UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al., Plaintiffs, v. UNITED STATES OF AMERICA, et al., Defendants.	Civil Action No. 4:18-cv-00167-O

BRIEF OF AMICI CURIAE AARP AND AARP FOUNDATION IN OPPOSITION TO PLAINTIFFS' APPLICATION FOR A PRELIMINARY INJUNCTION

Iris González (Texas Bar No. 24042545)
Maame Gyamfi (District of Columbia Bar No. 462842)*
AARP Foundation
601 E Street, N.W.
Washington, D.C. 20049
Telephone (202) 434-6291
Facsimile (202) 434-6424
igonzalez@aarp.org
mgyamfi@aarp.org

Counsel for Amici Curiae

*Pro Hac Vice pending

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STATEMENT OF INTEREST

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness. Among other things, AARP and AARP Foundation advocate for access to quality health care across the country and frequently appear as friends of the court on issues affecting older Americans, including challenges to the Patient Protection and Affordable Care Act (ACA or "the Act"). *See, e.g.*, Brief of AARP, et al., *King v. Burwell*, No. 14-114 (U.S. Jan. 28, 2015); Brief of AARP, et al., *NFIB v. Sebelius*, Nos. 11-393 & 11-400 (U.S. Jan. 27, 2012); Brief of AARP, et al., *Halbig v. Burwell*, No. 14-5018, (D.C. Cir. Nov. 3, 2014).

SUMMARY OF ARGUMENT

The ACA has become an integral part of the nation's health care system. Congress designed the Act to address numerous inadequacies in health care, including making health care more accessible and affordable, improving the quality of health care services, reducing health care costs, and increasing consumer protections.

Prior to the enactment of the ACA, millions of Americans paid a human toll for the lack of accessible, affordable health care. Access to affordable health care was especially challenging for adults ages 50 to 64 (hereinafter "pre-Medicare adults") who faced barriers in obtaining

adequate and affordable health insurance in the private and employer-based markets and were not eligible for publicly funded insurance unless they were eligible for Medicaid.

Uninsured pre-Medicare adults faced nearly insurmountable challenges to securing insurance because they 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 as much as 11 times greater than their younger counterparts solely based on their age. Even a healthy person who was age 50 to 64 with no preexisting conditions faced markedly higher insurance premium rates than a younger person. Age rating put the cost of insurance out of reach for many pre-Medicare 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 pre-Medicare group's lack of health-care coverage resulted in worse health outcomes and even death. Their inability to secure coverage also negatively impacted personal finances, health care spending, federal programs such as Medicare, and the national economy.

The ACA reflects Congress's intent to address these problems. Congress designed key reform provisions to reduce barriers to access, encourage people to obtain health insurance, and resolve additional long-standing problems with the health care system. The lives of older adults improved dramatically as they have gained key protections, including prohibitions on denying coverage to people with preexisting health conditions or basing premiums on health status, and limits on age rating (referred to as "guaranteed issue" and "community rating" provisions, respectively). They also have gained access to quality, affordable health insurance through their employer, the individual market, and Medicaid. Adults with Medicare have gained cost-savings

for prescription drugs and preventative care, and everyone gained protections related to elder abuse and neglect.

Congress did not intend to rip these important gains away from vulnerable adults through its reduction of a tax penalty in the Tax Cuts and Jobs Act of 2017 (TCJA), Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). Even though Congress had the opportunity, it did not repeal the minimal coverage provision (often referred to as the "individual mandate") or any other provision of the ACA in the TCJA. It only amended the penalty amount. As such, the minimum coverage provision remains constitutional and the entire ACA stands. Moreover, even if this Court determines that the minimum coverage provision is unconstitutional, all remaining parts of the ACA, including the guaranteed issue and community rating provisions, should remain in force.

A ruling in favor of Plaintiffs is not in the public interest. It would have a catastrophic, nationwide effect on the health and financial stability of all Americans, but especially older adults who will be precluded from receiving the health care services that they desperately need.

ARGUMENT

I. BEFORE THE ACA, HEALTH INSURANCE WAS UNAVAILABLE OR UNAFFORDABLE TO MILLIONS OF PRE-MEDICARE ADULTS.

Before the ACA, the number of uninsured Americans aged 50 to 64, and thus not yet eligible for Medicare, was growing at an alarming rate – increasing from 5.2 million in 2000 to 9.2 million in 2012. *See* Gerry Smolka et al., AARP Pub. Policy Inst., *Health Care Reform: What's at Stake for 50- to 64-Year Olds?* 1 (March 2009),[1] [hereinafter *What's at Stake*]; Gerry Smolka et al., AARP Pub. Policy Inst., *Effect of Health Reform for 50-to 64-Year-Olds* 1 (Dec.

[1] https://assets.aarp.org/rgcenter/health/i24_hcr.pdf.

2013),[2] [hereinafter *Effect of Health Reform*]. Most uninsured pre-Medicare adults did not have access to affordable employer-sponsored insurance, could not afford private insurance on the individual market, or did not qualify for publicly funded insurance programs. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population* 2 (Sept. 2013).[3] The economic and health consequences for these individuals, their families, and the nation were devastating.

For example, many pre-Medicare adults found that employer-sponsored insurance was unavailable or was unaffordable. In 2012, an estimated 11 million working pre-Medicare adults did not have employer-sponsored insurance. *Effect of Health Reform*, *supra*, at 2. Of these, less than half could obtain coverage from another source. *Id*.

Many pre-Medicare adults also could not afford adequate insurance policies on the private individual market. In 2007, 61% of pre-Medicare adults who tried to purchase health insurance on the private market found it very difficult or impossible to afford. *See* Sara Collins, et al., The Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010*, at 5, ex. 4 (Dec. 14, 2010).[4] Among those who purchased insurance, 60% reported difficulty paying medical bills or accessing services due to costs, leaving them underinsured. *Id.* at 6, ex. 5. High health insurance premiums and out-of-pocket medical expenses for older adults were linked to insurance underwriting policies that allowed insurers to deny coverage or offer sparse policies to people with preexisting conditions, charge

[2] https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/effect-of-health-reform-for-50-64-year-olds.pdf.
[3] https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.
[4] https://www.commonwealthfund.org/publications/issue-briefs/2010/dec/realizing-health-reforms-potential-adults-ages-50-64-and.

high premiums based on age alone, or offer policies with high cost sharing. Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers*, at 10 (Aug. 2012);[5] Lynn Nonnemaker, AARP Pub. Policy Inst., *Beyond Age Rating: Spreading Risk in Health Insurance Markets*, at 3, tbl. 1 (Oct. 2009)[6] [hereinafter *Beyond Age Rating*].

These underwriting policies disproportionately affected pre-Medicare adults because 48 to 86% of people ages 55 to 64 had preexisting health conditions. U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, at 4, fig. 1 (2011).[7] Insurers routinely denied coverage to applicants with a wide variety of prior health problems such as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, or stroke. *See* Gary Claxton, et al., The Kaiser Family Foundation, *Preexisting Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA* (Dec. 12, 2016).[8] Insurers who did not deny coverage would often limit benefits or charge excessive premiums. H.R. Rep. No. 111-443, pt. 2, at 981 (2010).

In addition to charging higher rates based on preexisting or chronic conditions, insurers frequently charged people ages 50 to 64 exorbitant rates – even as much as 11 times greater than their younger counterparts – solely based on their age. *See* Karen Pollitz, et al., Georgetown Univ. Inst. For Health Care Research and Policy; and The Kaiser Family Foundation, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (June

[5] http://www.naic.org/documents/committees_conliaison_1208_consumer_recs_aca.pdf.
[6] https://assets.aarp.org/rgcenter/ppi/health-care/i35-age-rating.pdf.
[7] https://aspe.hhs.gov/system/files/pdf/76376/index.pdf.
[8] http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA.

2001).[9] Even a healthy person who was age 50 to 64 and had no preexisting conditions faced markedly higher rates than younger people.

Insurers used the applicant's age, commonly referred to as "age rating," when setting the applicant's premium rates because, they argued, people's health status declines as they age, leading to more insurance claims. *See* NAIC & the Ctr. for Ins. and Policy Research, *Health Insurance Rate Regulation.*[10] This practice put the cost of health insurance out of reach for many in the pre-Medicare age group. "For many older adults and older families, the higher out-of-pocket costs that come with greater medical use in older age, combined with high premiums due to steep age rating [], would lead to a high burden of total health care costs relative to income." Linda J. Blumberg et al., Urban Inst., *Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens*, at 8 (Oct. 2009).[11]

II. PRE-MEDICARE ADULTS' INABILITY TO ACCESS AFFORDABLE HEALTH CARE RESULTED IN WORSE HEALTH OUTCOMES AND DEATH, AND NEGATIVELY IMPACTED FINANCIAL STABILITY, THE HEALTH CARE SYSTEM, FEDERAL HEALTH CARE PROGRAMS, AND THE NATIONAL ECONOMY.

Older adults' lack of health care insurance harmed them in many ways. As uninsured adults age, they are more likely to experience chronic health conditions, resulting in worse health outcomes and increased mortality. The prevalence of multiple chronic conditions is greater in adults ages 45 to 64 than in younger adults, and this prevalence skyrocketed between 2001 and

[9] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf.
[10] http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.
[11] https://www.urban.org/sites/default/files/publication/30701/411970-Age-Rating-Under-Comprehensive-Health-Care-Reform-.pdf.

2010. Brian W. Ward & Jeannine S. Schiller, *Prevalence of Multiple Chronic Conditions among US Adults: Estimates from the National Health Interview Survey* 5 (Apr. 25, 2013).[12]

Uninsured pre-Medicare adults are about three times less likely to be up-to-date with clinical preventive services than those who are insured. *See* Megan Multack, *Midlife Not Getting Recommended Preventative Services*, AARP Pub. Policy Inst., (Sept. 11, 2013).[13] Uninsured adults have higher mortality rates because they are less likely to be aware of heart disease and its risk factors, and are more likely to have cancers that are not diagnosed and treated at early stages. Inst. of Med. (IOM), *America's Uninsured Crisis: Consequences for Health and Health Care* 72-83 (2009).[14]

As a consequence of being without health insurance prior to becoming eligible for Medicare at 65, many pre-Medicare adults are sicker and more expensive to care for than they would have been had they had access to adequate preventative care throughout adulthood. *Id.* 72, 77. The IOM found that when these older adults gain Medicare coverage at age 65, they experience improved health outcomes and a decreased risk of dying when hospitalized for serious conditions. *Id.* These findings suggest that pre-Medicare adults have significant unmet health needs before age 65, when they qualify for Medicare. *Id.* As a result, the treatment of previously uninsured people is far more costly to the Medicare system than treatment of those with insurance prior to turning 65 years of age. *See* U.S. Gov't Accountability Off., GAO-14-53, *Medicare: Continuous Insurance Before Enrollment Associated With Better Health and Lower Program Spending* 9 (Dec. 2013)[15] (finding that the previously uninsured had 35% more

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3652717/pdf/PCD-10-E65.pdf.
[13] http://blog.aarp.org/2013/09/11/midlife-adults-not-getting-recommended-preventive-services/.
[14] https://www.ncbi.nlm.nih.gov/books/NBK214966/.
[15] https://www.gao.gov/assets/660/659753.pdf.

program spending in the first year of Medicare enrollment than those previously insured continuously for six years). Thus, Medicare is more likely to remain solvent if people are healthier when they enter Medicare. Robert Pear, *Medicare Trust Fund Is Set to Run Out in 8 Years. Social Security, 16* (June 5, 2018).[16]

The lack of adequate, affordable health insurance profoundly affected the financial stability of pre-Medicare adults and, in turn, the national economy—restricting labor market mobility and causing individuals to incur medical care costs that depleted retirement savings and contributed to debt and bankruptcy. Many pre-Medicare workers who relied on employer-sponsored health insurance did not leave their jobs, switch jobs, reduce their hours, or retire for fear that they will lose and be unable to regain health benefits. *See* Richard W. Johnson et al., AARP Pub. Policy Inst., *Older Workers on the Move: Recareering in Later Life* at 10, 18 (Apr. 2009);[17] *see also* Sara R. Collins et al., The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* at 3 (March 16, 2011)[18] [hereinafter *Help on the Horizon*] (57% of adults ages 18 to 64 who lost a job with health benefits in 2010 could not regain insurance). Thus, many of the nation's most experienced and valuable workers were discouraged from redirecting their talents where they were most needed, including to entrepreneurship. *See* Robert W. Fairlie et al., *Is Employer-Based Health Insurance a Barrier to Entrepreneurship* (Jan. 2011)[19] (finding that the threat of losing employer-based coverage prevents people from leaving jobs to start their own businesses).

[16] https://www.nytimes.com/2018/06/05/us/politics/medicare-social-security-finances.html.
[17] https://assets.aarp.org/rgcenter/econ/2009_08_recareering.pdf.
[18] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2011/mar/1486_collins_help_on_the_horizon_2010_biennial_survey_report_final_v2.pdf.
[19] http://isiarticles.com/bundles/Article/pre/pdf/25321.pdf.

People with inadequate or no health insurance had financially debilitating health care costs. *See, e.g.*, Karen Pollitz et al., Kaiser Family Found., *Medical Debt Among People With Health Insurance* at 12 (Jan. 2014)[20] (profiling a fifty-one-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, ex. 12. Another 22 million were unable to pay for basic necessities such as rent, food, and utilities due to medical bills. *Id.* The median pre-Medicare household with a newly ill and uninsured member lost between 30 and 50% of its assets. Keziah Cook et al., *Does Major Illness Cause Financial Catastrophe?*, 45 Health Servs. Res. 418, 419 (Apr. 2010). These health-care-related financial burdens severely hampered retirement security.

III. THE ACA DRAMATICALLY IMPROVES THE LIVES OF OLDER ADULTS BY MAKING QUALITY HEALTH INSURANCE MORE ACCESSIBLE AND AFFORDABLE.

Consistent with its primary purpose, the ACA improved the lives of older adults by making health insurance, and thus health care, more accessible and affordable. 42 U.S.C. § 18091(2)(D)-(H); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (purpose of the Act is "to increase the number of Americans covered by health insurance and decrease the cost of health care"). As a result of the Act, millions of Americans have gained health insurance since 2010, including adults ages 50 to 64. *See, e.g.*, Kaiser Family Foundation, *Key Facts About the Uninsured Population* (Nov. 29, 2017).

The ACA has become a lifeline for pre-Medicare adults, helping them obtain much needed health care services while avoiding financial ruin. The Act does this through several

[20] https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf.

provisions designed to increase access to quality, affordable health insurance. These provisions: (1) expand access to private coverage with strong consumer protections such as prohibiting bans against covering people with preexisting health conditions and establishing limits on age rating; (2) increase access by incentivizing employers to expand the existing employer-based health insurance system; (3) increase access by providing income-based premium and cost-sharing subsidies and credits for individual coverage offered in Marketplaces; and (4) increase access by providing financial incentives for states to expand Medicaid coverage. The result is that millions of newly-insured older adults have access to health care.

A. The ACA Protects Older Adults From Insurance Discrimination Based on Age or Health Status.

The ACA eliminates or significantly reduces the barriers that many pre-Medicare adults previously faced in accessing affordable health insurance in the individual market. *See supra* Part I.B; *What's at Stake*, *supra,* at 5. The Act's consumer protection provisions, including the guaranteed issue and community rating requirements, transformed the health care landscape for older adults. *See* 42 U.S.C. § 300gg to gg-4.

The Act requires insurers to "accept every employer and individual in the State that applies for such coverage," regardless of preexisting conditions. 42 U.S.C. § 300gg-1(a). As noted above, these protections are vital to all Americans, but are especially crucial for older adults because they have a high incidence of preexisting conditions that increase as they age. Without this protection, four out of ten adults ages 50 to 64 – or about 25 million people in this age group – could be denied health coverage because of a preexisting condition. *See,* Claire Noel-Miller and Jane Sung, AARP Pub. Policy Inst., *In Health Reform, Stakes are High for*

Older Americans with Preexisting Health Conditions, (March 2017).[21] The ACA also bans insurers' practice of cancelling the policies of people who became ill. 42 U.S.C. § 300gg–12. Thus, the ACA protects consumers by ensuring that insurance, once gained, is not lost when a person needs it most.

The Act also prohibits setting insurance premiums based on health status and other health status-related factors such as disability, claims experience, receipt of health care, and medical history, 42 U.S.C. § 300gg-4, and eliminates coverage limits, 42 U.S.C. § 300gg-11.

The ACA's community rating provisions increased access to health services for older adults by making them more affordable. Among other provisions, the Act established that, although insurers may still use a formula that considers age when determining premiums, they may not charge older adults premiums that are more than three times the premiums charged to younger adults (3:1 age rating). 42 U.S.C. §300gg(a)(1)(A)(iii). This limit ensures adults ages 50 to 64 have access to affordable health insurance coverage, while fairly taking into consideration predictions of increased health care consumption. *See* Jane Sung, AARP Pub. Policy Inst., *Protecting Affordable Health Insurance for Older Adults: The Affordable Care Act's Limit on Age Rating*, (Jan. 2017).[22]

An increase in the age rating formula would financially devastate older adults. For example, the median income of people ages 60 to 64 who are buying into the individual market is $20,000. *See* AARP Pub. Policy Inst., *Weakening Age Rating Protections Will Make Health Care Unaffordable For Older Adults* (Jan. 2017).[23] (hereinafter "*Weakening Age Rating"*). An

[21] https://www.aarp.org/content/dam/aarp/ppi/2017-01/ACA-Protects-Millions-of-Older-Adults-with-Preexisting-Health-Conditions-PPI-AARP.pdf.
[22] https://www.aarp.org/ppi/info-2016/protecting-affordable-health-insurance-for-older-adults.html.
[23] https://www.aarp.org/content/dam/aarp/ppi/2017-01/Age%20Rating%20Infographic.pdf.

increase in rating from 3:1 to a 5:1 age rating limit would result in a 22 % increase in premiums for an adult age 60 and over and an average additional payment of $3,192 per year. *See,* Jane Sung and Olivia Dean, AARP Pub. Policy Inst., *Impact of Changing the Age Rating Limit for Health Insurance Premiums,* (Feb. 2017).[24] Yet the medium of people ages 60 to 64 who are buying into the individual market is $20,000. *See Weakening Age Rating, supra.* Those in the same age group who do not qualify for subsidies would have an annual premium of $18,000 if the age-rating prevision were weakened to 5:1. *Id.* Paying this additional cost at the time when older adults should be saving for retirement damages their health, financial security, and well-being. In addition, it puts public insurance programs at risk of having higher expenditures for older adults who go without preventive care and early diagnoses and treatments.

B. The ACA Increases Older Adults' Access to Employer-Based Health Insurance.

Employer-based insurance has traditionally been the backbone of the American health insurance system where most adults purchase coverage. However, prior to the ACA, many pre-Medicare adults could not access employer-based health insurance. The ACA addresses this problem by encouraging employers to offer health insurance. The Act imposes a shared responsibility requirement on large employers, under which they 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); 26 U.S.C. § 36B(c)(2)(C). Further, the Act provides that larger employers must offer affordable health insurance that meets minimum standards. 26 U.S.C. § 4980H(b)-(d). Small employers are also encouraged to provide health benefits to their employees through the Small Business Health

[24] https://www.aarp.org/ppi/info-2016/Impact-of-Changing-the-Age-Rating-Limit-for-Health-Insurance-Premiums.html.

Options Program (SHOP), which is designed to increase their buying power on the group market. *See* 42 U.S.C. § 18031(b)(1)(B), *see also* 26 U.S.C. § 45R.

C. The ACA Increases Older Adults' Access to Health Insurance on the Individual Market Through the ACA Marketplaces, Tax Credits, and Subsidies.

The ACA also improved pre-Medicare adults' access to health insurance in the individual market by establishing the ACA marketplaces and providing direct financial assistance in the form of tax credits and subsidies to make the insurance more affordable. *See* 42 U.S.C. § 18031(b); 26 U.S.C. § 36B(b)(3)(A); 42 U.S.C. § 18071(c)(2). In 2018, 11.8 million people enrolled in the health insurance exchanges nationwide. Ctr. for Medicare & Medicaid Servs., *CMS' Final Report Shows 11.8 Million Consumers Enroll in 2018 Exchange Coverage Nationwide* (Apr. 2018).[25] The tax credits 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), and subsidies to reduce out-of-pocket expenses for people with incomes under 250% of the federal poverty level, 42 U.S.C. § 18071(c)(2). Over 3 million low and moderate-income adults ages 50 to 64 rely on tax credits to purchase health insurance coverage in the individual health insurance market. *See,* Jane Sung et al., AARP Pub. Policy Inst., *Adequate Premium Tax Credits are Vital to Maintain Access to Affordable Health Coverage for Older Adults* (March 2017);[26] Laura Skopec et al., Urban Inst. & AARP Pub. Policy Inst., *Fewer Americans Ages 50-64 Have Difficulty Paying Family Medical Bills after Early ACA Marketplace Implementation* (Jan. 2016).[27]

[25] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html.
[26] https://www.aarp.org/content/dam/aarp/ppi/2017-01/adequate-premium-tax-credits-are-vital-to-maintain-access-to-affordable-health-coverage-for-older-adult.pdf.
[27] https://www.aarp.org/content/dam/aarp/ppi/2015/fewer-americans-ages-50-64-have%20-difficulty-paying-family-medical-bills-after-early-aca-marketplace%20Implementation.PDF.

The availability of non-employer-based insurance substantially reduced the problem of job lock as workers no longer felt tied to a job because they did not believe they could get affordable health care. *See* Harris Meyer, *Self-Employed fear Obamacare-repeal means 'job lock,'* Modern Healthcare (Dec. 28, 2016).[28] In 2014, one out of every five Marketplace consumers were small business owners, self-employed, or both. Dan Mangan, *Small-business owners and self-employed more likely to buy Obamacare plans*, CNBC (Jan. 12, 2017).[29] Thus, the ACA has not only allowed people to access health insurance, but also has improved employee mobility.

D. The ACA Increases Access to Health Coverage for Lower Income Older Adults By Expanding the Categories of People Who Are Eligible for Medicaid.

The Act increases access to health insurance for lower income older adults by encouraging states to expand their Medicaid programs. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Prior to the ACA, in most states, low-income adults without dependent children were not eligible for Medicaid, unless they had a disability. Adults in this category whose incomes are at or below 138% of federal poverty are eligible for Medicaid if their state chose to participate in this expansion. 42 U.S.C. § 1396d(y); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 588 (making Medicaid expansion optional for the states). Currently, 34 states and the District of Columbia have chosen to expand Medicaid, resulting in more than 15 million Americans gaining Medicaid insurance. Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision*, (June 7, 2018).[30]

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[28] http://www.modernhealthcare.com/article/20161228/NEWS/161229966.
[29] https://www.cnbc.com/2017/01/12/small-business-owners-self-employed-bought-many-obamacare-plans.html.
[30] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-

IV. THE ACA PROVIDES SAVINGS TO OLDER ADULTS WHO ALREADY HAVE MEDICARE BY IMPROVING ACCESS TO PRESCRIPTION DRUGS AND PREVENTATIVE SERVICES.

The ACA also makes substantial changes to the quality of Medicare coverage by enhancing access to specific medical services and products. Prior to these changes, many older adults faced reduced access to prescription drugs and preventative care because they could not afford the costs. The ACA reduces those costs.

First, the ACA decreases the amount that Medicare Part D beneficiaries pay for prescription drugs. The cost of prescriptions drugs is a critical issue for older Americans because, as noted above, they have the higher rates of chronic health conditions and are prescribed proportionately greater numbers of prescription drugs. National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities* 168-69, 272-73 (May 2016).[31]

Before the ACA, Medicare Part D required enrollees to pay for all their drug costs while they were in the benefit's coverage gap, commonly known as the Part D "donut hole." Dena Bunis, AARP, *Medicare "Doughnut Hole" Will Close in 2019* (Feb. 2018).[32] Part D plans covered the cost of medications until plan and enrollee spending reached an initial coverage limit. After hitting this gap in coverage, enrollees had to pay 100% of their prescription drug costs until they spent enough to reach catastrophic coverage. In 2010, a Medicare enrollee had to spend a total of $4,550 out-of-pocket to reach catastrophic coverage for that year. Leigh Purvis,

act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[31] http://www.cdc.gov/nchs/data/hus/hus15.pdf.

[32] https://www.aarp.org/health/medicare-insurance/info-2018/part-d-donut-hole-closes-fd.html.

AARP Pub. Policy Inst., *Health Care Reform Legislation Closes the Medicare Part D Coverage Gap* 1 (Apr. 2010).[33]

The ACA helped reduce Part D enrollees' out-of-pocket expenses by effectively closing the donut hole through a series of escalating contributions from drug manufacturers and Part D plans. 42 U.S.C. § 1395w-102. As a result, more than 11.8 million Medicare beneficiaries have saved over $26.8 billion on prescription drugs under the ACA. Ctr. for Medicare & Medicaid Servs., *Nearly 12 million people with Medicare have saved over $26 billion on prescription drugs since 2010* (Jan. 13, 2017)[34] (hereinafter "*Nearly 12 million people with Medicare*"). Older adults can now use these savings to cover other essential expenses during retirement and stave off the necessity to seek public financial assistance to meet those needs.

The ACA also eliminated cost-sharing for many screening services, such as mammograms, pap smears, bone mass measurement for those with osteoporosis, depression screening, diabetes screening, HIV screening, and obesity screening and counseling. 42 U.S.C. §1395l(a)(1)(T); *see also* Nat'l Council on Aging, *Nat'l Ctr. for Benefits Outreach & Enrollment, Quick Reference Chart: Medicare's Preventive Benefits* 1-7 (Nov. 2013).[35] Other preventive health services that no longer require cost-sharing include medical-nutrition therapy for people with diabetes and kidney disease and smoking-cessation counseling. *Id.*

The reduction of Medicare cost-sharing for preventive services improves the quality of health care obtained by persons over age 65, increasing access to preventive care to minimize more expensive and restrictive services such as hospitalizations and nursing facility admissions.

[33] http://assets.aarp.org/rgcenter/ppi/health-care/fs182-doughnut-hole-reform.pdf.
[34] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.
[35] https://benefits.usc.edu/files/2014/07/medicare-preventive-benefits-chart.pdf.

In 2016, an estimated 40.1 million people with Medicare took advantage of at least one preventive service with no copays or deductibles, and more than 10.3 million Medicare beneficiaries took advantage of an annual wellness visit. *Nearly 12 million people with Medicare, supra*.

V. THE ACA PROTECTS OLDER ADULTS BY IMPROVING QUALITY AND SAFETY IN NURSING FACILITIES, AND PROTECTING AGAINST ELDER ABUSE, NEGLECT, AND UNNECESSARY INSTITUTIONAL SEGREGATION.

The ACA's Nursing Home Transparency and Elder Justice Act provisions are vitally important to older people and people with disabilities. These provisions improve conditions and safety in nursing facilities and prevent abuse and neglect of elderly and disabled people residing in nursing facilities.

The ACA's "Nursing Home Transparency and Improvement" provisions improve transparency of and access to nursing facility information with the intention of improving accountability in nursing facilities. Among other things, the ACA requires (1) nursing facilities to disclose their owners, operators, and financers so they are accountable to residents; (2) nursing facilities to establish a Quality Assurance and Performance Improvement Program to improve quality standards; and (3) U.S. Department of Health and Human Services to collect and report nursing home staffing information. 42 U.S.C. §1320a-7j(c), (g). The Nursing Home Transparency and Improvement Act reflects provisions that Senators Chuck Grassley and Herb Kohl introduced for at least two years, most recently as the Nursing Home Transparency and Improvement Act of 2009.

When discussing the vital need to improve the quality of nursing facilities by ensuring greater accountability and other goals of the Nursing Home Transparency and Improvement Act

in 2007, Senator Grassley said:

> A recent Government Accountability Office report examined 63 nursing homes that had been identified as having serious quality problems. Of these, nearly half continued to cycle in and out of compliance between years 2000 and 2005. Twenty-seven of the 63 homes were cited 69 times for deficiencies warranting immediate sanctions. Yet in 15 of these cases sanctions were not even imposed. Eight of the homes reviewed cycled in and out of compliance seven or more times each period. This is unacceptable. But the real meaning of substandard care isn't about numbers. It isn't about statistics. It is about real people - our mothers, fathers, grandparents and loved ones. Every day there are stories reported across the [n]ation about residents suffering or even dying from preventable situations … It is not humanitarian. It is an outrage. The current system provides incentives to correct problems only temporarily and allows homes to avoid regulatory sanctions, while continuing to deliver substandard care to residents.

Nursing Home Transparency and Improvement: Hearing Before the Special Comm. on Aging, 110th Cong. 3-4 (2007) (statement of Sen. Grassley, ranking member, Sen. Finance Comm.).[36] The transparency provisions allow citizens to see where resources are going and protect against fraudulent self-dealing using government money.

The ACA's Elder Justice Act ("EJA"), 42 U.S.C. § 1305 *et seq*., among other things, coordinates federal, state, local, and private agencies' activities addressing elder abuse, neglect, and exploitation. The EJA: established funding for Adult Protective Services; created state demonstration grants testing methods for detecting and preventing elder abuse; established Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise; and created grants for Long-Term Care Ombudsman Programs and to enhance long-term-care staffing. 42 U.S.C. § 1397l(d).

Medicaid provides funding for long-term care services both in institutions, such as nursing facilities, and in the community. The ACA contains several provisions designed to incentivize states to shift Medicaid long-term care spending from institutions to the community.

[36] https://www.gpo.gov/fdsys/pkg/CHRG-110shrg41836/html/CHRG-110shrg41836.htm.

Many of these provisions are designed for people already receiving Medicaid coverage for long-term care services in institutions. By providing financial incentives to move people out of institutions and into the community, Congress sought to facilitate an improved quality of life for older persons receiving Medicaid-funded long-term care services and help states comply with their obligations under the Americans with Disabilities Act. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999) (holding "unjustified segregation or isolation of" people with disabilities is discrimination).

For example, the ACA established a new program, the Community First Choice Option, to assist with the costs of transitioning from an institution to the community. 42 U.S.C. § 1396n(k). That program enables states to provide Medicaid coverage for transition costs including rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities to facilitate the individual's transition to the community from a nursing facility. The ACA was thus responsive to the fact that overwhelming majority of people would prefer to receive care in their homes rather than in an institution. *See* Rodney Harrell, et al., AARP Pub. Policy Inst., *What is Livable? Community Preferences of Older Adults*, 7 (Apr. 2014).[37]

VI. THE ENTIRE ACA REMAINS IN FORCE AFTER THE PENALTY REDUCTION IN THE TAX CUTS AND JOBS ACT OF 2017 BECAUSE CONGRESS DID NOT REPEAL THE ACA OR THE MINIMUM COVERAGE PROVISION.

The ACA is constitutional and should remain in force. In passing the TJCA, Congress did not repeal the ACA or the minimum coverage provision. Instead, the text of the TJCA shows that the extent of Congress's action was to reduce the tax penalty to $0. See TCJA § 11081. When a

[37] https://www.aarp.org/ppi/issues/livable-communities/info-2015/what-is-livable-AARP-ppi-liv-com.html.

statute's text is plain and unambiguous, it must be enforced according to its terms. *See generally King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). Here, a plain language reading of the TJCA shows that Congress intended to reduce the tax penalty but leave the rest of the ACA intact. Any conclusion that Congress intended to eliminate the entire ACA through the TCJA would be the judicial branch stepping into the role of the legislative branch to yield a result that the legislative branch was unwilling or unable to obtain.

The legislative history further confirms that Congress intended every other provision of the ACA to remain operational even after it zeroed out the tax penalty. For example, Senator Tim Scott explained that, "the individual mandate and its effects in our bill take nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage—it does not have a single letter in there about preexisting conditions or any actual health feature." *See* 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017) (emphasis added).

Senator Orrin Hatch also emphasized:

> [L]et us be clear, repealing the tax does not take anyone's health insurance away. No one would lose access to coverage or subsidies that help them pay for coverage unless they choose not to enroll in health coverage once the penalty for doing so is no longer in effect.
>
> No one would be kicked off of Medicare. No one would lose insurance they are currently getting from insurance carriers. Nothing—nothing—in the modified mark impacts Obamacare policies like coverage for preexisting conditions or restrictions against lifetime limits on coverage.

See Continuation of the Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" Before the S. Comm. On Fin., at 106 (Nov. 15. 2017) (statement of Sen. Orrin Hatch, Chairman of Committee).[38] Senator Pat Toomey was equally clear when he stated:

[38] https://www.finance.senate.gov/imo/media/doc/11-15-17%20--%20The%20Tax%20Cuts%20and%20Jobs%20Act%20--%20Day%203.pdf.

"We don't actually repeal the mandate, but we eliminate that tax penalty, and that is going to be very helpful for low-and middle-income families." 163 Cong. Rec. 196 S7672 (daily ed. Dec. 1, 2017).

Thus, both the text and legislative history leave no doubt that Congress did not intend to strike the entire ACA through its penalty reduction. Instead, Congress wanted the ACA to function without the tax penalty. Nothing in the TCJA's text or legislative history supports the conclusion that Congress intended to stop improving the quality of Medicare, Medicaid, and nursing facilities, increasing access to health insurance, and protecting elders from abuse when it zeroed out the penalty for failing to meet the minimum coverage requirement. The provisions listed in Sections III to V above are just a handful of the provisions that should remain unchanged. All other provisions should remain including the provisions that allow children to be on the parent's insurance until age 26; combat Medicare fraud; and prohibit discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Congress's intent to leave the ACA intact should be followed and the ACA should not be changed.

Finally, the guaranteed issue and community rating provisions, including those that address preexisting conditions, health status, and the limits on age rating, should remain in force because Congress determined that those provisions could operate as intended without the tax penalty. The legislative history and the text of the TCJA show that Congress did not want to eliminate them, with good reason.

Those provisions benefit every American. Over 100 million adults have a preexisting condition that could lead insurers to deny them coverage if insurers resumed their pre-ACA medical underwriting policies. ASPE, *Health Insurance Coverage for Americans with Pre-*

*Existing Conditions: The Impact of the Affordable Care Ac*t (Jan. 2017).[39] That estimate underscores an important point: virtually all Americans are touched by preexisting conditions – either individually or through a loved one. The impact of eliminating the guaranteed issue or community rating provisions would be devastating for millions of people and the entire nation. Uninsured people would again be denied health care and medical debt would again crush families' financial security. The corrosive impact of losing these protections will not just be limited to individuals, but will also extend to the national economy. Nothing in the TCJA suggests that Congress was seeking to remove these provisions and disrupt the health and financial security of millions of Americans. Thus, the provisions must stand.

[39] https://aspe.hhs.gov/pdf-report/health-insurance-coverage-americans-pre-existing-conditions-impact-affordable-care-act.

CONCLUSION

The changes made by the TCJA do not, by their plain meaning or any reasonable construction, call for the upending of the ACA. Millions of people have benefitted from the many protections of the ACA for years. As discussed in detail herein, a preliminary injunction is not in the public interest. Indeed, it is very much against the public interest as the ACA is a lifeline for older adults that ensures they have access to quality, affordable health insurance and important consumer protections. Any interruption in the enforcement and operation of the ACA will have a devastating effect as they rely heavily on the law for their health and financial stability. They cannot afford to return to pre-ACA days and lose essential protections. For these reasons, the Court should deny the application for preliminary injunction.

Dated: June 14, 2018

Respectfully Submitted,

/s/ Iris González
Iris González (Texas Bar No. 24042545)
Maame Gyamfi, (District of Columbia Bar No. 462842)*
AARP Foundation
601 E Street, NW
Washington, DC 20049
Telephone (202) 434-6291
Facsimile (202) 434-6424
igonzalez@aarp.org
mgyamfi@aarp.org

Counsel for Proposed Amici Curiae

*Pro Hac Vice pending

CERTIFICATE OF SERVICE

On June 14, 2018, I electronically submitted the foregoing document with the Clerk of Court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all parties to the action electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Iris Gonzalez
Iris González