Nos. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL., PETITIONERS

v.

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

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE AMERICAN ACADEMY OF ACTUARIES AS AMICUS CURIAE SUPPORTING RESPONDENTS ON THE SEVERABILITY ISSUE

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INTEREST OF AMICUS CURIAE

The American Academy of Actuaries (Academy) is a nonprofit professional association for actuaries of all specialties (including health care) practicing in the United States. Founded in 1965, the Academy now has more than 17,000 members nationwide. Before obtaining admission to the Academy, actuaries must satisfy rigorous educational and experiential requirements, and many

States require membership in the Academy before an actuary can perform certain professional services.

As the public voice for the actuarial profession in the United States, the Academy provides independent and objective actuarial information, analysis, and education for the formulation of sound public policy. In particular, the Academy identifies and addresses issues of public interest as to which actuarial science provides a unique understanding. To that end, the Academy files briefs as amicus curiae in cases of interest to the actuarial community in which its expertise may be of assistance.[1]

Critically for purposes of these cases, the Academy played an important role in the congressional debate leading to the enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (Act). The Academy submitted testimony at key hearings and issued public statements commenting on the legislation. See, *e.g.*, *Health Reform In The 21st Century: Proposals To Reform The Health System: Hearing Before The H. Comm. On Ways And Means*, 111th Cong., 1st Sess. 379-384 (2009) (statement of Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries); American Academy of Actuaries, *Critical Issues In Health Reform: Market Reform Principles* (May 2009) <tinyurl.com/aaamay09>.

Throughout the debate, the Academy took the position that the insurance-market reforms being contem-

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[1] Pursuant to Rule 37.6, the Academy affirms that no counsel for a party authored this brief in whole or in part and that no person other than the Academy, its members, or its counsel have made a monetary contribution intended to fund the preparation or submission of the brief. The parties have entered blanket consents to the filing of amicus briefs, and copies of their letters of consent are on file with the Clerk's Office.

plated by Congress—in particular, the prohibitions on denying coverage or charging higher premiums because of a person's medical condition or history—would be workable only to the extent that "a broad cross section" of Americans participate in the reformed health-insurance market. Letter from Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries, to Sens. Reid and McConnell, at 1, reprinted at 156 Cong. Rec. S833 (daily ed. Mar. 1, 2010). The Academy specifically expressed concern that "[i]mplementing market reforms to prohibit insurers from denying coverage and to restrict how much premiums can vary will result in adverse selection and upward pressure on premiums unless lower-risk individuals have incentives to purchase coverage." *Ibid.*

During the debate, Congress took note of the Academy's expertise on the actuarial aspects of health-care reform. See, *e.g.*, 156 Cong. Rec. S760 (daily ed. Feb. 25, 2010) (statement of Sen. Cornyn); 156 Cong. Rec. S833 (daily ed. Mar. 1, 2010) (statement of Sen. Alexander). And when Congress passed the Act, it recognized the Academy's expertise, specifically directing the Secretary of Health and Human Services to consider the Academy's standards and recommendations in implementing the Act. See, *e.g.*, 42 U.S.C.A. 18061(b)(2)(A)(ii) (ordering the Secretary to use a methodology approved by the Academy to identify high-risk individuals).

The Academy is filing this brief in an effort to assist the Court in understanding the actuarial consequences of a decision to invalidate 26 U.S.C.A. 5000A, the Act's "individual-mandate" or "minimum-coverage" provision. That provision was an integral part of the reforms to the health-insurance market mandated by the Act. In the Academy's view, a decision invalidating the individual-mandate provision, while leaving in place the "guaran-

teed-issue" and "community-rating" provisions,[2] would have adverse effects on the affordability and accessibility of health insurance in the United States.

SUMMARY OF ARGUMENT

The Academy takes no position on the constitutionality of the individual-mandate provision, or on any of the other issues besides severability that are before the Court in the litigation concerning the Act. The Academy files this brief for the sole purpose of informing the Court of its judgment that, from an actuarial perspective, a decision invalidating only the individual-mandate provision would impose an unsound regulatory regime on the American health-insurance market—a regime that Congress would not have intended.

As a matter both of actuarial science and of basic economics, health-insurance premiums reflect the health-care costs of a plan's enrollees. Rules that allow greater numbers of individuals with high health-care costs to join health-insurance pools necessarily put upward pressure on premiums. Increased premiums, in turn, encourage individuals with lower health-care costs (such as healthier and/or younger individuals) to exit the health-insurance market, driving up premiums even further. If the individual-mandate provision were struck down but the guaranteed-issue and community-rating provisions were left intact, the ultimate result would be less stable health-insurance pools, higher premiums, and a greater-than-projected number of uninsured Ameri-

[2] As discussed below, the "community-rating" provisions actually require only *modified* community rating. See p. 7. In referring to the provisions simply as the community-rating provisions, the Academy follows the practice of the parties.

cans than if the individual mandate were retained—thus undermining the basic purposes of the Act.

Recent studies lend support to the Academy's judgment. The Congressional Budget Office and several independent researchers have simulated the effects of implementing the Act with and without the individual mandate. The consistency of their conclusions is striking: eliminating the individual-mandate provision, while retaining the guaranteed-issue and community-rating provisions, would result in higher premiums and less insurance coverage.

ARGUMENT

SHOULD THE COURT INVALIDATE THE INDIVIDUAL-MANDATE PROVISION OF THE ACT, IT SHOULD ALSO INVALIDATE THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS

A. Invalidating Only The Individual-Mandate Provision Would Be Inconsistent With Fundamental Actuarial Principles

1. Health care is a subject of boundless complexity. But the basic economic principles behind health insurance are relatively straightforward. Individuals pay premiums to an insurer that guarantees them coverage for medical expenses in the event they become sick or injured. Every individual who holds a similar policy from the same insurer is a member of an insurance pool. In order for an insurer to remain economically viable, total premiums must be sufficient to cover claims and administrative costs. Health-care costs, however, vary widely from person to person: costs for individuals in poor health can greatly exceed those for individuals in good health, and costs for older individuals are typically higher than those for younger individuals. An insurance pool therefore must contain a broad cross-section of risk:

that is, the pool must contain enough lower-risk individuals (whose premiums exceed their claims) to offset higher-risk individuals (whose claims exceed their premiums). Consequently, the key to the survival of any health-insurance pool—and potentially to the survival of the insurer—is to attract lower-risk individuals.

Historically, health insurers have had two primary mechanisms for encouraging lower-risk individuals to buy insurance. The first is the ability to charge lower premiums to those individuals; the second is the ability to refuse coverage for individuals with preexisting conditions. Under the current regime, a lower-risk individual has an incentive to obtain health insurance even if he does not expect to get sick in the near future, because he merely has to pay a relatively modest premium in order to obtain the security of knowing that his medical expenses would be covered if the unforeseen occurs.

Even with those incentives in place, however, health insurers have struggled for decades to bring sufficient numbers of lower-risk individuals into the health-insurance market. Young adults between the ages of 19 and 29 represent the largest and fastest-growing segment of the population without health insurance, and they are uninsured at almost twice the rate of adults between the ages of 30 and 64. See Namrata Kotwani & Marion Danis, *Expanding The Current Health Care Reform Debate: Making The Case For Socio-Economic Interventions For Low Income Young Adults*, 12 J. Health Care L. & Pol'y 17, 27-28 (2009). As a result, there has been a lower than optimal diversity of risk in health-insurance pools, resulting in higher premiums. And when individuals who have voluntarily forgone insurance develop medical conditions that require treatment, many seek emergency-room care that they cannot pay for. Those costs are then passed on to individuals

with insurance: studies have suggested that "free riders" impose a "hidden tax" on premiums of between 2% and 10%. See Lucien Wulsin, Jr. & Adam Dougherty, California Research Bureau, *Individual Mandate: A Background Report* 4 (Apr. 2009) <tinyurl.com/crbreport>.

Through the guaranteed-issue and community-rating provisions, the Act eliminates the ability of insurers to deny coverage based on preexisting conditions, eliminates the ability of insurers to base premiums on health status, and substantially limits the ability of insurers to vary premiums based on other characteristics associated with health-care costs. The guaranteed-issue provisions require insurers to provide coverage to all comers and prohibits policy exclusions for preexisting conditions. See 42 U.S.C.A. 300gg-1, 300gg-3, 300gg-4(a). The community-rating provisions prohibit insurers from charging higher premiums except on the basis of how old the applicant is, where the applicant resides, whether the applicant uses tobacco, and whether the policy covers individuals or families. See 42 U.S.C.A. 300gg(a)(1), 300gg-4(b). Insurers are therefore forbidden from charging higher premiums on the basis of health status, claims experience, or recent medical care, see *ibid.*—factors that, as an actuarial matter, greatly increase the likelihood that an individual will make substantial claims on his policy.

In light of the guaranteed-issue and community-rating provisions, the individual-mandate provision of the Act is a vital mechanism for keeping insurance pools fully stocked with lower-risk individuals (and thereby ensuring broad participation in the health-insurance market). As the Court will be aware, that provision penalizes individuals who do not buy health insurance. See 26 U.S.C.A. 5000A. If the individual-mandate provision

were struck down but the guaranteed-issue and community-rating provisions were left intact, insurers would be powerless to prevent lower-risk individuals from exiting the system, but would still be required to provide coverage for any higher-risk individual who seeks it—and to do so without the ability to charge higher premiums to account for the likelihood that such an individual will make larger claims. Based on actuarial principles, it is the Academy's conclusion that such a regime would lead to lower diversity in health-insurance pools, higher premiums, and lower coverage rates.

2. The actuarial impact of a decision invalidating only the individual-mandate provision is perhaps best understood through a simplified hypothetical scenario.

Assume that a health insurer operating under the preexisting regime could break even as long as 80% of its pool consists of lower-risk individuals paying premiums of $100 each, and 20% consists of higher-risk individuals paying premiums of $400 each. Implementation of the community-rating and guaranteed-issue provisions, without the individual-mandate provision, will have three primary effects:

First, premiums for higher-risk individuals will go down and premiums for lower-risk individuals will go up. Once the community-rating provisions go into effect, the insurer will no longer be able to charge different premiums by health status and will need to charge each individual $160—the weighted-average premium—in order to break even.

Second, some number of higher-risk individuals, who had been either ineligible for coverage or priced out of the market under the preexisting regime, will now obtain coverage.

Third, some number of lower-risk individuals will either decide not to obtain coverage or choose to opt out of

it, as they now will have to pay a higher premium than they would have paid if health status could be used as a rating factor. With the guaranteed-issue provisions in place but without the individual-mandate provision, lower-risk individuals will be able to leave the pool without triggering a penalty, secure in the knowledge that they will be able to reenter the pool should they later develop a condition that requires costly medical treatment.

As a result of those three effects, the ratio of higher-risk individuals to lower-risk individuals in the pool will increase, causing a corresponding increase in the break-even premium. If the resulting pool consists of 70% lower-risk individuals and 30% higher-risk individuals, the average premium would need to increase to $190 (a 19% increase over the weighted-average premium) in order for the insurer to break even. Such an increase could cause even more lower-risk individuals to opt out of coverage, resulting in another increase in the ratio and further upward pressure on premiums. If the resulting pool consists of 60% lower-risk individuals and 40% higher-risk individuals, premiums would need to increase to $220 (a 38% increase over the weighted-average premium in the original pool).

As a conceptual matter, therefore, it is clear that invalidating the individual-mandate provision, while leaving in place the guaranteed-issue and community-rating provisions, would increase premiums and swell the ranks of the uninsured.

B. Recent Studies Support The Conclusion That Invalidating Only The Individual-Mandate Provision Would Undermine The Effectiveness Of Health-Insurance Reform

The problems with invalidating only the individual-mandate provision are more than merely theoretical. A number of studies have attempted to quantify the effects

of such a regime. In particular, the Congressional Budget Office (CBO) and several independent researchers have conducted microsimulations comparing the potential effects of implementing the Act with and without the individual-mandate provision.[3] The Academy believes that the studies amply confirm the conceptual proposition set out above: *viz.*, that invalidating only the individual-mandate provision would result in higher premiums and lower coverage rates. Although the studies differ to some extent in their estimates of the magnitude of the effects of implementing the Act with and without the individual mandate, they broadly agree on the nature and direction of those effects. The studies therefore illustrate the need for effective policy mechanisms, such as an individual mandate, to stabilize the market when implementing supply-side mechanisms such as the Act's guaranteed-issue and community-rating requirements.

1. A recent study, conducted by Matthew Buettgens and Caitlin Carroll of the Urban Institute, simulates the Act as if it were fully implemented in 2011. See Matthew Buettgens & Caitlin Carroll, Robert Wood Johnson Foundation & Urban Institute, *Eliminating The Individual Mandate: Effects On Premiums, Coverage, And Uncompensated Care* (Jan. 2012) <tinyurl.com/buettgens> (Buettgens & Carroll). A predecessor to Buettgens and Carroll's model was used in the development of

[3] Microsimulation is an economic modeling technique that predicts individual reactions to a set of rules, allowing researchers to aggregate the predicted reactions and draw conclusions about the overall effects of a change in the rules. See International Microsimulation Association, *What Is Microsimulation?* <tinyurl.com/microsimulation>.

health-care reform in Massachusetts, and its estimates proved to be accurate. *Id.* at 2 n.9.

Buettgens and Carroll project that, with the individual mandate in place, the Act would "decrease the nonelderly uninsured population by 23.9 million, from 50.3 million to 26.4 million." Buettgens & Carroll 3. "[A]verage premiums in the total nongroup market would be $5,100." *Id.* at 6.[4] The average government subsidy for premiums in that market would be $4,426, resulting in approximately $340 billion in net government spending. *Id.* at 5.

Without the individual mandate, however, Buettgens and Carroll estimate that the Act would decrease the non-elderly uninsured population only by between 8.1 million and 10.5 million, depending on the strength of participation in subsidies and exchange coverage. See Buettgens & Carroll 3. And because of the phenomenon of "adverse selection" described above, average premiums in the total non-group market would rise by some 10% to 20%, to between $5,600 and $6,100. *Id.* at 6. Although net government spending would decline, it would do so only slightly (to between $315 billion and $330 billion), because the lower participation rate would largely be offset by more expensive subsidies. *Id.* at 5. In short, the expected decline in coverage would more than outweigh the modestly positive effect on the public fisc: "[e]ven though the gain in coverage under reform is cut by more than half, the government would only spend 3 to 8 percent less on acute care for the nonelderly." *Id.* at 7.

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[4] Buettgens and Carroll focused on the non-group market because "[t]he effects of not having an individual mandate or an effective equivalent will be most pronounced" in that market. Buettgens & Carroll 7.

2. Microsimulations conducted by the Congressional Budget Office and Jonathan Gruber, an economics professor at the Massachusetts Institute of Technology, model the impact of the Act on employer and individual behavior with and without the individual-mandate provision. CBO estimates that, with the mandate, 23 million non-elderly individuals will be uninsured in 2019; without the mandate, however, approximately 39 million individuals would be uninsured as of that date. See CBO, *Effects Of Eliminating The Individual Mandate To Obtain Health Insurance* 2 (June 16, 2010) <tinyurl.com/cbostudy> (CBO). Similarly, Professor Gruber estimates that eliminating the mandate would "cut the number of newly insured individuals by three quarters"—from 32 million with the mandate to 8 million without it. Jonathan Gruber, Center for American Progress, *Health Care Reform Without The Individual Mandate: Replacing The Individual Mandate Would Significantly Erode Coverage Gains And Raise Premiums For Health Care Consumers* 2 (Feb. 2011) <tinyurl.com/gruberstudy> (Gruber).

Both studies also project higher premiums absent the mandate. CBO estimates an increase of 15% to 20%; Professor Gruber, 27%. CBO 2; Gruber 2. And like Buettgens and Carroll, CBO projects that "the budgetary savings from removing the mandate would be less than proportional to the reduction in insurance coverage." CBO 2. Professor Gruber similarly concludes that "removing the mandate would significantly lower the 'bang for the buck' of health policy, reducing coverage by 50 percent to 75 percent while only lowering costs by 25 percent to 30 percent." Gruber 2. Whatever the exact figures, those studies confirm that invalidating only the individual-mandate provision would have substantial and

deleterious effects on the market for health insurance in the United States.

* * * * *

From an actuarial standpoint, it is clear that, in order for the community-rating and guaranteed-issue provisions in the Act to operate as intended, they must be paired with an effective mechanism to ensure broad participation in the health-insurance market, such as an individual mandate. Should this Court follow the lead of the Eleventh Circuit and invalidate only the individual-mandate provision, the Nation will be left with an incomplete and unbalanced package of market reforms, resulting in a system in which "those who enroll [in insurance coverage] would be less healthy, on average, than those enrolled with a mandate" and "adverse selection would increase premiums." CBO 2. That is not an outcome that the Congress that passed the Act would have wanted. However the Court rules on the constitutionality of the individual-mandate provision, therefore, the guaranteed-issue and community-rating provisions should stand or fall together with it.

CONCLUSION

In the event the Court concludes that the individual-mandate provision is unconstitutional, it should reverse the judgment of the Eleventh Circuit to the extent it upheld the guaranteed-issue and community-rating provisions as severable.

Respectfully submitted.

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JANUARY 2012

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