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

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

Counsel of Record

CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

A. Parties and Amici

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

B. Ruling Under Review

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

C. Related Cases

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

Respectfully submitted,

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

CORPORATE DISCLOSURE STATEMENTS

The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) (1993) of the Internal Revenue Code and is exempt from income tax. AARP is also organized and operated as a non-profit corporation pursuant to Title 29 of Chapter 6 of the District of Columbia Code 1951. Other legal entities related to AARP include AARP Foundation, AARP Services, Inc., Legal Counsel for the Elderly, Experience Corps, d/b/a, AARP Experience Corps, AARP Insurance Plan, also known as the AARP Heoeon bia CodAC5ermnc

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

Date: November 3, 2014.

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins

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Legislative Materials

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GLOSSARY

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

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SUMMARY OF ARGUMENT

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

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

younger adults and, for this older population

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

B. When Uninsured Older Adults

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

Obtaining preventive services and medical treatments earlier could reduce the cost of medical and drug treatments for individuals enrolled in Medicare because conditions would be diagnosed at less advanced stages and/or better controlled. *See The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 50 (2008)

sponsored health insurance compared to those who do not rely on such coverage. Kevin T. Stroupe et al., *Chronic Illness and Health Insurance-Related Job Lock*, 20 J. Policy Analysis & Mgmt. 525, 525 (2000). Older workers who turn 65 and are eligible for Medicare but must maintain health coverage for a younger spouse or dependent child are also deterred from retiring or reducing their work hours. *See* Sid Groememan, AARP, *Staying Ahead of the Curve 2007: The AARP Work and Career Study* at 23 (2008). Consequently,

valuable workers are discouraged from redirecting their talents where they are most needed, including to entrepreneurship. *See* Robert W. Fairlie et al., *Is Employer-Based Health Insurance a Barrier to Entrepreneurship?* at 45-47 (Rand. Corp., Working Paper No. WR

Medical Debt Among People With Health Insurance at 12 (2014) (profiling a 51-year-old man with household income below 400% of FPL and high insurance premiums that contributed to his bankruptcy). One study estimated that 29 million people had used all of their savings on medical expenses. *Help on the Horizon*, *supra*, at 12. Another 22 million were unable to pay for basic necessities such as rent, food, and utilities due to medical bills. *Id.* More than two-thirds of older adults who participated in the individual insurance market paid more than 10%

(2012). As the District Court noted,

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

Employer-based insurance is the traditional backbone of the American health insurance system where most adults purchase coverage. Yet, in 2012, 10.8 million older workers did not have access to employer-based insurance, and 5.9 million of those workers were not able to obtain coverage from another source. *Effect of Health Reform*, *supra*, at 2, tbl. 2. The ACA addresses this problem by encouraging employers to offer health insurance. The Act imposes a shared responsibility requirement on large employers, who now face a tax penalty if they do not offer adequate and affordable insurance to their full-time employees. *See* 26 U.S.C. § 4980H(a) (2012) (penalizing large employers who do not offer affordable minimum coverage to employees); 26 U.S.C. §36B(c)(2)(C)(i)(II) (2012) (employer-

the premium for self-only coverage is more than 9.5 percent of his or her household income); 26 U.S.C. § 4980H(b)-(d) (employer is penalized after verification that it did not offer insurance that meets the affordability and adequacy standards defined by law). Small employers are also encouraged to provide health benefits to their employees through the Small Business Health Options Program (SHOP), which is designed to increase their buying power on the group market by making tax credits available. 42 U.S.C. § 18031(b)(1)(B), *see also* 26 U.S.C. §

45R (2012)

minimum health coverage.[3] 26 U.S.C. § 5000A(a) (2012). Between guaranteed issue provisions, rating limitations, and the individual mandate, the ACA seeks to create

products . . . le of varying

health statuses. 42 U.S.C. § 18091(2)(G).

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

In addition to reducing barriers to access, the ACA makes health insurance on the individual market more affordable through two principal forms of direct financial assistance to qualified individuals buying coverage offered on the Health Insurance Exchange/Marketplace: tax credits to reduce the cost of premiums for people with incomes between 100 and 400% of the federal poverty level, 26 U.S.C. § 36B(b)(3)(A) (2012), and subsidies to reduce out-of-pocket expenses under their plan for people with incomes under 250% of the federal poverty level, 42 U.S.C.

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

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

A.

Health insurance would also become unaffordable for millions more in the next 10 years. The CBO projects that the number of people who will purchase insurance on the Exchanges with the assistance of premium tax credits will be 10 million in 2015 and 19 million each year from 2016 to 2024, with the exception of 2018 when the number will reach 20 million. *Effects of Insurance Coverage Provisions*, Table 3. Though the -578.5 Tmunot break these estimates down by type of exchange, the data thus far suggests that most of these people would purchase health insurance via federally-facilitated Exchanges.

B.

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

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

The availability of premium tax credits in all states is

purchased health insurance on the federally-facilitated Exchanges (8.1 million people) would be exempt from the individual mandate under the unaffordability exemption without the premium tax credits. *Potential Side Effects*, *supra*. In contrast, only 3% of those who purchased insurance on State Exchanges will qualify for the unaffordability exemption. *Id*. Without the ability to attract more healthy people to the insurance risk pool in states with federally-facilitated Exchanges as tax credits currently do by reducing premiums by an average of 76% the number of insurance providers in the individual market would decrease thus reducing competition and increasing premiums. *See* Human Servs., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014* at 2, 17-18 (2014).

All other ACA reforms designed to make coverage more accessible, such as the guaranteed issue provisions and limitations on age rating, will be meaningless to those who cannot afford the premiums. *See* Parts III.B.1-3, *supra*. Moreover, eliminating premium assistance in the 22 states with federally-facilitated Exchanges that are not expanding Medicaid eligibility means that low-income residents in these states will not have new options for affordable coverage. *See* Parts III.B.4 and IV.A., *supra*.

interpretative theory, employers in 36 states would be able to evade the employer mandate simply because their state chose not to establish an Exchange thus

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

CONCLUSION

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

CERTIFICATE OF SERVICE

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

Date: November 3, 2014.

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

CERTIFICATE OF COMPLIANCE

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

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

3. Pursuant to Fed. R. App. P. 29, amici curiae certify that all parties have consented to the filing of this brief. Amici further certify that no party or

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Dated: November 3, 2014.

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