



TESTIMONY BEFORE THE UNITED STATES CONGRESS
House Committee on Energy & Commerce

TEXAS v. U.S.
Its Impacts on Americans With Pre-Existing Conditions

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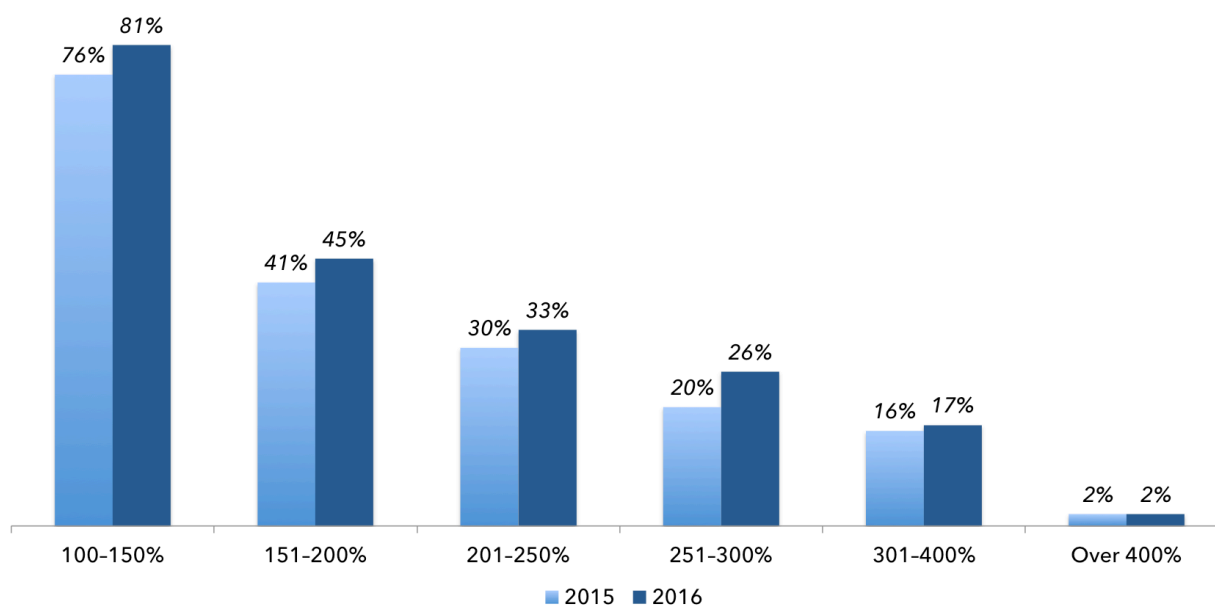
February 6, 2019

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INTRODUCTION

Ensuring that every American—rich or poor, healthy or sick—has access to affordable health insurance is one of the most important policy goals Congress could have. The Foundation for Research on Equal Opportunity has, since its founding, been an unwavering advocate of the central relationship between universal health insurance and equality of economic opportunity.

Figure 1. Percentage of Eligible Individuals in Exchange Plans, by Income (% of Federal Poverty Level)

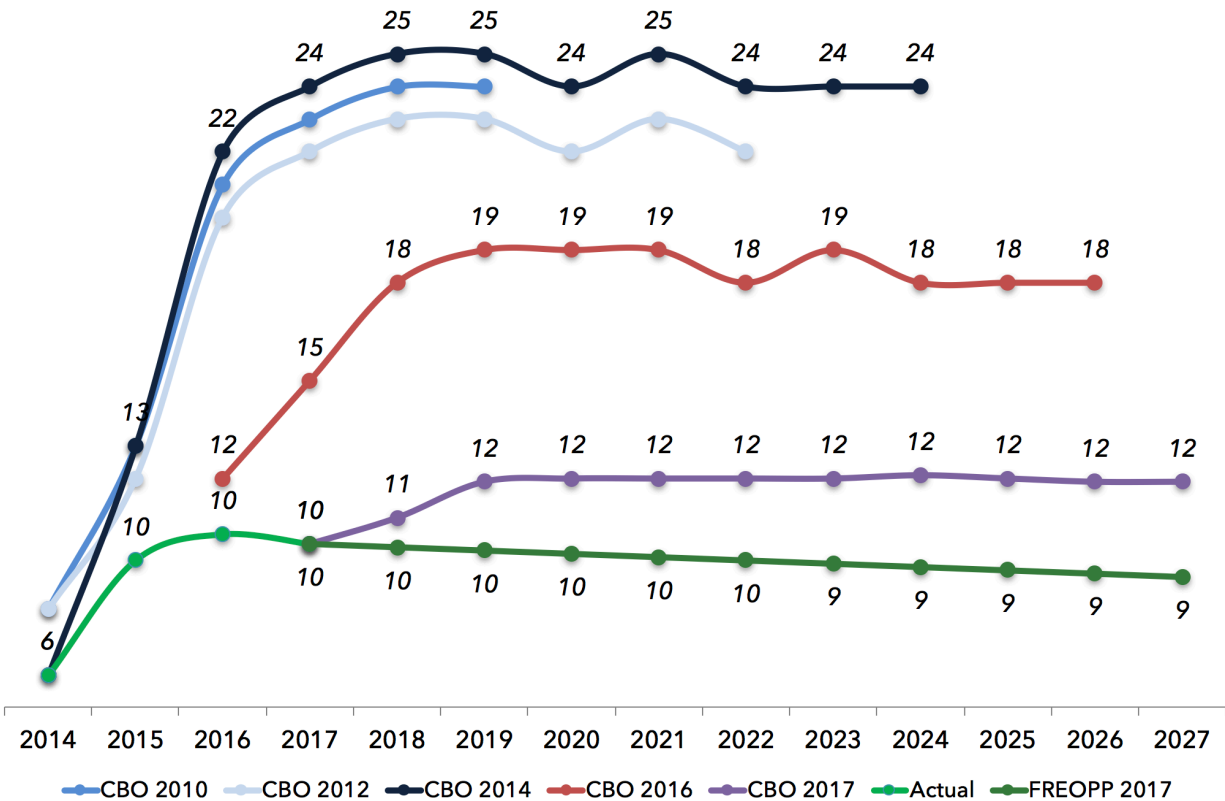


ACA premium subsidies are not sufficient to compensate for higher ACA gross premiums. The ACA's premium increases, driven by the law's extensive regulations of the individual insurance market, exceed the subsidies that most Americans are eligible for. As a result, as one ascends the income scale, net premiums are costlier today than they were prior to the debut of the exchanges in 2014. (Sources: Avalere Health, HHS Assistant Secretary for Planning and Evaluation)

It is widely known that the United States spends more than any other country in the world on health care. Indeed, the two most important problems with American health care stem from its high cost. The high cost of U.S. health care is the reason that tens of millions go without health insurance. In addition, the unsustainable trajectory of the federal deficit and debt are driven by growth in public spending on health care, a problem primarily driven by growth in the unit price of health care goods and services. If unsustainable public debt forces the United States to engage in aggressive fiscal austerity at some point in the future,

it will be those most dependent on public health expenditures—the poor, the elderly, and the vulnerable—who will have the most to lose.

Figure 2. CBO Exchange Enrollment Projections Over Time (Millions of Enrollees)



2018 enrollment was 15 million short of CBO’s 2010 estimates. The Congressional Budget Office has significantly reduced its estimates of exchange enrollees. The CBO’s March 2016 baseline remained optimistic that enrollment would increase substantially in 2017 and 2018, but that did not materialize. (Source: Congressional Budget Office)

The Affordable Care Act of 2010 sought to solve the first problem—tens of millions going without health insurance—by deliberately ignoring the high unit price of health care goods and services. Instead, the ACA sought to fund the cost of covering some uninsured Americans through three mechanisms: (1) raising taxes by \$1.2 trillion over a decade; (2) reducing Medicare spending by \$800 billion over a decade; and (3) overcharging uninsured Americans who are young and/or healthy.

The third approach—overcharging uninsured Americans who are young and/or healthy—is central to the policy concerns of the Committee on this occasion.

THE ACA'S 'THREE-LEGGED STOOL' HAS ALWAYS BEEN HIGHLY UNSTABLE

The Affordable Care Act's reforms of the individual market for health insurance—i.e., the market for those who purchase insurance on their own, and do not receive it from their employers, or from Medicare, Medicaid, or other federal programs—were based on a flawed understanding of the economics of health insurance.

Congress sought to enact two worthwhile and important reforms. The first was to require insurers in the individual market to offer coverage to everyone, irrespective of pre-existing conditions: what in insurance parlance is called *guaranteed issue*. The second was to require insurers to charge equal premiums to everyone, regardless of prior health status; i.e., to overcharge the healthy in order to undercharge the sick: what insurers call *community rating according to health status*.

Some advocates of the ACA argue—illogically—that these two reforms required the enactment of 2,000 pages of other reforms; that is, the Affordable Care Act in its entirety. But this is illogical on its face. For example, as noted above, Congress sought to fund the Affordable Care Act in part by reducing Medicare spending by \$800 billion over a decade; Congress could have enacted the ACA's Medicare provisions independently of whether or not the ACA included guaranteed issue and community rating according to health status in the individual market for health insurance—a market that, at the time, served less than 10 percent of the U.S. population.

The District Court ruling in *Texas v. Azar* adheres to the same indefensible logic as that of ACA supporters who argue that the law *in its entirety* is a necessary consequence of its provisions regarding pre-existing conditions. No credible economist or health policy expert believes this to be true.

A more reasonable argument is that certain other provisions of Title I of the ACA are connected to its guaranteed issue and health status community rating provisions. The theories of MIT economist Jonathan Gruber have been influential in this regard. Gruber, widely considered the “architect” of the ACA, has long argued that regulating the individual health insurance market should be thought of as a “three-legged stool,” in which the three legs are:

- *Guaranteed issue* and *community rating by health status*, which overcharges healthy uninsured individuals;
- Forcing healthy people to buy costlier coverage with an *individual mandate*; and
- Distributing taxpayer-funded *subsidies* to those forced, by the individual mandate, to purchase otherwise unaffordable coverage.

Most relevant to *Texas v. Azar* is the theory that the ACA's *individual mandate*—its requirement that nearly everyone in America purchase health insurance, or face a financial penalty—is a necessary consequence of requiring that insurers offer coverage to everyone, regardless of preexisting conditions, and of the ACA's requirement that healthy uninsured individuals be overcharged for coverage in order to reduce premiums for those who are sick.

Gruber theorized that if individuals were guaranteed an offer of coverage, irrespective of their health status, they would only buy insurance when sick, increasing premiums for everyone else (because insurance premiums are calculated by taking the total health care claims of a given pool of individuals, divided by the number of people in the risk pool, plus administrative costs).

In addition, Gruber believed that because community rating by health status forces insurers to overcharge healthy enrollees in order to undercharge sick enrollees, under such a system many healthy individuals would choose to forego coverage rather than pay inflated prices. These individuals, he thought, could be forced back into the system with an individual mandate.

This “three-legged stool” formulation sounds reasonable in theory, but in the case of the ACA, has been unstable in practice. To abuse the analogy, the problem with the ACA is that the three “legs” of the stool are of different length and varying angles, making the “stool” impossible to sit upon.

The ACA’s bevy of insurance regulations—including, but not limited to, guaranteed issue and community rating by health status—are the longest leg of the stool, as they more than doubled the average cost of individually-purchased health insurance from 2014 to 2018. Additional ACA provisions that drove up the cost of individually-purchased health insurance include *community rating by age*, which overcharges young people for coverage,¹ and *actuarial value* mandates, which force individuals to buy costlier coverage than they may need or want.²

The ACA’s individual mandate was and is the shortest leg of the stool, because its penalties, even as originally enacted, were too low, and contained numerous exemptions. In addition, the Obama administration weakly enforced the mandate, effectively allowing healthy people to drop out of the market.³

The ACA’s subsidies are the stool leg of medium length. The subsidies are robust enough to help many people whose incomes are near the Federal Poverty Level afford the ACA’s costly insurance plans. But as those subsidies phase out as one goes up the income scale, fewer and fewer have enrolled. In March of 2010, on the eve of the ACA’s passage in Congress, the Congressional Budget Office predicted that 25 million Americans would be enrolled in the ACA’s exchanges. The actual number is more likely to be 10 or 11 million.⁴

The flaws in Professor Gruber’s three-legged stool theory can be summarized quite simply. In 2009, in an interview with Ezra Klein, then of the *Washington Post*, Gruber said: “What we know for sure the bill will do is that it will lower the cost of buying non-group health insurance” before the impact of subsidies is considered.⁵

¹ Roy A, “How Obamacare Dramatically Increases The Cost of Insurance for Young Workers.” Forbes. 2012 Mar 22; <https://www.forbes.com/sites/theapothecary/2012/03/22/how-obamacare-dramatically-increases-the-cost-of-insurance-for-young-workers/#690e4b317e46>.

² Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; <https://freopp.docsend.com/view/utmr2i6>.

³ Roy A, “Obamacare’s Dark Secret: The Individual Mandate is Too Weak.” Forbes. 2012 Jul 9; <https://www.forbes.com/sites/theapothecary/2012/07/09/obamacares-dark-secret-the-individual-mandate-is-too-weak/#6a4f97df6abf>.

⁴ Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; <https://freopp.docsend.com/view/utmr2i6>.

⁵ Roy A, “Obamacare was built to fail.” Vox.com. 2016 Oct 7, <https://www.vox.com/the-big-idea/2016/10/7/13191250/obamacare-exchanges-crisis-arrogant-progressives>.

THE SEVERABILITY OF THE INDIVIDUAL MANDATE FROM THE ACA

As noted above, in the cases that became consolidated before the Supreme Court as *NFIB v. Sebelius*, a key question that came up is whether or not the individual mandate is *severable* from the rest of the ACA. While the ACA contained no severability provision, long-standing judicial doctrine requires courts to act as surgically as possible in severing unconstitutional provisions from otherwise constitutional statutes.

In considering these issues as it related to the individual mandate, the Supreme Court relied on the statutory text of the ACA. Section 1501(a)(2)(I) of the ACA states, “if there were no requirement [to buy health insurance], many individuals would wait to purchase health insurance until they needed care...the requirement is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.” (Emphasis added.)

Congress, in other words, made clear its view that the individual mandate, guaranteed issue, and community rating by health status were intricately connected, and that while other parts of the ACA may indeed be severable from the individual mandate, these two provisions were not.

Neal Katyal, the U.S. Solicitor General under President Obama when *NFIB v. Sebelius* was argued before the Supreme Court, made exactly the same argument in oral arguments and briefs, and in media interviews. For example, in a March 2012 interview with National Public Radio, when asked if the individual mandate is severable from the rest of the ACA said,

I mean, the law is 2,400 pages long and has all sorts of stuff that have nothing to do with the individual mandate, things like funding for abstinence education in classrooms and the like. So certainly a good part of the law could stand. I mean, the government's position in the case has been, well, most of the law could stand, but some of it has to go. If the individual mandate goes so, too, the government says, must the provisions that force insurers to insure everyone at a low cost, the so-called guaranteed issue and community rating provisions.⁶

From a factual standpoint, it is simply not correct that the individual mandate is necessary for the proper functioning of the ACA’s policies meant to benefit those with pre-existing conditions, for several reasons.

First, the ACA’s individual mandate is too weak. Its financial penalties, prior to the enactment of the Tax Cuts and Jobs Act, were too weak to dissuade healthy individuals from purchasing costly coverage. Many individuals were exempted from the mandate on income or affordability criteria. Still others were able to file for hardship exemptions. And the Obama administration only loosely enforced the mandate, for example by not requiring documentation demonstrating an actual hardship.

Second, the ACA specifies limited enrollment periods for the purchase of individual health insurance. Currently, individuals are given a six week period to purchase health insurance for the following year; if they do not, they are no longer eligible for the ACA’s pre-existing condition protections. This provision has done far more to prevent gaming of the system than has the ACA’s weak individual mandate.

⁶ Katyal N, “Defending the Affordable Care Act.” National Public Radio. 2012 Mar 23; <https://www.npr.org/2012/03/23/149222905/defending-the-affordable-care-act>.

Third, contrary to the belief of some conservatives, skyrocketing premiums under the ACA are not a result of the ACA's protections of those with pre-existing conditions. Rather, they are the result of two other ACA regulations: the one that requires insurers to overcharge the young, called *community rating by age*, or *age bands*, and the one that eliminates low-premium plans with an *actuarial value* below 60 percent.

This is why the individual market reforms I have proposed would preserve guaranteed issue and community rating by health status, and also the TCJA's zeroing out of the mandate penalty, while reforming age bands and actuarial value requirements, and adding reinsurance, to strengthen the direct subsidy of sicker individual-market patients.

WHAT CONGRESS SHOULD DO NOW

In *Texas v. Azar*, the Trump administration's Department of Justice filed a memorandum that echoed the Obama administration's view. In the memorandum, Justice Department lawyers disagreed with the *Texas v. Azar* plaintiffs' claim that a finding that the individual mandate was unconstitutional necessitated the invalidation of the entirety of the ACA. Instead the lawyers wrote, if the Court found that the mandate was unconstitutional, "this Court should consider...entering a declaratory judgment that the ACA's provisions containing the individual mandate as well as the guaranteed-issue and community-rating requirements will all be invalid beginning on January 1, 2019." The DOJ lawyers also stated that "the remainder of the ACA, however, can stand despite the invalidation of these provisions."⁷

This uncontroversial statement—that the intent of Congress and the Obama administration was that the individual mandate and the guaranteed issue and community rating by health status provisions of the ACA be inextricably linked—has been mischaracterized as implying that the Trump administration opposes protecting Americans with pre-existing conditions. By contrast, President Trump has repeatedly expressed his insistence that any reforms or replacements of the ACA cover those with pre-existing conditions. After the District Court issued its opinion in *Texas v. Azar*, the White House issued a statement that "The Trump Administration looks forward to working with Congress on a bipartisan basis to continue to protect people with pre-existing conditions."

Similarly, after the ruling, I argued that Congress should pass a simple bill reiterating the requirements of guaranteed issue and community rating by health status in the individual market. By doing so, in the extremely unlikely event that the Supreme Court upholds the District Court opinion, Congress would ensure that those with pre-existing conditions remain protected.

I understand that a motion to produce such legislation was proposed by House Republicans during floor debate at the beginning of this Congress—one that would guarantee that no American could be denied coverage, or be charged higher premiums or cost sharing, as a result of a previous or current illness—and that the motion was defeated by the majority.

To me, this is a shame, as such legislation would ensure that Americans with pre-existing conditions would be protected whatever the courts decide. I hope that Congress will reconsider its position.

I have spent my entire career in public policy arguing that all policymakers—including Republicans and conservatives—should embrace the cause of universal coverage. America—the wealthiest country in the history of the world—spends more than enough to

⁷ Federal defendants' memorandum in response to plaintiffs' application for preliminary injunction in *Texas v. Azar*.

cover everyone, if we do it the right way and at the right price. I look forward to working with members of both parties to achieve this goal.