de facto public option as it administers the not-for-profit that's in the national exchange that is available to people who are in States that don't set up a State-based exchange.

It is a public option by another name. Unfortunately, the Senator that sought to prevent that from happening did not see the way this was going to work out in their own Senate bill. So when I say the doctors who look at retiring from practice, if there is a public option in the bill, perhaps the more they get to understand that this public option is really in the bill, maybe they will rethink their willingness to continue to work within the system.

Are there other ways to change this bill that we passed last night? Certainly, everyone ought to be treated equally under this bill, and they haven't been. Maybe that's one of the technical fixes we could work on so that there is no geographic disparity, there is no racial disparity. People, equals, ought to be treated equally, and that is one of the things that really we should work on.

I think we should work on getting rid of the individual mandates and the employer mandates. Certainly we could encourage comprehensive coverage for seniors. Right now, look what we are doing to Medicare Advantage. Look what we are doing to putting the tax on the supplemental insurance.

We really should, rather than discouraging seniors from having a Medicare Advantage plan or a supplemental plan, maybe we ought to encourage that. After all, the Medicare Advantage plans are doing what we asked them to do. We asked them for care, coordination, disease management, expanded health IT, expanded use of physician assistants, nurse practitioners, paraprofessionals.

Medicare Advantage plans are performing those functions. They are just now getting to the point where they are really starting to see the cost savings that we all said would be there if they would do those things, and now we are going to take them away. Okay, never mind, we shouldn't have done it anyway, so sorry about that.

Allow health insurance to be sold across State lines. We have talked about this a lot. If you want competition, don't have the Office of Personnel Management create a nonprofit that everyone is going to compete with. That's only one other bit of competition. Let the 1,300 insurance companies that exist in this country, let them compete. Let them compete up on the Internet, let them compete across State lines.

The portability of insurance, Congress attempted to address that back in 1996, arguably made kind of a mess of things. But if we would do things that would establish and create an enhanced portability of insurance, we would go a long way towards establishing a longitudinal relationship, a patient with their insurance company.

If you go from job to job, you don't change insurance companies. You have your insurance company, and you can take it with you. Allow private insurance and alternatives to Medicaid and SCHIP, special health savings account for the chronically ill, health insurance plans to specialize in solving problems for the chronically ill.

All of these things are out there and within our purview. These are all things we should undertake to fix the egregious problems that are in the Senate bill.

$13 BILLION A YEAR FOR HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes.

Mr. KING of Iowa. Madam Speaker, I very much appreciate being able to address you here on the floor of the United States House of Representatives and what has been referred to in the past as the world's greatest deliberative body—and what has to struggle to reach that standard these days, I would say, Madam Speaker.

You know, we are not done yet. This legislation passed the House sometime this morning. I will just say, first of all, I am grateful that this usurpation of American liberty technically in its final phase didn't take place on the Sabbath during Lent, although most of the machinations, debates, and battles, and some of the votes, actually did take place on the Sabbath during lent.

Our Founding Fathers would have considered it a serious violation of the standards of decency to assault liberty on the Sabbath, especially during Lent, and I consider it the same. Sacrilegious may have been something that would have come to mind.

But what we have seen is the Senate version of the bill, which has come over here to the House and was voted on and debated on first, and voted on. And the identical form is the Senate—was the legislation that most of us heard President Obama refer to, and I believe it was in the conference February 25 at the Blair House, as ObamaCare.

Thirty-some million more people put on the rolls, and many of them on Medicaid rolls, many of them don't quite fit the standards that seem to be the highest ideals of the initiation of this legislation. The argument is, if there is $130 billion, it will be reducing the deficit over a 10-year period of time, $130 billion over 10 years. The American people can move a decimal point one place to the left and figure out what that is annually, $13 billion a year by their calculations.

Madam Speaker, I could take you down through the list of the spending that has been out of control by this Congress. It all has to be initiated here, promoted by the President of the United States, trillions, trillions of dollars added up, $700 billion in TARP, $787 billion, which rolled into over $800 billion and the economic stimulus plan, of which only 94 percent of Americans believe did any good, and that

Exhibit 25

Landrieu	Nelson (NE)	Shelby
Lautenberg	Nelson (FL)	Specter
Leahy	Pryor	Stabenow
LeMieux	Reed	Tester
Levin	Reid	Udall (CO)
McCaskill	Risch	Udall (NM)
Menendez	Rockefeller	Webb
Merkley	Sanders	Whitehouse
Mikulski	Schumer	Wicker
Murray	Shaheen	Wyden

NOT VOTING—2

Bunning	Byrd

The PRESIDING OFFICER. On this vote, the yeas are 32, the nays are 66. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment is withdrawn.

Mr. DURBIN. Mr. President, I move to reconsider the vote and to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I am going to ask to have printed in the RECORD a letter dated December 1, 2009, from the insurance commissioner of the State of Oklahoma—she happens to be of your party, the majority's party—outlining the significant problems that she sees for our State if this bill becomes law. This is not a partisan document. This is a document that relates to what is going to happen to Oklahoma.

If I might summarize, very shortly: It will increase premium costs and increase the number of uninsured people in Oklahoma. That is according to our State insurance commissioner, who is of your party. It will decrease the amount of availability of insurance to people who do not have insurance today.

The letter states it will not rein in the cost. In fact, it will increase costs for everybody else in the State of Oklahoma. It will drive up costs and increase the number of uninsured. It will increase the costs for the private plans, negatively impacting medical providers and the health delivery system in Oklahoma, and it will encourage fewer businesses in Oklahoma to offer benefits.

That is a fairly strong indictment from somebody who cares about the people of Oklahoma and what is going to happen in health care.

Mr. President, I ask unanimous consent to have printed in the RECORD this letter from the State insurance commissioner of Oklahoma.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OKLAHOMA INSURANCE DEPARTMENT,
STATE OF OKLAHOMA,
Oklahoma City, OK, December 1, 2009.

Re Senate Leadership Bill Patient Protection and Affordable Care Act.

Senator TOM COBURN,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR, I appreciate the opportunity to give you an Oklahoma perspective on the latest health care reform measure being considered by the US Senate. As you are well aware, the challenges associated with health care in America are immense. These complex problems require solutions grounded in fact and sound deliberation.

Large numbers of uninsured Oklahomans generate more than $954 million dollars in uncompensated medical care each and every year in our state alone. This cost is shifted to those with insurance. Recent estimates indicate that this adds an additional $2,911 annually to health insurance premiums for an Oklahoma family of four.

As Oklahoma Insurance Commissioner, I strongly support efforts to provide our citizens with high quality health care and affordable health insurance. Many features of the Senate Bill attempt to accomplish this, at least in part, when taken together. However, in the absence of a strong inducement to purchase coverage, the consequences of adverse selection can cause market disruption, higher costs and lower than desired take-up rates.

IMPACT TO OKLAHOMA

(1) Individual Mandate:

The Oklahoma Health Care Authority has estimated that there are nearly 600,000 uninsured working Oklahomans—nearly half between the ages of 19 and 32. There is no indication that most of those uninsured would voluntarily enroll in any health benefit plan.

Our popular Insure Oklahoma individual plan offers comprehensive, guaranteed issue coverage to individuals earning less than 200% of federal poverty level for less than $40 per month, yet we have only 6,000 covered by that plan and most are over age 30. A healthy 25-year-old male in Oklahoma can purchase a comprehensive individual health insurance policy from a major Oklahoma medical insurer for just $1,634 annually. In Oklahoma, affordability is not the issue for this age cohort. Therefore, we support an individual mandate to purchase health insurance that includes a strong inducement to take up health coverage to avoid the likelihood of adverse selection when only the older and healthier are motivated to enroll.

The Senate Leadership bill includes a minor penalty for non-enrollment scheduled to be phased in over a three year period beginning in 2014. The penalty is $95 the first year, increasing to $750 in year three. This penalty is inadequate to induce a large-scale take up of health coverage among Oklahoma's uninsured. Even with generous premium credits, the absence of a strong non-compliance penalty will not encourage the desired and necessary take-up among the young and healthy to offset the greater risk and cost of the older and unhealthier.

(2) Guarantee Issue:

The Senate Leadership bill would require insurers to offer individual plans on a guaranteed issue basis without pre-existing condition limitations. We support guaranteed coverage when accompanied by a mandate to purchase coverage that is strongly enforced. The absence of a meaningful penalty for non-enrollment will likely result in those with chronic or serious health issues purchasing coverage while younger healthier individuals simply choose to pay the nominal penalty. The result will be higher insurance rates due to a higher percentage of insured being higher risk/expense individuals.

(3) Qualified Health Benefit Plans (QHBP):

The Senate Leadership bill would establish ''Qualified Health Benefit Plans'' and require all individual/family plans to conform to QHBP standards by 2014. While the minimum coverage requirements are suitable for some, they restrict individual choice and limit the ability of healthy and/or wealthier individuals from self-insuring part of their risk.

(4) Rating Standards:

The Senate Leadership bill would restrict the use of risk factors in determining rates to geographic area, smoking and age and would limit age bands to a 3:1 ratio. The age band restriction will shift the cost of the older individual to the younger individual. Blue Cross estimates that this factor alone will increase the base cost for a healthy 25-year-old by 44 percent in Oklahoma. This higher cost burden on the young will further discourage coverage take-up and drive up costs to the remaining insured's.

(4) Employer Penalties:

The Senate Leadership bill would impose a penalty on employers who do not offer coverage equal to $750 for any employee who purchases coverage through a state exchange. This penalty is inadequate to induce an employer to establish a plan. Most employers who do not offer coverage have fewer than 50 employees (only 37 percent of Oklahoma small businesses offer coverage compared to 48 percent nationally) and most uninsured Oklahomans work for small businesses. This nominal penalty creates a potential incentive for certain small employers who currently offer coverage to employees to drop their plan and simply incur the penalty at less expense than the cost of a plan—particularly once the small employer tax credits sunset.

(5) State-Based Health Insurance Exchanges:

The Senate Leadership bill would require the formation of state-based exchanges from which individual coverage would be solely available and small group insurance may be purchased. While we support the state-based exchange concept and are currently in the planning stages for a similar concept here in Oklahoma, the infrastructure costs have been estimated in the millions of dollars. In the absence of a financial grant, current state budget limitations will preclude Oklahoma from making the necessary investment to create the exchange.

(6) Public Health Insurance Option:

The Senate Leadership bill would allow for a federal ''Public Health Insurance Option'' from which states may opt-out. Oklahoma would likely resist participation as long as the private insurance market remains robust and competitive. Although the bill provides that the federal government would ''negotiate'' provider rates, experience with Medicare and Medicaid suggests that reimbursement rates for a federal public option would result in low reimbursement rates.

Currently, our medical provider community relies on private pay to make up the difference in cost of services over government reimbursement rates resulting in higher private insurance rates—more cost-shift. In addition, we have concerns over the potential for government to assert an unfair advantage that would adversely affect our insurance markets and further stress our health care delivery system.

(7) Health Insurance Cooperatives (Co-Ops):

The Senate Leadership bill would provide funding to establish non-profit health insurance ''co-ops,'' We question the likelihood that this notion will produce a lower cost option while meeting all requirements stipulated in the bill (specifically, benefit and solvency requirements). Some of the principles embodied in this idea already exist. For example, Oklahoma's largest health insurer, with nearly 30% of the Oklahoma health insurance marketplace, is a mutual company owned by policyholders for the benefit of policyholders.

(8) Premium Credits:

The Senate Leadership bill would provide ''Premium Credits'' for individuals with incomes up to 400% of FPL. The majority (approximately 65%) of Oklahoma's uninsured population have incomes less than 250% of FPL. Currently, 74% of Oklahoma's total population has incomes of 400% of FPL or less.

(9) Medicaid Eligibility Expansion:

The Senate Leadership bill would increase eligibility requirements for Medicaid. Recently, the Oklahoma State Coverage Initiative (SCI) process reached consensus and recommended that Medicaid be extended to adults with incomes up to 100% of FPL. The Senate Leadership bill would expand eligibility to all non-elderly persons with incomes up to 133% of FPL. This would increase Medicaid rolls by an estimated 285,000 adults and the state's annual cost share by $116 million. This rough estimate is based on current Medicaid experience and does not include working-aged individuals who have not accessed reasonable and timely medical care due to an inability to pay. Our concern is that the cost of this expansion for the state is severely underestimated.

(10) Long-Term Care:

The Senate Leadership bill would provide for a federal, voluntary long-term care insurance plan. This plan appears to directly compete with the private insurance market based on reasons other than need.

(11) Anti-Trust Exemption:

The Senate Leadership bill would leave in place the anti-trust exemption established by the McCarren-Ferguson Act. We support such a decision. This exemption has long provided for a more competitive insurance marketplace and has facilitated solvency among carriers.

(12) Controlling Cost:

As mentioned in the opening of this letter, coverage is essential to increasing access to affordable health care. However, this bill does very little to address rapidly increasing health care costs. Data shows that the number one driver in health insurance premium costs are increased medical costs and utilization. As you know, on average, between $0.80 and $0.90 of every premium dollar for a comprehensive health plan is spent directly on benefits to policyholders.

In Oklahoma, we are studying the issue of rising costs as it relates specifically to our non-profit self-insured state plan. Medical costs for the Oklahoma State Employee and Education Group Insurance plan have increased an average of 10% annually in recent years.

Of concern to us are reports from the CBO and others that the Senate reform plan will reduce premium costs. In actuality, we believe premium costs will rise substantially if adverse selection is allowed to occur and if the cost of medical care is not addressed. While the generous premium subsidies contemplated by the bill will indeed reduce an individual's expense in financing their health care needs (a strategy we agree is necessary to ensure affordability), health insurance premiums will not be lower.

Again, I thank you for the opportunity to provide this perspective and I hope that you have found it helpful. If you wish to further discuss this matter, please do not hesitate to contact me at anytime.

Sincerely,

KIM HOLLAND,
Commissioner.

Mr. COBURN. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent to call up my amendment No. 2942.

I see the Senator from Arkansas is standing. I thought I was supposed to offer my amendment first. Is the Senator from Arkansas supposed to go first?

Mr. PRYOR. I believe the sequence was that I would go first.

Mr. GREGG. I will reserve.

The PRESIDING OFFICER. The Senator from Arkansas.

AMENDMENT NO. 2939 TO AMENDMENT NO. 2786

Mr. PRYOR. Mr. President, I call up amendment No. 2939.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Arkansas [Mr. PRYOR] proposes an amendment numbered 2939 to amendment No. 2786.

Mr. PRYOR. I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require the Secretary to provide information regarding enrollee satisfaction with qualified health plans offered through an Exchange through the Internet portal)

On page 134, between lines 10 and 11, insert the following:

(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

Mr. GREGG. Mr. President, I ask unanimous consent that the amendment of the Senator from Arkansas be set aside so I may call up my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2942 TO AMENDMENT NO. 2786

Mr. GREGG. Mr. President, I call up amendment No. 2942.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from New Hampshire [Mr. GREGG], for himself, and Mr. CORKER, Mr. THUNE, Mr. COBURN, Mr. ENSIGN, Mr. ISAKSON, Mr. BURR, Mr. ENZI, Mr. ALEXANDER, Mr. BARRASSO, Mr. CORNYN, Mr. MCCAIN, and Mr. LEMIEUX, proposes an amendment numbered 2942 to Amendment No. 2786.

Mr. GREGG. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To prevent Medicare from being raided for new entitlements and to use Medicare savings to save Medicare)

At the appropriate place, insert the following:

SEC. _____. PREVENTING THE IMPLEMENTATION OF NEW ENTITLEMENTS THAT WOULD RAID MEDICARE.

(a) BAN ON NEW SPENDING TAKING EFFECT.—

(1) PURPOSE.—The purpose of this section is to require that savings resulting from this Act must fully offset the increase in Federal spending and reductions in revenues resulting from this Act before any such Federal spending increases or revenue reductions can occur.

(2) IN GENERAL.—Notwithstanding any other provision of this Act, the Secretary of the Treasury and the Secretary of Health and Human Services are prohibited from implementing the provisions of, and amendments made by, sections 1401, 1402, 2001, and 2101, or any other spending increase or revenue reduction provision in this Act until both the Director of the Office of Management and Budget (referred to in this section as ''OMB'') and the Chief Actuary of the Centers for Medicare and Medicaid Services Office of the Actuary (referred to in this section as '' CMS OACT'') each certify that they project that all of the projected Federal spending increases and revenue reductions resulting from this Act will be offset by projected savings from this Act.

(3) CALCULATIONS.—For purposes of this section, projected savings shall exclude any projected savings or other offsets directly resulting from changes to Medicare and Social Security made by this Act.

(b) LIMIT ON FUTURE SPENDING.—On September 1 of each year (beginning with 2013), the CMS OACT and the OMB shall each issue an annual report that—

(1) certifies whether all of the projected Federal spending increases and revenue reductions resulting from this Act, starting with the next fiscal year and for the following 9 fiscal years, are fully offset by projected savings resulting from this Act (as calculated under subsection (a)); and

(2) provides detailed estimates of such spending increases, revenue reductions, and savings, year by year, program by program and provision by provision.

Mr. PRYOR. Mr. President, I ask unanimous consent that no further amendments or motions be in order today.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, this issue of health care and health care reform has been an issue that has caused a great deal of advertising and claims on television from both sides, back and forth. A substantial amount of the advertising we have seen has been totally and completely without foundation—completely inaccurate. But, nonetheless, political dialogue in this country allows one to say whatever one wishes, so the very aggressive discussion about this issue of health care has taken on interesting tones—claims by some that Congress is working to undermine the Medicare Program.

The fact is, those of us on this side of the aisle are the ones who created the Medicare Program, at a time when most senior citizens had no health insurance at all. There were no insurance companies in this country tracking down senior citizens and saying: Do you mind if we sell you a policy for health care? At a time when people's lives were going to need an increasing claim on health care benefits, were insurance companies tracking them down and saying: Can I do business with you? Of course they weren't. Over half the American people had no access to health insurance. Folks reaching the end of their lives, retired, would lay their head down on their pillow at night and wonder if tomorrow would be

Exhibit 26

1/4/10 USA TODAY 8A
2010 WLNR 148256
Loaded Date: 01/04/2010

USA Today (USA)

January 4, 2010

Section: NEWS

Don ' t trust states to create health care exchanges

If you have a potentially costly ailment, or if you own a small business, or if you just want to change jobs without worrying about losing your health insurance, one key aspect of the health care bills now working their way through Congress could be a godsend. It's the promise that you could buy medical insurance at a reasonable price through "exchanges," where policies would be sold.

But in neither the House bill nor the Senate bill would they go into effect any time soon. In the Senate version, Americans would have to wait until 2014. Meanwhile, there would be some interim benefits, such as subsidies to provide coverage to people deemed too high a risk to get it currently, tax credits to small businesses that insure their workers, and a ban on the cancellation of existing policies for reasons other than fraud. But these measures are stopgap in nature. It is the exchanges that would provide people with reliability and peace of mind.

In part, the delay is a deplorable budgetary gimmick designed to lowball the bill's cost over the next 10 years. (Republicans did the same thing when they created a new Medicare drug benefit in 2003.)

But the delay in the Senate is also due to needless complexity. While the House would create a single national health care exchange, with an opt-out provision for states that have the ability and the desire to create their own exchanges, the Senate would have each of the 50 states creating its own exchange. The federal government would jump in if and when a state failed to act.

Not only would the 50-state approach add a year of delay, it would invite problems.

Start with the small population and lack of competition among insurers in some states. According to the American Medical Association, a number of them, including Alabama, Arkansas, Iowa, Maine, Montana and Rhode Island, have one dominant insurance carrier, a situation that could limit competition in a statewide exchange.

Creating further headaches is the game of political chicken that would surely arise from trying to get all 50

states to act. Some state officials hostile to reform are already trying to block implementation. If they are required to enact laws to create an exchange in their state, it's all but certain they would stall.

In theory the federal government would create its own exchange, which would be available to residents of states that fail to act. But it is unclear when Washington would get to work creating this exchange. Nor is there a compelling rationale for having Washington's first action upon the passage of landmark legislation be to sit back and wait for states to act, or not act.

States have a long history of regulating insurers of all kinds. And for that reason, some say they are better positioned than the federal government to manage exchanges. In fact, states do have considerable experience, but their record has been mixed. To look at a state like Florida, for instance, it's hard to see what would be gained by bringing its political apparatus into decision-making about health care. The state government has all but taken over the homeowners' insurance business after a string of hurricanes prompted private insurers to raise their rates. The state charges rates that are politically convenient rather than actuarially sound, and its undercapitalized catastrophe fund is a Washington bailout waiting to happen.

Here's a better idea: If there's going to be health care reform, do it right and move on. Don't fill it with gimmicks and stalling tactics that serve only to hide costs and provide new opportunities for polarizing political theatrics by the losing side. Doing it right begins with making insurance available in the most efficient, practical way: a national exchange.

---- INDEX REFERENCES ---

COMPANY: AMERICAN MEDICAL ASSOCIATION

NEWS SUBJECT: (Government (1GO80))

INDUSTRY: (U.S. National Healthcare Reform (1US09); Healthcare Cost-Benefits (1HE10); Healthcare (1HE06); Healthcare Regulatory (1HE04); Healthcare Economics (1HE56))

REGION: (North America (1NO39); Americas (1AM92); USA (1US73))

Language: EN

OTHER INDEXING: (AMERICAN MEDICAL ASSOCIATION; REPUBLICANS; SENATE) (Montana; Start)

KEYWORDS: (Debate)

Word Count: 746
1/4/10 USATD 8A
END OF DOCUMENT

Exhibit 27

TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATON ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT"

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

March 21, 2010
JCX-18-10

C. Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan (secs. 1401, 1411, and 1412[20] of the Senate amendment and new sec. 36B of the Code)

Present Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through State Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the Code.

Health coverage tax credit

Certain individuals are eligible for the health coverage tax credit ("HCTC"). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The HCTC is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

COBRA continuation coverage premium reduction

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA")[21] requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

---

[20] Sections 1401, 1411 and 1412 of the Senate amendment, as amended by sections 10104, 10105, 10107, are further amended by section 1001 of the Reconciliation bill.

[21] Pub. L. No. 99-272.

Section 3001 of the American Recovery and Reinvestment Act of 2009,[22] as amended by the Department of Defense Appropriations Act, 2010,[23] and the Temporary Extension Act of 2010[24] provides that, for a period not exceeding 15 months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct).[25] In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending March 31, 2010.

The COBRA continuation coverage subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the subsidy. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the COBRA continuation coverage subsidy. Taxpayers with modified adjusted gross income exceeding $145,000 (or $290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income

[22] Pub. L. No. 111-5.

[23] Pub. L. No. 111-118.

[24] Pub. L. No. 111-144.

[25] TEA expanded eligibility for the COBRA subsidy to include individuals who experience a loss of coverage on account of a reduction in hours of employment followed by the involuntary termination of employment of the covered employee. For an individual entitled to COBRA because of a reduction in hours and who is then subsequently involuntarily terminated from employment, the termination is considered a qualifying event for purposes of the COBRA subsidy, as long as the termination occurs during the period beginning on the date following TEA's date of enactment and ending on March 31, 2010.

tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Explanation of Provision

Premium assistance credit

The provision creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an exchange.[26] The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an exchange.

Under the provision, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income and the Treasury pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan.[27] Individuals who fail to pay all or part of the remaining premium amount are given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. For employed individuals who purchase health insurance through a State exchange, the premium payments are made through payroll deductions. Initial eligibility for the premium assistance credit is based on the individual's income for the tax year ending two years prior to the enrollment period. Individuals (or couples) who experience a change in marital status or other household circumstance, experience a decrease in income of more than 20 percent, or receive unemployment insurance, may update eligibility information or request a redetermination of their tax credit eligibility.

The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level ("FPL") for the family size involved who do not received health insurance through an employer or a spouse's employer.[28] Household income is defined as the sum of: (1) the taxpayer's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer's family size (but only if such individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as

---

[26] Individuals enrolled in multi-state plans, pursuant to section 1334 of the Senate amendment, are also eligible for the credit.

[27] Although the credit is generally payable in advance directly to the insurer, individuals may elect to purchase health insurance out-of-pocket and apply to the IRS for the credit at the end of the taxable year. The amount of the reduction in premium is required to be included with each bill sent to the individual.

[28] Individuals who are lawfully present in the United States but are not eligible for Medicaid because of their immigration status are treated as having a household income equal to 100 percent of FPL (and thus eligible for the premium assistance credit) as long as their household income does not actually exceed 100 percent of FPL.

adjusted gross income increased by: (1) the amount (if any) normally excluded by section 911 (the exclusion from gross income for citizens or residents living abroad), plus (2) any tax-exempt interest received or accrued during the tax year. To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section 7703) must file a joint return. Individuals who are listed as dependants on a return are ineligible for the premium assistance credit.

As described in Table 1 below, premium assistance credits are available on a sliding scale basis for individuals and families with household incomes between 100 and 400 percent of FPL to help offset the cost of private health insurance premiums. The premium assistance credit amount is determined by the Secretary of HHS based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL for the family size involved to 9.5 percent of income for those at 400 percent of FPL for the family size involved. Beginning in 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year (in order to hold steady the share of premiums that enrollees at a given poverty level pay over time). Beginning in 2018, if the aggregate amount of premium assistance credits and cost-sharing reductions[29] exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year. For purposes of calculating household size, individuals who are in the country illegally are not included. Individuals who are listed as dependants on a return are ineligible for the premium assistance credit.

Premium assistance credits, or any amounts that are attributable to them, cannot be used to pay for abortions for which federal funding is prohibited. Premium assistance credits are not available for months in which an individual has a free choice voucher (as defined in section 10108 of the Senate amendment).

The low income premium credit phase-out

The premium assistance credit increases, on a sliding scale in a linear manner, as shown in the table below.

[29] As described in section 1402 of the Senate amendment.

Household Income (expressed as a percent of poverty line)	Initial Premium (percentage)	Final Premium (percentage)
100% through 133%	2.0	3.0
133% through 150%	3.0	4.0
150% through 200%	4.0	6.3
200% through 250%	6.3	8.05
250% through 300%	8.05	9.5
300% through 400%	9.5	9.5

The premium assistance credit amount is tied to the cost of the second lowest-cost silver plan (adjusted for age) which: (1) is in the rating area where the individual resides, (2) is offered through an exchange in the area in which the individual resides, and (3) provides self-only coverage in the case of an individual who purchases self-only coverage, or family coverage in the case of any other individual. If the plan in which the individual enrolls offers benefits in addition to essential health benefits,[30] even if the State in which the individual resides requires such additional benefits, the portion of the premium that is allocable to those additional benefits is disregarded in determining the premium assistance credit amount.[31] Premium assistance credits may be used for any plan purchased through an exchange, including bronze, silver, gold and platinum level plans and, for those eligible,[32] catastrophic plans.

[30] As defined in section 1302(b) of the Senate amendment.

[31] A similar rule applies to additional benefits that are offered in multi-State plans, under section 1334 of the Senate amendment.

[32] Those eligible to purchase catastrophic plans either must have not reached the age of 30 before the beginning of the plan year, or have certification or an affordability or hardship exemption from the individual responsibility payment, as described in new sections 5000A(e)(1) and 5000A(e)(5), respectively.

Minimum essential coverage and employer offer of health insurance coverage

Generally, if an employee is offered minimum essential coverage[33] in the group market, including employer-provided health insurance coverage, the individual is ineligible for the premium tax credit for health insurance purchased through a State exchange.

If an employee is offered unaffordable coverage by his or her employer or the plan's share of provided benefits is less than 60 percent, the employee can be eligible for the premium tax credit, but only if the employee declines to enroll in the coverage and satisfies the conditions for receiving a tax credit through an exchange. Unaffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee's household income, based on the type of coverage applicable (e.g., individual or family coverage).[34] The percentage of income that is considered unaffordable is indexed in the same manner as the percentage of income is indexed for purposes of determining eligibility for the credit (as discussed above). The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employees receiving a premium tax credit.

No later than five years after the date of the enactment of the provision the Comptroller General must conduct a study of whether the percentage of household income used for purposes of determining whether coverage is affordable is the appropriate level, and whether such level can be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided health coverage. The Secretary reports the results of such study to the appropriate committees of Congress, including any recommendations for legislative changes.

Procedures for determining eligibility

For purposes of the premium assistance credit, exchange participants must provide information from their tax return from two years prior during the open enrollment period for coverage during the next calendar year. For example, if an individual applies for a premium assistance credit for 2014, the individual must provide a tax return from 2012 during the 2103 open enrollment period. The Internal Revenue Service ("IRS") is authorized to disclose to HHS limited tax return information to verify a taxpayer's income based on the most recent return information available to establish eligibility for the premium tax credit. Existing privacy and safeguard requirements apply. Individuals who do not qualify for the premium tax credit on the basis of their prior year income may apply for the premium tax credit based on specified changes in circumstances. For individuals and families who did not file a tax return in the prior tax year, the Secretary of HHS will establish alternative income documentation that may be provided to determine income eligibility for the premium tax credit.

The Secretary of HHS must establish a program for determining whether or not individuals are eligible to: (1) enroll in an exchange-offered health plan; (2) claim a premium

[33] As defined in section 5000A(f) of the Senate amendment.

[34] The 9.5 percent amount is indexed for calendar years beginning after 2014.

assistance credit; and (3) establish that their coverage under an employer-sponsored plan is unaffordable. The program must provide for the following: (1) the details of an individual's application process; (2) the details of how public entities are to make determinations of individuals' eligibility; (3) procedures for deeming individuals to be eligible; and, (4) procedures for allowing individuals with limited English proficiency to have proper access to exchanges.

In applying for enrollment in an exchange-offered health plan, an individual applicant is required to provide individually identifiable information, including name, address, date of birth, and citizenship or immigration status. In the case of an individual claiming a premium assistance credit, the individual is required to submit to the exchange income and family size information and information regarding changes in marital or family status or income. Personal information provided to the exchange is submitted to the Secretary of HHS. In turn, the Secretary of HHS submits the applicable information to the Social Security Commissioner, Homeland Security Secretary, and Treasury Secretary for verification purposes. The Secretary of HHS is notified of the results following verification, and notifies the exchange of such results. The provision specifies actions to be undertaken if inconsistencies are found. The Secretary of HHS, in consultation with the Social Security Commissioner, the Secretary of Homeland Security, and the Treasury Secretary must establish procedures for appealing determinations resulting from the verification process, and redetermining eligibility on a periodic basis.

An employer must be notified if one of its employees is determined to be eligible for a premium assistance credit because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable. The notice must include information about the employer's potential liability for payments under section 4980H and that terminating or discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.[35] An employer is generally not entitled to information about its employees who qualify for the premium assistance credit. Employers may, however, be notified of the name of the employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

Personal information submitted for verification may be used only to the extent necessary for verification purposes and may not be disclosed to anyone not identified in this provision. Any person, who submits false information due to negligence or disregard of any rule, and without reasonable cause, is subject to a civil penalty of not more than $25,000. Any person who intentionally provides false information will be fined not more than $250,000. Any person who knowingly and willfully uses or discloses confidential applicant information will be fined not more than $25,000. Any fines imposed by this provision may not be collected through a lien or levy against property, and the section does not impose any criminal liability.

The provision requires the Secretary of HHS, in consultation with the Secretaries of the Treasury and Labor, to conduct a study to ensure that the procedures necessary to administer the determination of individuals' eligibility to participate in an exchange, to receive premium

[35] Pub. L. No. 75-718.

assistance credits, and to obtain an individual responsibility exemption, adequately protect employees' rights of privacy and employers' rights to due process. The results of the study must be reported by January 1, 2013, to the appropriate committees of Congress.

Reconciliation

If the premium assistance received through an advance payment exceeds the amount of credit to which the taxpayer is entitled, the excess advance payment is treated as an increase in tax. For persons whose household income is below 400% of the FPL, the amount of the increase in tax is limited to $400. If the premium assistance received through an advance payment is less than the amount of the credit to which the taxpayer is entitled, the shortfall is treated as a reduction in tax.

The eligibility for and amount of premium assistance is determined in advance of the coverage year, on the basis of household income and family size from two years prior, and the monthly premiums for qualified health plans in the individual market in which the taxpayer, spouse and any dependent enroll in an exchange. Any advance premium assistance is paid during the year for which coverage is provided by the exchange. In the subsequent year, the amount of advance premium assistance is required to be reconciled with the allowable refundable credit for the year of coverage. Generally, this would be accomplished on the tax return filed for the year of coverage, based on that year's actual household income, family size, and premiums. Any adjustment to tax resulting from the difference between the advance premium assistance and the allowable refundable tax credit would be assessed as additional tax or a reduction in tax on the tax return.

Separately, the provision requires that the exchange, or any person with whom it contracts to administer the insurance program, must report to the Secretary with respect to any taxpayer's participation in the health plan offered by the Exchange. The information to be reported is information necessary to determine whether a person has received excess advance payments, identifying information about the taxpayer (such as name, taxpayer identification number, months of coverage) and any other person covered by that policy; the level of coverage purchased by the taxpayer; the total premium charged for the coverage, as well as the aggregate advance payments credited to that taxpayer; and information provided to the Exchange for the purpose of establishing eligibility for the program, including changes of circumstances of the taxpayer since first purchasing the coverage. Finally, the party submitting the report must provide a copy to the taxpayer whose information is the subject of the report.

Effective Date

The provision is effective for taxable years ending after December 31, 2013.

D. Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans (secs. 1402, 1411, and 1412 of the Senate amendment[36])

Present Law

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through State Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the Code.

Health coverage tax credit

Certain individuals are eligible for the HCTC. The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The HCTC is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

COBRA continuation coverage premium reduction

COBRA[37] requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

---

[36] Sections 1401, 1411 and 1412 of the Senate amendment, as amended by section 10104, is further amended by section 1001 of the Reconciliation bill.

[37] Pub. L. No. 99-272.

Section 3001 of the American Recovery and Reinvestment Act of 2009,[38] as amended by the Department of Defense Appropriations Act, 2010,[39] and the Temporary Extension Act of 2010[40] provides that, for a period not exceeding 15 months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct).[41] In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending March 31, 2010.

The COBRA continuation coverage subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the subsidy. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the COBRA continuation coverage subsidy. Taxpayers with modified adjusted gross income exceeding $145,000 (or $290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income

[38] Pub. L. No. 111-5.

[39] Pub. L. No. 111-118.

[40] Pub. L. No. 111-144.

[41] TEA expanded eligibility for the COBRA subsidy to include individuals who experience a loss of coverage on account of a reduction in hours of employment followed by the involuntary termination of employment of the covered employee. For an individual entitled to COBRA because of a reduction in hours and who is then subsequently involuntarily terminated from employment, the termination is considered a qualifying event for purposes of the COBRA subsidy, as long as the termination occurs during the period beginning on the date following TEA's date of enactment and ending on March 31, 2010.

tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Explanation of Provision

Cost-sharing subsidy

A cost-sharing subsidy is provided to reduce annual out-of-pocket cost-sharing for individuals and households between 100 and 400 of percent FPL (for the family size involved). The reductions are made in reference to the dollar cap on annual deductibles for high deductable health plans in section 223(c)(2)(A)(ii) (currently $5,000 for self-only coverage and $10,000 for family coverage). For individuals with household income of more than 100 but not more than 200 percent of FPL, the out-of-pocket limit is reduced by two-thirds. For those between 201 and 300 percent of FPL by one-half, and for those between 301 and 400 percent of FPL by one-third.

The cost-sharing subsidy that is provided must buy out any difference in cost-sharing between the qualified health insurance purchased and the actuarial values specified below. For individuals between 100 and 150 percent of FPL (for the family size involved), the subsidy must bring the value of the plan to not more than 94 percent actuarial value. For those between 150 and 200 percent of FPL, the subsidy must bring the value of the plan to not more than 87 percent actuarial value. For those between 201 and 250 percent of FPL, the subsidy must bring the value of the plan to not more than 73 percent actuarial value. For those between 251 and 400 percent of FPL, the subsidy must bring the value of the plan to not more than 70 percent actuarial value. The determination of cost-sharing subsidies will be made based on data from the same taxable year as is used for determining advance credits under section 1412 of the Senate amendment (and not the taxable year used for determining premium assistance credits under section 36B). The amount received by an insurer as a cost-sharing subsidy on behalf of an individual, as well as any out-of-pocket spending by the individual, counts towards the out-of-pocket limit. Individuals enrolled in multi-state plans, pursuant to section 1334 of the Senate amendment, are eligible for the subsidy.

In addition to adjusting actuarial values, plans must further reduce cost-sharing for low-income individuals as specified below. For individuals between 100 and 150 percent of FPL (for the family size involved) the plan's share of the total allowed cost of benefits provided under the plan must be 94 percent. For those between 151 and 200 percent of FPL, the plan's share must be 87 percent, and for those between 201 and 250 percent of FPL the plan's share must be 73 percent.

The cost-sharing subsidy is available only for those months in which an individual receives an affordability credit under new section 36B.[42]

As with the premium assistance credit, if the plan in which the individual enrolls offers benefits in addition to essential health benefits,[43] even if the State in which the individual resides

[42] Section 1401 of the Senate amendment.

requires such additional benefits, the reduction in cost-sharing does not apply to the additional benefits. In addition, individuals enrolled in both a qualified health plan and a pediatric dental plan may not receive a cost-sharing subsidy for the pediatric dental benefits that are included in the essential health benefits required to be provided by the qualified health plan. Cost-sharing subsidies, and any amounts that are attributable to them, cannot be used to pay for abortions for which federal funding is prohibited.

The Secretary of HHS must establish a program for determining whether individuals are eligible to claim a cost-sharing credit. The program must provide for the following: (1) the details of an individual's application process; (2) the details of how public entities are to make determinations of individuals' eligibility; (3) procedures for deeming individuals to be eligible; and, (4) procedures for allowing individuals with limited English proficiency proper access to exchanges.

In applying for enrollment, an individual claiming a cost-sharing subsidy is required to submit to the exchange income and family size information and information regarding changes in marital or family status or income. Personal information provided to the exchange is submitted to the Secretary of HHS. In turn, the Secretary of HHS submits the applicable information to the Social Security Commissioner, Homeland Security Secretary, and Treasury Secretary for verification purposes. The Secretary of HHS is notified of the results following verification, and notifies the exchange of such results. The provision specifies actions to be undertaken if inconsistencies are found. The Secretary of HHS, in consultation with the Treasury Secretary, Homeland Security Secretary, and Social Security Commissioner, must establish procedures for appealing determinations resulting from the verification process, and redetermining eligibility on a periodic basis.

The Secretary notifies the plan that the individual is eligible and the plan reduces the cost-sharing by reducing the out-of-pocket limit under the provision. The plan notifies the Secretary of cost-sharing reductions and the Secretary makes periodic and timely payments to the plan equal to the value of the reductions in cost-sharing. The provision authorizes the Secretary to establish a capitated payment system with appropriate risk adjustments.

An employer must be notified if one of its employees is determined to be eligible for a cost-sharing subsidy. The notice must include information about the employer's potential liability for payments under section 4980H and explicit notice that hiring, terminating, or otherwise discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.[44] An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or the cost-sharing subsidy. Employers may, however, be notified of the name of an employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

---

[43] As defined in section 1302(b) of the Senate amendment.

[44] Pub. Law No. 75-718.

The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employee receiving a cost-sharing subsidy.

The provision implements special rules for Indians (as defined by the Indian Health Care Improvement Act) and undocumented aliens. The provision prohibits cost-sharing reductions for individuals who are not lawfully present in the United States, and such individuals are not taken into account in determining the family size involved.

The provision defines any term used in this section that is also used by section 36B as having the same meaning as defined by the latter. The provision also denies subsidies to dependents, with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which the individual's taxable year begins. Further, the provision does not permit a subsidy for any month that is not treated as a coverage month.

Effective Date

The provision is effective on date of enactment.

Exhibit 28

The result was announced—yeas 57, nays 42, as follows:

[Rollcall Vote No. 391 Leg.]

YEAS—57

Akaka	Gillibrand	Murray
Baucus	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bingaman	Inouye	Pryor
Boxer	Johnson	Reed
Brown	Kaufman	Reid
Burris	Kerry	Rockefeller
Byrd	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Shaheen
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Conrad	Leahy	Tester
Dodd	Levin	Udall (CO)
Dorgan	Lieberman	Udall (NM)
Durbin	Lincoln	Warner
Feingold	Menendez	Webb
Feinstein	Merkley	Whitehouse
Franken	Mikulski	Wyden

NAYS—42

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bayh	Ensign	McCaskill
Bennet	Enzi	McConnell
Bennett	Graham	Murkowski
Bond	Grassley	Risch
Brownback	Gregg	Roberts
Burr	Hatch	Sessions
Chambliss	Hutchison	Shelby
Coburn	Inhofe	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Bunning

The motion was agreed to.

Mr. REID. I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

HUTCHISON POINT OF ORDER

The PRESIDING OFFICER. There is now 2 minutes, equally divided, prior to a vote on the constitutional point of order made by the Senator from Texas, Mrs. HUTCHISON.

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, the 10th amendment says:

The powers not delegated to the United States by the Constitution . . . are reserved to the States. . . .

In this bill, a State such as Texas and many other States that have taken full responsibility for insurance plans for their employees and teachers will have to justify any change in those terms to the Federal Government.

The majority claims the commerce clause gives them the power to do what is in this bill. But what they fail to mention is the power to regulate interstate commerce has not been the basis for a robust role in insurance regulation.

This is an encroachment of the Federal Government into a role left to the States in the Constitution. The 10th amendment is being eroded by an activist Congress, and it is time to stop it now.

I urge a vote to uphold this point of order.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the bill before us is clearly an appropriate exercise of the commerce clause. We further believe Congress has power to enact this legislation pursuant to the taxing and spending powers. This bill does not violate the 10th amendment because it is an appropriate exercise of powers delegated to the United States, and because our bill fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges fully within the provisions as interpreted by the Supreme Court of the 10th amendment.

I urge my colleagues to vote against the point of order.

The PRESIDING OFFICER. The question is on the constitutional point of order made by the Senator from Texas, Mrs. HUTCHISON, that the amendment violates the 10th amendment.

The question is, Is the point of order well taken?

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 60, as follows:

[Rollcall Vote No. 392 Leg.]

YEAS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker

NAYS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NOT VOTING—1

Bunning

The PRESIDING OFFICER. The point of order is not agreed to.

The Senator from South Carolina.

Mr. DEMINT. Mr. President, since I have not used or yielded 10 minutes, I ask to be recognized for up to 10 minutes under rule XXII, paragraph 2.

The PRESIDING OFFICER. The Senator has that right.

The Senator from South Carolina.

DEMINT MOTION TO SUSPEND

Mr. DEMINT. Mr. President, in just a moment I will move to suspend the rules for the purpose of offering an amendment that would ban the practice of trading earmarks for votes.

While I want to be careful not to suggest wrongdoing by any Member, there has been growing public concern that earmarks were used to buy votes for this legislation. It has been argued by some that this practice is acceptable because it is necessary to get things done in the Senate. I reject that argument, and I urge my colleagues to put an end to business as usual here in the Senate.

The House of Representatives has a rule prohibiting the use of earmarks to buy votes for legislation. If we were in the House considering this bill, vote trading would be a direct violation of the ethics rules. Unfortunately, a vote-trading rule does not exist in the Senate.

During the debate on the lobbying and ethics reform bill in the 110th Congress, the senior Senator from Illinois, Mr. DURBIN, and I offered an earmark reform amendment which contained the following language:

A Member may not condition the inclusion of language to provide funding for a congressional earmark . . . on any vote cast by another Member.

The Durbin-DeMint amendment was written to mirror Speaker PELOSI's earmark reforms in the House. The Durbin-DeMint amendment passed the Senate by a vote of 98 to 0 and was included in S. 1, the Honest Leadership and Open Government Act, which passed the Senate by a vote of 96 to 2.

The rule against trading votes for earmarks was in the bill when it left the Senate, but then the bill moved to a closed-door negotiation. Somehow, at some point in those closed-door negotiations, someone dropped the earmark-for-vote language. I have no idea who it was, and we may never know. Remember, this bill was called the Honest Leadership and Open Government Act. In any case, the vote-trading rule was dropped from the bill, which then passed the Senate and was signed by the President.

Just to confirm all of this, I wish to make a parliamentary inquiry to the Chair. Is the Chair aware of any prohibition in the Standing Rules of the Senate such as the previously referenced rule contained in the Durbin-DeMint amendment or in the Rules of the House of Representatives?

The PRESIDING OFFICER. No such rule exists in the Senate.

Mr. DEMINT. No such rule exists.

I have an amendment which would correct this error. It mirrors the Durbin-DeMint language which passed the Senate 98 to 0, and I will read the relevant parts. I quote:

It shall not be in order in the Senate to consider a congressionally directed spending

Exhibit 29

U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans

Posted on Monday, January 11th, 2010

Doggett, Members of the Texas Democratic Delegation Urge President Obama, House Leadership to Adopt National Health Insurance Exchange

Washington— Today, U.S. Congressman Lloyd Doggett (D-TX-25), a senior Member of the Ways and Means Health Subcommittee, and Members of the Texas Democratic Delegation, urged President Obama, Speaker Pelosi, and Majority Leader Hoyer, to adopt a single, national health insurance exchange, to protect Texans from second-rate care. A state-based plan reduces the market leverage of the exchange, increases complexity, and relies on laggard state leadership that, in Texas, would be unwilling or unable to administer the exchange, leaving millions of Texans no better off. Larger exchanges and stronger regulators are better exchanges with more competition and more protection for consumers. The Members urged adoption of the House's national exchange.

"With 1 in 4 Texans living without insurance, we should not settle for second-rate care. Instead we should ensure access to the lowest cost, highest-quality insurance plans, which means we need a national health insurance exchange," said Rep. Doggett.

Historically in Texas, relying on state authority to provide care for its citizens has proved a treacherous path. As it stands today, not one Texas child has received any benefit from the *Children's Health Insurance Program Reauthorization Act* approved by Congress early last year.

The U.S. House of Representatives and U.S. Senate are currently working to merge their two bills, which will be sent to President Obama's desk for signature.

[The full text of the letter follows below]

A letter was sent to Speaker Pelosi and Majority Leader Hoyer and President Obama.

President Barack Obama

The White House

1600 Pennsylvania Ave NW

Washington, D.C. 20500

Dear Mr. President:

In adjusting the House and Senate versions of health insurance reform legislation, we know you share our goal of achieving reform that is real and meaningful. Any bill that we support must not shortchange Texans by including weak, state-based health insurance exchanges. We cannot support second-rate coverage in our state with the highest rate of uninsured in the country – where 1 in 4 Texans lack insurance and health insurance premiums have increased more than 100% since 2000. In order to ensure that Texans have access to the lowest cost, highest-quality health insurance plans as soon as possible, the bill we pass should include a single, national health insurance exchange, as adopted by the House in the Affordable Health Care for America Act.

The House bill establishes a national insurance exchange, but allows states with the political will and the resources available to establish their own exchanges, as long as the state-based exchange meets the same strong standards as the national health insurance exchange. This approach

protects existing state exchanges and allows innovation, while ensuring that consumers enjoy the same coverage and protections afforded in the national exchange.

As you know, the Senate bill does not establish a national health insurance exchange. Instead, each state is required to set up its own exchange. If the state does not set up the exchange, then the Secretary of Health and Human Services is required to set up an exchange for the state. The states will set up one exchange for individual coverage and another exchange for small businesses. The state may also set up regional exchanges within the state, which would create multiple exchanges in one state.

This approach not only reduces the market leverage of the exchange and increases complexity, but it also relies on states with indifferent state leadership that are unwilling or unable to administer and properly regulate a health insurance marketplace. A number of states opposed to health reform have already expressed an interest in obstruction.

In Texas, we know from experience that the dangers to the uninsured from greater State authority are real. Not one Texas child has yet received any benefit from the Children's Health Insurance Program Reauthorization Act (CHIPRA), which we all championed, since Texas declined to expand eligibility or adopt best practices for enrollment. We also know that when states face difficult budget years, among the first programs to see reductions is Medicaid. The Senate approach would produce the same result — millions of people will be left no better off than before Congress acted. Further, multiple exchanges fracture the market, diluting the risk pooling benefits of the exchange. This will be especially true if the state sets up multiple exchanges. Also, many states currently only have one or two dominant insurers. State-based exchanges will do nothing to bring more insurers into the area. The Senate bill also allows insurance companies to continue offering insurance outside of the exchange. This further weakens the risk pooling effect of the exchanges and creates incentives for adverse selection.

Reforming our nation's health care system is a national effort that requires a national solution, not a piecemeal approach. A single, national health insurance exchange will not only administer federal affordability credits and receive federal start-up funds, but will also be charged with enforcing federal laws and regulations. As the Commonwealth Fund recently reported, a single, national health insurance exchange would ensure uniform, national availability of health insurance plans, better serve consumers, and have the resources to appropriately regulate insurers.

As we work toward the conclusion of the health care bill, please help us ensure that our constituents receive the care they deserve. We are grateful for your leadership in advancing this reform and we stand ready to support your efforts to establish a national health insurance exchange.

Lloyd Doggett	Gene Green
Henry Cuellar	Solomon Ortiz
Sheila Jackson Lee	Ciro Rodriguez
Silvestre Reyes	Eddie Bernice Johnson
Charles Gonzalez	Al Green
Ruben Hinojosa	

Posted in: Harlingen.

← Say no to Valerie Garcia candidate for JP of precinct 5 place 2
FORMER FEDERAL JUROR CHARGED WITH JURY TAMPERING →

5 Comments

1. *The IRS Has Gone Rogue : Sandhu Homes Adult Care* says:
   Thursday, September 27, 2012 at 10:39 am

   [...] could clear both chambers. On January 11, eleven House Democrats from the Texas delegation sent a letter to President Obama, House Speaker Nancy Pelosi (D., Calif.), and House Majority Leader Steny Hoyer [...]

2. *The IRS Has Gone Rogue - ALIPAC* says:
   Saturday, September 29, 2012 at 5:35 am

   [...] [...]

3. *The IRS Has Gone Rogue « Constitutional Free America* says:
   Monday, October 1, 2012 at 2:43 pm

   [...] could clear both chambers. On January 11, eleven House Democrats from the Texas delegation sent a letter to President Obama, House Speaker Nancy Pelosi (D., Calif.), and House Majority Leader Steny Hoyer [...]

4. *OBAMA TURNS IRS LOOSE ON US | PatriotsBillboard* says:
   Sunday, October 7, 2012 at 2:53 am

Exhibit 30

EXECUTIVE COMMITTEE MEETING TO CONSIDER
HEALTH CARE REFORM
WEDNESDAY, SEPTEMBER 23, 2009
U.S. Senate,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:34 a.m., in room 216, Hart Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, and Cornyn.

Also present: Democratic Staff: Russ Sullivan, Staff Director; Bill Dauster, Deputy Staff Director and General Counsel; Liz Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Cathy Koch, Chief Tax Counsel; Andrew Hu, Health Research Assistant; Scott Berkowitz, Fellow; Alan Cohen, Senior Budget Analyst; Tom Klouda, Professional Staff, Social Security; and David Hughes, Senior Business and Accounting Advisor. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; Michael Park, Health Policy Counsel; Chris Condeluci, Tax Benefits Counsel; Mark Hayes, Health Policy Director and Chief Health Counsel; and Randoe Dice, Detailee.

frankly. Frankly from my perspective, the more one looks at it, analyzes it, the more one realizes we need to act in this area.

I do not know exactly what to do, but we need to act. I have seen all kinds of studies to which doctors practice defensive medicine. It is hard to know exactly how much defensive medicine is practiced because all of the surveys are based, they are self-reporting docs and what might be defensive medicine for one doctor might be just more caution by another.

I have seen studies as high as 20 percent of health care costs because of defensive medicine in this country because we do not have tort reform. On the other hand, and I may be wrong in this, the last CBO report I saw on this, as I recall, was about 2/10 of a percent of health care costs according to CBO is due to defensive medicine.

Now, that is a very good debate and we need to have some place to discuss it to try to find the correct answer to it. But unfortunately this committee does not have jurisdiction to address that. We discussed this many times tonight. I think the proper place is on the floor of the Senate. I am sure there will be many amendments on the floor and they will deal with this issue. It will be a good debate.

Senator Ensign. Mr. Chairman, can I ask you a

question?

The Chairman. Sure.

Senator Ensign. If the argument that you are making that basically we do not have the jurisdiction over the committee because we are trying to change laws, you know, state laws basically that would be more the jurisdiction of the Judiciary Committee and we are using Medicaid.

Is this bill, the underlying premise in this bill that for Medicaid laws, we are making states change their laws, their coverage laws? Aren't we doing that? And so why would not most of the coverage rules in this bill, underlying bill, be out of the jurisdiction and only in the jurisdiction of the Help Committee and not in the jurisdiction of this committee?

The Chairman. Well, Medicaid is exclusively the jurisdiction of the Finance Committee. The HELP Committee does not have jurisdiction over Medicaid, for example, even though they legislate in the area to some degree. And frankly --

Senator Ensign. No, but I am talking about changing the rules requiring state laws on coverage.

The Chairman. We are. But that is under Medicaid.

Senator Ensign. No, not just Medicaid. Requiring state laws change laws on a lot of things on coverage.

On certain minimum plans, exchanges. All those coverage things are state laws.

The Chairman. That is true, but the main point is, the main point is that the thrust of your amendment is med mal. This committee does not have jurisdiction on medical malpractice. That is the trust. That is the totality. If you look at the --

Senator Ensign. How do we have jurisdiction over changing state laws on coverage? Outside of Medicare or Medicaid. Outside of Medicaid, how do we have --

The Chairman. There are conditions to participate in the exchange.

Senator Ensign. That is right.

The Chairman. For setting up an exchange.

Senator Ensign. These would be conditions to participate.

The Chairman. And exchange is essentially tax credits. Taxes aren't the jurisdiction of this committee.

Senator Ensign. Medicaid is the jurisdiction of this committee. We gave the hook.

The Chairman. Anyway, I have ruled. I looked at this totally honestly as a whole and we do not have jurisdiction.

Senator Cornyn. Mr. Chairman, may I ask a

West Virginia (WV)

Select the Age you would like to use for Rates	54

# of Rating Areas (Total)	11
# of Rating Areas (Visible)	11

Minimum Catastrophic Rate in State	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
306.16	334.55	395.08	395.08	481.19

State	Rating Area ID	Total # of Issuers	Total # of QHPs	# of Catastrophic QHPs	# of Bronze QHPs	# of Silver QHPs	# of Gold QHPs	# of Platinum QHPs	Lowest Cost Catastrophic QHP	Lowest Cost Bronze QHP	Lowest Cost Silver QHP	2nd Lowest Cost Silver QHP	Lowest Cost Gold QHP
WV	1	1	13	1	3	4	5	0	373.37	408.00	481.81	481.81	586.80
WV	2	1	13	1	3	4	5	0	373.37	408.00	481.81	481.81	586.80
WV	3	1	13	1	3	4	5	0	373.37	408.00	481.81	481.81	586.80
WV	4	1	13	1	3	4	5	0	373.37	408.00	481.81	481.81	586.80
WV	5	1	13	1	3	4	5	0	328.56	359.04	423.99	423.99	516.39
WV	6	1	13	1	3	4	5	0	306.16	334.55	395.08	395.08	481.19
WV	7	1	13	1	3	4	5	0	306.16	334.55	395.08	395.08	481.19
WV	8	1	13	1	3	4	5	0	339.76	371.28	438.44	438.44	533.98
WV	9	1	13	1	3	4	5	0	339.76	371.28	438.44	438.44	533.98
WV	10	1	13	1	3	4	5	0	339.76	371.28	438.44	438.44	533.98
WV	11	1	13	1	3	4	5	0	321.10	350.89	414.36	414.36	504.65

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 13-0623 (PLF)
KATHLEEN SEBELIUS, U.S. Secretary of Health and Human Services, *et al.*,	)	
Defendants.	)	

ORDER

For the reasons set forth in the Opinion issued this same day, it is hereby

ORDERED that the employer plaintiffs are dismissed from this action pursuant to the Anti-Injunction Act, 26 U.S.C. § 7421(a); it is

FURTHER ORDERED that the plaintiffs' motion for summary judgment [Dkt. No. 17] is DENIED; it is

FURTHER ORDERED that the defendants' motion for summary judgment [Dkt. No. 49] is GRANTED. Judgment is entered for the defendants; and it is

FURTHER ORDERED that the Clerk of the Court shall remove this case from the docket of this Court. This is a final appealable order. See FED. R. APP. P. 4(a).

SO ORDERED.

/s/_____
PAUL L. FRIEDMAN
United States District Judge

DATE: January 15, 2014

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*, Plaintiffs, v. KATHLEEN SEBELIUS, U.S. Secretary of Health and Human Services, *et al.*, Defendants.	)	Civil Action No. 13-0623 (PLF)

OPINION

On May 23, 2012, the Internal Revenue Service issued a final rule implementing the premium tax credit provision of the Patient Protection and Affordable Care Act (the "ACA" or "Act"). In its final rule, the IRS interpreted the ACA as authorizing the agency to grant tax credits to certain individuals who purchase insurance on either a state-run health insurance "Exchange" or a federally-facilitated "Exchange." Plaintiffs contend that this interpretation is contrary to the statute, which, they assert, authorizes tax credits only for individuals who purchase insurance on state-run Exchanges. Plaintiffs therefore assert that the rule promulgated by the IRS exceeds the agency's statutory authority and is arbitrary, capricious, and contrary to law, in violation of the Administrative Procedure Act.

This matter is now before the Court on the parties' cross-motions for summary judgment. The Court heard oral argument on the motions on December 3, 2013. After careful consideration of the parties' papers and attached exhibits, the Act and other relevant legal authorities, the regulations promulgated by the IRS, and the oral arguments presented by counsel

in open court, the Court will grant the defendants' motion, deny the plaintiffs' motion, and enter judgment for the defendants.[1]

I. BACKGROUND

A. The Affordable Care Act

On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), with the aim of increasing the number of Americans covered by health insurance and decreasing the cost of health care. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2580 (2012).[2] Under the ACA, most Americans must either obtain "minimum essential" health insurance coverage or pay a tax penalty imposed by the Internal Revenue Service. 26 U.S.C. § 5000A; see Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2580. Uninsured individuals who might otherwise have difficulty obtaining health

[1] The papers reviewed in connection with the pending motions include the following: the complaint ("Compl.") [Dkt. No. 1]; plaintiffs' motion for summary judgment ("Pls.' SJ Mot.") [Dkt. No. 17]; declaration of David Klemencic ("Klemencic Decl."), attached to plaintiffs' opposition to defendants' motion to dismiss [Dkt. No. 24-1]; declaration of Daniel Kessler, J.D., Ph.D. ("Kessler Decl."), attached to plaintiffs' opposition to defendants' motion to dismiss [Dkt. No. 24-2]; defendants' motion for summary judgment and opposition to plaintiffs' summary judgment motion ("Defs.' SJ Mot.") [Dkt. No. 49]; third declaration of Donald B. Moulds, Acting Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services ("Third Moulds Decl."), attached to defendants' motion for summary judgment [Dkt. No. 49-2]; plaintiffs' reply and opposition to defendants' motion for summary judgment ("Pls.' SJ Opp.") [Dkt. No. 57]; defendants' reply ("Defs.' SJ Reply") [Dkt. No. 62]; Brief of *Amicus Curiae* American Hospital Association [Dkt. No. 52]; Brief of *Amicus Curiae* Families USA [Dkt. No. 54]; Brief of *Amicus Curiae* Commonwealth of Virginia [Dkt. No. 60]; Brief of *Amicus Curiae* Jonathan H. Adler and Michael F. Cannon [Dkt. No. 61]; October 21, 2013 Transcript of Oral Argument on Motion for Preliminary Injunction and Motion to Dismiss ("Oct. 21, 2013 Tr.") [Dkt. No. 64]; October 22, 2013 Transcript of Oral Ruling ("Oct. 22, 2013 Tr."); and December 3, 2013 Transcript of Oral Argument on Summary Judgment ("Dec. 3, 2013 Tr.") [Dkt. No. 65].

[2] A week after the Patient Protection and Affordable Care Act was passed, Congress amended the Act through the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010).

insurance are provided certain tools to facilitate the purchase of such insurance. Specifically, the law provides for the establishment of "Exchanges," through which individuals can purchase competitively-priced health insurance. See 42 U.S.C. §§ 18031, 18041. The Act also authorizes a federal tax credit for many low- and middle-income individuals to offset the cost of insurance purchased on these Exchanges. 26 U.S.C. § 36B. Large employers are expected to share the costs of health insurance coverage for their full-time employees, and employers who do not provide affordable health care may be subject to an "assessable payment" or tax. 26 U.S.C. § 4980H.

At issue in this case is whether the ACA allows the IRS to provide tax credits to residents of states that declined to establish their own health insurance Exchanges, that is, in states where the federal government has stepped in and is running the Exchange. Because this dispute necessitates a careful examination of certain features of the ACA – in particular, the Exchanges, the Section 36B tax credits, the minimum insurance requirement for individuals, and the Section 4980H assessment imposed on some employers – these features are described in more detail below.

1. The Exchanges

The ACA provides for the establishment of American Health Benefit Exchanges, or "Exchanges," to facilitate the purchase of health insurance by private individuals and small businesses. See 42 U.S.C. § 18031(b)(1); 42 U.S.C. § 300gg-91(d)(21). The Department of Health and Human Services ("HHS") has described an Exchange as "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality." Centers for Medicare & Medicaid Services, *Initial Guidance to*

States on Exchanges, http://www.hhs.gov/cciio/resources/files/guidance_to_states_on_exchanges.html (visited Jan. 5, 2014); see also H.R. REP. NO. 111-443, pt. II, at 976 (March 17, 2010) (describing an Exchange as "an organized and transparent 'marketplace for the purchase of health insurance' where individuals and employees (phased-in over time) can shop and compare health insurance options") (internal quotation omitted).

Each health insurance plan offered through an Exchange must provide certain minimum benefits, as set forth in regulations promulgated by HHS. 42 U.S.C. §§ 18021(a)(1), 18022. In addition to serving as a marketplace for health insurance, an Exchange can determine an individual's eligibility to obtain an advance payment of a federal premium tax credit and his or her eligibility to be deemed exempt from the individual minimum coverage requirement. See 42 U.S.C. § 18031(d)(4).

Section 1311 of the ACA provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange')[.]" ACA § 1311(b)(1), *codified at* 42 U.S.C. § 18031(b)(1). If, however, a state decides not to establish its own Exchange, or fails to establish an Exchange consistent with federal standards, Section 1321 of the Act directs HHS to step in and establish "such Exchange" in that state. ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1); see 45 C.F.R. § 155.105(f). While sixteen states and the District of Columbia have elected to set up their own Exchanges, thirty-four states rely on federally-facilitated Exchanges. Seven of these thirty-four states have chosen to assist the federal government with its operation of federally-run Exchanges, while twenty-seven states have declined to undertake any aspect of Exchange implementation. See State Decisions for Creating Health Insurance Marketplaces, Kaiser State Health Facts, http://kff.org/health-reform/state-indicator/health-insurance-Exchanges/ (visited Jan. 5, 2014).

2. Premium Tax Credits

The Act authorizes tax credits for many low- and middle-income individuals who purchase health insurance through the Exchanges. The Exchanges administer a program to provide advance payments of tax credits for eligible individuals; where an advance payment is approved, the Exchange arranges for the payment to be made directly to the individual's insurer, lowering the net cost of insurance to the individual. 42 U.S.C. §§ 18081-18082. The section of the Act setting forth how this tax credit is determined – ACA § 1401, codified at 26 U.S.C. § 36B – calculates this credit based in part on the premium expenses for the health plan "enrolled in [by the individual] through an Exchange established by the State under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(b)(2)(A); see also 26 U.S.C. § 36B(c)(2)(A)(i).

As an example, amicus Families USA calculates that a single parent with two children in Florida, earning $41,000, would likely be charged about $5700 per year for a "silver-level" insurance plan on the federally-facilitated Exchange operating in that state. If the tax credit is available, the family would pay approximately $2700 for this insurance, after receiving a tax credit of about $3000. If the tax credit is unavailable, the family would bear the full cost of health insurance. Brief of *Amicus Curiae* Families USA 7 (citing Kaiser Family Foundation, Subsidy Calculator, *available at* http://kff.org/interactive/subsidy-calculator).

3. Minimum Insurance Requirement and Unaffordability Exemption

Under the Act, most individuals must obtain health insurance or face a tax penalty imposed by the IRS. This penalty in 2014 is one percent of an individual's yearly income or $95 for the year, whichever is higher, 26 U.S.C. § 5000A(c)(2)-(3), but it "cannot exceed the cost of 'the national average premium for qualified health plans' meeting a certain level of coverage." Liberty Univ., Inc. v. Lew, 733 F.3d 72, 84 (4th Cir. 2013) (quoting 26 U.S.C.

§ 5000A(c)(1)(B)). Individuals unable to afford coverage, however, are exempt from the minimum insurance requirement, and therefore can avoid the tax penalty. 26 U.S.C. § 5000A(e). The unaffordability exemption generally is available to an individual whose health insurance costs exceed eight percent of his or her annual household income. 26 U.S.C. § 5000A(e)(1)(A). An individual's costs are determined with reference to the price of the relevant insurance premium minus the tax credit described above. 26 U.S.C. § 5000A(e)(1)(B)(ii).

4. Section 4980H Assessable Payments on Large Employers

Under the ACA, many or most employers are expected to offer health insurance plans to their employees, and large employers who do not offer affordable health insurance coverage to their full-time employees are subject to an "assessable payment" or tax under 26 U.S.C. § 4980H. Imposition of the Section 4980H assessment is triggered when a full-time employee purchases subsidized coverage on an Exchange. 26 U.S.C. § 4980H(a)-(b). After an employee purchases insurance, the Exchange determines whether the employer failed to offer affordable health insurance to that employee. If so, and if the employee meets the income requirements and other criteria, the employee will be deemed eligible for a premium tax credit. The Exchange then notifies the employer that the employer will be assessed a Section 4980H payment. 26 U.S.C. § 4980H(d). The employer has the opportunity to administratively appeal that notice. 26 U.S.C. § 18081(f)(2).

B. The IRS Rule

The Internal Revenue Service has promulgated regulations making the premium tax credit available to qualifying individuals who purchase health insurance on state-run or federally-facilitated Exchanges. See 26 C.F.R. § 1.36B-1(k); Health Insurance Premium Tax

Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012) (the "IRS Rule"). Specifically, 26 C.F.R. § 1.36B-2(a)(1) provides that an applicable taxpayer who meets certain other criteria is allowed a tax credit if he or she, or a member of his or her family, "[i]s enrolled in one or more qualified health plans through an Exchange." 26 C.F.R. § 1.36B-1(k) provides that the term Exchange "has the same meaning as in 45 C.F.R. § 155.20," which in turn defines Exchange in the following manner:

> Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes [Qualified Health Plans] available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a [Small Business Health Options Program] serving the small group market for qualified employers, *regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.*

45 C.F.R. § 155.20 (emphasis added). Participants in federally-facilitated Exchanges thus are eligible for the premium tax credit under the IRS Rule.

In describing the Rule, the IRS noted that "[c]ommentators disagreed on whether the language in [26 U.S.C. §] 36B(b)(2)(A) limits the availability of the premium tax credit only to taxpayers who enroll in qualified health plans on State Exchanges." 77 Fed. Reg. at 30,378. The IRS rejected such a limitation, explaining:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

Id.

C. This Litigation

Plaintiffs are a group of individuals and employers residing in states that have declined to establish Exchanges.[3] Pursuant to its statutory authority under 42 U.S.C. § 18041(c)(1), HHS has established Exchanges in those states. Under the IRS Rule, tax credits are available to eligible individuals purchasing qualified health plans in those states.

Plaintiffs contend that 26 C.F.R. § 1.36B-1(k) and related regulations violate the plain language of the ACA, which provides that an individual's tax credit is calculated based on the cost of insurance purchased on "an Exchange *established by the State* under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(b)(2)(A). Plaintiffs argue that the regulations exceed the scope of the agency's statutory authority and are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," in violation of the Administrative Procedure Act, and they therefore must be set aside. 5 U.S.C. § 706(2)(A), (C); see Compl. ¶¶ 37, 40. Plaintiffs also contend that the agency's explanation for its interpretation of the statute is "arbitrary, capricious, unsupported by a reasoned basis, and contrary to law." Compl. ¶ 41.

Plaintiffs filed this action on May 2, 2013, naming as defendants HHS, the Department of the Treasury ("Treasury"), and the IRS, as well as the heads of those agencies. After serving defendants, plaintiffs promptly moved for summary judgment, and defendants filed a motion to dismiss. Briefing on plaintiffs' summary judgment motion was stayed pending a decision on defendants' motion to dismiss. In their motion to dismiss, the defendants argued that plaintiffs lacked standing; that their claims were not ripe; that this suit was precluded by the Anti-Injunction Act and other statutes; and that the case must be dismissed for failure to join

[3] The individual plaintiffs are Jacqueline Halbig, David Klemencic, Carrie Lowery, and Sarah Rumpf. Compl. ¶¶ 12-15. The employer plaintiffs are Innovare Health Advocates, Community National Bank, and a group of restaurants under the common control of J. Allen Tharp. Id. ¶¶ 16-18.

indispensable parties. Plaintiffs in turn filed a motion for a preliminary injunction. For the reasons stated in open court on October 22, 2013, the Court denied plaintiffs' motion for preliminary injunction on the ground that plaintiffs had failed to establish risk of irreparable harm. The Court also denied the defendants' motion to dismiss, with leave to renew their justiciability challenges at the summary judgment stage.

Briefing on plaintiffs' summary judgment motion resumed, and defendants filed a cross-motion for summary judgment. These motions are now ripe for decision.

II. JUSTICIABILITY OF PLAINTIFFS' CLAIMS

Defendants urge this Court to dismiss plaintiffs' claims on various jurisdictional and prudential grounds. Defendants argue that the individual plaintiffs lack Article III standing and that their suit is barred by a provision of the Administrative Procedure Act, 5 U.S.C. § 704. Defendants raise similar challenges against the employer plaintiffs. In addition, defendants assert that the employer plaintiffs' claims are precluded by the Anti-Injunction Act, 26 U.S.C. § 7421(a), and by prudential standing principles. The Court rejects defendants' arguments as to the individual plaintiffs, but agrees that the Anti-Injunction Act bars the claims of the employer plaintiffs.

A. Individual Plaintiffs

1. Article III Standing

The defendants previously argued in their motion to dismiss that the individual plaintiffs lacked Article III standing, and the Court rejected this argument in its oral ruling on October 22, 2013. See Oct. 22, 2013 Tr. 13-18. The Court concluded that at least one individual plaintiff, David Klemencic, had adequately shown economic injury likely to result from the IRS

Rule. Id. The defendants have renewed their challenge here, and the Court rejects this challenge for identical reasons.

In order to establish standing under Article III of the United States Constitution, a plaintiff must show, at an "irreducible constitutional minimum," that (1) he or she has suffered an injury-in-fact – *i.e.*, the invasion of a legally protected interest; (2) the injury is fairly traceable to the defendants' conduct (a causal connection); and (3) a favorable decision on the merits likely will redress the injury. Sprint Commc'ns Co., L.P. v. APPC Servs., Inc., 554 U.S. 269, 273-74 (2008) (citing Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992)).

David Klemencic is one of four individual plaintiffs in this suit.[4] He avers in a declaration – and the government does not dispute – that he expects to earn approximately $20,000 in 2014. Klemencic Decl. ¶ 4; Third Moulds Decl. ¶ 2. For ideological reasons, Klemencic does not wish to purchase minimum essential health coverage. Klemencic Decl. ¶ 8. Mr. Klemencic also has introduced evidence that the cost of minimum health insurance coverage, if unsubsidized, would exceed eight percent of his income. See Kessler Decl. ¶ 21. Thus, if tax credits were unavailable, he would be eligible for an "unaffordability exemption" under the ACA and could forego purchasing health insurance without incurring a tax penalty under Section 5000A.

The effect of the IRS Rule, however, is that the tax credit available to Mr. Klemencic lowers the cost of his insurance premiums so significantly that he no longer qualifies

[4] Both plaintiffs and defendants focus on whether Mr. Klemencic has established injury-in-fact. The Court therefore does not decide whether the remaining individual plaintiffs have established standing. As the Court previously stated, Oct. 22, 2013 Tr. at 13, a court may consider a claim so long as at least one plaintiff has established standing as to that claim. See Watt v. Energy Action Educ. Found., 454 U.S. 151, 160 (1981); Mountain States Legal Found. v. Glickman, 92 F.3d 1228, 1232 (D.C. Cir. 1996).

for the unaffordability exemption. See Kessler Decl. ¶ 22; Klemencic Decl. ¶ 7. The Rule thereby places Klemencic in a position where he has to purchase subsidized health insurance, estimated at approximately $20 per year, see Third Moulds Decl. ¶ 6, or he will have to pay some higher amount per year as a Section 5000A tax penalty. Counterintuitively, by making health insurance more affordable, the IRS Rule imposes a financial cost on Klemencic.

Although the economic injury is rather small, defendants cite no authority that suggests that the amount at issue – only about $1.70 per month, or $20 per year – is too small to establish injury-in-fact for jurisdictional purposes. Mr. Klemencic's economic injury, albeit a non-intuitive one, meets the requirements for Article III standing. It is "concrete, particularized, and actual or imminent; fairly traceable to the challenged action; and redressable by a favorable ruling." Clapper v. Amnesty Int'l USA, 133 S. Ct. 1138, 1147 (2013) (internal quotation omitted).[5]

2. The Administrative Procedure Act and the Tax Refund Alternative

As noted, plaintiffs bring suit under the Administrative Procedure Act, which provides a "generic cause of action in favor of persons aggrieved by agency action." Cohen v. United States, 650 F.3d 717, 723 (D.C. Cir. 2011) (*en banc*) (quoting Maryland Dep't of Human Res. v. Dep't of Health & Human Servs., 763 F.2d 1441, 1445 n.1 (D.C. Cir. 1985)). The APA permits judicial review of any "[a]gency action made reviewable by statute," as well as any "final agency action *for which there is no other adequate remedy in a court*." 5 U.S.C. § 704 (emphasis added). Section 704 thus excludes from APA review those agency actions for which there are alternative judicial remedies in place. As the Supreme Court has explained:

[5] The Court also previously concluded that Mr. Klemencic has satisfied the requisites for prudential standing. See Oct. 22, 2013 Tr. 24-28.

> At the time the APA was enacted, a number of statutes creating administrative agencies defined the specific procedures to be followed in reviewing a particular agency's action . . . . When Congress enacted the APA to provide a general authorization for review of agency action in the district courts, it did not intend that general grant of jurisdiction to duplicate the previously established special statutory procedures relating to specific agencies.

Bowen v. Massachusetts, 487 U.S. 879, 903 (1988) (footnotes omitted).

The APA thus "does not provide additional judicial remedies in situations where the Congress has provided special and adequate review procedures." Bowen v. Massachusetts, 487 U.S. at 903 (quoting Attorney General's Manual on the Administrative Procedure Act 101 (1947)). Instead, where Congress already has created a separate cause of action for review of agency action, "[t]he form of proceeding for judicial review is the special statutory review proceeding relevant to the subject matter in a court specified by statute" unless that proceeding is "inadequat[e]." 5 U.S.C. § 703.

Although Section 704 disallows APA review of agency actions when other, *adequate* remedies are provided by statute, the Supreme Court has noted that this provision "should not be construed to defeat the central purpose of providing a broad spectrum of judicial review of agency action." Bowen v. Massachusetts, 487 U.S. at 903. Therefore, when determining whether alternative remedies are adequate, "the court must give the APA 'a hospitable interpretation' such that 'only upon a showing of clear and convincing evidence of a contrary legislative intent should the courts restrict access to judicial review.'" Garcia v. Vilsack, 563 F.3d 519, 523 (D.C. Cir. 2009) (quoting El Rio Santa Cruz Neighborhood Health Ctr. v. U.S. Dep't of Health & Human Servs., 396 F.3d 1265, 1272 (D.C. Cir. 2005) (quoting Abbott Labs. v. Gardner, 387 U.S. 136, 141 (1967))).

Defendants assert that a special, time-honored statutory procedure exists for challenges to IRS actions: the tax refund suit. 28 U.S.C. § 1346 provides that a district court has original jurisdiction of "[a]ny civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority[.]" 28 U.S.C. § 1346(a)(1). Under the Internal Revenue Code, however, no such suit may be brought until after the challenged tax has been paid and "a claim for refund or credit has been duly filed with the Secretary, according to the provisions of law in that regard, and the regulations of the Secretary established in pursuance thereof." 26 U.S.C. § 7422(a); see United States v. Clintwood Elkhorn Mining Co., 553 U.S. 1, 4 (2008).[6]

The parties agree that the critical question is whether the tax refund suit provides an adequate judicial remedy in this case. See Cohen v. United States, 650 F.3d at 731. In some respects, the tax refund suit clearly provides a path to a potential remedy. If plaintiffs forego purchasing insurance and face a higher tax burden as a penalty, they will be able to pay the tax and then bring a refund suit under 26 U.S.C. § 7422, like any other taxpayer. If plaintiffs prevail on their challenge in a tax refund suit, they will be entitled to repayment in full, plus interest, of any overpayment. 26 U.S.C. § 7422; see 28 U.S.C. § 2411 (authorizing payment of interest).

But in other ways, the tax refund mechanism is inferior to an APA suit and fails to provide complete relief to these plaintiffs. Relegating plaintiffs' claims to a tax refund action would force plaintiffs to make a choice between purchasing insurance, thereby waiving their

[6] Defendants also note that in some circumstances, a plaintiff may refrain from paying the tax, wait to be sued, and allow the issue to be resolved in the United States Tax Court. See Oct. 21, 2013 Tr. 19. As with the refund suit, resolution of plaintiffs' challenge in that forum would take place only after the tax year had ended.

claims, or foregoing insurance and incurring the tax penalty, which they will recover much later, and only if they prevail. They also will be deprived of the opportunity to obtain prospective certificates of exemption. See 45 C.F.R. § 155.605(g)(2). Such certificates provide a safe harbor to an individual who can establish that he or she likely will meet the requirements of the unaffordability exemption for that tax year; such certificates guarantee that individuals will avoid the tax penalty "notwithstanding any change in an individual's circumstances," such as an unexpected increase in income. 45 C.F.R. § 155.605(g)(2)(vi).

Defendants argue that the tax refund suit is adequate because it is a *de novo* proceeding. See Democratic Leadership Council v. United States, 542 F. Supp. 2d 63, 70 (D.D.C. 2008) (tax refund actions are *de novo* proceedings). *When* that proceeding occurs is irrelevant, according to defendants. As the D.C. Circuit explained in Garcia, "relief will be deemed adequate 'where a statute affords an opportunity for *de novo* district-court review,'" as "Congress did not intend to permit a litigant challenging an administrative denial . . . to utilize simultaneously both [the review provision] and the APA." Garcia v. Vilsack, 563 F.3d at 522-23 (alterations in original) (quoting El Rio Santa Cruz Neighborhood Health Ctr. v. U.S. Dep't of Health & Human Servs., 396 F.3d at 1270).

But Garcia is distinguishable from the present case in a number of significant ways. In Garcia, there was no substantive difference between the relief available in the special judicial proceeding and that available in an APA action, and plaintiffs were in fact attempting to pursue both avenues of relief *at the same time*. See Garcia v. Vilsack, 563 F.3d at 521, 523 (noting that plaintiffs brought claims under Equal Credit Opportunity Act and the APA in the same lawsuit). By contrast, here prospective relief – including the ability to qualify for a certificate of exemption – is available *only* in the APA action brought by plaintiffs; such relief is

not available in the tax refund suit. See Cohen v. United States, 650 F.3d at 732 (noting that tax refund suit appeared to provide only individualized, retroactive relief, and not the ability to challenge a regulation or policy without penalty). As in Cohen, the tax refund remedy would not provide the relief appellants sought because, among other things, it does not allow for prospective relief. Id. at 732.[7]

Furthermore, although the tax refund suit provision typically will preclude suits by parties who bring a tax challenge in federal court without first exhausting their administrative remedies, see Cohen v. United States, 650 F.3d at 733, this is not a typical case. As in Cohen, plaintiffs here bring a pre-enforcement challenge to a final agency rule, rather than individualized adjudications of tax liability. The dispute before the Court is purely legal and ripe for review. Any administrative challenge would be futile, as the Secretary of the Treasury can be expected to deny plaintiffs' complaint as contrary to the issued IRS regulations. Abstaining from a decision now would simply kick the can down the road until 2015, after the Secretary of the Treasury reaffirms the view he already has announced in promulgating the Rule. See Oct. 21, 2013 Tr. 18-20.

[7] Defendants maintain that it is "well-settled that a tax refund action provides an adequate remedy at law, even though the tax must first be imposed before the suit is brought." Defs.' SJ Reply 7 (citing Bob Jones Univ. v. Simon, 416 U.S. 725, 742 (1974), and Alexander v. "Americans United" Inc., 416 U.S. 752, 762 (1974)). But the cases cited by defendants address the question of whether pre-collection tax suits are precluded by the Anti-Injunction Act – not whether an action may proceed under the APA. Bob Jones Univ. v. Simon, 416 U.S. at 742-46; Alexander v. "Americans United" Inc., 416 U.S. at 761-62. These cases do no more than establish that the tax refund remedy is not so inadequate a remedy as to constitute a clear violation of a taxpayer's constitutional due process rights. Bob Jones Univ. v. Simon, 416 U.S. at 746-47 (finding that relegation of plaintiff to tax refund remedy resulted in serious delay and possibly irreparable injury, but that these problems did not "rise to the level of constitutional infirmities"); Alexander v. "Americans United" Inc., 416 U.S. at 761-62 (noting that a showing of irreparable injury was not sufficient to avoid application of the Anti-Injunction Act). They have nothing to say about whether the tax refund suit is an "adequate" alternative remedy to an APA action.

The Court therefore concludes that the tax refund suit is not an adequate alternative to the judicial review provisions of the APA in this case. The "doubtful and limited relief" possibly available sometime in the future in a tax refund suit is "not an adequate substitute" for APA review here and now. Bowen v. Massachusetts, 487 U.S. at 901; see id. at 904-05 (rejecting federal agency's assertion that an after-the-fact action in the Claims Court was an adequate alternative for prospective relief requested by state plaintiff in APA suit). To the extent that this is a close call, the Court relies on the Supreme Court's directive that the APA's review provisions should be given "a 'hospitable' interpretation," as the APA's underlying purpose is to "remove obstacles to judicial review of agency action." Id. at 904 (internal quotations omitted). The Court therefore concludes that plaintiffs' suit is not barred under the APA.

B. Employer Plaintiffs and the Anti-Injunction Act

Defendants raise several challenges regarding the justiciability of the employer plaintiffs' claims. Because their challenge under the Anti-Injunction Act is dispositive with respect to the employer plaintiffs, the Court proceeds directly to that issue.[8]

Although the APA waives sovereign immunity for suits against the federal government, 5 U.S.C. § 702, it "preserves 'other limitations on judicial review' and does not 'confer[ ] authority to grant relief if any other statute . . . expressly or impliedly forbids the relief which is sought.'" Cohen v. United States, 650 F.3d at 724 (alterations in original) (quoting 5 U.S.C. § 702). The Anti-Injunction Act (the "AIA") is one such limitation on judicial review.

[8] Individual plaintiffs bring suit for the purpose of avoiding a potential tax penalty under 26 U.S.C. § 5000A, a statute to which the Supreme Court has concluded the Anti-Injunction Act does not apply. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2583-84. Defendants therefore raise the issue of the Anti-Injunction Act with respect only to the employer plaintiffs, who seek to enjoin tax liability under 26 U.S.C. § 4980H. See Compl. ¶¶ 6, 16-18, 31.

The AIA provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. § 7421(a). The statute acts as a limitation on a court's subject matter jurisdiction, Gardner v. United States, 211 F.3d 1305, 1311 (D.C. Cir. 2000), and generally applies regardless of whether the suit presents a constitutional, statutory, or regulatory challenge. See, e.g., Alexander v. "Americans United" Inc., 416 U.S. at 759-60 (finding AIA barred constitutional challenge to denial of tax-exempt status); Enochs v. Williams Packing & Nav. Co., 370 U.S. 1, 3, 7-8 (1962) (applying AIA to statutory challenge).

"The manifest purpose of § 7421(a) is to permit the United States to assess and collect taxes alleged to be due without judicial intervention, and to require that the legal right to the disputed sums be determined in a suit for refund" after the taxes have been paid. Cohen v. United States, 650 F.3d at 724 (quoting Enochs v. Williams Packing & Nav. Co., 370 U.S. at 7). The AIA arose out of a concern by Congress "about the . . . danger that a multitude of spurious suits, or even suits with possible merit, would so interrupt the free flow of revenues as to jeopardize the Nation's fiscal stability." Id. (quoting Alexander v. "Americans United" Inc., 416 U.S. at 769 (Blackmun, J., dissenting)). The AIA "has 'almost literal effect': It prohibits only those suits seeking to restrain the assessment or collection of taxes." Id. (quoting Bob Jones Univ. v. Simon, 416 U.S. at 737). The AIA applies regardless of whether its application results in uncertainty or hardship for the taxpayer. Bob Jones Univ. v. Simon, 416 U.S. at 745; Alexander v. "Americans United" Inc., 416 U.S. at 762.

Although the employer plaintiffs are challenging the legality of a regulation governing tax *credits*, not a tax collection, they do so in order to restrain the IRS from assessing the payments described in 26 U.S.C. § 4980H, which are triggered by the award of tax credits to

their employees. In fact, their theory of injury hinges on this relationship. See Pls.' SJ Opp. 38-41. The Court therefore must address the question of whether the Section 4980H assessment is a tax for purposes of the Anti-Injunction Act. See Alexander v. "Americans United" Inc., 416 U.S. at 760 (adopting broad interpretation of AIA's "suit for the purpose of restraining the assessment or collection of any tax" language).

In Nat'l Fed'n of Indep. Bus., the Supreme Court held that the label that Congress gives to an assessment collected by the IRS matters for purposes of the AIA. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2583. Chief Justice Roberts, writing for a majority of the Court, explained: "The Anti-Injunction Act and the Affordable Care Act . . . are creatures of Congress's own creation. How they relate to each other is up to Congress, and the best evidence of Congress's intent is the statutory text." Id. He then concluded that the penalty imposed on individuals who fail to obtain minimum coverage under 26 U.S.C. § 5000A – though a tax for constitutional purposes – was not a tax for purposes of the Anti-Injunction Act. Id. at 2583-84. Why not? Because Congress consistently used the term "penalty" rather than the term "tax" in describing the Section 5000H exaction. Id. By contrast, other payments imposed under the ACA were expressly described by Congress as "taxes," id. at 2583, and the statute's "consistent distinction between the terms 'tax' and 'assessable penalty'" reflected an intent to distinguish these two exactions for purposes of the AIA. Id. at 2584.

Unlike the Section 5000A "assessable penalty" examined by the Supreme Court in Nat'l Fed. of Indep. Business, the Section 4980H assessment is described at various places in the statutory text both as an "assessable payment" and as a "tax." In Section 4980H itself, the fee is called an "assessable payment" seven times and a "tax" twice. See 26 U.S.C. § 4980H(b)(1)(B) (referring to "assessable payment"); Section 4980H(c)(2)(D)(i)(I) (same);

Section 4980H(d) (referring to "assessable payment" four times); Section 4980H(b)(2) (referring to the "aggregate amount of tax determined" that an employer must pay); Section 4980H(c)(7) (referring to the "denial of deduction for the tax imposed by this section"). This same assessment is described as a tax at least once elsewhere in the ACA. 42 U.S.C. § 18081(f)(2) ("The Secretary [of HHS] shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a *tax* imposed by section 4980H of Title 26[.]") (emphasis added).

The Fourth Circuit recently concluded that the occasional use of the word "tax" in Section 4980H was insufficient to implicate the Anti-Injunction Act. Liberty Univ., Inc. v. Lew, 733 F.3d at 86-89 (noting that the ACA "does not consistently characterize the exaction as a tax"). That court also found that it would be anomalous to allow individuals to bring pre-enforcement challenges to Section 5000A penalties (the provision considered by the Supreme Court in Nat'l Fed. of Indep. Business) while permitting employers to bring only post-enforcement challenges to Section 4980H assessments. Id. at 88-89. The Fourth Circuit therefore reasoned that the AIA did not prohibit a statutory challenge to Section 4980H. Id. at 89.

This Court is not persuaded by the Fourth Circuit's reasoning. That court reads the term "assessable payment" as nullifying the effect of the word "tax." In this Court's view, however, the natural conclusion to draw from Congress's interchangeable use of the terms "assessable payment" and "tax" in Section 4980H is simply that Congress saw no distinction between the two terms. See Cohen v. United States, 650 F.3d at 731 ("A baker who receives an order for 'six' donuts and another for 'half-a-dozen' does not assume the terms are requests for different quantities of donuts. . . . Different verbal formulations can, and sometimes do, mean

the same thing."). Absent a clear indication by Congress, the Court views the term "tax" as used in 26 U.S.C. § 7421(a), the Anti-Injunction statute, as having the same meaning as the term "tax" as used elsewhere in the Internal Revenue Code, including in Section 4980H. See Powerex Corp. v. Reliant Energy Servs., Inc., 551 U.S. 224, 232 (2007) (recognizing "standard principle of statutory construction . . . that identical words and phrases within the same statute should normally be given the same meaning").

Furthermore, there is no other reason to presume that the AIA does not apply. The Section 4980H assessment *acts* like a tax and *looks* like a tax. The Court therefore embraces a modified version of the "now-infamous 'duck test'": "WHEREAS it looks like a duck, and WHEREAS it walks like a duck, and WHEREAS it quacks like a duck," *and WHEREAS it is called a duck by Congress on multiple occasions*, "[THE COURT] THEREFORE HOLD[S] that it is a duck." Hussain v. Obama, 718 F.3d 964, 968 (D.C. Cir. 2013) (quoting Dole v. Williams Enterprises, Inc., 876 F.2d 186, 188 n.2 (D.C. Cir. 1989)).

Like most classic taxes, the exaction created by Section 4980H serves a revenue-raising function: the fees collected by the employers are based on, and presumably are used to offset, tax credits dispensed to individuals purchasing their own insurance on the Exchanges. There therefore is no reason to treat a Section 4980H assessment as a regulatory penalty, rather than as a tax. Cf. Korte v. Sebelius, 735 F.3d 654, 669 (7th Cir. 2013) (distinguishing between "severe and disproportionate" penalties which are used to "regulate[] private conduct and make[] noncompliance painful," and taxes that function to raise revenue) (internal quotations omitted); see also Direct Marketing Ass'n v. Brohl, 735 F.3d 904, 916 n.7 (10th Cir. 2013) (noting distinction "between a 'classic tax [that] sustains the essential flow of revenue to the government,' . . . and a penalty that 'rais[es] money to help defray an agency's regulatory

expenses'") (internal quotations omitted).[9] Furthermore, Section 4980H is located in the Internal Revenue Code, and the payment is assessed by the Internal Revenue Service. Cf. Fed. Energy Admin. v. Algonquin SNG, Inc., 426 U.S. 548, 558 n.9 (1976) (noting that fees imposed outside of Internal Revenue Code generally are not barred by the AIA).

Nor does it seem anomalous that Congress would have intended to allow pre-enforcement challenges by individuals while prohibiting pre-enforcement suits by employers. In fact, another provision in Section 4980H confirms that Congress assumed that employers would raise their challenges in post-collection suits. The statute provides that the Secretary of the Treasury "shall prescribe rules . . . for the *repayment* of any assessable payment . . . if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment." 26 U.S.C. § 4980H(d)(3) (emphasis added). No such comparable provision exists with respect to individuals. See generally 26 U.S.C. § 5000A.

In sum, for purposes of the Anti-Injunction Act, the Court concludes that the assessable payment described in 26 U.S.C. § 4980H must be considered a tax. The Anti-Injunction Act therefore bars the employer plaintiffs' claims, and those plaintiffs will be dismissed from this case.

[9] In Korte, the Seventh Circuit concluded that the AIA did not bar suits relating to penalties under 26 U.S.C. § 4980D, which the court found "meant to penalize employers for noncompliance with the various mandates in the Affordable Care Act and its implementing regulations." Korte v. Sebelius, 735 F.3d at 670. After finding that the exaction under Section 4980D was not a tax under the AIA, the Seventh Circuit then stated, without further discussion, that "[b]y parallel reasoning the same is true of the alternative payment in Section 4980H." Id. at 671. The Court does not agree with the Seventh Circuit's conclusion.

Because the Court has jurisdiction over at least one of the individual plaintiffs' claims, however, it proceeds to a decision on the merits.

III. THE IRS RULE

A. Legal Standards

As noted above, plaintiffs' principal argument calls into question the IRS's interpretation of the ACA, as set forth in its regulations. When the action under review involves an agency's interpretation of a statute that the agency is charged with administering, the Court applies the familiar analytical framework set forth in Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984).

"Under step one of Chevron, [the court] ask[s] whether Congress has directly spoken to the precise question at issue." Sec'y of Labor, Mine Safety & Health Admin. v. Nat'l Cement Co. of California, Inc., 494 F.3d 1066, 1073 (D.C. Cir. 2007) (internal quotation and quotation marks omitted). In determining whether Congress has directly spoken to the precise question at issue, the Court uses the "traditional tools of statutory construction," including an examination of the statute's text, the structure of the statute, and (as appropriate) legislative history. Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. at 843 n.9; see Bell Atl. Tel. Cos. v. FCC, 131 F.3d 1044, 1047 (D.C. Cir. 1997). "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Meredith v. Fed. Mine Safety & Health Review Comm'n, 177 F.3d 1042, 1053 (D.C. Cir. 1999) (internal quotation omitted).

If, however, the Court concludes that "the statute is silent or ambiguous with respect to the specific issue . . . , [the Court] move[s] to the second step and defer[s] to the agency's interpretation as long as it is 'based on a permissible construction of the statute.'" In

Def. of Animals v. Salazar, 675 F. Supp. 2d 89, 94 (D.D.C. 2009) (quoting Sec'y of Labor, Mine Safety & Health Admin. v. Nat'l Cement Co. of California, Inc., 494 F.3d at 1074). At Chevron step two, the court must uphold the agency's interpretation "if it is reasonable and consistent with the statutory purpose and legislative history." Bell Atl. Tel. Cos. v. FCC, 131 F.3d at 1049. "Unlike [the court's] Chevron step one analysis, [its] review at this stage is 'highly deferential.'" Vill. of Barrington, Ill. v. Surface Transp. Bd., 636 F.3d 650, 665 (D.C. Cir. 2011) (quoting Nat'l Rifle Assn. of Amer. v. Reno, 216 F.3d 122, 137 (D.C. Cir. 2000)).

Plaintiffs also object to the IRS Rule as being arbitrary and capricious. An agency rule is arbitrary and capricious "if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Agape Church, Inc. v. FCC, --- F.3d ----, 2013 WL 6819158, at *11 (D.C. Cir. 2013) (quoting Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983)). As the D.C. Circuit recently noted, "[t]he analysis of disputed agency action under Chevron Step Two and arbitrary and capricious review is often 'the same, because under Chevron step two, [the court asks] whether an agency interpretation is arbitrary or capricious in substance.'" Id. at *11 (quoting Judulang v. Holder, 132 S. Ct. 476, 483 n.7 (2011)).

Congress expressly delegated authority to the Secretary of the Treasury to resolve any ambiguities in Section 36B. 26 U.S.C. § 36B(g) ("The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section."); see also 26 U.S.C. § 7805(a). As plaintiffs note, however, Treasury and HHS share joint responsibility for administering parts of the Act, including implementation of the tax credit scheme. HHS, for

example, oversees the advance payments of premium tax credits. 42 U.S.C. § 18082(a) ("The Secretary [of HHS], in consultation with the Secretary of the Treasury, shall establish a program under which" advance determinations and payments of tax credits are made). The two agencies "work[ed] in close coordination . . . to release guidance related to Exchanges," Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931, 50,932 (Aug. 17, 2011), and HHS has promulgated its own regulations providing that participants on both state and federal Exchanges are eligible for advance payments of the credits. See 45 C.F.R. § 155.20.

Plaintiffs argue that this shared authority precludes Chevron deference, as courts regularly decline to defer to agencies interpreting statutes that they do not have sole authority in administering. See, e.g., Collins v. Nat'l Transp. Safety Bd., 351 F.3d 1246, 1253 (D.C. Cir. 2003) ("For statutes . . . where the agencies have specialized enforcement responsibilities but their authority potentially overlaps – thus creating risks of inconsistency or uncertainty – de novo review may . . . be necessary."); Benavides v. U.S. Bureau of Prisons, 995 F.2d 269 (D.C. Cir. 1993) (no Chevron deference to agency interpretation of the Privacy Act, a statute of general applicability administered by multiple agencies). But where, as here, "the subject matter of the statute falls squarely within the agencies' areas of expertise, and the Regulations were issued as a result of a statutorily coordinated effort among the agencies, Chevron is the governing standard." Individual Reference Servs. Grp., Inc. v. FTC, 145 F. Supp. 2d 6, 24 (D.D.C. 2001), aff'd, Trans Union LLC v. FTC, 295 F.3d 42 (D.C. Cir. 2002); see also Nat'l Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 665-66 (2007).[10] The Court therefore proceeds to Chevron step one and examines whether the statute is ambiguous.

[10] The Court rejects as meritless plaintiffs' argument that the IRS Rule conflicts with regulations promulgated by HHS.

B. Chevron Step One

1. Plain Language of Section 36B(a)-(c) and Cross-Referenced Provisions

In construing a statute's meaning, the Court "begin[s], as always, with the language of the statute." Duncan v. Walker, 533 U.S. 167, 172 (2001). The statutory provision that authorizes the premium tax credits provides as follows:

> In the case of an *applicable taxpayer*, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the *premium assistance credit amount* of the taxpayer for the taxable year.

26 U.S.C. § 36B(a) (emphasis added).

The term "applicable taxpayer" is defined as "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved." 26 U.S.C. § 36B(c)(1)(A). This statutory provision does not distinguish between taxpayers residing in states with state-run Exchanges and those in states with federally-facilitated Exchanges.

Subsection (b) of Section 36B – which sets forth the formula for calculating the premium tax credit – contains the language that plaintiffs say precludes tax credits for taxpayers on federal Exchanges. This provision directs the Internal Revenue Service to calculate an individual's premium tax credit – or the "premium assistance credit amount" – by adding up the "premium assistance amounts" for all "coverage months" in a given year. 26 U.S.C. § 36B(b)(1). The "premium assistance amount" is based in part on the cost of the monthly premium for the health plan that the taxpayer purchased "through an Exchange established by the State under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(b)(2). A "coverage month" likewise is defined as any month during which the taxpayer (or spouse or dependent) is enrolled in, and pays the premium for, a qualified health plan "that was enrolled in through an Exchange established

by the State under [42 U.S.C. § 18031]." 26 U.S.C. § 36B(c)(2)(A)(i). Thus, the tax credit to a qualifying individual is tied to the cost of insurance purchased "through an Exchange established by the State under [42 U.S.C. § 18031]." The term "Exchange" is not defined in Section 36B, but the phrase "established by the State under [42 U.S.C. § 18031]" directs the Treasury Secretary and the IRS Commissioner to define "Exchange" with reference to other provisions of the ACA, located in Title 42 of the United States Code. 26 U.S.C. § 36B(b)(2); 26 U.S.C. § 36B(c)(2)(A)(i).

Plaintiffs contend that by using the phrase "established by the State under [42 U.S.C. § 18031]," as opposed to a phrase like "established under this Act," see 42 U.S.C. § 18032(d)(3)(D)(i)(II), Congress intended to refer exclusively to state-run Exchanges, as opposed to federally-facilitated Exchanges, and thus to limit the availability of the Section 36B tax credits to persons residing only in the states that have established their own Exchanges. Under plaintiffs' construction of the Act, a taxpayer in a state with a federal Exchange will never purchase insurance "enrolled in through an Exchange established by the State under [42 U.S.C. § 18031]." The premium assistance credit amount available to "applicable taxpayers" residing in states with federally-facilitated Exchanges therefore will always be zero.

On its face, the plain language of 26 U.S.C. § 36B(b)-(c), viewed in isolation, appears to support plaintiffs' interpretation. The federal government, after all, is not a "State," which is explicitly defined in the Act to mean "each of the 50 States and the District of Columbia." ACA § 1304(d), *codified at* 42 U.S.C. § 18024(d). The phrase "Exchange established by the State under [42 U.S.C. § 18031]" therefore, standing alone, could be read to refer only to state-run Exchanges.

In making the threshold determination under Chevron, however, "a reviewing court should not confine itself to examining a particular statutory provision in isolation. Rather, [t]he meaning – or ambiguity – of certain words or phrases may only become evident when placed in context." Nat'l Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. at 666 (internal quotations and quotation marks omitted). As the D.C. Circuit has observed, "the literal language of a provision taken out of context cannot provide conclusive proof of congressional intent, any more than a word can have meaning without context to illuminate its use." Petit v. U.S. Dept. of Educ., 675 F.3d 769, 781 (D.C. Cir. 2012) (quoting Bell Atl. Tel. Cos. v. FCC, 131 F.3d at 1047); see also Household Credit Servs., Inc. v. Pfennig, 541 U.S. 232, 239, 241 (2004) (examining surrounding statutory language and related provisions). So here, one cannot look at just a few isolated words in 26 U.S.C. § 36B, but also must at least look at the other statutory provisions to which it refers. See United States v. McGoff, 831 F.2d 1071, 1080 (D.C. Cir. 1987) (rejecting construction that isolated disputed statutory provision from expressly cross-referenced statute).

The cross-referenced 42 U.S.C. § 18031 provides that "*[e]ach State shall*, not later than January 1, 2014, *establish* an American Health Benefit Exchange (referred to in this title as an "Exchange")[.]" 42 U.S.C. § 18031(b)(1) (emphasis added). That section then states that "[a]n Exchange shall be a governmental agency or nonprofit entity that is *established by a State*." 42 U.S.C. § 18031(d)(1) (emphasis added). In both of these provisions, Congress describes an "Exchange" as necessarily being established by a State. The definitions section of the ACA, Section 1563(b), clarifies that this description is definitional: Section 1563(b) provides that "[t]he term 'Exchange' means an American Health Benefit Exchange established under [42 U.S.C. § 18031]." ACA § 1563(b)(21), *codified at* 42 U.S.C. § 300gg-91(d)(21).

Plaintiffs and defendants agree that 42 U.S.C. § 18031 does not mean what it literally says; states are not actually required to "establish" their own Exchanges. Pls.' SJ Opp. 14 ("*All* agree that states are free *not* to establish Exchanges.") (emphasis in original). This is because Section 1321 of the ACA provides that a state may "elect" to establish an Exchange and implement federal requirements for that Exchange. ACA § 1321, *codified at* 42 U.S.C. § 18041. If a state (i) is not an "electing State," (ii) fails to have "a required Exchange operational by January 1, 2014," or (iii) has not taken the actions necessary to establish an operational Exchange consistent with federal requirements, "the Secretary shall . . . establish and operate *such Exchange* within the State and the Secretary shall take such actions as are necessary to implement such other requirements." 42 U.S.C. § 18041(c) (emphasis added). In other words, if a state will not or cannot establish its own Exchange, the ACA directs the Secretary of HHS to step in and create "such Exchange" – that is, by definition under the statute, "an American Health Benefit Exchange established under [Section 18031]." 42 U.S.C. § 18041(c); 42 U.S.C. § 300gg-91(d)(21).

Looking only at the language of 26 U.S.C. § 36B(b)-(c), isolated from the cross-referenced text of 42 U.S.C. § 18031, 42 U.S.C. § 18041, and 42 U.S.C. § 300gg-91(d)(21), the plaintiffs' argument may seem the more intuitive one. Why would Congress have inserted the phrase "established *by the State* under [42 U.S.C. § 18031]" if it intended to refer to Exchanges created by a state *or* by HHS? But defendants provide a plausible and persuasive answer: Because the ACA takes a state-established Exchange as a given and directs the Secretary of HHS to establish such Exchange and bring it into operation if the state does not do so. See 42 U.S.C. §§ 18031(b)-(d), 18041(c). In other words, even where a state does not actually establish an

Exchange, the federal government can create "an Exchange established by the State under [42 U.S.C. § 18031]" *on behalf of* that state.[11]

Because each side provides a credible construction of the language of Section 36B(b)-(c) – though defendants' is the more credible when viewed in light of the cross-referenced provisions – the Court moves on to consider the other "traditional tools of statutory construction" under Chevron step one, including the structure of the statute and the context in which the language of Section 36B is set. Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. at 843 n.9.

2. Other Provisions of the ACA

Courts have a "duty to construe statutes, not isolated provisions." Graham County Soil and Water Conservation Dist. v. United States ex rel. Wilson, 559 U.S. 280, 290 (2010) (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 568 (1995)); Household Credit Servs., Inc. v. Pfennig, 541 U.S. at 239, 241. Thus, even beyond Section 36B(b)-(c) and the other provisions of the ACA it specifically cross-references, the Court must "interpret the statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.'" FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 132-33 (2000) (internal quotations omitted).

[11] Plaintiffs invoke the canon against surplusage, arguing that deleting the statutory modifier "established by the State" would violate the principle of statutory construction that no word of a statute be superfluous. See Duncan v. Walker, 533 U.S. at 174 (noting court's duty "to give effect, if possible, to every clause and word of a statute"). But plaintiffs' construction would render superfluous other portions of the ACA, such as the advance payment reporting requirements under Section 36B(f). See infra at 30-31. Thus the canon against surplusage is of no use here. The canon "is not an absolute rule," and "assists only where a competing interpretation gives effect to every clause and word of a statute." Marx v. Gen. Revenue Corp., 133 S. Ct. 1166, 1177 (2013).

The defendants point to various provisions of the ACA that appear to reflect an intent by Congress to make tax credits available to taxpayers purchasing insurance from the federally-facilitated Exchanges; they also cite provisions that, if construed consistently with plaintiffs' proposed definition, would create numerous anomalies within the statute that Congress could not have intended. See 26 U.S.C. § 36B(f)(3) (requiring reporting by federally-run Exchanges of advance payments of tax credits); 42 U.S.C. § 18032(f)(1)(A)(ii) (restricting *any* Exchange-based purchase of health insurance to residents of "the State that established the Exchange"); 42 U.S.C. § 1396a(gg) (providing that a state must maintain certain standards in its Medicaid program until "an Exchange established by the State under [42 U.S.C. § 18031] is fully operational"); 42 U.S.C. § 1397ee(d)(3)(B) (requiring HHS to determine, for each state, whether health plans offered through "an Exchange established by the State under [42 U.S.C. § 18031]" provide benefits for children comparable to those offered in the state's CHIP plan).

The Court finds the defendants' arguments compelling and the plaintiffs' counter-arguments unpersuasive. The Court need not discuss each of the many such provisions highlighted by defendants. It is sufficient to illustrate the persuasiveness of their arguments to focus on two provisions in the ACA: the reporting requirements for state and federal Exchanges, and the eligibility requirements for individuals purchasing insurance through the Exchanges.

a. The Advance Payment Reporting Requirements Under 26 U.S.C. § 36B(f)(3)

Subsection (f) of Section 36B – titled "Reconciliation of credit and advance credit" and located in the same section as the disputed statutory phrase – provides that the premium tax credit that a taxpayer receives at the end of the year must be reduced by the amount of any advance payment of such credit. 26 U.S.C. § 36B(f)(1). In order for the IRS to track these advance payments, the statute mandates that "[e]ach Exchange (or any person carrying out

1 or more responsibilities of an Exchange under [42 U.S.C. § 18031] *or [42 U.S.C. § 18041]*)" provide certain information to the Secretary of the Treasury and to the taxpayer "with respect to any health plan provided through the Exchange." 26 U.S.C. § 36B(f)(3) (emphasis added). The provision requires the reporting of information on the level of coverage provided to each taxpayer, the price of the insurance premium, and the amount of the advance payment.

By invoking both Section 18031 and Section 18041, this advance payment provision is expressly directed at *every* Exchange, regardless of whether the Exchange is state- or federally-run. Section 36B(f) would serve no purpose with respect to the federally-facilitated Exchanges, and the language referencing 42 U.S.C. § 18041 would be superfluous, if federal Exchanges were not authorized to deliver tax credits. Section 36B(f) thus indicates that Congress assumed that premium tax credits would be available on any Exchange, regardless of whether it is operated by a state under 42 U.S.C. § 18031 or by HHS under 42 U.S.C. § 18041.

b. Qualified Individuals Under 42 U.S.C. § 18032

Section 1312 of the ACA, codified at 42 U.S.C. § 18032, sets forth provisions regarding which individuals may purchase insurance from the Exchanges. This section provides that only "qualified individuals" may purchase health plans in the individual markets offered through the Exchanges, and requires that a "qualified individual" be a person who "resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A)(ii). There is no separate provision defining "qualified individual" for purposes of the federally-facilitated Exchanges.

If this provision were read literally, no "qualified individuals" would exist in the thirty-four states with federally-facilitated Exchanges, as none of these states is a "State that established [an] Exchange." The federal Exchanges would have no customers, and no purpose. Such a construction must be avoided, if at all possible. See Fund for Animals, Inc. v.

Kempthorne, 472 F.3d 872, 877 (D.C. Cir. 2006) ("[C]ourts presume that Congress has used its scarce legislative time to enact statutes that have some legal consequence."). And this absurd construction can be avoided, say defendants, by viewing 42 U.S.C. § 18041 – the provision which grants states flexibility in the operation of Exchanges and permits the Secretary to establish and operate an Exchange when a state declines to do so – as authorizing the federal government to "stand[] in the shoes of the state" for purposes of Section 18032's residency requirement. See Defs.' Reply 13.

Plaintiffs concede that the federally-run Exchanges *must* be able to offer insurance, and suggest that the Court should not interpret the residency requirement literally. According to plaintiffs, the residency provision "*assumes* that a state created the Exchange; so it can quite readily be construed as not prohibiting eligibility [to apply for insurance] where that assumption proves false." Pls.' SJ Opp. 15; see also Dec. 3, 2013 Tr. 24-25. But plaintiffs' concession only proves the defendants' point. Various provisions of the ACA besides the residency provision reflect an assumption that a state-established Exchange exists in each state. See, e.g., 42 U.S.C. § 18032(f)(1)(A)(ii); 42 U.S.C. § 1396a(gg) (requiring state compliance with certain Medicaid standards until "an Exchange established by the State under [42 U.S.C. § 18031] is fully operational"); 42 U.S.C. § 1397ee(d)(3)(B) (directing HHS to assess compliance of certain benefits of health plans offered through "an Exchange established by the State under [42 U.S.C. § 18031]"); see also 42 U.S.C. § 18031(d)(1) ("An Exchange shall be a governmental agency or nonprofit entity that is *established by a State*.") (emphasis added). If construed literally, these provisions would be nullified when applied to states without state-run Exchanges, leading to strange or absurd results. These provisions make far more sense when construed consistently with defendants' interpretation of the Act – *i.e.*, viewing 42 U.S.C.

§ 18041 as authorizing the federal government to create "an Exchange established by the State under [42 U.S.C. § 18031]" on behalf of a state that declines to establish its own Exchange.

3. Purpose of the Affordable Care Act

In adopting the ACA, Congress believed that the Act would address the lack of access by many Americans to affordable health care, ACA § 1501(a)(2)(E)-(G), *codified at* 42 U.S.C. § 18091(2)(E)-(G), and would lead to "near-universal coverage." ACA § 1501(a)(2)(D), *codified at* 42 U.S.C. § 18091(2)(D). Indeed, Title I of the ACA is titled "Quality, Affordable Health Care for *All* Americans" (emphasis added). Plaintiffs' proposed construction in this case – that tax credits are available only for those purchasing insurance from state-run Exchanges – runs counter to this central purpose of the ACA: to provide affordable health care to virtually all Americans. Such an interpretation would violate the basic rule of statutory construction that a court must interpret a statute in light of its history and purpose. See Zuni Pub. Sch. Dist. No. 89 v. Dep't of Educ., 550 U.S. 81, 90-93 (2007); Ragsdale v. Wolverine World Wide, Inc., 535 U.S. 81, 88 (2002) (rejecting Department of Labor rule as "contrary to the [statute's] remedial design").

Plaintiffs try to explain away the inconsistency between their proposed construction and the statute's underlying purpose by proposing that Congress had another, equally pressing goal when it passed the ACA: convincing each state to set up its own health insurance Exchange. See Pls.' SJ Opp. 23-24; Dec. 3, 2013 Tr. 8. According to plaintiffs, Congress desperately wanted to keep the federal government out of the business of running any Exchange, and it therefore sought to persuade the states to establish and operate the Exchanges. Pls.' SJ Opp. 23-24. As an inducement, say plaintiffs, Congress made premium tax credits available only to those states that set up their own Exchanges. Id.; see also Dec. 3, 2013 Tr. 8

(Congress needed to provide states with "a big incentive" to undertake "a thankless, very controversial task"); Dec. 3, 2013 Tr. 12 ("Everyone assumed that the states would take the deal. . . . [T]his deal is free federal money. . . . Who turns down a gift horse like that in the mouth?"). According to plaintiffs, "Congress obviously wanted subsidies in every state, but it wanted something else. It wanted the states to run it. And they thought they were getting both because they thought it was a deal nobody could refuse." Dec. 3, 2013 Tr. 17.

Plaintiffs' theory is tenable only if one accepts that in enacting the ACA, Congress intended to compel states to run their own Exchanges – or at least to provide such compelling incentives that they would not decline to do so. The problem that plaintiffs confront in pressing this argument is that there is simply no evidence in the statute itself or in the legislative history of any intent by Congress to ensure that states established their own Exchanges. And when counsel for plaintiffs was asked about this at oral argument, he could point to none. See Dec. 3, 2013 Tr. 8-18. Indeed, if anything, the legislative history cuts in the other direction and suggests that Congress intended to provide states with flexibility as to whether or not to establish and operate Exchanges. See infra at 35-38.

Nor does plaintiffs' theory make intuitive sense. A state-run Exchange is not an end in and of itself, but rather a mechanism intended to facilitate the purchase of affordable health insurance. And there is evidence throughout the statute of Congress's desire to ensure broad access to affordable health coverage. See, e.g., 42 U.S.C. § 18091(2)(D)-(G). It makes little sense to assume that Congress sacrificed nationwide availability of the tax credit – which plaintiff David Klemencic previously described as critical to the operation of the Exchanges, Brief for Private Petitioners on Severability, Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct.

2566 (2012) (Nos. 11-393 & 11-400), 2012 WL 72440, at *51-52 (Defs.' SJ Mot., Ex. 14) – in an attempt to promote state-run Exchanges.[12]

In sum, while there is more than one plausible reading of the challenged phrase in Section 36B when viewed in isolation, the cross-referenced sections, the surrounding provisions, and the ACA's structure and purpose all evince Congress's intent to make premium tax credits available on both state-run and federally-facilitated Exchanges. Thus, the intent of Congress is clear at Chevron step one. See Nat'l Cable & Telecomms. Ass'n v. FCC, 567 F.3d 659, 663, 665 (D.C. Cir. 2009) (employing all "traditional tools of statutory interpretation," including "text, structure, purpose, and legislative history," to ascertain Congress's intent at Chevron step one); Catawba County, North Carolina v. Envtl. Prot. Agency, 571 F.3d 20, 35 (D.C. Cir. 2009).

4. Legislative History

If there were any remaining uncertainty as to the ACA's meaning – and there is not – the scant relevant legislative history in this case confirms Congress's intent on this point. See, e.g., Nat'l Cable & Telecomms. Ass'n v. FCC, 567 F.3d at 665 (considering legislative

[12] Moreover, the statutory formula for calculating the tax credit seems an odd place to insert a condition that the states establish their own Exchanges if they wish to secure tax credits for their citizens. See Whitman v. Am. Trucking Ass'ns, 531 U.S. 457, 468 (2001) ("[Congress] does not, one might say, hide elephants in mouseholes."). One would expect that if Congress had intended to condition availability of the tax credits on state participation in the Exchange regime, this condition would be laid out clearly in subsection (a), the provision authorizing the credit, or some other provision outside of the calculation formula. This is particularly so because courts presume that "Congress when it enacts a statute is not making the application of the federal act dependent on state law." Mississippi Band of Choctaw Indians v. Holyfield, 490 U.S. 30, 43 (1989) (collecting cases); see also United States v. Irvine, 511 U.S. 224, 238 (1994) ("[T]he revenue laws are to be construed in the light of their general purpose to establish a nationwide scheme of taxation uniform in its application.").

history at Chevron step one); Sierra Club v. Envtl. Prot. Agency, 551 F.3d 1019, 1027 (D.C. Cir. 2008) (same).[13]

Early proposals for comprehensive health insurance reform contemplated that the federal government would establish and operate the Exchanges, and an earlier version of the House Bill so provided. See Reconciliation Act of 2010, H.R. 4872 §§ 141(a), 201(a) (2010) (version reported in the House on March 17, 2010) (establishing a national exchange within a newly created Health Choices Administration located in the Executive Branch); see also H. REP. NO. 111-443, at 18, 26 (2013). Ultimately, however, these proposals proved politically untenable and doomed to failure in the Senate, so the Senate passed a bill that provided "flexibility" to each state as to whether it would operate the Exchange. See 42 U.S.C. § 18041 (titled "State Flexibility in operation and enforcement of Exchanges . . . "). As the Chairman of the Senate Finance Committee – the committee that considered and reported the bill – described it, the ACA "fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges." 155 Cong. Rec. S13,832 (Dec. 23, 2009) (Sen. Baucus). The Senate Finance Committee expressly contemplated that the federal government could "establish state exchanges." See S. REP. NO. 111-89, at 19 (Oct. 19, 2009) ("If these [state] interim exchanges are not operational within a reasonable period after enactment, the Secretary [of HHS] would be required to contract with a nongovernmental entity *to establish state exchanges* during this interim period.") (emphasis

[13] Because the House and Senate versions of the Act were synthesized through a reconciliation process, rather than the standard conference committee process, no conference report was issued for the Act, and there is a limited legislative record relating to the final version of the bill. The legislative history that is available, however, supports defendants' argument that Congress intended that state-run and federally-facilitated Exchanges operate identically.

added). This history reveals an intent to grant states the option of establishing their own Exchanges, rather than an intent to coerce or entice states into participating.

Furthermore, there is no evidence that either the House or the Senate considered making tax credits dependent upon whether a state participated in the Exchanges. To the contrary, Congress assumed that tax credits would be available nationwide. See, e.g., Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, Defs.' SJ Mot., Ex. 5, at 2, 4-7 (Nov. 30, 2009) (calculating anticipated subsidies across all states); Letter from Douglas W. Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, House Committee on Oversight and Government Reform, Defs.' SJ Mot., Ex. 17, at 1 (Dec. 6, 2012) ("To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered."). Plaintiffs hang much of their argument on the suggestion of one contemporaneous commentator that Congress could incentivize state participation in the Exchanges "by offering tax subsidies for insurance only in states that complied with federal requirements." Timothy S. Jost, *Health Insurance Exchanges: Legal Issues* 7, O'Neill Institute, Georgetown Univ. Law Ctr., no. 23, April 27, 2009, http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1022&context=ois_papers. But there is no evidence in the legislative record that the House, the Senate, any relevant committee of either House, or any legislator ever entertained this idea.

In sum, the Court finds that the plain text of the statute, the statutory structure, and the statutory purpose make clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated Exchanges. What little relevant legislative

history exists further supports this conclusion and certainly – despite plaintiffs' best efforts to suggest otherwise – it does not undermine it. The Court therefore concludes that "Congress has directly spoken to the precise question" of whether an "Exchange" under 26 U.S.C. § 36B includes federally-facilitated Exchanges. Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. at 842. And that must be "the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Id. at 842-83. The IRS has done exactly that by promulgating regulations authorizing the provision of tax credits to individuals who purchase health insurance on federally-facilitated Exchanges as well as to those who purchase insurance on state-run Exchanges.[14]

IV. CONCLUSION

For the reasons discussed above, the Court finds that the IRS Rule is consistent with the text, structure, and purpose of the Affordable Care Act. Section 36B must be read as authorizing the IRS to deliver tax credits to individuals purchasing health insurance on federally-facilitated Exchanges. The Court therefore denies plaintiffs' motion for summary judgment and

[14] Even if the statute could be characterized as ambiguous – which it cannot – the IRS Rule must be upheld at Chevron step two as a permissible construction of the statute. For the reasons set forth above, the plain text of the statute, when considered in light of the statutory structure, the statute's purpose, and the limited legislative history, establish that the Secretary's interpretation is, at minimum, a reasonable one. Similarly, because the Court finds that the IRS Rule comports with the unambiguous meaning of the statute, and, alternatively, the Secretary's interpretation of the statute in promulgating the Rule was at least permissible, it finds no merit in plaintiffs' argument that the agency has failed to demonstrate that it arrived at its interpretation of the statute through reasoned decision-making.

grants defendants' motion for summary judgment. An Order consistent with this Opinion will issue this same day.

/s/_____
PAUL L. FRIEDMAN
United States District Judge

DATE: January 15, 2014

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued March 25, 2014 Decided July 22, 2014

No. 14-5018

JACQUELINE HALBIG, ET AL.,
APPELLANTS

v.

SYLVIA MATHEWS BURWELL, IN HER OFFICIAL CAPACITY AS U.S. SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
APPELLEES

Appeal from the United States District Court
for the District of Columbia
(No. 1:13-cv-00623)

Michael A. Carvin argued the cause for appellants. With him on the briefs were *Yaakov M. Roth* and *Jonathan Berry*.

Rebecca A. Beynon, *E. Scott Pruitt*, Attorney General, Office of the Attorney General for the State of Oklahoma, *Patrick R. Wyrick*, Solicitor General, *Luther Strange*, Attorney General, Office of the Attorney General for the State of Alabama, *Sam Olens*, Attorney General, Office of the Attorney General for the State of Georgia, *Patrick Morrisey*, Attorney General, Office of the Attorney General for the State of West Virginia, *Jon Bruning*, Attorney General, Office of the Attorney General for the State of Nebraska, and *Alan Wilson*, Attorney General, Office of the Attorney General for

the State of South Carolina were on the brief for *amici curiae* Consumer's Research, et al.

C. Boyden Gray, *Adam J. White*, and *Adam R.F. Gustafson* were on the brief for *amicus curiae* The Galen Institute in support of appellants.

Charles J. Cooper, *David H. Thompson*, *Howard C. Nielson*, and *Michael E. Roman* were on the brief for *amici curiae* Senator John Cornyn, et al. in support of appellants.

John R. Woodrum was on the brief for *amicus curiae* National Federation of Independent Business Legal Center in support of appellants.

Bert W. Rein, *William S. Consovoy*, *John M. Connolly*, and *Ilya Shapiro* were on the brief for *amici curiae* Pacific Research Institute, et al. in support of appellants.

Derek Schmidt, Attorney General, Office of the Attorney General for the State of Kansas, *Jeffrey A. Chanay*, Deputy Attorney General, *Stephen R. McAllister*, Solicitor General, *Bryan C. Clark*, Assistant Solicitor General, *Bill Schuette*, Attorney General, Office of the Attorney General for the State of Michigan, and *Jon Bruning*, Attorney General, Office of the Attorney General for the State of Nebraska, were on the brief for *amici curiae* States of Kansas, et al. in support of appellants.

Andrew M. Grossman was on the brief for *amici curiae* Jonathan Adler, et al. in support of appellants.

Stuart F. Delery, Assistant Attorney General, U.S. Department of Justice, argued the cause for appellees. With him on the brief were *Ronald C. Machen, Jr.*, U.S. Attorney,

Beth S. Brinkmann, Deputy Assistant Attorney General, and *Mark B. Stern* and *Alisa B. Klein*, Attorneys.

Martha Jane Perkins, *Kelly Bagby*, *Iris Y. Gonzalez*, and *Michael Schuster* were on the brief for *amici curiae* AARP and National Health Law Program in support of appellees.

Mary P. Rouvelas was on the brief for *amici curiae* The American Cancer Society, et al. in support of appellees.

H. Guy Collier and *Ankur J. Goel* were on the brief for *amici curiae* Public Health Deans, Chairs, and Faculty in support of appellees.

Elizabeth B. Wydra and *Simon Lazarus* were on the brief for *amici curiae* Members of Congress and State Legislatures in support of appellees.

Dominic F. Perella, *Sean Marotta*, and *Melinda Reid Hatton* were on the brief for *amicus curiae* The American Hospital Association in support of appellees.

Andrew J. Pincus and *Brian D. Netter* were on the brief for *amicus curiae* America's Health Insurance Plans in support of appellees.

Matthew S. Hellman and *Matthew E. Price* were on the brief for *amici curiae* Economic Scholars in support of appellees.

Robert Weiner and *Murad Hussain* were on the brief for *amicus curiae* Families USA in support of appellees.

Before: GRIFFITH, *Circuit Judge*, and EDWARDS and RANDOLPH, *Senior Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* GRIFFITH.

Concurring opinion filed by *Senior Circuit Judge* RANDOLPH.

Dissenting opinion filed by *Senior Circuit Judge* EDWARDS.

GRIFFITH, *Circuit Judge*: Section 36B of the Internal Revenue Code, enacted as part of the Patient Protection and Affordable Care Act (ACA or the Act), makes tax credits available as a form of subsidy to individuals who purchase health insurance through marketplaces—known as "American Health Benefit Exchanges," or "Exchanges" for short—that are "established by the State under section 1311" of the Act. 26 U.S.C. § 36B(c)(2)(A)(i). On its face, this provision authorizes tax credits for insurance purchased on an Exchange established by one of the fifty states or the District of Columbia. *See* 42 U.S.C. § 18024(d). But the Internal Revenue Service has interpreted section 36B broadly to authorize the subsidy also for insurance purchased on an Exchange established by the federal government under section 1321 of the Act. *See* 26 C.F.R. § 1.36B-2(a)(1) (hereinafter "IRS Rule").

Appellants are a group of individuals and employers residing in states that did not establish Exchanges. For reasons we explain more fully below, the IRS's interpretation of section 36B makes them subject to certain penalties under the ACA that they would rather not face. Believing that the IRS's interpretation is inconsistent with section 36B, appellants challenge the regulation under the Administrative Procedure Act (APA), alleging that it is not "in accordance with law." 5 U.S.C. § 706(2)(A).

On cross-motions for summary judgment, the district court rejected that challenge, granting the government's motion and denying appellants'. *See Halbig v. Sebelius*, No. 13 Civ. 623 (PLF), 2014 WL 129023 (D.D.C. Jan. 15, 2014). After resolving several threshold issues related to its jurisdiction, the district court held that the ACA's text, structure, purpose, and legislative history make "clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated Exchanges." *Id.* at *18. Furthermore, the court held that even if the ACA were ambiguous, the IRS's regulation would represent a permissible construction entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

Appellants timely appealed the district court's orders, and we have jurisdiction under 28 U.S.C. § 1291. Our review of the orders is de novo, and "[o]n an independent review of the record, we will uphold an agency action unless we find it to be 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.'" *Holland v. Nat'l Mining Ass'n*, 309 F.3d 808, 814 (D.C. Cir. 2002) (quoting 5 U.S.C. § 706(2)(A)). Because we conclude that the ACA unambiguously restricts the section 36B subsidy to insurance purchased on Exchanges "established by the State," we reverse the district court and vacate the IRS's regulation.

I

Congress enacted the Patient Protection and Affordable Care Act in 2010 "to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 132 S. Ct. 2566, 2580 (2012). The ACA pursues these goals through

a complex network of interconnected policies focused primarily on helping individuals who do not receive coverage through an employer or government program to purchase affordable insurance directly. Central to this effort are the Exchanges. 42 U.S.C. § 18031(b)(1). Exchanges are "governmental agenc[ies] or nonprofit entit[ies]" that serve as both gatekeepers and gateways to health insurance coverage. *See id.* § 18031(d)(1). Among their many functions as gatekeepers, Exchanges determine which health plans satisfy federal and state standards, and they operate websites that allow individuals and employers to enroll in those that do. *See id.* § 18031(b)(1), (d)(1)-(d)(4). Section 1311 of the ACA delegates primary responsibility for establishing Exchanges to individual states. *See id.* § 18031(b)(1) (providing that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State"). However, because Congress cannot require states to implement federal laws, *see Printz v. United States*, 521 U.S. 898, 904-05, 935 (1997), if a state refuses or is unable to set up an Exchange, section 1321 provides that the federal government, through the Secretary of Health and Human Services (HHS), "shall . . . establish and operate such Exchange within the State." 42 U.S.C. § 18041(c)(1). As of today, only fourteen states and the District of Columbia have established Exchanges. The federal government has established Exchanges in the remaining thirty-six states, in some cases with state assistance but in most cases not. *See* Richard Cauchi, *State Actions To Address Health Insurance Exchanges*, NAT'L CONFERENCE OF STATE LEGISLATURES (May 9, 2014), http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

Under section 36B, Exchanges also serve as the gateway to the refundable tax credits through which the ACA

subsidizes health insurance. *See* 26 U.S.C. § 36B(a). Generally speaking, section 36B authorizes credits for "applicable taxpayer[s]," *id.*, defined as those with household incomes between 100 and 400 percent of the federal poverty line, *id.* § 36B(c)(1)(A). But section 36B's formula for calculating the credit works further limits on who may receive the subsidy. According to that formula, the credit is to equal the sum of the "premium assistance amounts" for each "coverage month." *Id.* § 36B(b)(1). The "premium assistance amount" is based on the cost of a "qualified health plan . . . enrolled in through an Exchange established by the State under [section] 1311 of the [ACA]." *Id.* § 36B(b)(2); *see also* 42 U.S.C. §§ 18021(a)(1), 18031(c)(1) (establishing requirements for "qualified health plans"). Likewise, a "coverage month" is a month for which, "as of the first day of such month the taxpayer . . . is covered by a qualified health plan . . . that was enrolled in through an Exchange established by the State under section 1311 of the [ACA]." 26 U.S.C. § 36B(c)(2)(A)(i). In other words, the tax credit is available only to subsidize the purchase of insurance on an "Exchange established by the State under section 1311 of the [ACA]."

But, in a regulation promulgated on May 23, 2012, the IRS interpreted section 36B to allow credits for insurance purchased on either a state- or federally-established Exchange. Specifically, the regulation provided that a taxpayer may receive a tax credit if he "is enrolled in one or more qualified health plans through an Exchange," 26 C.F.R. § 1.36B-2(a)(1), which the IRS defined as "an Exchange serving the individual market for qualified individuals . . . , *regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS*." 45 C.F.R. § 155.20 (emphasis added); *see* 26 C.F.R. § 1.36B-1(k) (incorporating the definition in 45 C.F.R. § 155.20 by reference). In

promulgating this broader rule, the IRS acknowledged that "[c]ommentators disagreed on whether the language in section 36B(b)(2)(A) limits the availability of the premium tax credit only to taxpayers who enroll in qualified health plans on State Exchanges," but asserted without elaboration that "[t]he statutory language of section 36B and other provisions of the [ACA]," as well as "the relevant legislative history," supported its view. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012).

This broader interpretation has major ramifications. By making credits more widely available, the IRS Rule gives the individual and employer mandates—key provisions of the ACA—broader effect than they would have if credits were limited to state-established Exchanges. The individual mandate requires individuals to maintain "minimum essential coverage" and, in general, enforces that requirement with a penalty. *See* 26 U.S.C. § 5000A(a)-(b). The penalty does not apply, however, to individuals for whom the annual cost of the cheapest available coverage, *less any tax credits*, would exceed eight percent of their projected household income. *See id.* § 5000A(e)(1)(A)-(B). By some estimates, credits will determine on which side of the eight-percent threshold millions of individuals fall. *See* Br. of Economic Scholars in Support of Appellees 18. Thus, by making tax credits available in the 36 states with federal Exchanges, the IRS Rule significantly increases the number of people who must purchase health insurance or face a penalty.

The IRS Rule affects the employer mandate in a similar way. Like the individual mandate, the employer mandate uses the threat of penalties to induce large employers—defined as those with at least 50 employees, *see* 26 U.S.C. § 4980H(c)(2)(A)—to provide their full-time employees with health insurance. *See generally id.* § 4980H(a). Specifically,

the ACA penalizes any large employer who fails to offer its full-time employees suitable coverage *if* one or more of those employees "enroll[s] . . . in a qualified health plan with respect to which an applicable tax credit . . . is allowed or paid with respect to the employee." *Id.* § 4980H(a)(2); *see also id.* § 4980H(b) (linking another penalty on employers to employees' receipt of tax credits). Thus, even more than with the individual mandate, the employer mandate's penalties hinge on the availability of credits. If credits were unavailable in states with federal Exchanges, employers there would face no penalties for failing to offer coverage. The IRS Rule has the opposite effect: by allowing credits in such states, it exposes employers there to penalties and thereby gives the employer mandate broader reach.

II

Before we can turn to the merits of the parties' dispute, we must first address the government's argument that all appellants lack standing and that, even if they have standing, the APA does not provide them with a cause of action to challenge the IRS Rule. Because we find that appellant David Klemencic has standing and a cause of action under the APA, we do not reach the issue of our jurisdiction over the remaining appellants' claims. *See Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) (explaining that as long as one plaintiff has standing for a claim, "we need not consider the standing of the other plaintiffs to raise that claim").

A

The "'irreducible constitutional minimum'" a plaintiff must show to establish standing is (1) an injury in fact (2) fairly traceable to the alleged conduct of the defendant

(3) that is likely to be redressed by the relief the plaintiff seeks. *Sprint Commc'ns Co. v. APCC Servs., Inc.*, 554 U.S. 269, 273-74 (2008) (quoting *Lujan v. Defenders of Wildlife*, 405 U.S. 555, 560-61 (1992)). The district court determined that at least one of the appellants, David Klemencic, has standing. Klemencic resides in West Virginia, a state that did not establish its own Exchange, and expects to earn approximately $20,000 this year.[1] He avers that he does not wish to purchase health insurance and that, but for federal credits, he would be exempt from the individual mandate because the unsubsidized cost of coverage would exceed eight percent of his income. The availability of credits on West Virginia's federal Exchange therefore confronts Klemencic with a choice he'd rather avoid: purchase health insurance at a subsidized cost of less than $21 per year or pay a somewhat greater tax penalty.

The government primarily questions whether Klemencic has suffered an injury in fact. An injury in fact is "a concrete and particularized invasion of a legally protected interest." *Sprint Commc'ns Co.*, 554 U.S. at 273 (internal quotation marks omitted). The government characterizes Klemencic's injury as purely ideological and hence neither concrete nor particularized. But, although Klemencic admits to being at

[1] Although West Virginia actually passed legislation authorizing the establishment of an Exchange, *see* W. VA. CODE § 33-16G-1 *et seq.*, it subsequently decided to allow the federal government to establish the Exchange, in partnership with the state, due to cost concerns, *see* Nat'l Conference of State Legislatures: Health Insurance Exchanges or Marketplaces: State Action—May 2014, http://www.ncsl.org/Portals/1/Documents/Health/Health_Insurance_Exchanges_State_Profiles.pdf#page=49 (last visited June 12, 2014).

least partly motivated by opposition to "government handouts," he has established that, by making subsidies available in West Virginia, the IRS Rule will have quantifiable economic consequences particular to him. *See Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138, 1147 (2013) (explaining that a "threatened injury" that is "certainly impending" may "constitute injury in fact" (emphasis and internal quotation marks omitted)). Those consequences may be small, but even an "'identifiable trifle'" of harm may establish standing. *Chevron Natural Gas v. FERC*, 199 F. App'x 2, 4 (D.C. Cir. 2006) (quoting *United States v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 689 n.14 (1973)); *see Bob Jones Univ. v. United States*, 461 U.S. 574, 581-82 (1983) (noting that Bob Jones University sued for a tax refund of $21.00). Klemencic thus satisfies the requirement of establishing an injury in fact, and because that injury is traceable to the IRS Rule and redressable through a judicial decision invalidating the rule, we find that he has standing to challenge the rule. We therefore proceed to consider whether Klemencic may mount his challenge under the APA.

B

The APA provides a cause of action to challenge final agency action "for which there is no other adequate remedy in a court." 5 U.S.C. § 704. The government argues that even if Klemencic has standing to challenge the IRS Rule, he cannot do so under the APA because he has an adequate alternative remedy in the form of a tax-refund suit: Klemencic could violate the individual mandate, pay the penalty, and then sue for a refund, raising the same arguments he makes here. *See* 28 U.S.C. § 1346(a)(1); *see also* 26 U.S.C. § 7422(a). Such a remedy is adequate, the government contends, because if

Klemencic were successful, the suit would make him financially whole.

The APA "embodies the basic presumption of judicial review" of agency action. *Abbott Labs. v. Gardner*, 387 U.S. 136, 140 (1967). Therefore, in determining whether an alternative remedy is adequate, we must give the APA's "generous review provisions" a "hospitable interpretation," such that "only upon a showing of clear and convincing evidence of a contrary legislative intent should the courts restrict access to judicial review." *Id.* at 141 (internal quotation marks omitted); *see Garcia v. Vilsack*, 563 F.3d 519, 523 (D.C. Cir. 2009). Under this standard, "[a]n alternative remedy will not be adequate . . . if the remedy offers only 'doubtful and limited relief.'" *Garcia*, 563 F.3d at 522 (quoting *Bowen v. Massachusetts*, 487 U.S. 879, 901 (1988)). Although "the alternative remedy need not provide relief identical to relief under the APA," it must "offer[] relief of the 'same genre.'" *Id.* at 522 (quoting *El Rio Santa Cruz Neighborhood Health Ctr. v. U.S. Dep't of Health & Human Servs.*, 396 F.3d 1265, 1272 (D.C. Cir. 2005)).

In arguing that a tax refund suit provides an adequate alternative remedy, the government emphasizes Klemencic's ability to recover any assessed overpayment, plus interest. But that backward-looking relief differs in kind from the prospective relief Klemencic could obtain under the APA. *See Bowen*, 487 U.S. at 904-05 (rejecting as "unprecedented" the government's argument that a suit for monetary damages is an adequate alternative to prospective relief under the APA). Specifically, requiring Klemencic to proceed via refund suit would deprive him of the opportunity to obtain a "certificate of exemption." *See* 45 C.F.R. § 155.605(g)(2). Such certificates are a form of safe harbor, allowing an individual to obtain an exemption from the mandate's penalty on the

basis of projected income, "notwithstanding any [subsequent] change in an individual's circumstances." *Id.* § 155.605(g)(2)(vi). Unlike the "prospective[]" assurance such certificates offer, *id.*, a refund suit would require Klemencic to violate the law as it now stands, pay a penalty, and only then challenge the assessment of the penalty for that previous year based on his actual income. And even if Klemencic were to prevail, his relief—financial restitution—would be backwards looking, meaning that Klemencic would have to repeat the cycle the following year. The government offers no suggestion that he could obtain a certificate of exemption through a refund action.

Furthermore, it is not clear that Klemencic could obtain any prospective relief through a refund action, let alone that which he seeks under his APA claim—namely, a declaration that the IRS Rule is invalid and an injunction barring its implementation. As we explained in *Cohen v. United States*, the provision authorizing refund suits "does not, at least explicitly, allow for prospective relief." 650 F.3d 717, 732 (D.C. Cir. 2011) (en banc); *see* 26 U.S.C. § 7422(a) (setting forth requirements applicable to any "suit or proceeding . . . for the *recovery* . . . of any penalty claimed to have been collected without authority" (emphasis added)). And the government here does not suggest that it implicitly allows such relief, maintaining instead the studied silence as to the availability of non-monetary relief that, in *Cohen*, we interpreted as a concession of the limited nature of the remedies a refund suit under section 7422 offers. *See Cohen*, 650 F.3d at 732. (noting that, by being "agnostic concerning the availability of broad equitable remedies as part of a refund suit," the IRS "unknowingly concedes" that an action under section 7422 does not offer prospective relief). We must therefore conclude that a tax refund suit is inadequate as an alternative remedy: it is "doubtful" that it offers prospective

relief at all, and the monetary relief it does offer is clearly not "of the same genre" as the relief available to appellants under the APA. *See Garcia*, 563 F.3d at 522 (internal quotation marks omitted). Because a tax refund suit thus offers Klemencic only "doubtful and limited relief," *Bowen*, 487 U.S. at 901, we hold that the APA provides him with a cause of action to challenge the IRS Rule and turn to the merits of his claim.

III

On the merits, this case requires us to determine whether the ACA permits the IRS to provide tax credits for insurance purchased through federal Exchanges. To make this determination, we begin by asking "whether Congress has directly spoken to the precise question at issue," for if it has, we must give effect to its unambiguously expressed intent. *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984). The text of section 36B is only the starting point of this analysis. That provision is but one piece of a vast, complex statutory scheme, and we must consider it both on its own and in relation to the ACA's interconnected provisions and overall structure so as to interpret the Act, if possible, "as a symmetrical and coherent scheme." *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (internal quotation marks omitted); *Wolf Run Mining Co. v. Fed. Mine Safety & Health Review Comm'n*, 659 F.3d 1197, 1200 (D.C. Cir. 2011).

Although both appellants and the government argue that the ACA, read in its totality, evinces clear congressional intent, they dispute what that intent actually is. Appellants argue that if taxpayers can receive credits only for plans enrolled in "through an Exchange established by the State under section 1311 of the [ACA]," then the IRS clearly

cannot give credits to taxpayers who purchased insurance on an Exchange established by the federal government. After all, the federal government is not a "State," *see* 42 U.S.C. § 18024(d) (defining "State" to "mean[] each of the 50 States and the District of Columbia"), and its authority to establish Exchanges appears in section 1321 rather than section 1311, *see id.* § 18041(c)(1). The government counters that appellants take a blinkered view of the ACA and that sections 1311 and 1321 of the Act establish complete equivalence between state and federal Exchanges, such that when the federal government establishes an Exchange, it does so standing in the state's shoes. Furthermore, the government argues, whereas appellants' construction of section 36B renders other provisions of the ACA absurd, its own view brings coherence to the statute and better promotes the purpose of the Act.

We conclude that appellants have the better of the argument: a federal Exchange is not an "Exchange established by the State," and section 36B does not authorize the IRS to provide tax credits for insurance purchased on federal Exchanges. We reach this conclusion by the following path: First, we examine section 36B in light of sections 1311 and 1321, which authorize the establishment of state and federal Exchanges, respectively, and conclude that section 36B plainly distinguishes Exchanges established by states from those established by the federal government. We then consider the government's arguments that this construction generates absurd results but find that it does not render other provisions of the ACA unworkable, let alone so unreasonable as to justify disregarding section 36B's plain meaning. Finally, turning to the ACA's purpose and legislative history, we find that the government again comes up short in its efforts to overcome the statutory text. Its appeals to the ACA's broad aims do not demonstrate that Congress

manifestly meant something other than what section 36B says.

A

The crux of this case is whether an Exchange established by the federal government is an "Exchange established by the State under section 1311 of the [ACA]." We therefore begin with the provisions authorizing states and the federal government to establish Exchanges. Section 1311 provides that states "shall" establish Exchanges. 42 U.S.C. § 18031(b)(1). But, as the parties agree, despite its seemingly mandatory language, section 1311 more cajoles than commands. A state is not literally required to establish an Exchange; the ACA merely encourages it to do so. And if a state elects not to (or is unable to), such that it "will not have any required Exchange operational by January 1, 2014," section 1321 directs the federal government, through the Secretary of Health and Human Services, to "establish and operate *such Exchange* within the State." *Id.* § 18041(c)(1) (emphasis added).

The phrase "such Exchange" has twofold significance. First, the word "such"—meaning "aforementioned," *see* BLACK'S LAW DICTIONARY 1473 (8th ed. 2004); WEBSTER'S THIRD INT'L DICTIONARY 2283 (1981)—signifies that the Exchange the Secretary must establish is the "required Exchange" that the state failed to establish. In other words, "such" conveys what a federal Exchange is: the equivalent of the Exchange a state would have established had it elected to do so. The meaning of "Exchange" in the ACA reinforces and builds on this sense. The ACA defines an "Exchange" as "an American Health Benefit Exchange established under [section 1311 of the ACA]." 42 U.S.C. § 300gg-91(d)(21). If we import that definition into the text of section 1321, the

provision directs the Secretary to "establish . . . such American Health Benefit Exchange established under [section 1311 of the ACA] within the State." This suggests not only that the Secretary is to establish the type of exchange described in section 1311, but also that when she does so, she acts under section 1311, even though her authority appears in section 1321. Thus, section 1321 creates equivalence between state and federal Exchanges in two respects: in terms of what they are and the statutory authority under which they are established.

The problem confronting the IRS Rule is that subsidies also turn on a third attribute of Exchanges: who established them. Under section 36B, subsidies are available only for plans "enrolled in through an Exchange *established by the State* under section 1311 of the [ACA]." 26 U.S.C. § 36B(c)(2)(A)(i) (emphasis added); *see also id.* § 36B(b)(2)(A). Of the three elements of that provision—(1) an Exchange (2) established by the State (3) under section 1311—federal Exchanges satisfy only two: they are Exchanges established under section 1311. Nothing in section 1321 deems federally-established Exchanges to be "Exchange[s] established by the State." This omission is particularly significant since Congress knew how to provide that a non-state entity should be treated as if it were a state when it sets up an Exchange. In a nearby section, the ACA provides that a U.S. territory that "elects . . . to establish an Exchange . . . shall be treated as a State."[2] 42 U.S.C. § 18043(a)(1). The absence of similar language in section

[2] Specifically, the ACA permits territories to be treated as states for the limited purposes of sections 1311, 1312, and 1313. *See* 42 U.S.C. § 18043(a).

1321 suggests that even though the federal government may establish an Exchange "within the State," it does not in fact stand in the state's shoes when doing so. *See NFIB*, 132 S. Ct. at 2583 ("Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally." (citing *Russello v. United States*, 464 U.S. 16, 23 (1983))).

The dissent attempts to supply this missing equivalency by pointing to section 1311(d)(1), which provides: "An Exchange shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(d)(1). According to the dissent, (d)(1) means that an Exchange established under section 1311 is, by definition, established by a state. Therefore, the dissent argues, because federal Exchanges are established under section 1311, they too, by definition, are established by a state.

The premise that (d)(1) is definitional, however, does not survive examination of (d)(1)'s context and the ACA's structure. The other provisions of section 1311(d) are operational requirements, setting forth what Exchanges must (or, in some cases, may) do.[3] *See generally* 42 U.S.C. § 18031(d)(2)-(7) (listing "[r]equirements"). Read in keeping

[3] Although we attach little weight to section titles, the title of section 1321(c)—"Failure to establish Exchange or implement requirements"—reinforces this interpretation. *See Gorman v. Nat'l Transp. Safety Bd.*, 558 F.3d 580, 588 n.5 (D.C. Cir. 2009) (recognizing that "headings 'are of use . . . when they shed light on some ambiguous word or phrase'" (ellipsis in original) (quoting *Bhd. of R.R. Trainmen v. Balt. & O. R. Co.*, 331 U.S. 519, 529 (1947))).

with that theme, (d)(1) would simply require that an Exchange operate as either a governmental agency or nonprofit entity. But the dissent would have us construe (d)(1) differently. In its view, (d)(1) plays a definitional role unique among section 1311(d)'s otherwise operational provisions, creating a legal fiction that any Exchange is, by definition, established by a state, even when, as a matter of fact, it is not. That reading, however, would render (d)(1) the odd man out twice over: both within section 1311(d) and among the ACA's other definitional provisions, which, unlike (d)(1), employ the (unmistakably definitional) formula of "The term 'X' means . . . ." *See, e.g.*, 42 U.S.C. §§ 300gg-91, 18024; *see also* 26 U.S.C. § 4980H(c).

The dissent's reading would also require us to overlook the fact that section 1311(d) would be a strange place for Congress to have buried such a legal fiction. Section 1311, after all, concerns Exchanges that are established by states *in fact*; the legal fiction the dissent urges would matter only to Exchanges established by the federal government. To accept the dissent's construction would therefore transform (d)(1) into the proverbial elephant in the mousehole—the "ancillary provision[]" that "alter[s] the fundamental details of a regulatory scheme." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). The Supreme Court has repeatedly held that Congress does not legislate in this manner, *see id.*; *accord Gonzales v. Oregon*, 546 U.S. 243, 267 (2006), and we see no evidence that it did so here.[4] Indeed, we are particularly loath

[4] The government makes its own elephants-in-mouseholes argument, asserting that the formula for calculating tax credits (located in section 36B(b)) is an odd place to insert a condition that the states must establish their own Exchanges if they wish to secure tax credits for their citizens. The more natural location, the

to accept the dissent's construction given that there are far more natural locations to place this fiction, such as section 1321 or the provision defining the term "Exchange," 42 U.S.C. § 300gg-91(d)(21).

The dissent's construction of (d)(1) also ignores the structural relationship between sections 1311 and 1321. Just as section 1311(b)(1) assumes that states will establish Exchanges in general, *see* 42 U.S.C. § 18031(b)(1), section

---

government suggests, would have been section 36B(a), which authorizes the credit in the first place. *See* 26 U.S.C. § 36B(a). But even under the government's reading of section 36B(b), the statutory formula houses an elephant: namely, the rule that subsidies are only available for plans purchased through Exchanges. Given that this other crucial limitation on the availability of subsidies is found only in section 36B's formula, the government's contention that the formula is a mere mousehole is unpersuasive.

Equally unpersuasive is the dissent's suggestion that section 36B cannot mean what it plainly says because Congress did not use an "if/then" formula to signify that credits are available only on state-established Exchanges. The dissent cites no authority for requiring such magic words, and we perceive none. Section 36B(b) also does not employ an "if/then" construction for the requirement that credit-eligible coverage be purchased through an Exchange, yet neither the government nor dissent disputes that requirement. It is simply not the case that Congress expresses conditions only through such language. Indeed, in 26 U.S.C. § 35, which establishes a tax credit to offset the cost of health insurance for certain workers displaced by foreign competition, Congress made the availability of the credit turn, in part, on state cooperation without employing "if/then" language, simply through its definition of the phrase "eligible coverage month." *See* 26 U.S.C. § 35(e)(2)(A).

1311(d) assumes that states will carry out the specific requirements Exchanges must meet. But if those assumptions prove wrong, section 1321 assigns the federal government responsibility both to establish the Exchange and to ensure that it satisfies the particulars of section 1311(d). *See id.* § 18041(c) (directing the Secretary to "establish and operate such Exchange" *and* to "take such actions as are necessary to implement such other requirements" pertaining to Exchanges). In other words, section 1321 creates a limited scheme of substitution: the requirements assigned to states by 1311(d) are transferred to the federal government if a state fails to establish an Exchange. The specific requirement that (d)(1) assumes each state will fulfill is to establish an Exchange in the form of "a governmental agency or nonprofit entity." So if a state elects not to participate in the creation of an Exchange, section 1321 directs the federal government that *it* must create "a governmental agency or nonprofit entity" to serve as the Exchange. Crucially, this construction does not entail ignoring the plain meaning of "established by a State" in section 1311(d)(1); here, section 1321 *tells* us to substitute the federal government for the state under a certain scenario. But there is nothing comparable with respect to section 36B: no analogue to section 1321 says that section 36B should be read to encompass federally-established Exchanges. Accordingly, we reject the dissent's argument that, because federal Exchanges are established under section 1311, they are by definition "established by a State."

Instead, sections 1311 and 1321 lead us to interpret section 36B essentially as appellants do. Those provisions, to be sure, establish some degree of equivalence between state and federal Exchanges—enough, indeed, that if section 36B had authorized credits for insurance purchased on an "Exchange established under section 1311," the IRS Rule would stand. But section 36B actually authorizes credits only

for coverage purchased on an "Exchange *established by the State* under section 1311," 26 U.S.C. § 36B(c)(2)(A)(i), and the government offers no textual basis—in sections 1311 and 1321 or elsewhere—for concluding that a federally-established Exchange is, in fact or legal fiction, established by a state. Moreover, as we have noted, that absence is especially glaring given that the ACA elsewhere provides that a federal territory that establishes an Exchange "shall be treated as a State," 42 U.S.C. § 18043(a), clearly demonstrating that Congress knew how to deem a non-state entity to be a "State." Thus, at least in light of sections 1311 and 1321, the meaning of section 36B appears plain: a federal Exchange is not an "Exchange established by the State."

B

The government argues that we should not adopt the plain meaning of section 36B, however, because doing so would render several other provisions of the ACA absurd. Our obligation to avoid adopting statutory constructions with absurd results is well-established. *See Pub. Citizen v. U.S. Dep't of Justice*, 491 U.S. 440, 454-55 (1989). Under this principle, we will not give effect to a statute's literal meaning when doing so would "render[the] statute nonsensical or superfluous or . . . create[] an outcome so contrary to perceived social values that Congress could not have intended it." *United States v. Cook*, 594 F.3d 883, 891 (D.C. Cir. 2010) (internal quotation marks omitted). But we do not disregard statutory text lightly. The Constitution assigns the legislative power to Congress, and Congress alone, *see* U.S. CONST. art. I, § 1, and legislating often entails compromises that courts must respect. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 461 (2002). *See generally* John F. Manning, *The Absurdity Doctrine*, 116 HARV. L. REV. 2387, 2434-2435 (2003) (warning that an overbroad application of the absurdity

doctrine "contradicts the rule-of-law objectives implicit in the Constitution's strict separation of lawmaking from judging"). We therefore give the absurdity principle a narrow domain, insisting that a given construction cross a "high threshold" of unreasonableness before we conclude that a statute does not mean what it says. *Cook*, 594 F.3d at 891. A provision thus "may seem odd" without being "absurd," and in such instances "it is up to Congress rather than the courts to fix it," even if it "may have been an unintentional drafting gap." *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 565 (2005) (internal quotation marks omitted); *see also Sierra Club v. EPA*, 294 F.3d 155, 161 (D.C. Cir. 2002) ("Because our role is not to 'correct' the text so that it better serves the statute's purposes, we will not ratify an interpretation that abrogates the enacted statutory text absent an extraordinarily convincing justification." (internal quotation marks and citation omitted)).

i

The government first argues that we must uphold the IRS Rule to avoid rendering language in 26 U.S.C. § 36B(f) superfluous. Titled "Reconciliation of credit and advance credit," section 36B(f) requires the IRS to reduce a taxpayer's end-of-year credit by the amount of any advance payments made by the government to the taxpayer's insurer to offset the cost of monthly premiums. *Id.* § 36B(f)(1); *see* 42 U.S.C. § 18082(c)(2)(A) (authorizing such advance payments). As relevant here, section 36B(f) also requires "each Exchange"—*i.e.*, both state and federal Exchanges—to report certain information to the government. With respect to any health plan it provides, an Exchange must report:

> (A) The level of coverage . . . and the period such coverage was in effect.

> (B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of [the ACA].
> (C) The aggregate amount of any advance payment of such credit or reductions . . . .
> (D) The name, address, and [taxpayer identification number (TIN)] of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.
> (E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.
> (F) Information necessary to determine whether a taxpayer has received excess advance payments.

26 U.S.C. § 36B(f)(3). The government contends that these reporting requirements assume that credits are available on federal Exchanges, and it argues that the requirements would be superfluous, even nonsensical, as applied to federal Exchanges if we were to reject that assumption.

Not so. Even if credits are unavailable on federal Exchanges, reporting by those Exchanges still serves the purpose of enforcing the individual mandate—a point the IRS, in fact, acknowledged in promulgating a recent regulation, 26 C.F.R. § 1.6055-1(d)(1). That regulation exempts insurers from 26 U.S.C. § 6055, which otherwise would require that, for each policy they issue, insurers report to the IRS such information as "the name, address, and TIN of the primary insured," the dates of coverage, and the "amount (if any) or any advance payment . . . or of any premium tax credit under section 36B with respect to such coverage." 26 U.S.C. § 6055(b)(1)(B). The IRS justified the exemption for insurers on the ground that "Exchanges must report on this coverage under section 36B(f)(3)." Information Reporting of

Minimum Essential Coverage, 79 Fed. Reg. 13,220, 13,221 (Mar. 10, 2014); *see* 26 C.F.R. § 1.6055-1(d)(1).[5] The government's claim that section 36B(f)(3)'s reporting requirement serves no purpose other than reconciling credits is therefore simply not true.[6]

Furthermore, holding that credits are unavailable on federal Exchanges would not convert the specific reporting requirements concerning credits into an "'empty gesture.'" Gov't Br. 28 (quoting *Fund for Animals, Inc. v. Kempthorne*, 472 F.3d 872, 878 (D.C. Cir. 2006)). Those requirements would still allow the reconciling of credits on state Exchanges; as applied to federal Exchanges, they would simply be over-inclusive. Over-inclusiveness, however, remains a problem even if we were to agree that section 36B allows credits on federal Exchanges. Section 36B(f)(3), after all, mandates reporting "with respect to *any* health plan provided through the Exchange," 26 U.S.C. § 36B(f)(3) (emphasis added), even though only plans purchased by taxpayers with incomes between 100 and 400 percent of the federal poverty line may be subsidized, *see id.* § 36B(a),

[5] Appellants also suggest that the information collected from federal Exchanges could be useful for the "Study on Affordable Coverage" mandated by the ACA in that same section. *See* ACA § 1401(c), 124 Stat. at 220.

[6] The dissent takes a slightly different tack, emphasizing that the "*principal* purpose" of the reporting requirement is to reconcile advance and end-of-year payments. Dissenting Op. at 22. We agree but fail to see how this helps the government. Reporting by state-established Exchanges still would serve this purpose, while reporting by federally-established Exchanges would serve the secondary purpose implicitly recognized by 26 C.F.R. § 1.6055-1(d)(1).

(c)(1)(A). A weakness common to both views of the availability of credits hardly serves as a basis for choosing between them.

ii

The government next points to the supposedly absurd consequences appellants' interpretation of section 36B would have for section 1312 of the ACA, which defines the rights of "qualified individuals." *See* 42 U.S.C. § 18032. The term "'qualified individual' means, with respect to an Exchange, an individual who— (i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange." *Id.* § 18032(f)(1)(A). If this provision is given its plain meaning, then the 36 states with federal Exchanges (that, obviously, the states did not establish) have no qualified individuals. That outcome is absurd, the government argues, because in its view section 1312 restricts access to Exchanges to qualified individuals alone. *See* 45 C.F.R. § 155.20. The absence of qualified individuals would mean that federal Exchanges have no customers and therefore no purpose. The government urges us to avoid this outcome by construing section 1321 to authorize the federal government to establish Exchanges "*on behalf of*" states that decline to do so. Gov't Br. 21 (internal quotation marks omitted).

The government, however, tilts at windmills. It assumes that when section 1312(a) states that "[a] qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible," 42 U.S.C. § 18032(a)(1), it means that *only* a qualified individual may enroll in such a plan. The obvious flaw in this interpretation is that the word "only" does not appear in the provision. We have repeatedly emphasized that it is "not our

role" to "engage in a statutory rewrite" by "insert[ing] the word 'only' here and there." *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 699-700 (D.C. Cir. 2014); *see Lamie v. U.S. Tr.*, 540 U.S. 526, 538 (2004) (rejecting an interpretation that "would have [the Court] read an absent word into the statute" because such an interpretation "would result 'not [in] a construction of [the] statute, but, in effect, an enlargement of it by the court'" (second and third alterations in original) (quoting *Iselin v. United States*, 270 U.S. 245, 251 (1926))); *Pub. Citizen*, 533 F.3d at 817 ("Congress knows well how to say that disclosures may be made *only* under specified provisions or circumstances, but it did not do so here." (footnote omitted)). Section 1312(a)'s actual language simply establishes the right of a qualified individual to enroll in any qualified health plan, at any level of coverage.[7] On this reading, giving the phrase "established by the State" its plain meaning creates no difficulty, let alone absurdity. Federal Exchanges might not have qualified individuals, but they would still have customers—namely, individuals who are not "qualified individuals."[8]

---

[7] Under the ACA, qualified health plans may offer four different levels of coverage: bronze, silver, gold, and platinum. The level of coverage reflects the percentage of the insured's medical costs that the plan's benefits are designed to cover. *See* 42 U.S.C. § 18022(d)(1). Lower levels of coverage have higher deductibles and thus higher out-of-pocket costs and, as a general matter, lower premiums. *See id.*; *see also id.* § 18032(a)(2) (providing that qualified employers may "select[] any level of coverage under section 18022(d) . . . to be made available to employees through an Exchange").

[8] The government warns that interpreting section 1312(a) as a non-discrimination provision would allow undocumented aliens to shop on Exchanges. Gov't Br. at 31. But section 1312 specifically

Several other provisions in section 1312 imply that not only "qualified individuals" may participate in an Exchange. Take, for example, the provision concerning incarcerated convicts. Section 1312(f)(1)(B) states that "[a]n individual shall not be treated as a qualified individual if, *at the time of enrollment*, the individual is incarcerated, other than incarceration pending the disposition of charges." 42 U.S.C. § 18032(f)(1)(B) (emphasis added). By implying that an incarcerated convict may enroll in coverage through an Exchange despite not being a "qualified individual," this provision suggests that participation in an Exchange does not depend on "qualified individual" status. That proposition gains further strength from section 1312(d)(3), which states, first, that "[n]othing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange," 42 U.S.C. § 18032(d)(3)(A), and, second, that "[n]othing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange," *id.* § 18032(d)(3)(B). The second provision, which speaks of "individual[s]" generally, would be wholly unnecessary if only "qualified individuals" were eligible to participate in the Exchanges.[9]

---

addresses that concern, providing that aliens not "lawfully present in the United States . . . may not be covered under a qualified health plan in the individual market that is offered through an Exchange." 42 U.S.C. § 18032(f)(3).

[9] We note that section 1312's heading, "Consumer Choice," and subsection 1312(a)'s heading, "Choice," also suggest that the purpose of section 1312(a) is primarily to protect choice among levels of coverage, not restrict access to Exchanges.

iii

The government also claims that a plain meaning reading of section 36B would have peculiar effects under 42 U.S.C. § 1396a(gg)(1). That provision states that, as a condition of receiving Medicaid funds, a State may not tighten its Medicaid eligibility standards for adults until "the date on which the Secretary determines that an Exchange established by the State under [section 1311] is fully operational." 42 U.S.C. § 1396a(gg)(1). If a federally-established Exchange is not one "established by the State," the government argues, states with federal Exchanges "would *never* be relieved of th[is] . . . requirement," transforming an "interim measure" into a "perpetual obligation." Gov't Br. at 33. But appellants propose a logical explanation for why the ACA might establish this rule: to preserve Medicaid benefits for the impoverished residents of states where, as a result of having federally-established Exchanges, subsidies are unavailable. *Cf. Pub. Citizen*, 533 F.3d at 817 (adopting a reasonable explanation of a provision's purpose despite not being able to "know for certain what purpose Congress had in mind"). In this light, the results produced by giving section 36B its plain meaning seem sensible, not absurd.[10]

[10] In a footnote, the government identifies another set of provisions that supposedly embodies the assumption that federal Exchanges are Exchanges "established by the State": 42 U.S.C. § 1397ee(d)(3)(B)-(C). Those provisions instruct states to enroll children in coverage "offered through an Exchange established by the State under section [1311]" in the event of a funding shortfall in a state's Children's Health Insurance Program. *See id.* § 1397ee(d)(3)(B). Although we recognize the oddity of requiring some states and not others to take this step, we do not see how it makes the statute nonsensical or otherwise meets the high threshold

30

iv

The government urges us, in effect, to strike from section 36B the phrase "established by the State," on the ground that giving force to its plain meaning renders other provisions of the Act absurd. But we find that the government has failed to make the extraordinary showing required for such judicial rewriting of an act of Congress. Nothing about the imperative to read section 36B in harmony with the rest of the ACA requires interpreting "established by the State" to mean anything other than what it plainly says.

C

This conclusion places us at a fork in our precedent. One line of cases instructs us to cease our inquiry and give effect to the statute's unambiguous language. *See Coal. for Responsible Regulation, Inc. v. EPA*, 684 F.3d 102, 137 (D.C. Cir. 2012) (per curiam) (noting, in the *Chevron* context, that "'[w]hen the words of a statute are unambiguous . . . judicial inquiry is complete'" (ellipsis in original) (quoting *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992)), *aff'd in relevant part sub nom. Util. Air Regulatory Grp. v. EPA* (*UARG*), 134 S. Ct. 2427, 2448 (2014); *accord Dep't of Housing & Urban Dev. v. Rucker*, 535 U.S. 125, 132-33 (2002); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999) ("As in *any* case of statutory construction, our analysis

---

of absurdity. The statute remains workable, and nothing suggests that in states with federal Exchanges, the federal government could not step in and perform the same service for uninsured children. The government's bare citation to the provisions thus hardly demonstrates absurdity.

begins with the language of the statute. And where the statutory language provides a clear answer, it ends there as well." (emphasis added) (internal quotation marks and citation omitted)); *see also Am. Fed'n of Gov't Emps. v. Shinseki*, 709 F.3d 29, 33 (D.C. Cir. 2013). Another tells us to wade into the legislative history in the hope of glimpsing "new light on congressional intent." *Sierra Club v. EPA*, 551 F.3d 1019, 1027 (D.C. Cir. 2008). But, though we recognize that our decision about which path to travel implicates substantial theoretical questions of statutory interpretation, its practical consequences are less momentous here because both paths lead to the same destination. Therefore, assuming *arguendo* that it is proper to consult legislative history when the statutory text is clear, we consider what light the ACA's history offers.

We begin by clarifying the role the ACA's legislative history might play in our analysis. Legislative history is a means to an end, to be consulted for evidence of congressional intent. *See, e.g.*, *Sierra Club*, 551 F.3d at 1027. But legislative history is not the sole, or even the primary, source of such evidence. Rather, "[t]he most reliable guide to congressional intent is the legislation the Congress enacted." *Sierra Club*, 294 F.3d at 161; *see also Cal. Indep. Sys. Operator Corp. v. FERC*, 372 F.3d 395, 400 (D.C. Cir. 2004) ("[W]e assume 'that the legislative purpose is expressed by the ordinary meaning of the words used.'" (quoting *Sec. Indus. Ass'n v. Bd. of Governors of Fed. Reserve Sys.*, 468 U.S. 137, 149 (1984))); *Engine Mfrs. Ass'n*, 88 F.3d at 1088 (noting that the "most traditional tool" for "determin[ing] Congressional intent" is "to read the text"). Where used, legislative history plays a distinctly secondary role. Its purpose is not to confirm already clear text; clear text speaks for itself and requires no "amen" in the historical record. *See, e.g.*, *Harrison v. PPG Indus., Inc.*, 446 U.S. 578, 592 (1980)

("[I]t would be a strange canon of statutory construction that would require Congress to state in committee reports or elsewhere in its deliberations that which is obvious on the face of a statute."). Instead, only when "apparently plain language compels an 'odd result'" might we look to legislative history to ensure that the "'literal application of a statute will [not] produce a result demonstrably at odds with the intentions of its drafters.'" *Engine Mfrs. Ass'n*, 88 F.3d at 1088 (quoting *Public Citizen*, 491 U.S. at 454, and *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989)). Thus, accepting for the sake of argument the government's contention that the results of appellants' construction of section 36B are odd, our inquiry into the ACA's legislative history is quite narrow. In the face of the statute's plain meaning—a federal Exchange is not an "Exchange established by the State"—we ask only whether the legislative history provides evidence that this literal meaning is "*demonstrably* at odds with the intentions" of the ACA's drafters. Unless evidence in the legislative record establishes that it is, we must hew to the statute's plain meaning, even if it compels an odd result. *See id.* ("[T]here must be evidence that Congress meant something other than what it literally said before a court can depart from plain meaning."); *accord Garcia v. United States*, 469 U.S. 70, 75 (1984) (noting that "only the most extraordinary showing of contrary intentions . . . would justify a limitation on the 'plain meaning' of the statutory language"); *Bldg. & Constr. Trades Dep't, AFL-CIO v. U.S. Dep't of Labor Wage Appeals Bd.*, 932 F.2d 985, 990 (D.C. Cir. 1991).

Here, the scant legislative history sheds little light on the precise question of the availability of subsidies on federal Exchanges. The government points, for example, to a Congressional Budget Office report from November 2009, before the ACA's adoption, that calculated the cost of

subsidies based on the assumption that they would be available in all states. But that assumption is as consistent with an expectation that all states would cooperate (*i.e.*, establish their own Exchanges) as with an understanding that subsidies would be available on federal Exchanges as well. *Cf.* Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, at A17 (Aug. 5, 2012) ("When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange . . . ."). Equally unilluminating are floor statements by Senate sponsors of the ACA touting the availability and benefits of premium tax credits in general, but not addressing the precise issue of whether they would be available on federal Exchanges.

The government and its amici are thus left to urge the court to infer meaning from silence, arguing that "during the debates over the ACA, no one suggested, let alone explicitly stated, that a State's citizens would lose access to the tax credits if the State failed to establish its own Exchange." Br. of Amici Members of Congress and State Legislatures 8. The historical record, however, belies this claim. The Senate Committee on Health, Education, Labor, and Pensions (HELP) proposed a bill that specifically contemplated penalizing states that refused to participate in establishing "American Health Benefit Gateways," the equivalent of Exchanges, by denying credits to such states' residents for four years. *See* Affordable Health Choices Act, S. 1679, 111th Cong. § 3104(a), (d)(2) (2009). This is not to say that section 36B necessarily incorporated this thinking; we agree that inferences from unenacted legislation are too uncertain to be a helpful guide to the intent behind a specific provision. *See Village of Barrington v. Surface Transp. Bd.*, 636 F.3d 650, 666 (D.C. Cir. 2011). But the HELP Committee's bill certainly demonstrates that members of Congress at least

considered the notion of using subsidies as an incentive to gain states' cooperation.

In any case, even if the historical record were silent, that silence is unhelpful to the government. For the court to depart from the ACA's plain meaning, which favors appellants, "there must be *evidence* that Congress meant something other than what it literally said," from which the court can conclude that applying the statute literally would be "'*demonstrably* at odds with the intentions of [the ACA's] drafters.'" *Engine Mfrs. Ass'n*, 88 F.3d at 1088 (quoting *Ron Pair Enters.*, 489 U.S. at 242) (emphases added). As Chief Justice Marshall wrote, "it is incumbent on those who oppose" a statute's plain meaning "to shew an intent varying from that which the words import." *United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1805). Nothing the government or its amici cite demonstrates what that precise intent was. And "[i]n the absence of such evidence, the court cannot ignore the text by assuming that if the statute seems odd to us, i.e., the statute is not as we would have predicted beforehand that Congress would write it, it could be the product only of oversight, imprecision, or drafting error." *Engine Mfrs. Ass'n*, 88 F.3d at 1088-89; *see also id.* at 1091 ("With such a meager record of what happened in conference, the court is unable to reconstruct the legislative compromises that were made. Even if the final product might strike us as unexpected . . . the court could not make the leap from such an impression to the certainty that such a result was unintentional.").

The government, together with the dissent, also leans heavily on a more abstract form of legislative history—Congress's broad purpose in passing the ACA—urging the court to view section 36B through the lens of the ACA's economic theory and ultimate aims. They emphasize that to achieve the goals of "near universal coverage" and

"lower[ing] health insurance premiums," 42 U.S.C. § 18091(2)(D), (F), the ACA relies on three interrelated policies: insurance market reforms prohibiting insurers from denying coverage or charging higher premiums based on an individual's health status, *see, e.g.*, *id.* § 300gg (community rating requirement); *id.* § 300gg-1 (guaranteed issue requirement); the individual mandate, *see* 26 U.S.C. § 5000A; and subsidies to individuals purchasing insurance in the individual market, *see id.* § 36B. These policies, the government and dissent explain, are like the legs of a three-legged stool; remove any one, and the ACA will collapse. The insurance market reforms are necessary to expand the availability of insurance. The individual mandate is necessary to avoid the adverse selection that would result if people could exploit the insurance market reforms to wait to purchase insurance until they were sick. And subsidies are necessary both to make the mandated insurance affordable and, in so doing, to expand the reach of the individual mandate by reducing the cost of insurance below the threshold—eight percent of household income—at which taxpayers are exempt from the mandate's penalty. *See* 26 U.S.C. § 5000A(e)(1)(A)-(B). Given this structure, the government and dissent argue that it is "inconceivable" to think Congress would have risked the ACA's stability by making subsidies conditional on states establishing Exchanges.[11] Dissenting Op. at 2.

[11] Appellants do not challenge the government's account of the economic theory behind the ACA, but they contend that the theory must be understood through the lens of political reality. In their telling, section 36B is the product of legislative compromise to secure the support of Nebraska Senator Ben Nelson, the crucial sixtieth vote needed to avoid a filibuster. Nelson opposed House plans for a national, federally-run exchange, fearing that it would

set the United States down a path to a single-payer system. *See* Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO (Jan. 25, 2010), http://www.politico.com/livepulse/0110/Nelson_National_exchange_a_dealbreaker.html. To gain Nelson's support, proponents of the ACA scrapped the national exchange in favor of establishing exchanges on a state-by-state basis. This change, in turn, required Congress to devise means of inducing states to take on the politically and technologically challenging task of establishing exchanges. Congress's solution, appellants maintain, was a package of "carrots" and "sticks" for states. The carrots included federal grants to states for "activities (including planning activities) related to establishing an [Exchange]." 42 U.S.C. § 18031(a)(3). The sticks included the prohibition against tightening Medicaid eligibility requirements imposed on states that do not create their own Exchanges. *See id.* § 1396a(gg). The most important incentive of all, appellants argue, was the provision at issue here: making premium tax credits available only for individual coverage purchased through state-established Exchanges. According to appellants, the ACA's supporters believed no state would refuse so good an offer—and, appellants add, perhaps no state would have had the IRS not eliminated this incentive by proposing and promulgating the IRS Rule, making subsidies available regardless of which entity established an Exchange, before states had to elect whether to establish Exchanges. *See* Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012); Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931, 50,934 (Aug. 17, 2011).

Like the government, however, appellants fail to marshal persuasive evidence (apart from the statutory text, that is) in support of their theory. Senator Nelson may have opposed a single, national exchange, but it does not necessarily follow that he opposed making subsidies available on federal fallback Exchanges in uncooperative states. Similarly, the fact that the ACA contained some incentives to states does not necessarily mean that section 36B is one of them. Nor does the fact that Congress has conditioned federal benefits on state cooperation in other contexts shed light on

Yet the supposedly unthinkable scenario the government and dissent describe—one in which insurers in states with federal Exchanges remain subject to the community rating and guaranteed issue requirements but lack a broad base of healthy customers to stabilize prices and avoid adverse selection—is exactly what the ACA enacts in such federal territories as the Northern Mariana Islands, where the Act imposes guaranteed issue and community rating requirements without an individual mandate. *See* 26 U.S.C. § 5000A(f)(4) (exempting residents of such federal territories as Puerto Rico and the Northern Mariana Islands from the individual mandate by providing that they are automatically treated as having "minimum essential coverage"); 42 U.S.C. § 201(f) (providing that the Public Health Service Act, where the guaranteed issue and community rating requirements appear, applies to residents of such territories). This combination, predictably, has thrown individual insurance markets in the territories into turmoil. *See* Sarah Kliff, *Think Your State Has Obamacare Problems? They're Nothing Compared to Guam*, WASH. POST (Dec. 19, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/12/19/think-your-state-has-obamacare-problems-theyre-nothing-compared-to-guam/. But HHS has nevertheless refused to exempt the territories from the guaranteed issue and

---

the precise question of whether Congress did so in section 36B. Thus, the most that can be said of appellants' theory is that it is plausible. But we need not endorse appellants' historical account to agree with their construction of section 36B. "Where the statutory language is clear and unambiguous, we need neither accept nor reject a particular 'plausible' explanation for why Congress would have written a statute [as it did]." *Barnhart*, 534 U.S. at 460.

community rating requirements, recognizing that, "[h]owever meritorious" the reasons for doing so might be, "HHS is not authorized to choose which provisions of the [ACA] might apply to the territories." Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, HHS, to Sixto K. Igisomar, Secretary of Commerce, Commonwealth of the Northern Mariana Islands (July 12, 2013), *available at* http://www.doi.gov/oia/igia/upload/12-3-HHS-CMS-CNMI-Letter-igisomar7-12-13.pdf.

Moreover, the territories are not the only instance where the ACA did the unimaginable. A separate title of the ACA, known as the Community Living Assistance Services and Supports (CLASS) Act, *see* ACA, Pub. L. No. 111-148, §§ 8001-8002, 124 Stat. 119, 828-47 (2010), required the Secretary of HHS to establish a long-term care insurance program subject to guaranteed issue and community rating requirements but unaided by an individual mandate or premium subsidies, *see* 124 Stat. at 834. This recipe for adverse selection risk never materialized only because Congress, in response to actuarial analyses predicting that the CLASS Act would be fiscally unsustainable, repealed the provision in 2013.[12] *See* American Taxpayer Relief Act of

[12] The dissent attempts to distinguish the market targeted by the CLASS Act from the individual insurance market by pointing out that the CLASS Act contains no individual mandate. In the dissent's view, the omission "of a tool [Congress] knew to be important to preventing adverse selection merely indicates that Congress had a substantially higher tolerance for the risk of adverse selection" in peripheral markets than in the core market. Dissenting Op. at 19. This argument, however, assumes the very conclusion at issue, taking for granted that the mandate in the individual market indeed is as broad as it must be to eliminate all adverse selection risk. But the plain language of section 36B suggests that it is not. If

2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013); Sarah Kliff, *The Fiscal Cliff Cuts $1.9 Billion from Obamacare. Here's How*, WASH. POST (Jan. 2, 2013), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/02/the-fiscal-cliff-cuts-1-9-billion-from-obamacare-heres-how/.

The CLASS Act and the provisions applicable to the territories attest that Congress twice did exactly what the government and the dissent insist it never would: introduce significant adverse selection risk to insurance markets. This is not to say that as Congress did in the CLASS Act and territories, so too must it have done in section 36B; perhaps Congress was willing to tolerate risks in those corners of the insurance market that it never would tolerate at its core. But perhaps not. The point is that we don't know, and in asking us to ignore the best evidence of Congress's intent—the text of section 36B—in favor of assumptions about the risks that Congress would or would not tolerate—assumptions

---

section 36B limits the availability of subsidies and thus curtails the reach of the individual mandate, this is evidence that Congress *was* tolerant of adverse selection risk in the core markets, although Congress might not have expected the risk to materialize.

We recognize that, from an economic standpoint, such adverse selection risk bodes ill for individual insurance markets. But it made no more sense economically in the CLASS Act. Congress may simply have miscalculated the consequences of omitting a mandate, as its decision to repeal the CLASS Act suggests. In any event, whether by error or design, the CLASS Act in clear terms created a significant adverse selection risk, which, as Congress and the government recognized, could be undone only by subsequent legislation, not administrative fiat. *Cf. UARG*, 134 S. Ct. at 2445 ("An agency has no power to 'tailor' legislation to bureaucratic policy goals by rewriting unambiguous statutory terms.").

doubtlessly influenced by hindsight—the government and dissent in effect urge us to substitute our judgment for Congress's. We refuse. As the Supreme Court explained just this term, "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *UARG*, 134 S. Ct. at 2446. And neither may we. "The role of th[e] [c]ourt is to apply the statute as it is written—even if we think some other approach might 'accor[d] with good policy.'" *Burrage v. United States*, 134 S. Ct. 881, 892 (2014) (quoting *Comm'r v. Lundy*, 516 U.S. 235, 252 (1996)) (third alteration in original); *see also Lewis v. City of Chicago*, 560 U.S. 205, 217 (2010) ("[I]t is not our task to assess the consequences of each approach [to interpreting a statute] and adopt the one that produces the least mischief. Our charge is to give effect to the law Congress enacted."); *United States v. Locke*, 471 U.S. 84, 95 (1985) ("[T]he fact that Congress might have acted with greater clarity or foresight does not give courts a carte blanche to redraft statutes in an effort to achieve that which Congress is perceived to have failed to do.").

More generally, the ACA's ultimate aims shed little light on the "precise question at issue," *Chevron*, 467 U.S. at 842—namely, whether subsidies are available on federal Exchanges because such Exchanges are "established by the State." As the Supreme Court has repeatedly warned, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law" because "no legislation pursues its purposes at all costs." *Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987) (per curiam); *see also Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 646-47 (1990); *MetroPCS Cal., LLC v. FCC*, 644 F.3d 410, 414 (D.C. Cir. 2011) ("'The Act must do everything necessary to achieve its broad purpose' is the slogan of the enthusiast, not the analytical tool of the arbiter."). Thus, if legislative intent is to be our lodestar, we

cannot assume, as the government does, that section 36B single-mindedly pursues the ACA's lofty goals.

The fact is that the legislative record provides little indication one way or the other of congressional intent, but the statutory text does. Section 36B plainly makes subsidies available only on Exchanges established by states. And in the absence of any contrary indications, that text is conclusive evidence of Congress's intent. *Cf. Ethyl Corp. v. EPA*, 51 F.3d 1053, 1063 (D.C. Cir. 1995) ("At best, the legislative history is cryptic, and this surely is not enough to overcome the plain meaning of the statute."). To hold otherwise would be to say that enacted legislation, on its own, does not command our respect—an utterly untenable proposition. Accordingly, applying the statute's plain meaning, we find that section 36B unambiguously forecloses the interpretation embodied in the IRS Rule and instead limits the availability of premium tax credits to state-established Exchanges.

IV

We reach this conclusion, frankly, with reluctance. At least until states that wish to can set up Exchanges, our ruling will likely have significant consequences both for the millions of individuals receiving tax credits through federal Exchanges and for health insurance markets more broadly. But, high as those stakes are, the principle of legislative supremacy that guides us is higher still. Within constitutional limits, Congress is supreme in matters of policy, and the consequence of that supremacy is that our duty when interpreting a statute is to ascertain the meaning of the words of the statute duly enacted through the formal legislative process. This limited role serves democratic interests by ensuring that policy is made by elected, politically accountable representatives, not by appointed, life-tenured judges.

Thus, although our decision has major consequences, our role is quite limited: deciding whether the IRS Rule is a permissible reading of the ACA. Having concluded it is not, we reverse the district court and remand with instructions to grant summary judgment to appellants and vacate the IRS Rule.

RANDOLPH, *Senior Circuit Judge*, concurring: A Supreme Court tax decision, and a tax decision of this court, flatly reject the position the government takes in this case.

As Judge Griffith's majority opinion—which I fully join—demonstrates, an Exchange established by the federal government cannot possibly be "an Exchange established by the State." To hold otherwise would be to engage in distortion, not interpretation. Only further legislation could accomplish the expansion the government seeks.

In the meantime, Justice Brandeis' opinion for the Supreme Court in *Iselin v. United States* is controlling: "What the government asks is not a construction of a statute, but, in effect, an enlargement of it by the court, so that what was omitted, presumably by inadvertence, may be included within its scope. To supply omissions transcends the judicial function." 270 U.S. 245, 251 (1926). We held the same in *National Railroad Passenger Corp. v. United States*, 431 F.3d 374, 378 (D.C. Cir. 2005), citing not only *Iselin* but also *Lamie v. United States Trustee*, 540 U.S. 526, 538 (2004), which reaffirmed *Iselin*'s "longstanding" interpretative principle.

EDWARDS, *Senior Circuit Judge*, dissenting: This case is about Appellants' not-so-veiled attempt to gut the Patient Protection and Affordable Care Act ("ACA"). The ACA requires every State to establish a health insurance "Exchange," which "shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(b)(1), (d)(1). The Department of Health and Human Services ("HHS") is required to establish "such Exchange" when the State elects not to create one. *Id.* § 18041(c)(1). Taxpayers who purchase insurance from an Exchange and whose income is between 100% and 400% of the poverty line are eligible for premium subsidies. 26 U.S.C. § 36B(a), (c)(1)(A). Appellants challenge regulations issued by the Internal Revenue Service ("IRS") and HHS making these subsidies available in all States, including States in which HHS has established an Exchange on behalf of the State. In support of their challenge, Appellants rely on a specious argument that there is no "Exchange established by the State" in States with HHS-created Exchanges and, therefore, that taxpayers who purchase insurance in these States cannot receive subsidies.

As explained below, there are three critical components to the ACA: nondiscrimination requirements applying to insurers; the "individual mandate" requiring individuals who are not covered by an employer to purchase minimum insurance coverage or to pay a tax penalty; and premium subsidies which ensure that the individual mandate will have a broad enough sweep to attract enough healthy individuals into the individual insurance markets to create stability. These components work *in tandem*. At the time of the ACA's enactment, it was well understood that without the subsidies, the individual mandate was not viable as a mechanism for creating a stable insurance market.

Appellants' proffered construction of the statute would permit States to exempt many people from the individual

mandate and thereby thwart a central element of the ACA. As Appellants' *amici* candidly acknowledge, if subsidies are unavailable to taxpayers in States with HHS-created Exchanges, "the structure of the ACA will crumble." Scott Pruitt, *ObamaCare's Next Legal Challenge*, WALL ST. J., Dec. 1, 2013. It is inconceivable that Congress intended to give States the power to cause the ACA to "crumble."

Appellants contend that the phrase "Exchange established by the State" in § 36B unambiguously bars subsidies to individuals who purchase insurance in States in which HHS created the Exchange on the State's behalf. This argument fails because "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (internal quotation marks omitted). When the language of § 36B is viewed in context – *i.e.*, in conjunction with other provisions of the ACA – it is quite clear that the statute does not reveal the plain meaning that Appellants would like to find.

Because IRS and HHS have been delegated authority to jointly administer the ACA, this case is governed by the familiar framework of *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Under *Chevron*, if "the statute is silent or ambiguous with respect to the specific issue," we defer to the agency's construction of the statute, so long as it is "permissible." *Id.* at 843. The Government's permissible interpretation of the statute easily survives review under *Chevron*. The Act contemplates that an Exchange created by the federal government on a State's behalf will have equivalent legal standing with State-created Exchanges. 42 U.S.C. § 18041. And the ACA would be self-defeating if taxpayers who purchase insurance from an HHS-created Exchange are deemed ineligible to receive subsidies.

Appellants' argument cannot be squared with the clear legislative scheme established by the statute as a whole.

Apparently recognizing the weakness of a claim that rests solely on § 36B, divorced from the rest of the ACA, Appellants attempt to fortify their position with the extraordinary argument that Congress tied the availability of subsidies to the existence of State-established Exchanges to encourage States to establish their own Exchanges. This claim is nonsense, made up out of whole cloth. There is no credible evidence in the record that Congress intended to condition subsidies on whether a State, as opposed to HHS, established the Exchange. Nor is there credible evidence that any State even considered the possibility that its taxpayers would be denied subsidies if the State opted to allow HHS to establish an Exchange on its behalf.

The majority opinion ignores the obvious ambiguity in the statute and claims to rest on plain meaning where there is none to be found. In so doing, the majority misapplies the applicable standard of review, refuses to give deference to the IRS's and HHS's permissible constructions of the ACA, and issues a judgment that portends disastrous consequences. I therefore dissent.

I. STANDARD OF REVIEW

The first question a reviewing court must ask in a case of this sort is whether the disputed provisions of the statute are clear beyond dispute. "If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Chevron*, 467 U.S. at 843 n.9. In determining whether a statutory provision is ambiguous,

however, a court must evaluate it within the context of the statute as a whole:

> [A] reviewing court should not confine itself to examining a particular statutory provision in isolation. Rather, the meaning – or ambiguity – of certain words or phrases may only become evident when placed in context. . . . It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.

Nat'l Ass'n of Home Builders, 551 U.S. at 666 (citations, alteration, and internal quotation marks omitted); *see also FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-33 (2000); *Davis v. Mich. Dep't of Treasury,* 489 U.S. 803, 809 (1989).

In other words, "[t]he plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole." *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997). The Supreme Court just recently reiterated this principle, making it clear that even when a statute is not "a *chef d'oeuvre* of legislative draftsmanship" – as the ACA is not – courts must bear "in mind the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Util. Air Regulatory Grp. v. EPA*, No. 12-1146, 2014 WL 2807314, at *9 (June 23, 2014) (internal quotation marks omitted).

When a "court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute." *Chevron*,

467 U.S. at 843. Rather, "the question for the court is whether the agency's answer is based on a permissible construction of the statute," *id.*, that is, whether the agency's interpretation is "manifestly contrary to the statute," *id*. at 844. *See, e.g.*, *Mayo Found. for Med. Educ. & Research v. United States*, 131 S. Ct. 704, 711 (2011) (deferring to the agency's interpretation because the statute did not speak with "the precision necessary" to definitively answer the question, and the agency's interpretation was not "manifestly contrary to the statute").

Appellants argue that *Chevron* deference is unwarranted because some of the provisions at issue "are codified in a chapter of Title 42 . . . the domain of *HHS*, not the IRS," and the "IRS has no power to enforce or administer those provisions." Br. for Appellants at 46. Appellants' position is mistaken. *Chevron* applies because IRS and HHS are tasked with administering the provisions of the ACA in coordination. *See* 42 U.S.C. § 18082(a); *Nat'l Ass'n of Home Builders*, 551 U.S. at 665 (applying *Chevron* deference to a regulation promulgated by the National Marine Fisheries Service and the Fish and Wildlife Service "acting jointly"). Here, there is no issue of one agency interpreting the statute in a way that conflicts with the other agency's interpretation. The IRS's rule defines "Exchange" by reference to the HHS's definition, which provides that subsidies are available to low-income taxpayers purchasing insurance on an Exchange "regardless of whether the Exchange is established and operated by a State . . . or by HHS." 45 C.F.R. § 155.20; 26 C.F.R. § 1.36B-1(k).

Appellants also argue that *Chevron* deference is precluded by the canon that "tax credits 'must be expressed in clear and unambiguous terms.'" Br. for Appellants at 51 (quoting *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 183 (1889)). Again, Appellants' position is mistaken. The Supreme Court

has made clear that "[t]he principles underlying [the] decision in *Chevron* apply with full force in the tax context." *Mayo Found.*, 131 S. Ct. at 713.

Chevron plainly applies to this case. And this court is obliged to defer to the IRS's and HHS's "permissible" interpretations of the ACA. *Chevron*, 467 U.S. at 843.

II. ANALYSIS

Appellants' argument focuses almost entirely on 26 U.S.C. § 36B, considered in isolation from the other provisions of the ACA. Repeating the phrase "Exchange established by the State" as a mantra throughout their brief, Appellants contend that this language unambiguously indicates that § 36B(b) conditions refundable tax credits on a *State* – and not *HHS* – establishing an Exchange.

Appellants' argument unravels, however, when the phrase "established by the State" is subject to close scrutiny in view of the surrounding provisions in the ACA. *See Brown & Williamson*, 529 U.S. at 132 ("The . . . ambiguity . . . of certain . . . phrases may only become evident when placed in context."). In particular, § 36B has no plain meaning when read in conjunction with § 18031(d)(1) and § 18041(c). And, more fundamentally, the purported plain meaning of § 36B(b) would subvert the careful policy scheme crafted by Congress, which understood when it enacted the ACA that subsidies were critically necessary to ensure that the goals of the ACA could be achieved. Simply put, § 36B(b) interpreted as Appellants urge would function as a poison pill to the insurance markets in the States that did not elect to create their own Exchanges. This surely is not what Congress intended.

Perhaps because they appreciate that no legitimate method of statutory interpretation ascribes to Congress the aim of tearing down the very thing it attempted to construct, Appellants in this litigation have invented a narrative to explain why Congress would want health insurance markets to fail in States that did not elect to create their own Exchanges. Congress, they assert, made the subsidies conditional in order to *incentivize* the States to create their own exchanges. This argument is disingenuous, and it is wrong. Not only is there no evidence that anyone in *Congress* thought § 36B operated as a condition, there is also no evidence that *any State* thought of it as such. And no wonder: The statutory provision presumes the existence of subsidies and was drafted to establish a formula for the payment of tax credits, not to impose a significant and substantial condition on the States.

It makes little sense to think that Congress would have imposed so substantial a condition in such an oblique and circuitous manner. *See Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) ("Congress . . . does not alter the fundamental details of a regulatory scheme in vague terms . . . ."). The simple truth is that Appellants' incentive story is a fiction, a *post hoc* narrative concocted to provide a colorable explanation for the otherwise risible notion that Congress would have wanted insurance markets to collapse in States that elected not to create their own Exchanges.

In the end, the question for this court is whether § 36B *unambiguously* operates as a condition limiting the tax subsidies that Congress understood were a necessary part of a functioning insurance market to *only* those States that created their own exchange. The phrase "Exchange established by the State," standing alone, suggests the affirmative. But there is powerful evidence to the contrary – both in § 36B and the

provisions it references, and in the Act as a whole – that shows Appellants' argument to be fatally flawed.

It is not the prerogative of this court to interpret the ambiguities uncovered in the ACA. Congress has delegated this authority to the IRS and HHS. And the interpretation given by these agencies is not only *permissible* but also the *better* construction of the statute because § 36B is not clearly drafted as a condition, because the Act empowers HHS to establish exchanges *on behalf of* the States, because parallel provisions indicate that Congress thought that federal subsidies would be provided on HHS-created exchanges, and, most importantly, because Congress established a careful legislative scheme by which individual subsidies were *essential* to the basic viability of individual insurance markets.

A. *Appellants' "Plain Meaning" Argument Viewed in Context*

In arguing that the ACA clearly and unambiguously bars subsidies to individuals who purchase insurance in States in which HHS created the Exchange on the State's behalf, Appellants rest on a narrow, out-of-context interpretation of § 36B(b) and § 36B(c)(2)(A)(i). Br. for Appellants at 16. Appellants argue that because there is no "Exchange established by the State" in States with HHS-created Exchanges, taxpayers who purchase insurance in these States cannot receive subsidies. This plain meaning argument, which views § 36B in isolation, is simplistic and wrong.

We cannot read § 36B in isolation; we must also consider the specific context of the provision and the "broader context of the statute as a whole." *Robinson*, 519 U.S. at 341. And viewing the matter through this wider lens, as we must, the provision which initially might appear plain is far from

unambiguous. To begin with, as the Government points out, § 36B refers to premiums for health plans enrolled in through "an Exchange established by the State *under 1331* [*i.e.*, 42 U.S.C. § 18031]." 26 U.S.C. § 36B(b) (emphasis added). The cross-referenced provision – 42 U.S.C. § 18031 – contains language indicating that *all* States are required to establish an exchange under the section. *See* 42 U.S.C. § 18031(b)(1) ("Each State *shall* . . . establish an American Health Benefit Exchange . . . ."); *see also id.* § 18031(d)(1) ("An Exchange *shall be* a governmental agency or nonprofit entity *that is established by a State*." (emphasis added)). In other words, if our statutory universe consisted only of these two provisions, it would be clear that § 36B intended that residents in *all* States would receive subsidies because *all* States were required to create such exchanges by the section of the Act referenced in § 36B.

Of course, the ACA is broader than just § 36B and § 18031, and in 42 U.S.C. § 18041 it permits a State to elect to allow HHS to establish the Exchange on behalf of the State. In such circumstances, however, the Act *requires* HHS to establish and operate "*such* Exchange." *Id.* § 18041(c) (emphasis added). The use of "such" can reasonably be interpreted to deem the HHS-created Exchange to be the equivalent of an Exchange created in the first instance by the State. That is, when HHS creates an exchange under § 18041(c), it does so *on behalf of* the State, essentially standing in its stead. Put differently, under the ACA, an Exchange within a State is a given. The only question is whether the State opts to create the Exchange on its own or have HHS do it on its behalf. On this view, "established by the State" is term of art that includes any Exchange within a State.

Indeed, the Act says as much when it defines the term "Exchange" as "a governmental agency or nonprofit entity

that is established by a State." 42 U.S.C. § 18031(d)(1). It is clear that § 18031 is the source of the definition of the term "Exchange" under the Act. *See* 42 U.S.C. § 300gg-91(d)(21) (defining "Exchange" for purpose of Public Health Service Act to mean what it does in § 18031); *id.* § 18111 (incorporating the definitions in § 300gg-91 for purpose of Title I of the ACA). It is also clear that § 18031 defines *every* "Exchange" under the Act as "a governmental agency or nonprofit entity that is *established by a State*." *Id.* § 18031(d)(1) (emphasis added). Because § 18041(c) authorizes the federal government to establish "Exchanges," the phrase "established by the State" in § 18031 must be broad enough to accommodate Exchanges created by the HHS on a State's behalf. Section 36B expressly incorporates this broad definition of "Exchange" when it uses the phrase an "Exchange established by the State *under [§ 18031]*." 26 U.S.C. § 36B(b) (emphasis added). Therefore, the phrase "established by the State" in § 36B is reasonably understood to take its meaning from the cognate language in the incorporated definition in § 18031, which embraces Exchanges created by HHS on the State's behalf. *See, e.g.*, *Gustafson v. Alloyd Co., Inc.*, 513 U.S. 561, 570 (1995) (noting "the normal rule of statutory construction that identical words used in different parts of the same act are intended to have the same meaning" (internal quotation marks omitted)). These provisions belie the "plain meaning" that Appellants attempt to attribute to § 36B.

What is more, Appellants' interpretation of the operative language in § 36B sits awkwardly with the section's structure. Subsection (a) provides tax credits to any "applicable taxpayer," defined in reference to the poverty line and without regard to what the taxpayer's State has or has not done. 26 U.S.C. § 36B(a), (c)(1)(A). Subsection (b) then establishes a numerical formula for calculating the amount of the subsidy. *Id.* § 36B(b). It is only in the context of this numerical formula

and its definition of "coverage month" that the purported condition is found. *Id.* § 36B(b)(1), (c)(2)(A)(i). If Congress intended to create a significant condition on taxpayer eligibility for subsidies of the sort advocated by Appellants, one would expect that it would say so plainly and clearly. *See Am. Trucking Ass'ns*, 531 U.S. at 468. There is no "if/then" or other such conditional language in § 36B. Instead, if Appellants are to be believed, Congress thought it appropriate to incentivize significant State action (creating Exchanges) through an oblique and indirect condition. This is an implausible reading of the statute.

The simple truth is that the phrase "established by the State" in § 36B does not have the plain meaning that Appellants would like. The inquiry does not end with a narrow look at § 36B. That provision must be read in conjunction with § 18031(d)(1) and § 18041(c); and these provisions, read together, defy any claim of plain meaning.

Furthermore, in order to address the question before us, this court is obliged to consider § 36B in "the broader context of the statute as a whole." *Robinson*, 519 U.S. at 341; *see also Zuni Pub. Sch. Dist. No. 89 v. Dep't of Educ.*, 550 U.S. 81, 98 (2007) (looking to "basic purpose and history" of statute). The Supreme Court's recent decision in *Michigan v. Bay Mills Indian Community*, 134 S. Ct. 2024 (2014), which Appellants cite, is not to the contrary. *See also Util. Air Regulatory Grp.*, 2014 WL 2807314, at *9 (reaffirming that courts must bear "in mind the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme" (internal quotation marks omitted)). Nothing in *Bay Mills* or *Utility Air Regulatory Group* purport to undermine the commonsense principle – repeatedly endorsed by the Court – that the operative text must be understood in its statutory context, nor

the subsidiary principle, which follows from the first, that evidence of meaning drawn from the broader statutory context can render the operative text ambiguous on a particular question of law. Appellants' argument in this case is illogical when cast in the context of the statute as a whole.

B. *The Statute Read as a Whole*

1. The "Three-Legged Stool" and the Indispensable Role of the Tax Subsidies

Appellants' interpretation is implausible because it would destroy the fundamental policy structure and goals of the ACA that are apparent when the statute is read as a whole. A key component to achieving the Act's goal of "near-universal coverage" for all Americans is a series of measures to reform the individual insurance market. 42 U.S.C. § 18091(2)(D). These measures – nondiscrimination requirements applying to insurers, the individual mandate, and premium subsidies – work *in tandem*, each one a necessary component to ensure the basic viability of each State's insurance market. Because premium subsidies are so critical to an insurance market's sustainability, Appellants' interpretation of § 36B would, in the words of Appellants' *amici*, cause "the structure of the ACA [to] crumble." Scott Pruitt, *ObamaCare's Next Legal Challenge*, WALL ST. J., Dec. 1, 2013.

This point is essential and worth explaining in detail. The ACA has been described as a "three-legged stool" in view of its three interrelated and interdependent reforms. Br. for Economic Scholars at 7. The first "leg" of the ACA is the "guaranteed issue" and "community rating" provisions, which prohibit insurers from denying coverage based on health status or history, 42 U.S.C. § 300gg-1, and require insurers to offer coverage to all individuals at community-wide rates, *id*.

§ 300gg(a). But such nondiscrimination provisions cannot function alone because of the problem of "adverse selection." When insurers cannot deny coverage or charge sick or high-risk individuals higher premiums, healthy people delay purchasing insurance (knowing they will not be denied coverage if and when they become sick), and insurers' risk pools thus become skewed toward high-risk individuals (as they are the only ones willing to pay the premiums). The result is that insurers wind up paying more per average on each policy, which leads them to increase the community-wide rate, which, in turn, serves only to exacerbate the "adverse selection" process (as now only those who are *really* sick will find insurance worthwhile). This is the so-called "death-spiral," which Congress understood would doom each State's individual insurance market in the absence of a multifaceted reform program. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2626 (2012) (Ginsburg, J., concurring in part and dissenting in part).

This is where the individual mandate, the second "leg" of the ACA, comes in. Congress recognized:

> [I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the [individual coverage] requirement, 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(2)(I). Accordingly, the Act requires each individual who is not covered by an employer to purchase minimum coverage or to pay a tax penalty. 26 U.S.C. § 5000A(a)-(b). But recognizing that individuals cannot be made to purchase what they cannot afford, Congress provided that the mandate would not apply if the cost of insurance exceeds eight percent of the taxpayer's income after subsidies. *Id.* § 5000A(e)(1).

The third "leg" of the ACA is the subsidies. The subsidies ensure that the individual mandate will have a broad enough sweep to attract enough healthy individuals into the individual insurance markets to create stability, *i.e.*, to prevent an adverse-selection death spiral. Without the subsidies, the individual mandate is simply not viable as a mechanism for creating a stable insurance market: the lowest level of coverage for typical subsidy-eligible participants will cost 23% of income, meaning that these individuals will be exempt from the mandate. *Id.*; Br. for Economic Scholars at 17-18. Congress was informed of the importance of the subsidies to the overall legislative scheme. *See Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Comm. On Finance*, 111th Cong. 504 (2009) (statement of Sandy Praeger, Comm'r of Insurance for the State of Kansas) ("State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate *and appropriate income-sensitive subsidies to make coverage affordable.*" (emphasis added)); *see also* CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 24 (Nov. 30, 2009), (estimating that approximately 78% of people purchasing their own coverage would receive subsidies). It is thus no surprise that Congress provided generous subsidies in the ACA and, importantly, expressly linked the operation of the individual mandate to the

cost of insurance *after* taking account of the subsidies. 26 U.S.C. § 5000A(e)(1)(B)(ii).

If nothing else, it is clear that premium subsidies are an essential component of the regulatory framework established by the ACA. If, as Appellants contend, a State could block subsidies by electing not to establish an Exchange, this would exempt a large number of taxpayers from the individual mandate, cause the risk pool to skew toward higher risk people, and effectively cut the heart out of the ACA. This is one of the points that was made in the joint opinion by Justice Scalia, Justice Kennedy, Justice Thomas, and Justice Alito in *National Federation of Independent Business v. Sebelius*:

> Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, the exchanges would not operate *as Congress intended* and may not operate at all.

132 S. Ct. at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (emphasis added); *see also* Br. for the Appellees at 38 ("Insurers in States with federally-run Exchanges would still be required to comply with guaranteed-issue and community rating rules, but, without premium tax subsidies to encourage broad participation, insurers would be deprived of the broad policy-holder base required to make those reforms viable."). This "adverse selection" is precisely what Congress sought to avoid when it enacted the individual mandate. 42 U.S.C. § 18091(2)(I). It is unfathomable that Congress intended to allow States to effectively nullify the individual mandate, which it recognized was necessary to the viability of an individual insurance market subject to the "guaranteed issue" and "community rating" requirements.

Section 36B cannot be interpreted divorced from the ACA's unmistakable regulatory scheme in which premium subsidies are an indispensable component of creating viable and stable individual insurance markets. Due regard for the carefully crafted legislative scheme casts § 36B in a clearer light. "Congress . . . 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." *Am. Trucking Ass'ns*, 531 U.S. at 468. If Congress meant to deny subsidies to taxpayers in States with HHS-created Exchanges – thereby initiating an adverse-selection death-spiral that would effectively gut the statute in those States – one would expect to find this limit set forth in terms as clear as day. But the subsection defining which taxpayers are eligible for subsidies make no mention of State-established Exchanges. Subsidies are available to an "applicable taxpayer," 26 U.S.C. § 36B(a), and "applicable taxpayer" is defined as any individual whose household income for the taxable year is between 100% and 400% of the poverty line, *id.* § 36B(c)(1)(A).

A comparison with the ACA's Medicaid expansion condition offers a striking case in point. This condition demonstrates that Congress knew how to speak clearly and provide notice to States when it intended to condition funding on State behavior. The Medicaid provision lays out an express conditional statement in the form of "*if, then*": "*If* the Secretary, after reasonable notice and opportunity for hearing," determines that the State is not in compliance with the Medicaid-expansion requirements, the Secretary "shall notify such State agency that further payments will not be made to the State." 42 U.S.C. § 1396c (emphasis added). This provision stands in stark contrast to § 36B. The formula for calculating subsidies does not say, for example, "*If* a State

does not create an Exchange, its taxpayers shall be ineligible for premium credit subsidies," or "*If* coverage is purchased on an Exchange established by HHS, premium credit subsidies will not be available." Furthermore, § 1396c ensures that States receive *notice* before Medicaid funding is withheld. In contrast, there is no similar notice to States that their taxpayers will be denied subsidies if the State elects to have HHS create an Exchange on its behalf.

The majority thinks it unremarkable that Congress would condemn insurance markets in States with federally-created Exchanges to an adverse-selection death spiral. It reaches this conclusion by observing that, in peripheral statutory provisions, Congress has twice created insurance markets that suffered from the defect of having guaranteed issue requirements without the other measures (such as a mandate or subsidies) necessary to ensure the soundness of the market. Congress did this, the majority notes, in the provisions covering the Northern Mariana Islands and other federal territories, *see* 26 U.S.C. § 5000A(f)(4); 42 U.S.C. § 201(f), and in the Community Living Assistance Services and Supports (CLASS) Act, Pub. L. No. 111-148, §§ 8001-8002, 124 Stat. 119, 828-47 (2010).

This argument entirely misses the point. These peripheral statutory provisions say nothing about the core provisions of the ACA at issue here, as both the majority and the Appellants recognize. In both provisions, Congress purposely decided not to impose an individual mandate. That is a crucial difference. The Government and supporting *amici*'s position in this case relies on Congress' express recognition that the individual mandate, "*together with the other provisions* of this Act, will minimize . . . adverse selection," and that, as such, the mandate "is essential to creating effective health insurance markets" with guaranteed-issue requirements. 42 U.S.C.

§ 18091(2)(I) (emphasis added). This recognition, together with Congress' linking the mandate to the subsidies available to taxpayers, 26 U.S.C. § 5000A(e)(1)(B)(ii), demonstrates that Congress appreciated that subsidies would be an integral part of ensuring that the individual mandate reached broadly enough to secure the viability of the insurance market. By not imposing individual mandates in the peripheral markets identified by the majority (*i.e.*, in the territories and the CLASS Act), Congress displayed a willingness to tolerate the risk that these markets would succumb to adverse selection. Congress displayed no such willingness here; in the markets covered by the core provisions of the ACA, Congress imposed an individual mandate linked to subsidies as an "essential" tool to ensure market viability. 42 U.S.C. § 18091(2)(I).

Appellants suggest that because Congress enacted peripheral statutory provisions covering territories and in the CLASS Act without including measures to ensure a broad base of healthy customers to stabilize prices and avoid adverse selection, it is reasonable to assume that Congress did the same thing with respect to the core provisions of the ACA. But this argument gets it backwards. The CLASS Act and the provisions covering the federal territories importantly demonstrate that when Congress determined to expose an insurance market to significant adverse selection risk, it specifically declined to enact an individual mandate. In other words, Congress acted intentionally when it passed the CLASS Act and the provisions covering the federal territories *without an individual mandate*. The core provisions of the ACA *include an individual mandate*, which of course indicates that Congress meant to treat the core provisions of the ACA differently.

Appellants' arguments to the contrary are perplexing, to say the least. Congress' omissions of an individual mandate –

which it recognized as an "essential" tool to prevent adverse selection, 42 U.S.C. § 18091(2)(I) – from the peripheral statutory provisions cited by the majority are not evidence that Congress had some monolithic statute-wide tolerance of the risk that insurance markets might succumb to adverse selection. To the contrary, Congress' intentional omissions in these peripheral insurance markets of a tool it knew to be important to preventing adverse selection merely indicates that Congress had a substantially higher tolerance for the risk of adverse selection in such markets vis-à-vis the core markets where it did impose the individual mandate. The CLASS Act and the provisions covering the territories thus do not rebut the Government's structural argument. Indeed, if anything, the subsequent history concerning the territories and the CLASS Act serve only to highlight that Congress was correct in its judgment that an individual mandate – accompanied by subsidies to ensure its scope was sufficiently large – was necessary to stave off adverse selection in insurance markets. As Appellants note, without an individual mandate, the CLASS Act was "unworkable," which led Congress to repeal it. Reply Br. for Appellants at 15.

The Government and supporting *amici*'s structural argument in this case cannot be dismissed as idle meanderings into legislative history. It is apparent from the statutory text of the ACA that Congress understood (1) the importance of a broadly applicable individual mandate that works "together with the other provisions" to ensure the viability of an insurance market against the threat of adverse selection, 42 U.S.C. § 18091(2)(I), and (2) the necessity of taxpayer subsidies to broaden the scope of the individual mandate, *see* 26 U.S.C. § 5000A(e)(1)(B)(ii). In giving short shrift to the clear statutory scheme adopted by Congress when it enacted the core provisions of the ACA, the majority has ignored congressional intent and improperly rejected the reasonable

interpretations of HHS and IRS. In sum, the majority has drawn the wrong lesson from the CLASS Act and the provisions covering federal territories, which demonstrate just the opposite of the conclusion reached by the majority.

2. The Advance Payment Reporting Requirements of § 36B(f)(3)

One of the subsections in § 36B – which is the section upon which Appellants stake their case – makes it clear that Congress intended that taxpayers on HHS-created Exchanges would be eligible for subsidies. Subsection (f), entitled "Reconciliation of credit and advance credit," tasks the IRS with reducing the amount of a taxpayer's end-of-year premium tax credit under § 36B by the sum of any advance payments of the credit. 26 U.S.C. § 36B(f). Crucially, subsection (f) establishes reporting requirements that *expressly apply to HHS-created Exchanges*. *Id.* § 36B(f)(3) (citing 42 U.S.C. § 18041(c)). These reporting requirements mandate that Exchanges provide certain information to the IRS, including the "aggregate amount of any advance payment of such credit"; information needed to determine the taxpayer's "eligibility for, and the amount of, such credit"; and "[i]nformation necessary to determine whether a taxpayer has received excess advance payments." *Id.* § 36B(f)(3)(C), (E), (F). The self-evident primary purpose of these requirements – reconciling end-of-year premium tax credits with advance payments of such credits – could not be met with respect to Exchanges created by HHS on behalf of a State if these Exchanges were not authorized to deliver tax credits. Indeed, HHS-created Exchanges would have nothing to report regarding subsidies were they barred from giving any. It is thus plain from subsection (f) that Congress intended credits under § 36B to be available to taxpayers in States with HHS-created Exchanges.

Appellants' attempts to minimize the importance of the reporting requirements are specious. They first argue that, even if credits are unavailable on federally-created Exchanges, the reporting provision would nevertheless serve a purpose: to enforce the individual mandate to buy insurance. This amounts to a sleight of hand. The argument ignores the clear purpose – apparent from the statutory text – of subsection (f) and its reporting requirements. The purpose is front and center in the subsection's title – "Reconciliation of credit and advance credit," *id.* § 36B(f) – and is reinforced by the wording and structure of the provision. Consistent with its title, subsection (f) charges the IRS with reconciling the ultimate tax credit to be paid with any advanced payments of the credit, *id.* § 36B(f)(1), including advance payments that "exceed the credit allowed" for the tax year, *id.* § 36B(f)(2). The IRS, of course, can accomplish these tasks only if it has adequate information, and the next paragraph, § 36B(f)(3), establishes the reporting requirements that ensure that the IRS has the information it needs to satisfy the terms of the statute. *See id.* § 36B(f)(3)(C), (E), (F) (requiring disclosure of information concerning advanced payments of tax credits). Obviously, *some* of the information covered by subsection (f)(3) will also assist in enforcing the individual mandate. But much of the information required to be disclosed by subsection (f)(3) is irrelevant to the purpose hypothesized by Appellants (*i.e.*, to enforcing the mandate). *See id.* § 36B(f)(3)(F) (mandating the reporting of "[i]nformation necessary to determine whether a taxpayer has received excess advance payments"); *id.* § 5000A(e)(1)(A)-(B) (in determining whether an individual is exempted from the mandate, the statute takes account of the "amount of the credit allowable," but not the amount of excess advance payments).

In a letter submitted to the court before oral argument, Appellants cited an IRS regulation, 26 C.F.R. § 1.6055-1(d)(1), that addresses information reporting requirements. "In order to reduce the compliance burden on" insurers, the IRS decided not to require insurers "to report under section 6055 for coverage under individual market qualified health plans purchased through an Exchange because Exchanges must report on this coverage under section 36B(f)(3)." Information Reporting of Minimum Essential Coverage, 79 Fed. Reg. 13,220, 13,221 (Mar. 10, 2014). Appellants seem to think that this regulation somehow vindicates their view of § 36B(f)(3), but their argument makes no sense. That the IRS determined that additional reporting by insurers in specified circumstances was unnecessary does not imply that Congress drafted § 36B(f)(3) solely to enforce the individual mandate, as Appellants would have it. What is clear here is that § 36B(f)(3) establishes reporting requirements for the *principal* purpose of requiring disclosure of information concerning advanced payments of tax credits, a purpose which cannot be squared with Appellants' interpretation under which no credits are available on federally-created Exchanges.

Appellants also argue that the reporting provisions in subsection § 36B(f) are already over-inclusive because they apply to plans serving taxpayers who, by reason of their income, are ineligible for subsidies. The implication suggested by Appellants – and accepted too easily by the majority – is that the reporting requirements in § 36B(f)(3) already suffer from over-inclusiveness (since such taxpayers will have neither credits nor advance payments) and that there is thus little reason to be concerned about the additional over-inclusiveness generated by Appellants' interpretation of § 36B. Framing the issue in this manner obscures a fundamental difference. Interpreting § 36B to foreclose credits on federally-created Exchanges would not merely increase the

"over-inclusiveness" of § 36B(f)(3)'s reporting requirements; it would render certain of the reporting requirements pointless as to *every single taxpayer* on an HHS-created Exchange. This is a nonsensical interpretation because Congress enacted the § 36B(f)(3) reporting requirements to apply to HHS-created Exchanges. *Id.* § 36B(f)(3) (citing 42 U.S.C. § 18041(c)). The provision is powerful evidence that Congress intended that tax credits be available on federally-created Exchanges.

3. Other Provisions

There are two other provisions of the ACA that strongly support the Government's claim that the statute, read as a whole, permits taxpayers who purchase insurance in non-electing States to receive subsidies. First, the statute defines a "qualified individual" as a person who "resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A)(ii). There is no separate definition of "qualified individual" for States with HHS-created Exchanges. If an HHS-created Exchange does not count as established by the State it is in, there would be no individuals "qualified" to purchase coverage in the 34 States with HHS-created Exchanges. This would make little sense.

Second, in a subparagraph entitled "Assurance of exchange coverage for targeted low-income children unable to be provided child health assistance as a result of funding shortfalls," the ACA requires States to "ensure" that low-income children who are not covered under the State's child health plan are enrolled in a health plan that is offered through "an Exchange established by the State under [§ 18031]." 42 U.S.C. § 1397ee(d)(3)(B). Here again, the statute simply presumes that the existence of such State-established exchanges. The statute's objective of "*assur[ing] exchange coverage for targeted low-income children*" would be largely

lost if States with HHS-created Exchanges are excluded. There is nothing in the statute to indicate that Congress meant to exclude benefits for low-income children in the 34 States in which HHS has established an Exchange on behalf of the State.

* * *

In view of the foregoing, Appellants' reliance on *Bay Mills* is entirely misplaced. In citing that case, Appellants simply cherry pick language which appears favorable to their side but which does not reflect the Court's reasoning. It is true, of course, that courts have no "roving license" to disregard a statute's unambiguous meaning. 134 S. Ct. at 2034. This was an important point in *Bay Mills* because it was undisputed in that case that the plaintiff's position could not be squared with the plain meaning of the statute. And the plaintiff in *Bay Mills* failed "to identify *any* specific textual or structural features of the statute to support its proposed result." *Id.* at 2033 (emphasis added). *Bay Mills* is plainly inapposite. Here, by contrast, there is considerable evidence – textual and structural – to render the ACA ambiguous on the question whether § 36B operates to bar tax subsidies in States in which HHS has established an Exchange on behalf of the State. And, as shown above, when the ACA is read as a whole – including its "textual [and] structural features," "purpose," "history and design," *id*. at 2033-34 – it is clear that the Government's interpretation of the ACA is permissible and reasonable, and, therefore, entitled to deference under *Chevron*.

C. *Appellants' Extraordinary Subsidies-As-Incentive Argument*

The foregoing examination of the statute shows that when the terms of § 36B are read "with a view to their place in the overall statutory scheme," *Nat'l Ass'n of Home Builders*, 551 U.S. at 666, Appellants' plain meaning argument fails. Appellants obviously recognize that their argument resting on § 36B in isolation, apart from the rest of the ACA, is ridiculous. This is clear because, in an effort to bolster their claim, Appellants proffer the extraordinary argument that Congress limited subsidies to State-run Exchanges as an incentive to encourage States to set up their own Exchanges. Br. for Appellants at 28. As noted above, this argument is nonsense. Appellants have no credible evidence whatsoever to support their subsidies-as-incentive theory.

The record indicates that, when the ACA was enacted, no State even considered the possibility that its taxpayers would be denied subsidies if the State opted to allow HHS to establish an Exchange on its behalf. Not one. Indeed no State even suggested that a lack of subsidies factored into its decision whether to create its own Exchange. Br. of Members of Congress and State Legislatures at 24-25 & n.30 (citing authorities). "States were motivated by a mix of policy considerations, such as flexibility and control, and 'strategic' calculations by ACA opponents, not the availability of tax credits." *Id*. at 24-25 n.30 (citing authorities). The fact that all States recognized and protested the Medicaid expansion condition, while no State raised any concern over the purported subsidy-condition shows that Appellants' argument is at best fanciful. *See* Br. for the Appellees at 42 ("[T]he twenty-six plaintiff states in [*Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. 2566,] repeatedly contrasted the Medicaid eligibility expansion with the 'real choice that the ACA offers States to

create exchanges or have the federal government do so.'" (quoting Br. for State Pet'rs on Medicaid, *Florida v. HHS*, No. 11-400, 2012 WL 105551, at *51 (2012))).

The legislative history also indicates that Congress assumed subsidies would be available on HHS-created Exchanges. First, earlier proposals for the legislation and an earlier version of the House Bill provided that the federal government would establish and operate Exchanges. *Halbig v. Sebelius*, 2014 WL 129023, at *17 (D.D.C. Jan. 15, 2014) (citing Reconciliation Act of 2010, H.R. 4872 §§ 141(a), 201(a) (2010) (version reported in the House on March 17, 2010); H. REP. NO. 111–443, at 18, 26 (2013)). When the legislation was modified so that States could operate their own Exchanges, the Senate Finance Committee expressly acknowledged that the federal government could "establish state exchanges." *Id*. (citing S. REP. NO. 111–89, at 19 (2009) ("If these [state] interim exchanges are not operational within a reasonable period after enactment, the Secretary [of HHS] would be required to contract with a nongovernmental entity to *establish state exchanges* during this interim period.") (emphasis added)).

In addition, the three House Committees with jurisdiction over the ACA legislation issued a fact sheet explaining that States would have a choice whether to create their own Exchanges or have one run by the federal government, and "the Exchanges" would make health insurance more affordable. The fact sheet recognized income level as the *only* criteria for subsidy-eligibility. Br. for Members of Congress and State Legislatures at 11-12. The Joint Committee on Taxation also reported that the subsidies would be available to those who purchase insurance through "an exchange." *Id*. at 12. And Congressional Budget Office estimates assumed that subsidies would be available nationwide. Letter from Douglas

W. Elmendorf, Director, CBO, to Rep. Darrell E. Issa, Chairman, House Committee on Oversight and Government Reform (Dec. 6, 2012) ("To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with *a wide range of Congressional staff* when the legislation was being considered." (emphasis added)).

The truth is that there is nothing in the record indicating that, aside from wanting to afford States *flexibility*, Congress preferred State-run to HHS-run Exchanges. Appellants have not explained why Congress would want to encourage States to operate Exchanges rather than the federal government doing so, nor is there any indication that Congress had this goal. "[T]he purpose of the tax credits was not to encourage States to set up their own Exchanges. Indeed, making the tax credits conditional on state establishment of the Exchanges would have empowered hostile state officials to undermine the core purpose of the ACA, a result that [the] architects of the ACA wanted to avoid, not encourage." Br. for Members of Congress and State Legislatures at 22.

Furthermore, Appellants assume without any basis that denying taxpayers premium subsidies would put political pressure on States to create Exchanges. This assumption runs counter to Appellants' own theory of harm: After all, Appellants object to the subsidies because they impose additional financial obligations on individuals and employers by triggering the individual mandate and assessable payments for employers. These obligations would not attach if the subsidies were not available in the State. Because the subsidies trigger additional costs for individuals and employers, it is not obvious that they would be popular among taxpayers or cause taxpayers to pressure their States to create Exchanges.

The single piece of evidence that Appellants cite to support their claim that Congress intended to restrict subsidies to State-run Exchanges is an article by a law professor. Br. for Appellants at 40 (citing Timothy S. Jost, *Health Insurance Exchanges: Legal Issues*, O'Neill Inst., Georgetown Univ. Legal Ctr., no. 23 (Apr. 7, 2009)). There is no evidence, however, that anyone in Congress read, cited, or relied on this article.

III. CONCLUSION

The Supreme Court has made it clear that "[t]he plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole." *Robinson*, 519 U.S. at 341. We cannot review a "particular statutory provision in isolation . . . . It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Nat'l Ass'n of Home Builders*, 551 U.S. at 666. Following these precepts and reading the ACA as a whole, it is clear that the statute does not unambiguously provide that individuals who purchase insurance from an Exchange created by HHS on behalf of a State are ineligible to receive a tax credit. The majority opinion evinces a painstaking effort – covering many pages – attempting to show that there is no ambiguity in the ACA. The result, I think, is to prove just the opposite. Implausible results would follow if "established by the State" is construed to exclude Exchanges established by HHS on behalf of a State. This is why the majority opinion strains fruitlessly to show plain meaning when there is none to be found.

The IRS's and HHS's constructions of the statute are perfectly consistent with the statute's text, structure, and purpose, while Appellants' interpretation would "crumble" the Act's structure. Therefore, we certainly cannot hold that that the agencies' regulations are "manifestly contrary to the statute." This court owes deference to the agencies' interpretations of the ACA. Unfortunately, by imposing the Appellants' myopic construction on the administering agencies without any regard for the overall statutory scheme, the majority opinion effectively ignores the basic tenets of statutory construction, as well as the principles of *Chevron* deference. Because the proposed judgment of the majority defies the will of Congress and the permissible interpretations of the agencies to whom Congress has delegated the authority to interpret and enforce the terms of the ACA, I dissent.