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# Florida v. HHS - Amicus Brief of AARP

American Association of Retired Persons

Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees/Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, et al.,
Defendants-Appellants/Cross-Appellees.

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA

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# BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF DEFENDANT-APPELLANT/CROSS-APPELLEE AND REVERSAL

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**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT**

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Rule 26.1-1 of the Rules of the Court of Appeals for the Eleventh Circuit, Amicus Curiae AARP hereby certifies that:

(1) AARP does not have a parent corporation;

(2) AARP does not issue stock; and

(3) Upon belief, the certificate contained in the first brief filed in this case by the United States Department of Health and Human Services, et al., Defendants-Appellants /Cross-Appellees on April 4, 2011 is complete with the exception of the following interested persons and parties:

a. AARP (Amicus Curiae)

b. AARP Foundation (Counsel for AARP)

c. Canan, Stacy (Counsel for AARP)

d. Cohen, Stuart R. (Counsel for AARP)

e. Schuster, Michael (Counsel for AARP)

/s/Stuart R. Cohen

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## STATEMENT OF ISSUES PRESENTED

1. Whether the district court erred in holding that the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") is not a valid exercise of Congress's commerce power.

2. Whether the court erred in holding that the minimum coverage provision is not independently authorized by Congress's taxing power.

3. Whether, even assuming that the minimum coverage provision was invalid, the court erred in declaring that the Affordable Care Act in its entirety is invalid and in awarding relief to plaintiffs without standing.

## STATEMENT OF INTEREST[1]

AARP is a nonpartisan, nonprofit organization dedicated to addressing the needs and interests of people aged 50 and older. Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled healthcare costs.

In response to the growing number of older people forgoing health care services and facing financial ruin due to health care and insurance becoming increasingly unaffordable and unavailable, AARP sought legislative solutions that

[1] Pursuant to Fed. R. App. P. 29, *amicus* certifies that all parties have consented to the filing of this brief; no party or party's counsel authored this brief in whole or in part; and no person other than *amicus* contributed money intended to fund the brief's preparation or submission.

would: protect Medicare benefits; reduce insurance rate disparities based on age or pre-existing conditions; reduce the rate of health care cost increases, including for prescription drugs; and eliminate waste, fraud, and abuse. Since 2007 AARP has collected thousands of personal accounts and testimonials from members and nonmembers describing the emotional and financial devastation they experienced when they were unable to pay for health insurance, were declined for insurance due to a prior illness, were unable to pay medical bills, or worse, were unable to receive necessary treatment or medicine when sick.

When Congress was debating health reform legislation, AARP's advocacy focused on six key priorities: 1) Guaranteeing access to affordable coverage for Americans age 50 to 64 in the individual market who have faced unaffordable insurance based on their age, pre-existing conditions, or health status; 2) Closing the Medicare Part D prescription drug coverage gap or "doughnut hole" so people are not forced to choose between paying for necessary medication and paying for other needed expenses; 3) Lowering drug costs by increasing availability of generic biologics, which are used to treat serious conditions like cancer, multiple sclerosis, anemia, and rheumatoid arthritis, and can cost as much as $10,000 or more per month; 4) Reducing costly hospital readmissions through a Medicare Transitional Care Benefit, which helps people safely transition to home or another setting after a hospital stay, thereby preventing costly, unnecessary hospital

readmissions; 5) Increasing funding and eligibility for home and community based services for people with chronic conditions, which would save money, improve quality of life for individuals who need these services, and better enable them to live at home; and 6) Helping low-income Americans so that people who saved a small nest egg can still receive assistance and help with premiums and out-of-pocket health costs.[2]

## SUMMARY OF ARGUMENT

When the Patient Protection and Affordable Care Act ("ACA") was enacted, 45 million Americans did not have health insurance, primarily because they could not afford it, healthcare costs were outpacing the rate of inflation, and the growing cost of insurance and individuals' contributions to it was far outpacing wages. In response, Congress enacted the ACA, a comprehensive law designed to reduce healthcare costs and ensure that every eligible person has access to affordable insurance.

Under the current healthcare system, insurers in the individual market have adopted industry-wide practices to cherry pick healthy people, weeding out those not as healthy by systematically denying coverage, limiting benefits, and charging excessive premiums to individuals with pre-existing conditions or perceived to be a

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[2] *See Comprehensive Health Reform Discussion Draft: Hearing Before the S. Comm. on Health of the H. Comm. on Energy and Commerce*, 111th Cong. (June 23, 2009) (statement of Jennie Chin Hansen, President of the Board, AARP).

high-risk. People under the age of 65 without job based coverage have limited options but to attempt to purchase insurance on the individual market. However, for people approaching retirement, coverage through the individual market is unaffordable, if not completely unavailable.

As people age, they are likely to have a prior or current health condition that insurers deem too risky to insure. While 9% to 35% of 18 to 24 year olds have a pre-existing condition, 48% to 86% of people ages 55 to 64 have one. For high risk applicants, insurers charge premium rates 20% to 80% above the base rate or refuse to issue a policy or issue a policy with an exclusion or elimination rider under which services for a specific condition are temporarily or permanently excluded.

Congress heard countless tragic examples of un- and under-insured people who could not receive treatment for serious illnesses and people saddled with crushing medical debts as a result of having policies with high deductibles and co-payments and annual lifetime limits.

In addition to increased premiums based on pre-existing conditions, insurers use age rating when setting premium rates: 50 to 64 year olds are charged rates frequently 3 to 6, and as much as 11, times greater than their younger counterparts solely based on their age. Even a healthy 50 to 64 year-old with no pre-existing

conditions faces markedly higher rates than younger people. Age rating puts the cost of insurance out of reach to many in the pre-Medicare age group.

Although there is an actuarial basis for charging older people higher premiums, they are unable to afford the higher rates. Among uninsured adults, median family income is virtually identical across all age groups; more than half of uninsured people age 55-64 live below 200% of the federal poverty line, making it extremely difficult for them to afford to purchase age rated private insurance.

Because insurance is the gateway to receiving care, older people without coverage are at risk of declining health and at much greater risk of premature death than their insured peers. Congress heard testimony that the status quo masks significant hidden cost to Medicare when millions of uninsured adults bring their health problems with them when they enroll in Medicare.

Congress recognized that, among other things, creating a robust insurance pool is essential in order to expand coverage for people who have been shut out from the current system due to health status or age. Private health coverage products "pool" the risk of high health care costs across a large number of people, both healthy and sick, permitting them to pay a premium based on the average cost of medical care for the group of people. This risk-spreading function helps make the cost of health care reasonably affordable for most people.

Congress therefore rationally concluded that expanding the risk pool would make insurance more accessible and affordable for those who have been unable to obtain coverage and care. Including the minimum coverage provision, which begins in 2014, enabled Congress to include consumer protections in the ACA that will help millions of Americans obtain care and coverage, which in turn will substantially benefit the national economy.

## ARGUMENT

### INTRODUCTION

Beyond the undisputed impact the lack of accessible and affordable health care has on the national economy, there is also a human toll that is paid by millions of Americans annually. People 50 to 64, who do not have job-based coverage and are not eligible for Medicaid or Medicare, have especially been harmed. They need more health services and are more likely to suffer from chronic conditions than their younger counterparts. Yet, they face extreme obstacles to buying insurance on the private market due to industry-wide insurance underwriting and rating practices that discriminate based on health status and age. The consequences have been dire. Not only have too many become laden with a tremendous amount of debt at a time in their lives when they should be saving for retirement, but they have also suffered worse health outcomes, including premature death, than their insured counterparts. Because they often forego or receive

inadequate health care, the uninsured and underinsured enter Medicare sicker and in greater need of services than their insured counterparts. Medicare, therefore, shoulders the burden of paying the costs for the services needed to care for those uninsured people once they enter Medicare.

Below are examples from four people, among the thousands who provided their personal stories to AARP, describing their hardships and struggle to afford health care:

> **Valerie D. from Portsmouth, Virginia** (Sept. 17, 2010)
> When I turned 63 my insurer wanted to raise my rate to $934 a month, which I am solely responsible for paying. At the same time my doctor was trying to pin down a diagnosis for some hip pain I've been having. She wanted to do an MRI (cost $3000) but my insurance wouldn't cover it. She put me on a prescription drug to try and ease the pain; again the insurance company wouldn't cover it. The only thing it seemed they would give me a good rate on was my prescription for minor cholesterol problems. That drug was costing about $160/month. I couldn't get my MRI and they wanted me to pay $934 for this privilege! So, unfortunately I was forced to cancel my insurance and reinsure myself with an extremely limited policy. This does not cover my prescription, will not cover the MRI and is very limited in their drug coverage program. […] So I now pay for almost everything except limited doctor visits and my doctor is trying to control my hip pain until next year when I turn 65 and will be eligible for Medicare.

> **William M. from Mount Dora, Florida** (Jan. 26, 2011)
> I am now approaching 62. When I turned 55 my health care and my wife's was covered by my work insurance. This ended with my job, two years ago. My COBRA insurance ended six months ago. This means that I have a little over three years (my wife four years) before Medicare even begins. We are left with only unpaid emergency room care and the cost being passed on to the insured. We are not able to get Medicaid because my wife still works. Both

my wife and I have worked and carried health insurance for over 40 years.

**Chris L. from Leicester, North Carolina** (Sept. 17, 2010)
I still haven't been able to get health insurance that I can afford. I live alone and just turned 64 this month. I have had two heart attacks of which I have three stints. I have atherosclerosis and osteoporosis. No one will insure me at a reasonable rate. My monthly income is very small also, so I can't afford any of the health insurance quotes I have seen.

**Sue B. from Decatur, Illinois** (Jan. 19, 2011)
I am 54 years old. Shortly after changing jobs from one I'd been at eight years the insurance company on the new job [. . .] denied coverage for pre-existing conditions because I was still in the enrollment period of about three months. This caused me to have to withdraw from my IRA and pay the 10% penalty. This money had been my retirement savings. I had to use it to pay the hospital bill. So in other words after paying premiums for eight years the so-called insurance was not there when I needed it.

## I. CONGRESS HAD THE CONSTITUTIONAL AUTHORITY TO ENACT THE ACA WHERE THERE WAS A RATIONAL BASIS FOR CONCLUDING THAT THE MINIMUM COVERAGE PROVISION WILL HAVE A SUBSTANTIAL EFFECT ON INTERSTATE COMMERCE.

When the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("ACA"), was enacted in March 2010, 45 million people across the United States did not have health insurance, primarily because they could not afford it; healthcare costs were outpacing the rate of inflation and the growing cost of health insurance and individuals' contributions

to it was far outpacing wages.[3] In response, Congress enacted the ACA, a comprehensive law designed to reduce healthcare costs and ensure that every eligible person has access to affordable health care.[4]

Congress has broad authority to regulate interstate commerce, including activities that "substantially affect" interstate commerce, so long as there is a rational basis for concluding that the "class of activities" has a substantial effect on interstate commerce. *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195 (2005).

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[3] Between 2000 and 2008, the cumulative increase in health insurance premiums grew over three times as fast as wage increases. Diane Rowland et al., *Health Care and the Middle Class: More Costs and Less Coverage*, The Kaiser Family Foundation 1, 7 (July 2009), *available at* http://www.kff.org/healthreform/upload/7951.pdf.

[4] As a result of the ACA, reduced healthcare costs and improved access to care have already been reported. For example, the 2010 Medicare trustees' annual report states that "[t]he outlook for Medicare has improved substantially because of program changes" made from the ACA. *A Summary of the 2010 Annual Reports*, Social Security and Medicare Bds. of Trustees, (Aug. 5, 2010), http://www.ssa.gov/oact/TRSUM/ index.html; *see also* Paul N. Van de Water, *2010 Medicare Trustees' Report Shows Benefits of Health Reform and Need for Its Successful Implementation*, Ctr. on Budget and Policy Priorities (Aug. 16, 2010).

Improvements in access to care include: adult children up to age 26 remaining on their parents' insurance; people with pre-existing health conditions getting coverage through state or federal high-risk pools; rebates issued to help pay drug costs for Medicare beneficiaries stuck in the "doughnut hole"; lifetime insurance benefits caps banned; and insurance companies prohibited from withdrawing coverage to people when they get sick. Drew Altman, *Health Reform's Six-Month Checkup*, The Kaiser Family Foundation (Sept. 23, 2010); *Fact Sheet: The Health Care Law and Improved Health Insurance Practices*, AARP (June 2010), http://www.aarp.org/health/health-care-reform/info-06-2010/fact_sheet_health_law_improved_health_insurance_practices.html.

Health insurance is such an activity. *U.S. v. Se. Underwriters Ass'n*, 322 U.S. 533, 64 S. Ct. 1162 (1944). Regulating the nationwide healthcare system as a whole involves and affects interstate commerce, which includes the purchase of health insurance. For example, in 2009, health care expenditures in the United States grew 4% to $2.5 trillion, or $8,086 per person, and accounted for 20% of gross domestic product (GDP). *National Health Expenditure Data Fact Sheet*, Centers for Medicare and Medicaid Services, *available at* http://www.cms.gov/NationalHealthExpendData/ 25_NHE_Fact_Sheet.asp.

The millions of uninsured people burden the fragmented and dysfunctional healthcare system nationwide and strain the economy. *The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of H. Comm. on Ways and Means*, 110th Cong. (Apr. 15, 2008) (statement of Diane Rowland, Exec. V.P. of the Kaiser Family Foundation) ("*The Instability of Health Coverage in America*"). Congress found that the cost of providing uncompensated care to the uninsured in 2008 was $43 billion. 42 U.S.C.A. § 18091(a)(2)(F). These costs are paid for by health care providers who pass on the cost to private insurers, which pass on the cost to those who are insured. *Id.*

## II. THE ACA SOUGHT TO ELIMINATE THE UNAVAILABILITY AND UNAFFORDABILITY OF HEALTH INSURANCE FOR MILLIONS OF AMERICANS, ESPECIALLY 50 TO 64 YEAR OLDS WHO MUST PURCHASE HEALTH INSURANCE ON THE INDIVIDUAL MARKET.

In 2009, 8.6 million 50 to 64 year olds were uninsured. Sara R. Collins et al., *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010*, The Commonwealth Fund, 1 (Dec. 2010) ("*Realizing Health Reform's Potential*"). This was almost a 25% increase from the 7.1 million uninsured 50 to 64 year olds in 2007. Gerry Smolka et al., *Health Care Reform: What's at Stake for 50- to 64-Year-Olds?* AARP Public Policy Inst., 1 (Mar. 2009) ("*What's at Stake for 50- to 64-Year-Olds?*"). Without health insurance coverage, an individual pays the full the cost of health services out of pocket. Considering that it costs tens to hundreds of thousands of dollars for medical care for cancer, heart attacks, and numerous surgeries, only the wealthiest uninsured have the ability to afford care when a major illness or accident occurs. *See infra* p16; David Himmelstein et al, *Medical Bankruptcy in the United States, 2007: Results of a National Study, American Journal of Medicine*, 122 Am. J. Med. 741 (2009).

Half of all Americans (54%) received employer-sponsored health coverage in 2006. Rowland, *The Instability of Health Coverage in America*, *supra*, at 11.[5]

[5] With the U.S. economy now in the midst of a downturn, employee coverage is in jeopardy for many as unemployment levels climbed from 4.9% in December 2007 to 9.5% in June 2009. Rowland, *Health Care and the Middle Class: More*

People under the age of 65 without job based coverage, have no option but to attempt to purchase health insurance on the individual market if they are not eligible for Medicaid or Medicare.[6] However, for people approaching retirement, coverage through the individual health insurance market is often unaffordable, if not completely unavailable as they are often denied coverage. *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States*, The Kaiser Family Foundation (Mar. 17, 1998), *available at* http:// www. kff.org/insurance/1376-barrierspr.cfm ("*Understanding Individual Health Insurance Markets"*); Smolka, *What's at Stake for 50- to- 64 Year Olds?* at 5.

Insurers routinely deny coverage to applicants with a wide variety of prior health problems such as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, or stroke. The Kaiser Family Foundation, *Understanding Individual Health Insurance Markets*, *supra.* In recent decades, the unavailability of coverage for the near Medicare age segment has worsened. According to a 2007

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*Costs and Less Coverage*, *supra* fn 3, at 1. In 2011, unemployment is at 9%, a continuing problem. *See The Employment Situation – January 2011*, Bureau of Labor Statistics, Dept. of Labor, http://www.bls.gov/news.release/pdf/empsit.pdf.

[6] Most uninsured 50 to 64 year olds are not eligible either for Medicare, the federal health insurance program for people age 65 or older (and some disabled people under age 65 and people with end-stage renal disease), or Medicaid, a joint federal and state run insurance program for low-income people with young or older dependents or who are disabled. Gretchen Jacobson et al., *Health Insurance for Older Adults: Implications of a Medicare Buy-In*, Kaiser Family Foundation, 1 (Dec. 2009) ("*Health Insurance for Older Adults*").

survey of 50 to 64 year olds who purchased or tried to buy a non-group health plan, 45% found it very difficult or impossible to buy coverage they needed, 61% found it very difficult or impossible to buy affordable coverage, 39% were turned down, charged a higher price, or only offered coverage that excluded a preexisting condition, and 69% never bought a plan. Collins, *Realizing Health Reform's Potential*, at 3.

In response to the alarming number of uninsured people closed out of the healthcare system and the adverse impact it has on the national economy, Congress enacted the ACA to, among other things, increase availability and improve affordability of health insurance for millions of Americans, especially 50 to 64 year olds, who must purchase health insurance on the individual market. *See* 42 U.S.C.A. § 18091(a).

### A. People 50 to 64 Are Systematically Denied Coverage or Priced Out of the Individual Market Because of Their High Incidences of Pre-Existing and Chronic Conditions.

Under the current healthcare system, health insurers attempt to avoid almost all risk. This is particularly true in the individual market where insurers have adopted industry-wide practices "to cherry pick healthy people and to weed out those who are not as healthy." H.R. Rep. No. 111-443, at 990 (2010). The individual market systematically denies coverage, limits benefits, and charges

excessive premiums to individuals with pre-existing conditions or those perceived to be a high-risk. *Id*. at 981.

As people age, they are likely to have a prior or current health condition that an insurer would deem too risky to insure. While 9% to 35% of 18 to 24 year olds have a pre-existing health condition, 48% to 86% of people ages 55 to 64 have a pre-existing condition. *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, U.S. Dept. of Health and Human Servs. (HHS) (Jan. 18, 2011), http://www.healthcare.gov/center/reports/preexisting.html ("*At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*"). While 36% of 18 to 34 year olds had one or more chronic condition, the number rose to 77% for those 55 to 64. Steven Machlin et al., *Health Care Expenses for Adults with Chronic Conditions, 2005*, Statistical Brief #203, Agency for Healthcare Research and Quality (May 2008).

When someone applies for health insurance on the individual market, the insurance company conducts an initial underwriting review of the applicant, eliminating likely high cost applicants. Non-group health insurers typically consider an applicant's current health status, medical history, and other characteristics, such as age, that are indicators of future medical costs. When an insurer determines that an applicant is high risk, the carrier often refuses to issue a policy or issues a policy with an exclusion or elimination rider under which services for a specific condition are temporarily or permanently excluded and/or

charges significantly higher premium rates. Mark Merlis, *Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool*, 2 Policy Analysis, National Institute for Health Care Reform, 2 (May 2010). The increased premiums for people in the individual market with pre-existing health conditions or risk factors, called "rate-ups," typically range from 20% to 80% above the base rate depending on the applicant's medical history. The Kaiser Family Foundation, *Understanding Individual Health Insurance Markets*, *supra*.

Commonly used exclusion and elimination riders effectively leave people who have acute or chronic illnesses in the same posture as they would be with no insurance. The problem of people who are under-insured is significant as 29% of people with insurance have inadequate coverage should they suffer a serious or catastrophic illness. H.R. Rep. No. 111-443, at 980 (citing to *Health Insurance: CR Investigates Health Care*, Consumer Reports (Sept. 2007)).

Congress heard countless tragic stories of under-insured people who could not receive treatment for serious illnesses and were saddled with crushing medical debts as a result of having policies with high deductibles, co-payments, and annual and lifetime limits.[7] For example:

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[7] Illness and medical bills contribute to a large and increasing share of bankruptcies. The cost for non-routine medical care is enormous. David Himmelstein et al, *Medical Bankruptcy in the United States, 2007: Results of a National Study, American Journal of Medicine*, 122 Am. J. Med. 741 (2009).

**Randy, 63 years old, Pennsylvania**
Following his diagnosis with Stage IV esophageal cancer, Randy had surgery to remove his esophagus and stomach. Radiation and intense chemotherapy followed. Randy quickly reached the $100,000 lifetime cap on his major medical coverage and now receives no further benefits. He has paid out of pocket for follow-up scans and labs to monitor his condition. […] Randy's only option, a guaranteed issue policy, includes a pre-existing condition exclusionary period of up to three years. […] Ultimately, Randy will have to wait two years to become Medicare eligible. He has no other choice.

**Kay, 61 years old, Florida**
Kay works part time at a large department store earning $13,000 per year. She has insurance through her employer but quickly exceeded the plan's $25,000 annual maximum following her diagnosis with Stage II breast cancer. She has received eight cycles of pre-operative chemotherapy, had a lumpectomy with auxiliary lymph node dissection, and now needs radiation. Kay already has $40,000 in outstanding medical bills from various diagnostic tests that were not covered. Now she's been told that she cannot begin radiation unless she plans to bring $115,000 with her to the first appointment.

*The Instability of Health Coverage in America*: *Hearing Before the Subcomm. on Health of H. Comm. on Ways and Means*, 110th Cong. (Apr. 15, 2008) (statement of Stephen Finan, Assoc. Dir. of Policy, American Cancer Society).

### B. Age Rating Substantially Raises Standard Insurance Rates Based Solely on Age Making Insurance Unaffordable for People 50 to 64.

In addition to facing rate-ups based on pre-existing or chronic conditions, 50 to 64 year olds are charged rates for insurance frequently 3 to 6, and as much as 11, times greater than their younger counterparts solely based on their age. *See* Karen Pollitz et al., *How Accessible is Individual Health Insurance for Consumers in*

*Less-Than-Perfect Health?* Georgetown Univ. Inst. For Health Care Research and Policy, The Kaiser Family Foundation (June 2001); Len Nichols, Dir., Ctr. for Health Policy Research and Ethics at George Mason Univ., Comment to *Age Rating: Battle of the Generations*, National Law Journal Expert Blogs (Aug. 31, 2009), http://healthcare.nationaljournal.com/2009/08/age rating-battle-of-the-gener.php. Even a healthy 50 to 64 year-old with no pre-existing conditions faces markedly higher rates than younger people.

Because people's health declines as they age, leading to increased claims, insurers use the applicant's age, commonly referred to as age rating, when setting the applicant's premium rates. *Health Insurance Rate Regulation*, NAIC & the Ctr. for Ins. and Policy Research, https://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf. This practice puts the cost of health insurance out of reach to 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., *Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens*, Urban Institute, 8 (Oct. 2009).

Prior to the ACA, the health care rating system in the non-group market was largely unregulated. When ACA was enacted, 33 states had no limit on ratings. *Individual Market Rate Restrictions*, The Kaiser Family Foundation, statehealthfacts.org (2010), http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7. While several states imposed rate restrictions for the individual market, only six states limited insurers from increasing standard rates based on age by ratios equal to or lower than the 3:1 age rating ratio limit in the ACA.[8] *See* Julie Appleby, *Health Insurance: How Much More Should Older People Pay*? Kaiser Health News, Curbing the Age Gap Chart (Aug. 31, 2009), http://www.kaiserhealthnews.org/Stories/2009/August/31/age-rating.aspx. The lack of rate limits across the states necessitated Congress to limit the rate disparities adversely effecting 50 to 64 year olds.

The charts below prepared by AARP Public Policy Institute (PPI) contain premium rates in several states quoted from the ehealthinsurance.com website in June 2009 and April 2011.[9] They illustrate that even before health status is taken

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[8] Starting in 2014, insurers may not vary rates by more than 3:1 for age. 42 U.S.C.A. § 300gg(a)(1)(A)(iii). *See infra* p 29.

[9] Ehealthinsurance.com is affiliated with eHealthInsurance Services, Inc., a private, for-profit company that aggregates and sells health insurance online for individuals, families, and small businesses. It is licensed to market and sell health insurance in all 50 states and the District of Columbia, for more than 180 health insurance companies, offering more than 10,000 health insurance products. https://www.ehealthinsurance.com/about-ehealth-index.

into account, a 60 year old will pay between three-to-seven times more than a 20 year-old for the same plan. These quotes do not reflect the premiums that someone with pre-existing health problems would face or out-of-pocket costs for deductibles and cost sharing, such as paying co-payments or a percent of medical bills.

The chart below reflects the rate disparities for older and younger purchasers of "best-selling" plans offered for July 1, 2009, from ehealthinsurance.com: [10]

[10] To get a sense of how rates for the same plan vary by age, PPI searched rates in the zip code where the AARP state office is located. Rate quotes were sought for a male, non-smoker age 60, and then age 20. For each location, PPI obtained an online quote for one of the plans that ehealthinsurance.com listed as a "bestseller" for 60 year olds. PPI then obtained a quote for the identical plan for the 20 year old. These prices reflect rates prior to any medical underwriting for health status of the individual.

The brief descriptions of the plans in the table are at a very high level. Plans vary in their benefit features, which includes the annual deductible, coinsurance and/or copayments, network requirements, and drug benefits. Rates for a particular plan reflect the design of the specific benefit package, the size and age range within the risk pool, and the underlying health care costs and benefit utilization of those in the plan's risk pool. As such, the rates reflect the prices and practice patterns in a geographic area and plan overhead.

Depending on the state's rate regulations for the individual market, an insurer determines the premium for an applicant based on the company's rate methodology; premiums commonly reflect applicant's age, gender, health, smoking status, individual/family status, and other allowed rating factors. Plans that carry the AARP name are made available in most states, but were not included in this survey because the provider of those plans only offers them to AARP members age 50 to 64.

| **Ehealthinsurance.com Premiums** | | | | |
|---|---|---|---|---|
| **State** | **60 yr old male** | **20 yr old male** | **Cost for 60 yr old relative to 20 yr old** | **A "Best Selling" Plan (**Benefit packages are highly varied. See fn 10) |
| | Monthly premium | Monthly premium | (Monthly premium for age 60 is X times that for age 20) | |
| Arkansas | $210 | $41 | 5.1 times | Humana Autograph Total/5000 Plus Rx |
| Arizona | $181 | $38 | 4.7 times | Blue Value 10000 |
| Delaware | $294 | $45 | 6.5 times | Aetna PPO Value 7500 |
| Florida | $286 | $38 | 7.5 times | Aetna POA OA Value 5000 |
| Idaho | $288 | $66 | 4.4 times | Regence Now/Select 2500 |
| Iowa | $216 | $50 | 4.3 times | Humana Autograph Share 80//5000 Plus Rx & Doctor Co-pay |
| Kansas | $195 | $49 | 4 times | Coventry One K1Q08A25025 30 (HSA Compatible) |
| Kentucky | $198 | $49 | 4 times | Anthem Blue Access Value $2000 |
| Michigan | $347 | $81 | 4.3 times | Aetna PPO 1500 |

| | | | | |
|---|---|---|---|---|
| Montana | $431 | $125 | 3.5 times | BCBS HDHP Montana Option I |
| Nevada | $196 | $36 | 5.4 times | Sierra Distinct Advantage PPO Plan4 5000 |
| New Jersey | $531 | $170 | 3 times | Horizon Basic & Essential EPO Plus |
| New Mexico | $224 | $75 | 3 times | Blue Direct Plan B 2000 |
| Oregon | $193 | $53 | 3.5 times | Lifewise Wise Essentials 7500 |
| Texas | $231 | $49 | 4.7 times | Blue Edge Individual HSA Plan VII 5000 |
| Utah | $159 | $28 | 5.7 times | Humana Monogram Total/7500 Plus Rx |
| Washington | $241 | $67 | 3.6 times | GroupHealth HealthPays HSA 2000 Individual Catastrophic |
| West Virginia | $311 | $62 | 5 times | UnitedHealth One Copay Seclect 70-5000 |
| Wyoming | $381 | $79 | 4.8 times | Aetna WY PPO Value 2500 |

The chart below reflects the rate disparities for older and younger purchasers of "best-selling" plans offered for April 1, 2011, from ehealthinsurance.com:

| **Ehealthinsurance.com Premiums** | | | | |
|---|---|---|---|---|
| **State** | **60 yr old male** | **20 yr old male** | **Cost for 60 yr old relative to 20 yr old** | **A "Best Selling" Plan (**Benefit packages are highly varied. See fn 10) |
| | Monthly premium | Monthly premium | (Monthly premium for age 60 is X times that for age 20) | |
| Alabama | $298 | $73 | 4.1 times | HumanaOne Autograph Share 80/5000 Plus Rx & Doctor Visit Copay |
| Alaska | $586 | $130 | 4.5 times | CeltiCare Preferred AnyDoc PPO 80/20 |
| Colorado | $430 | $124 | 3.5 times | Rocky Mountain Health Plans SOLO Outlook 1500 |
| Florida | $382 | $88 | 4.3 times | Cigna FL Open Access Value 2500/80% |
| Georgia | $251 | $56 | 4.5 times | BlueCross Blue Shield Smart Sense Plus POS 3500 |
| Ohio | $224 | $63 | 3.6 times | Anthem SmartSense Plus 30% |
| South Dakota | $516 | $101 | 5.1 times | UnitedHealthOne Plan 80 |

Although there is an actuarial basis for charging older people higher premiums, they often are unable to afford the higher rates. More than half of uninsured people age 55-64 live below 200% of the federal poverty line, making it extremely difficult for them to afford to purchase age rated private insurance. [11] Jacobson, *Health Insurance for Older Adults, supra* fn 6, at 3.

An analysis of the March 2008 Current Population Survey found that among uninsured adults, median family income is virtually identical across all age groups. For example, the median family income for uninsured 18 to 24 year olds was $28,461, whereas it was $30,000 for uninsured 50 to 64 year olds. Lynn Nonnemaker, PhD, *Beyond Age Rating: Spreading Risk in Health Insurance Markets* 3, AARP Public Policy Inst., Insight on the Issues I35, (Oct. 2009). Accordingly, when looking to the individual market to buy coverage, uninsured people age 50 to 64 are not better able to afford, compared to younger adults, premiums that are many times more expensive than the standard rates available to younger adults. *See also*, Blumberg, *Age Rating Under Comprehensive Health Care Reform*. Considering the small income difference among ages, keeping premiums within a moderate range for all is a key to keeping them affordable for everyone over their lifetime.

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[11] In 2009 and 2010, gross yearly income of $21,660 for an individual was 200% below the poverty line. Fed. Reg. Vol. 74, No. 14, Jan. 23, 2009, pp 4199; Fed. Reg. Vol. 75, No. 148, Aug. 3, 2010, pp. 45628.

## III. UNINSURED AND UNDERINSURED PEOPLE SUFFER WORSE HEALTH OUTCOMES REQUIRING MORE INTENSIVE AND COSTLIER CARE WHEN THEY ENTER MEDICARE AT 65 THAN PREVIOUSLY INSURED PEOPLE.

Because insurance is the gateway to receiving health care in the U.S., the uninsured and underinsured suffer the worse health outcomes or even premature death. Jill Bernstein et al., Issue Brief, *How Does Insurance Coverage Improve Health Outcomes?* Mathematica Policy Research, Inc., 1 (Apr. 2010). Uninsured people generally receive much less care, either preventive or for acute and chronic conditions, than insured people. For example, uninsured adults are less likely than insured adults to receive preventive services or screenings, such as mammograms, pap smears, or prostate screening. When people do not receive adequate prevention and screening, they are at an increased risk for developing serious illnesses and receiving delayed treatment when ill. *Id.*

Older people without coverage are even more at risk of declining health and at much greater risk of premature death than their insured peers. J. Michael McWilliams et al., *Health Insurance Coverage and Mortality Among the Near-Elderly*, 23 Health Affairs, 223-233 (2004). One study showed that continuously uninsured people ages 52 to 61 were 63% more likely than insured people to have a decline in their overall health and 23% more likely to have a new physical difficulty that affected mobility such as walking or climbing stairs. Even intermittently uninsured participants were at increased risk for declines in overall

health and mobility because of the periods in which they were less likely to have a primary care provider, more likely to delay seeking care, and more likely to go without needed care. David W. Baker, MD, M.P.H. et al., *Lack Of Health Insurance And Decline In Overall Health In Late Middle Age*, 345 New Eng. J. Med. 1106, 1108 (2001), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa002887. Alarmingly, in 2006 an estimated 22,000 Americans died prematurely as a consequence of being uninsured. Rowland, *The Instability of Health Coverage in America*, *supra*.

Significantly, the large number of uninsured pre-Medicare age people costs Medicare greatly. Uninsured people with deteriorated health conditions bring their problems with them when they become eligible for Medicare. "Near-elderly adults who were uninsured required more intensive and costlier care in the Medicare program after the age of 65 years than previously insured adults." J. Michael McWilliams, M.D., et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 347 New Eng. J. Med. 143-153 (2007). Providing health insurance coverage for near-elderly adults reduces their health care use and spending after age 65. *Id*. at 153.

Although all previously uninsured Medicare recipients had higher utilization of health care services once they became eligible for Medicare, the impact and costs were far greater for those with hypertension, diabetes, heart disease, or

stroke, where prevention and routine care can prevent costly acute care hospitalizations and interventions. *Id*. The uninsured with these chronic conditions reported 13% more doctor visits, 20% more hospitalizations, and 51% higher total medical expenditures from ages 65 to 72 than did the previously insured adults. *Id.* at 143.

"Uninsured adults – particularly those approaching age 65 – sometimes defer necessary care until they qualify for Medicare, putting their health at risk and increasing costs to the Medicare program." Jacobson, *Health Insurance for Older Adults*; *supra* at 1, *citing* J. Michael McWilliams, M.D. et al., *Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults*, JAMA 290, 757-64 (Aug. 2003).

Congress considered the financial impact on Medicare:

> The status quo masks hidden cost to the Medicare Program when millions of uninsured adults enroll in Medicare. Uninsured adults, particularly those with chronic medical conditions, have fewer visits to physicians and fewer hospitalizations than insured adults in similar health before age 65. After becoming eligible for Medicare, uninsured adults have a rapid increase in physician visits and hospitalizations that persist for at least seven years after age 65.
>
> Their care in the Medicare Program is thus more costly, because they reach age 65 in worse health and have more immediate and expensive medical needs than if they had been insured and well-treated in their fifties and sixties. If all adults in this age group had insurance coverage, the cost of covering them could be off-set by

> better health and potential savings for the Medicare program.

*The Instability of Health Coverage in America*: *Hearing Before the Subcomm. on Health of H. Comm. on Ways and Means*, 110th Cong. (Apr. 15, 2008) (statement of John Z. Ayanian, MD, Prof. of Med. and Health Care Policy, Harvard Med. School).

## IV. THE ACA'S CREATION OF A ROBUST INSURANCE POOL SPREADS INSURANCE RISKS, WHICH IN TURN ALLOWS FOR AFFORDABLE HEALTH CARE INSURANCE OPTIONS FOR AMERICANS OF ALL AGES AND WITH CHRONIC OR PRE-EXISTING HEALTH CONDITIONS.

Congress recognized that, among other things, creating a robust insurance pool is essential in order to expand coverage for people who have been shut out from the current system due to health status or age.[12] Private health coverage products "pool" the risk of high health care costs across a large number of people, both healthy and sick, permitting them to pay a premium based on the average cost of medical care for the group of people.[13] This risk-spreading function helps make

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[12] In addition to expanding the risk pool to ensure affordable coverage options, ACA provides subsidies in the form of refundable and advanceable tax credits for low-to-moderate income people. Advanceable tax credits allow individuals to receive assistance when purchasing insurance instead of waiting to be reimbursed, while refundable tax credits ensure that individuals are still eligible for assistance even when they do not have tax liability. Beginning in 2014, with certain limited exceptions, individuals and families earning 400% of the poverty line or less will be eligible to receive these tax credits, so long as they do not have access to health insurance through an employer or other public health insurance program. 26 U.S.C.A. § 36B(a)-(c).

[13] "Pooling" is the insurance industry practice of combining the insurance risk of individuals or groups in order to determine premiums. Hinda Chaikind et al.,

the cost of health care reasonably affordable for most people. Gary Claxton, Inst. for Health Care Research and Policy, Georgetown Univ., *How Private Insurance Works: A Primer*, The Kaiser Family Foundation, 1 (Apr. 2002).

Congress therefore rationally concluded that expanding the risk pool would make insurance more accessible and affordable for those who have been unable to obtain coverage and care.

> By significantly increasing health insurance coverage, the [minimum coverage] requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The provision 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.

42 U.S.C.A. § 18091(a)(2)(I).

Without the minimum coverage provision, premiums in the individual market would rise by about 11% since young healthy individuals would opt out of coverage. Jonathan Gruber, *Health Care Reform without the Individual Mandate*, Ctr. for American Progress (Feb. 2011), *available at* http://www.americanprogress.org/issues/2011/02/gruber_mandate.html. The CBO estimates that removing the minimum coverage provision will cut the number of individuals newly insured in half (from 32 million to 16 million). *Id.* Estimates regarding the amount premiums

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*Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, Prepared for Members and Comms. of Cong., Congressional Research Service, 13 (May 4, 2010).

in the individual market will rise without the minimum coverage provision range between 15 to 27%. *Id.*

Including the minimum coverage provision, which begins in 2014, enabled Congress to include consumer protections in the ACA that will help millions of Americans obtain care and coverage, which in turn will substantially benefit the national economy. Among other things, insurers will no longer be able to deny people coverage because of preexisting health conditions or consider health status in setting premiums, helping to make coverage available and more affordable to those with health problems and pre-existing conditions. 42 U.S.C.A. §§ 300gg, 300gg-1(a). In addition, ACA significantly ameliorates the age rating disparities because insurers starting in 2014 will not be allowed to vary rates by more than 3:1 for age. *Id.* § 300gg(a)(1)(A)(iii). For example, a premium for a 64-year-old man may not be more than three times higher than the same policy for a 20 year old man, thus improving the status quo by making premiums more affordable to 50 to 64 year olds.

Congress had the Constitutional authority to create a robust pool in order to achieve successful expansion of coverage options for the 50 to 64 age group, as well as others who have been priced out of the U.S. healthcare system, such as people with pre-existing conditions or who need treatment for chronic illnesses or disabilities.

## CONCLUSION

For the forgoing reasons, Amicus AARP urges the Court to reverse the decision below.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Pursuant to Fed. R. App. P. 32(a)(7)(B), I hereby certify that this brief contains 6,955 words, excluding the portions of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in Times New Roman 14-point font.

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## CERTIFICATE OF SERVICE

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