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January 31, 2012

U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: HHS Essential Health Benefits Bulletin—AHIP Comments

Submitted electronically: EssentialHealthBenefits@cms.hhs.gov.

Dear Sir or Madam:

AHIP appreciates the opportunity to provide comments in response to the HHS *Essential Health Benefits Bulletin* released on December 16, 2011. The Bulletin provides information and solicits comments on the regulatory approach that HHS intends to propose to define the "essential health benefits" (EHB) package under the Affordable Care Act (ACA), one of the most critical elements of the statute given the far-reaching implications it will have on the affordability of health insurance coverage.

In developing this guidance, the Bulletin notes that "HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input to date." AHIP agrees with the importance of balancing these goals to assure that a range of high-quality, affordable health care coverage choices are available to consumers in a competitive market.

While a considerable amount of the public discussion around essential benefits has focused on the specific benefits to be offered, we believe affordability should be the cornerstone of your consideration.

Unless the benefit package is affordable, many individuals and families will be unable to purchase insurance coverage and fewer employers, particularly small employers, will be able to maintain or offer coverage to their employees. The Institute of Medicine (IOM), in its recommendations to HHS, underscored the need to assure affordability in the EHB standard and cautioned that "if cost is not taken into account, the EHB package becomes increasingly expensive and, individuals and small businesses will find it increasingly unaffordable."

"If this occurs, the principal reason for the ACA—enabling people to purchase health insurance, and covering more of the population will not be met."[1] Our recommendations are aimed at assuring that the important goals of the EHB package can be met while—at the same time—assuring affordability that is

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[1] IOM Report—*Essential Health Benefits: Balancing Coverage and Cost.* October 7, 2011.

critical to creating a sustainable health care system that meets the goal of promoting access to high-quality and cost-effective care for patients and consumers.

State Benchmark Plans Must Be Affordable

AHIP supports the concept of state flexibility to select a benchmark plan as outlined in the Bulletin—as a two year transitional approach. Providing flexibility to states to select a benchmark plan—during this transition period—can help assure that benefit designs are affordable and appropriately tailored to the health needs of the population. After the two year transition period, however, the public policy goal should be to support an affordable evidence-based benefit package reflective of the 10 categories included in the ACA that is value promoting and assures high-quality care based on the best available scientific and medical evidence.

Recommendations:

- **We support state flexibility as a two year transitional approach and strongly recommend that HHS encourage states to use this flexibility to create the most affordable package that meets the requirements in the statute.** By choosing an affordable plan, states can help ensure that the greatest number of people have access to coverage and mitigate the potential impact of benefit "buy-up" by small businesses, individuals, and families. If states select a benchmark plan that features more comprehensive and extensive benefits than is typically covered under small group plans today, many small businesses and families would be unable to afford coverage and could be priced out of the marketplace. Small businesses and individuals will be the primary customers of exchange plan coverage, and states should carefully assess how the benchmark options compare with coverage typically purchased by small firms and families in the marketplace today and select the benchmark that promotes the greatest access to affordable coverage and care.

- **During the two year transition period, HHS should examine the potential cost impact of the benchmark approach—with a particular focus on affordability for small businesses and families buying coverage on their own.** As part of this assessment, HHS should carefully look at the coverage purchased by individuals and families in the individual marketplace today and how the EHB standard, as contemplated in the Bulletin, would affect affordability of coverage.

  The Congressional Budget Office found that "average premiums in the individual market would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained."[2] This is largely due to the fact the individual plans "would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits."[3] We believe

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[2] CBO Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act. November 30, 2009
[3] Ibid.

such an assessment can help avoid the potential of benefit "buy-up" for families, and assure that coverage is more affordable.

- **HHS should assure that the EHB package promotes value and high-quality care—through rigorous review of new and existing benefit requirements and incorporating the best available scientific evidence so that benefits promote high-quality, effective care for patients and consumers.** HHS should begin this process now—in part by establishing a process for a rigorous, evidence-based review of any new proposed mandates—as well as existing state mandates—based on their efficacy, clinical effectiveness, and cost. This will help assure—that after the two year transition period—the EHB package can be value-promoting and assure access to affordable, high-quality care.

State Mandated Benefit Requirements

The Bulletin provides for a transition period for states to "coordinate their benefit mandates. During this transition period (2014-2015), if a state chooses a benchmark subject to state mandates, such as a small group market plan, that benchmark would include those mandates in the state EHB package." Beginning in 2016, under the framework outlined in the Bulletin, HHS "will develop an approach that may exclude some state benefit mandates from inclusion in the state EHB package."

The transitional approach, as provided for under the Bulletin, raises concerns about the affordability of coverage as it will likely leave many expensive state mandates in place. In addition, the IOM pointed out that many of these mandates have little basis in scientific evidence. It also stands in contrast to the recommendations of the IOM report—*Essential Health Benefits: Balancing Coverage and Cost*—which concluded that "because state mandates are not typically subject to rigorous evidence-based review or cost analysis, cornerstones of the committee's criteria, the committee does not believe that state-mandated benefits should receive any special treatment in the definition of the EHB and should be subject to the same evaluative method."[4] Moreover, as the IOM noted, the approach of including state mandated benefits appears "contrary to ACA's statutory language which clearly contemplates requiring states to pay the premium cost that results from state mandates that exceed essential health benefit requirements."[5]

We urge the Department to take this opportunity to advance the goals of an evidence-based and more effective health care system. State mandated benefit requirements—many of which are not evidence-based and do not reflect clinical best practices—increase the cost of coverage and thereby make health insurance coverage less affordable and accessible to individuals, families, and small businesses. There are currently over 2,000 state mandates which vary widely across states both in terms of their scope and application. To the extent state mandates are inconsistent with clinical best practices and/or lack a strong

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[4] IOM Report—*Essential Health Benefits: Balancing Coverage and Cost.* October 7, 2011.
[5] IOM Report—*Essential Health Benefits: Balancing Coverage and Cost.* October 7, 2011. Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) § 1311(d)(3).

evidence-base, they may also work at cross-purposes with the goal of providing high-quality, effective care for patients and consumers in addition to increasing costs and making coverage less affordable.

Some states have examined the potential cost of state mandated benefit requirements—with a focus on mandates that exceed the 10 broad categories included in the ACA.

- In Connecticut, a Mercer study estimated the potential cost impact of mandates that exceed the 10 categories in the EHB package and found that **claims costs for these mandated benefits represents between 8.2% of claims (individual market) to 10.4% of claims (group market).**[6]

- In Maryland, an Oliver Wyman study estimated that the cost of mandates would be almost **$43 million in 2009 premium dollars**—to the extent they exceed the 10 categories under the ACA.[7]

- In North Carolina, a Milliman report estimated that the cost of continuing to require the same mandated benefits will be **approximately $32 million in 2014, $38 million in 2015, and $45 million in 2016.**[8]

While AHIP recognizes the goal of providing a transitional period for states, it is critically important that benefits are affordable and reflect the best available scientific evidence and clinical practices. Below are our specific recommendations for making the regulatory structure related to mandates more workable, affordable, and evidence-based over time.

Recommendations:

- **Starting in 2016, HHS should exclude state mandated benefit requirements from the EHB package that exceed the ACA's 10 categories and/or lack a strong evidence base.** Specifically, we recommend that HHS—during the two year transition period—examine current state mandated benefit requirements and assess whether they fall outside the scope of the 10 categories as specified under the ACA. As part of this analysis, HHS should examine the cost and medical evidence of mandates that exceed the 10 categories and develop a framework for excluding some state mandates from inclusion in the EHB package. We recommend that HHS establish a process for a rigorous, evidence-based review of any new proposed mandates—as well as existing state mandates—based on their efficacy, clinical effectiveness, and cost. As part of the evaluation of new benefit requirements, HHS should incorporate the IOM's criteria—that is, coverage for the item or service must:

    - Be safe—expected benefits should be greater than expected harms;

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[6] Mercer analysis before Connecticut Health Insurance Exchange Board meeting—November 17, 2011.
[7] "Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets." Oliver Wyman—Prepared for the Maryland Health Care Commission. June 16, 2011.
[8] "North Carolina Health Benefit Exchange Study." Milliman—Prepared for the North Carolina Department of Insurance. March 31, 2011.

- Be medically effective and supported by a sufficient evidence base, or in the absence of evidence on effectiveness, a credible standard of care is used;
- Demonstrate meaningful improvement in outcomes over current effective services/treatments;
- Be a medical service, not serving primarily a social or educational function; and
- Be cost effective, so that the health gain for the individual and population health is sufficient to justify the additional cost to taxpayers and consumers.[9]

- **Given the lack of strong medical evidence on the safety, effectiveness, and value of many state mandates and the IOM's recommendations, AHIP recommends that state mandates should <u>not</u> be automatically included in the benchmark plan selected by the states.** We make this recommendation because of the significant cost impact of including state mandates—given the large number of mandates and the considerable variation in terms of scope and application—and the fact that many state mandates lack a strong evidence-base, as recognized by the IOM.

    - At a minimum, HHS should clarify that state mandated benefits enacted after 2011 would not apply to the state-selected benchmarks subject to the state mandates (e.g., small-group plan) and that states would be required to pay any additional costs associated with new mandates enacted after 2011. Adding new and expensive mandates to the state-selected benchmark plan after 2011 raises affordability and quality of care concerns and would create administrative challenges for states and health plans.

- **HHS should require that existing limits on state mandated benefit requirements (including dollar or other quantitative limits) remain in place.** Many states have passed mandated benefit requirements, but allow health plans to place annual limits on such benefits. We believe this approach would be consistent with the transitional approach set out in the Bulletin. Allowing existing state limits on mandated benefits to remain in place could help assure greater affordability and promote stability in coverage.

- **Future rulemaking should reaffirm that the approach described in the Bulletin for the establishment of the essential health benefit benchmarks by the states applies solely for the purposes of plans in the individual and small-group markets.** Such guidance should also clarify that large group health plans (both insured and self-insured) may continue to make reasonable, good faith determinations of what constitutes an essential health benefit—taking into consideration the 10 categories of services included in the statute—for the purposes of the ACA prohibition on annual or lifetime dollar limits on EHBs. Section 2711 of the PHSA as added by the ACA prohibits group health plans and insurers from imposing annual or lifetime dollar limits on coverage that is "essential health benefits." Interim final rules issued in June 2010 implementing these prohibitions stated that the regulatory agencies will take into account good

[9] See IOM report—Criteria to Guide EHB Content on Specific Components.

faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for plan years that begin before final rules are issued defining the "essential benefits." We recommend that these current regulatory standards—as outlined in the interim final rule—continue to apply for the purposes of Section 2711.

- We also recommend that HHS clarify that employers and health plans may continue to establish treatment limits on "essential health benefits"—such as day and visit limits—in order to encourage retention of and consumer access to coverage for these services. The interim final rules implementing Section 2711 requirements state that the prohibition on lifetime and annual limits applies to the "dollar amount of benefits", "dollar limits", and "dollar value of all benefits."[10] A plain reading suggests it would only apply to limits on essential health benefits that are expressed in dollars and not to other types of limits such as the number of visits to a category of providers or the number of days of coverage. These and other types of limits are common features of private health insurance coverage and work in conjunction with plans' medical management tools to help assure access to high-quality services while promoting affordability.

Benefit Design Flexibility

Health plans are focused on providing the highest quality care to consumers at the lowest cost. To accomplish this, health plans have implemented innovative care and medical management tools that improve quality as well as promote greater value and affordability. Health plans have been at the forefront of developing innovations in care management and delivery that can play an important role in achieving meaningful change, better outcomes, and lower costs throughout the health care system. The value of these various health plan tools is supported by recent research which suggests that health plans can impact the quality of care through disease management, provider education efforts, patient education efforts, the development of reminder systems, and the use of financial incentives and other activities.[11]

Benefit design flexibility is an important element to assuring affordability and high-quality care and are a mainstay of administering benefits in the private health insurance marketplace. We note that recent regulatory guidance on coverage for preventive care services under the ACA[12] recognizes the use of

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[10] 75 Fed. Reg. 3723 (June 28, 2010).
[11] Laurence C. Baker and David S.P. Hopkins, International Journal for Quality in Health Care, "The Contribution of health plans and provider organizations to variations in measured plan quality," (March 18, 2010).
[12] October 8, 2010 -- DOL issued a frequently asked questions (FAQ) that clarified that "the interim final regulations regarding preventive health services provide that if a recommendation or guideline for a recommended preventive health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques (which generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or similar practices) to determine any coverage limitations under the plan. Thus, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and these established

reasonable medical management techniques to determine coverage limitations under the plan, and that the ACA allows for the use of commonly employed medical management tools[13]. As the IOM has noted, "these practices help hold down premiums, as do higher levels of deductibles and cost-sharing."[14]

The Bulletin also notes that HHS is considering permitting substitution in benefits—both within each of the 10 categories of services and potentially across the benefit categories. The Bulletin also seeks input on whether "substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories." Should benefit substitution be permitted, we believe that a level-playing field across issuers and transparency for consumers in substitution in benefits must be ensured in order to promote access to benefits, avoid market disruptions and help maintain a viable marketplace.

We also urge HHS to recognize the unique nature of expatriate plans and the population served by these plans as the Department determines how to best consider this distinctive coverage in the context of the essential health benefits framework.

Recommendation:

- **We support the Bulletin's approach to benefit design flexibility to assure that patients have access to safe, clinically effective, and affordable health care services.** As recognized in the Bulletin, allowing plans to have flexibility to design benefits within the 10 statutory EHB categories "would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits."

Timing on Benchmark Selection

The Bulletin contemplates that states would select a benchmark plan during the third quarter of 2012, but does not specify the process for how a state would select a benchmark (e.g. whether it requires the passage of a state law, executive order, or other state action). Moreover, the Bulletin does not provide a specific deadline for states to select a benchmark plan.

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techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service." http://www.dol.gov/ebsa/faqs/faq-aca2.html

[13] Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) § 1563.

[14] IOM Report—*Essential Health Benefits: Balancing Coverage and Cost.* October 7, 2011

Final, timely guidance on the EHB package (and related requirements such as cost-sharing and actuarial value) is critically important to assure that health plans have adequate time to develop new products and have them filed and approved by the appropriate regulatory authority.

The process for developing new products is a data-intensive and time consuming process that typically takes between 12-18 months. Critically important functions necessary to develop and launch new products include market research, product and rate development, contract development (including contracts with providers and third-party vendors), regulatory filings, rate and benefit system loading, and marketing and web development.

Recommendations:

- **HHS should establish a deadline of no later than June 30, 2012, for states to select an EHB benchmark.** If states do not select the benchmark plan by the deadline, HHS should specify the fallback plan as the largest small-group plan in the state by the deadline (consistent with the Bulletin). As part of this benchmark selection process, states would need to select the benchmark category and specify the specific plan within the benchmark that will serve as the reference plan and how the state intends to supplement the benchmark plan to the extent the benchmark plan does not cover all of the required 10 categories under the ACA.

- **HHS should issue timely guidance to states on the process for selecting the benchmark plan, and issue guidance on related standards on cost-sharing and actuarial value as soon as practicable.**

Updating the EHB Package

The ACA requires the HHS Secretary to periodically review and update EHBs—including assessing whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and affordability of coverage as it relates to EHB. The Bulletin invites comments on approaches for gathering information to making this assessment.

Recommendations: To assure that health benefits coverage promotes access to affordable, high-quality care, we recommend that HHS adopt the following criteria for updating the EHB package:

- **Adoption of the IOM's recommendations that benefits be value-promoting and incorporate the best available medical and scientific evidence on the clinical effectiveness of various treatments and services.**

- IOM recommends hierarchies of evidence in defining scope of benefit inclusions and the need to strengthen medical practice to be more evidence-based.

- **Assure that the structure of EHB benefits promotes high-value utilization** through strategies such as value-based insurance design (VBID), with flexibility for plans to develop innovation plan coverage designs, consistent with the IOM's recommendations.

- **Ensure that the EHB package provides value** (e.g. must provide a meaningful health benefit and demonstrates meaningful improvement over current effective services/treatments), is responsive to scientific and medical evidence as it becomes available, and promotes innovation in benefit design, service delivery, medical management, and new payment models to improve value.

Prescription Drug Coverage

The proposed regulatory standard in the Bulletin reflects Medicare Part D standards under which plans must cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes.

We are proud of the fact that health plans have a strong track record in providing high-quality and cost-effective prescription drug coverage to Medicare beneficiaries—including using proven and effective pharmacy management tools that provide greater value to consumers. But, we believe plans could promote even greater value in providing cost-effective prescription drug coverage absent specific Part D restrictions that constrain our ability to fully mobilize our tools to provide even more value to consumers. Therefore, we believe that the EHB standard should adopt a more market-oriented approach that can help assure that plans can effectively use their pharmacy management tools—without undue regulatory barriers— to assure access to high-value, cost-effective prescription drug coverage.

Recommendation:

- **While we share the Bulletin's goal of flexibility and ensuring value within pharmacy benefits, we believe that this can be best accomplished by utilizing private sector management tools to assure high-quality and cost-effective prescription drug coverage.** To that end, we recommend that HHS support market-based, commercial prescription drug coverage as the EHB standard—without regulatory constraints that would restrict the ability of plans to provide value to consumers. This flexibility is critical to assuring flexibility and innovation in pharmacy benefits and formulary design while promoting affordability for consumers and patients.

Coverage for habilitative services

The Bulletin provides two options for covering habilitative services, in the event the state's benchmark does not cover such services.

- Habilitative services would be offered at parity with rehabilitative services—a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in a similar scope, amount, and duration for habilitation; or

- As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

As noted in the Bulletin, habilitative services are one of the categories of services that are not routinely covered under typical employer coverage today, and such habilitative services are a less well defined area of care. Because habilitative services are not typically covered under employer plans today, it will be important to assure that coverage for habilitative services is affordable and that there is some level of flexibility in the administration of the coverage of habilitative services, especially given that habilitative services are a less well defined area of care and that there is considerably less evidence on what type of services are proven to be effective.

Recommendations:

- If the rules surrounding essential health benefits do not lead to affordable coverage, large numbers of families and individuals could be left out of the system altogether. In its recommendations to HHS, the Institute of Medicine (IOM) wrestled with this challenge. We agree with the IOM and believe essential health benefits coverage should focus on medical services, not social or educational needs. We believe that this principle should guide decisions around habilitative services. Habilitative services are not typically covered in small group and individual coverage and, in the past, have generally been offered through state and local educational and social services and not medical benefits. We urge the agency to follow the general recommendations of the IOM in developing its approach to habilitative services by focusing exclusively on medical benefits and not expanding medical benefits to services not traditionally covered by health insurance.

- We recommend providing plans with flexibility to ensure that medical management tools can be effectively used to ensure that beneficiaries have access to coverage at affordable rates. To ensure that care is safe, effective, and appropriate, we recommend that plans continue to have flexibility to credential licensed professionals providing habilitative services. Provision of care

by licensed professionals with expertise in the use of habilitative services is important to achieve the best possible results and help build the needed evidence base for these services. State licensure and plan accreditation requirements offer additional assurances that consumers will have access to quality providers whose credentials and licenses define their scope of practice.[15] This can help assure access to experienced, licensed clinicians while—at the same time—maintaining affordability of coverage though both flexibility and the use of proven care and medical management tools.

Coverage for pediatric dental and vision services

The Bulletin provides options for supplementing benchmarks that do not include coverage for pediatric oral and/or vision services.

For pediatric oral benefits, the state may select supplemental benefits from either:

- The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest enrollment; or

- The state's separate Children's Health Insurance Program.

For pediatric vision benefits, the Bulletin proposes that the benchmark plan must select supplemental benefits covered by the FEDVIP vision plan with the largest enrollment.

Similar to habilitative services, pediatric oral and vision services are not routinely covered under typical employer plans and only less than one-half of small-employer plans cover pediatric dental or vision benefits. As adding these benefits would increase the cost of coverage, it is important to assure that the pediatric vision and dental benefits are affordable for small businesses and families. Based on our research, the FEDVIP and CHIP benchmarks for dental coverage tend to be considerably more comprehensive than coverage provided under small group coverage today and would likely result in a significant increase in premiums. In addition, we believe that the dental coverage should retain features of currently available coverage, including dollar or other quantitative limits.

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[15] *See* NCQA 2012 Health Plan Accreditation Standards for Credentialing and Re-credentialing.

Recommendation:

- **HHS should reconsider these benchmarks and instead model pediatric dental and vision coverage after typical coverage provided in the small-group market today—with a focus on coverage for preventive and screening services.** This can help assure a more affordable pediatric dental and vision benefit while assuring access to critical dental and vision services.

Determining the benchmarks—products versus plans

Under the proposed regulatory framework, the Bulletin defines the small-group benchmark plan as "the largest plan by enrollment in any of the three largest small group insurance products in the state's small-group market."

However, there is some confusion about practical differences between insurance "products" versus "plans." From a purely administrative perspective, health plans generally do not report enrollment to the states or Federal government by "plan" level, instead it is reported at the "product" level. We note that for a short period in 2011, HHS collected plan level enrollment information for the individual market, but this was discontinued in the fall of 2011. Currently on the Healthcare.gov Plan Finder, consumers can sort plans in their given zip code by enrollment but the sorting functionality uses product level data not plan level data.

Recommendations:

- **The small-group benchmark should be based on "any of the three largest small group insurance products in the state's small group market." This could ease administrative and data collection burdens on states and plans—as enrollment information is generally not available to states and HHS at the plan level.** Moreover, the difference between products and plans is largely a function of different levels of cost-sharing.[16] As the Bulletin relates only to covered services, choosing a benchmark plan based on the product level appears to be the most reasonable and feasible approach.

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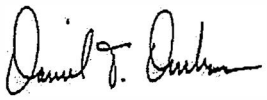
[16] For the purposes of the portal, HHS chose to define ''health insurance product'' as a package of benefits that an issuer offers that is reported to State regulators in an insurance filing (Source: Plan Finder Interim Final Regulation at 75 Fed. Reg. 24482). As it relates to definition of a "plan", HHS chose to define portal plan as the discrete pairing of a package of benefits with a particular cost-sharing option (not including premium rates or premium rate quotes). (Source: Plan Finder Interim Final Regulation at 75 Fed. Reg. 24482).

- **HHS should clarify that optional benefit riders should not be included in the benchmark selected by the state.** As the Bulletin notes, insurance products relate to the services covered by the issuer, which may have several cost-sharing options and riders as options. In selecting the benchmark, HHS should clarify that optional riders would not be part of the benefits covered under the state-selected benchmark for the purposes of determining the state's EHB package.

We appreciate the opportunity to share these comments, and stand ready to work in partnership with you and the States as health reform implementation moves forward.

Sincerely,



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Summary of Briefs submitted to the Supreme Court in
NFIB v. Sebelius, HHS v. Florida, and Florida v. HHS

This paper summarizes the initial round of briefs submitted to the U.S. Supreme Court in the individual mandate litigation. The Court will hear oral arguments on March 26 – 28, and briefs on various issues will continue to be filed through February. The briefs filed to date were the government's and their amici in favor of the constitutionality of the individual coverage provision, and the plaintiffs and their amici on the severability issue. This paper provides a short overview of the arguments that have been filed on those issues. We will compile a separate summary of briefs on the Medicaid issue after the filing of those briefs is completed.

Parties

United States (*Minimum Coverage Provision*)

The minimum coverage provision is a valid exercise of Congress's power under the Commerce and Necessary and Proper Clauses of the Constitution. The provision is necessary to effectuate comprehensive insurance reforms, and is itself an economic regulation of the timing and method of purchasing health care services. Moreover, the minimum coverage provision operates as a tax and is therefore authorized by the Taxing power.

NFIB and 26 States *(Severability)*

The mandate is not severable from the ACA. If the mandate is held to be unconstitutional, the ACA should be struck down. The guaranteed issue and community rating provisions were the key impetus for getting the Act passed. Without the promise of insuring the uninsured, there is no prospect the ACA would

have become law. The Supreme Court's precedents indicate that severability is governed by congressional intent, and without the market reform provisions Congress would not have passed the ACA.

The remaining provisions of the ACA should rise or fall with the market reforms, as Congress contemplated the financing of the supply and demand provisions of the law to work as a whole. The mandate was intended to ensure universal demand for insurance, while the insurance market reforms, exchanges, employer regulations and Medicaid expansion were intended to create universal supply. The supply expansion was intended to be paid for by the increased demand, and otherwise intended to work as a cohesive whole.

Stakeholders

AHIP-BCBSA *(severability)*

AHIP filed a joint brief with the Blue Cross Blue Shield Association on the severability issue. We argued that the insurance market reforms cannot function as Congress intended without the mandate and therefore should be struck down if the mandate is held to be unconstitutional. The insurance reforms include four provisions of Section 1201 of the Affordable Care Act: guaranteed issue; adjusted community rating, the ban on pre-existing condition exclusions; and the ban on discrimination based on health status.

U.S. Chamber of Commerce *(severability)*

The Chamber takes no position on the constitutionality of the mandate, but if it is struck down the rest of the ACA should be struck as well. Some provisions, such as the market reforms, would clearly need to be struck, while others such as the subsidies and the functioning of the exchanges, would not operate at the levels or in a manner contemplated by Congress if the mandate did not exist. The mandate is the proverbial string that, once pulled, causes the remainder of the Act's insurance reforms to unravel.

The sheer scope and complexity of the law make it impractical and inappropriate for the Court to make essentially legislative choices in deciding about the policy trade-offs on how the remaining ACA provisions would interact if the core provisions of the Act were struck down. Only Congress can decide how to

recalibrate health care policy without jeopardizing the expansion of coverage that Congress sought in the ACA.

American Hospital Association *(severability)*

The AHA filed a joint brief with several other hospital trade associations. They argued that the mandate is constitutional, but if the mandate falls, certain other Medicaid funding reductions and penalties should fall as well. The ACA contains several provisions that cut hospital reimbursements for treating Medicare and Medicaid patients or require hospitals to engage in spending to meet ACA mandates. In particular, three provisions are bound up with the mandate and would not have been enacted without it: the Disproportionate Share Hospital (DSH) reductions, readmissions program, and productivity and market-based adjustments. Those three program cuts, and associated revenue losses to the hospital community, were intended to be offset by the additional revenues generated by individual mandate.

Economists, *including Holtz-Eakin, Nobel laureates and former senior government officials (severability)*

The mandate is not severable from the ACA because Congress could not have intended the economic effects of the ACA without the mandate. The mandate provides an almost perfect balance necessary to fund the costs the ACA imposes on health insurance providers, hospitals and drug manufacturers and the law cannot function as intended to lower costs and broaden access if the mandate does not force people to purchase insurance who would not make the economically rational decision to bear the financial consequences of their own health risk.

Competitive Enterprise Institute, *including James Capretta, Thomas Miller, Scott Harrington, others (severability)*

The provisions of Title I of the ACA (mandate, insurance reform, exchanges) work together to regulate the terms, value, marketing, purchase and operation of individual and employer-provided group coverage, to increase the rate of coverage, and to drive coverage through exchanges. The structure and carefully staged timing requirements of Title I's requirements demonstrate they were intended to

work as an integrated whole. Accordingly, at a minimum, Title I of the ACA must be struck as a whole if the mandate is unconstitutional.

Texas Public Policy Foundation and Cato Institute *(severability)*

Titles I and II of the ACA must be struck down if the mandate is found unconstitutional. Virtually all of the health insurance reforms in Title I will cause an adverse selection spiral if undertaken without a mandate, and likewise the Medicaid expansion and insurance premium subsidies in Title II were designed to work with the mandate. The congressional objective of achieving affordable and accessible health care at an acceptable cost will be defeated by eliminating the mandate from the unified scheme of Medicaid, premium support and individual mandate that was designed to achieve those objectives.

American Cancer Society, American Diabetes Association, American Cancer Network, American Heart Association *(mandate)*

The mandate is constitutional. All Americans incur health care expenses, and how those expenses are financed has a substantial effect on interstate commerce. The insurance reforms that most directly impact citizens with chronic diseases – the ban on pre-existing condition exclusions and the prohibition on discrimination based on health status – cannot be effective without the mandate.