Nos. 11-1057, 11-1058

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

COMMONWEALTH OF VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II,
in his official capacity as Attorney General of Virginia,
Plaintiff-Appellee/Cross-Appellant,
v.

KATHLEEN SEBELIUS, Secretary of the Department of Health and Human Services, in her official capacity,
Defendant-Appellant/Cross-Appellee.

On Appeal from the United States District Court
for the Eastern District of Virginia

BRIEF FOR AMERICA'S HEALTH INSURANCE PLANS AS AMICUS CURIAE IN SUPPORT OF NEITHER PARTY

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March 7, 2011

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
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INTEREST OF AMICUS CURIAE[1]

America's Health Insurance Plans (AHIP) is a national trade association representing 1,300 companies that provide health insurance coverage to more than 200 million Americans. Its members offer a wide range of insurance options to consumers, employers of all sizes, and public purchasers across the country, providing AHIP with a unique understanding of how the nation's health care system works. AHIP's members also have extensive experience working with hospitals, physicians, pharmaceutical and device companies, and other health care stakeholders to ensure that patients have access to needed treatments and medical services.

Health plans have a significant stake in making the health insurance market work. AHIP and its members accordingly wish to assist the Court by providing information about how the health insurance market operates and the changes the Patient Protection and Affordable Care Act (PPACA or Act) will make, and by highlighting the potential consequences that would follow from any decision to retain PPACA's market reforms without an individual mandate. The district court's decision to decouple the individual mandate from other provisions of the Act that are closely linked to it would have dire consequences for the availability

[1] The parties have consented to the filing of this brief. This brief was not authored in any part by counsel for any of the parties, and no person or entity other than Amicus, its members, or its counsel has made a monetary contribution to the preparation or submission of this brief.

and affordability of health insurance coverage. PPACA is a complicated legislative scheme with many interdependent provisions. This brief focuses on the linkage between the individual mandate and the market reforms found in Section 1201 of the Act.

AHIP submits this brief in support of neither party. The parties' briefs will extensively address the legal questions surrounding the constitutionality and severability of the individual mandate provision. In this brief, our purpose is not to speak to those constitutional issues or to how or whether this Court should conduct a severability analysis in the event the mandate is determined to be unconstitutional. Rather, AHIP's purpose here is narrow and limited, seeking to draw on insurers' knowledge and experience in the States to assist the Court in understanding why the insurance market reforms found in Section 1201—particularly the guarantee issue and adjusted community rating requirements and the prohibition on pre-existing condition exclusions—would not be economically and actuarially sound if the individual mandate were struck down.

SUMMARY OF ARGUMENT

Congress enacted a series of interconnected provisions in PPACA that will transform today's voluntary insurance market into a market designed to make minimum essential coverage a requirement, with an economic disincentive for

failure to meet the requirement, while adopting insurance market reforms to expand access to health care coverage.

The viability of those insurance market reforms—in particular, the guarantee issue and adjusted community rating requirements and the prohibition on pre-existing condition exclusions—depends on having larger, broader, more representative pools across which insurers can spread risk. Without an individual mandate requirement, more individuals will make the rational economic decision to wait to purchase coverage until they expect to need health care services.[2] If imposed without an individual mandate provision, the market reform provisions would reinforce this "wait-and-see" approach by allowing individuals to move in and out of the market as they expect to need coverage, undermining the very purpose of insurance to pool and spread risk.

From an economic perspective, there are two naturally flowing consequences of the "wait-and-see" approach. *First*, when younger or healthier people choose to delay coverage, average premiums are higher for those individuals choosing to remain in the market, who are generally older or less healthy. *Second*, when individuals take the gamble of proceeding without coverage and "lose the bet" by suffering an unexpected injury or illness, the cost of

[2] Snook & Harris, Milliman Health Reform Briefing Paper, *Adverse Selection and the Individual Market* 1-2 (Oct. 2009).

their care frequently shifts to those who are covered by insurance or other payers. Together, these two factors lead to a self-reinforcing cycle known as a "premium spiral": Prices increase for everyone as the average health of those in the insurance market deteriorates, undermining the affordability of coverage and making participation even less attractive for the young and healthy, which in turn drives prices even higher.

The actuarial and economic projections on which these conclusions are based are not theoretical. Recent history indicates that enactment of insurance market reforms in a voluntary market has led to the deterioration of the individual markets in States that have enacted such laws. This real-world experience suggests that, without an individual mandate, reforms of the health insurance market will be less workable, premium costs will be higher, and consumers ultimately may have fewer coverage choices.

ARGUMENT

I. PPACA'S INDIVIDUAL MANDATE REQUIREMENT AND HEALTH INSURANCE REFORMS WILL FUNDAMENTALLY CHANGE HOW THE INDIVIDUAL MARKET OPERATES

Understanding the relationship between the individual mandate and the market reforms in Section 1201 requires an understanding of how the health insurance market currently works, the tools insurers use, and how the mandate,

working in tandem with the insurance market reforms, is designed to expand access to health insurance coverage for more Americans.

A. How Today's Health Insurance Market Works

Like other forms of insurance, the basic purpose of health insurance is to spread the risk of potential losses across a large and diverse pool so that no single person bears excessive costs in the event of an unexpected loss. In exchange for the payment of a premium, health insurers agree to pay a portion of the costs of both unanticipated care, like treatment for a serious illness, and anticipated, routine medical care like annual physicals.

Generally speaking, health insurance is sold through three types of markets: non-group (also known as the individual market), small group, and large group. More than 200 million Americans aged 64 or under currently access health care coverage through their employers in the small group or large group markets or through government programs, such as Medicare or Medicaid.[3] For those who do not have access to employer-sponsored coverage and are not eligible for public programs, access to quality health care coverage is available through the individual market. The individual mandate requirement found in Section 1501 of the Act and the insurance market reforms in Section 1201 will have significant consequences for how the market operates.

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[3] Kaiser Family Foundation, *The Uninsured, A Primer: Key Facts About Americans Without Health Insurance* 31 (Dec. 2010).

Approximately 14 million Americans purchase individual health insurance through state-regulated markets.[4] States have established varying rules for, among other things, how insurers are licensed, requirements for maintaining financial solvency, how claims are processed and paid, when insurers must accept applicants and provide coverage, when insurers must renew enrollees' coverage, and how premiums must be priced.[5] As a result, health insurers face a myriad of rules that may vary widely from one State to the next. The content of these laws in turn can have a significant effect on coverage rates and the costs of health insurance sold in individual markets.[6]

The individual market is particularly susceptible to the economic phenomenon called "adverse selection" and the closely-related problem of cost-shifting.[7] Adverse selection occurs when individuals with higher anticipated health care costs—generally less healthy or older individuals—are more likely than healthy, younger people to enter an insurance market. Health insurance is particularly prone to adverse selection because individuals know more about their

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4 *Id.*

5 *See* Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* 8-13 (Apr. 2008).

6 *See* Linehan, National Health Policy Forum, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 7-8 (June 4, 2009).

7 *Id.* at 4. In this context, we use the phrase "cost-shifting" in a narrow, particularized sense, and do not use the phrase as it is sometimes used in policy discussions to refer to payment differentials between public and private payers.

own health than insurers do, creating incentives for some people to participate in a market only when they expect to need medical treatment.[8] Like any consumer, those considering whether to purchase insurance engage in a cost-benefit analysis, asking whether the cost of the premium (and any money spent on deductibles, co-payments, and co-insurance) outweighs the anticipated benefits that might accrue from holding health care coverage. Individuals who expect to need medical services will value coverage more highly than healthy people who do not expect to require care.[9] Adverse selection results when people who do not expect to need care wait to purchase coverage until they suffer from an illness or experience poorer health, and it is of particular concern in the individual market. Because employers do not subsidize the cost of coverage, as they typically do in the large group and small group markets, each enrollee in the individual market must pay the full premium. Consumers are therefore more price-sensitive and more likely to wait to purchase insurance until they expect to need medical treatment.[10]

Adverse selection raises costs for all participants in an insurance pool. Because insurers generally set premiums according to the expected medical costs

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[8] *See* Snook & Harris, *Adverse Selection* 1; *see also* Linehan, *Underwriting in the Non-Group Health Insurance Market* 4.

[9] *See* Blumberg & Holahan, Urban Inst., *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* 1-2 (Jan. 2008).

[10] *See* AHIP, *Small Group Health Insurance in 2008, A Comprehensive Survey of Premiums, Product Choices, and Benefits* 4 (Mar. 2009).

of those participating in a coverage pool, premiums increase for all pool participants when individuals with higher expected health care costs constitute a majority of the pool.[11] As premiums rise, healthy people in turn grow even less inclined to purchase and maintain coverage; and as healthy people leave the pool, premiums increase even more for those who remain. Thus, the cost of health insurance may become financially prohibitive for many who wish to enroll, and many who need treatment for an unexpected illness may be unable to afford care because they lack coverage.

When people choose not to purchase health insurance, the cost of providing those individuals with medical care frequently shifts to the rest of society. Up to 20 percent of uninsured individuals have the financial means to obtain coverage but forgo it, relying instead on emergency care when they need medical treatment.[12] When these "free riders" require medical care, hospitals and other providers charge those who do have coverage higher prices. These higher prices, in turn, translate into increased health insurance premiums for those who purchase insurance coverage in the individual market, as well as for employers and employees who purchase coverage in the small and large group markets. The

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[11] *See* Blumberg & Holahan, *Do Individual Mandates Matter?* 2.

[12] *See* Wulsin & Dougherty, *Individual Mandate: A Background Report* 3-4 (Apr. 2009).

insured are ultimately hit with a "hidden tax" ranging from two to ten percent of private premiums to pay for this uncompensated care.[13]

To combat the problems of adverse selection and cost-shifting, many States allow for setting of premium rates in the individual market through an actuarial mechanism known as "underwriting."[14] Insurers manage risk—and seek to hold down costs for their existing enrollees—by assessing each applicant's health and, based on that assessment, make an actuarial judgment about the amount and types of medical services he or she will likely need to determine whether to issue a policy, the terms of the coverage offered, whether a waiting period should be imposed before coverage takes effect, and the amount of the premium. Thus, in offering a policy, an insurer might exclude coverage for an applicant's known pre-existing conditions in order to develop an acceptable premium. If an insurer does accept an applicant, it may, if permitted under state law, adjust premiums based on individual characteristics associated with higher expected medical costs, including age, health status, and geographic location.[15]

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[13] *See id.* at 4. One analysis by Milliman, independent actuarial consulting firm, estimated that the "hidden tax" in 2008 was $1,017 for family coverage and $368 for single coverage. *See* Stoll & Bailey, Families USA, *Hidden Health Tax: Americans Pay a Premium* 6-7 (2009).

[14] Linehan, *Underwriting in the Non-Group Health Insurance Market* 4.

[15] *See* Kaiser Family Foundation, *How Private Health Coverage Works* 5-7; *see also* Linehan, *Underwriting in the Non-Group Health Insurance Market* 4-6. A minority of States require insurers to use a community rating system or an

These underwriting practices produce lower premiums for younger, healthier people and are necessary to the sustainability of the individual market by keeping premium costs low enough so individuals will enter the market and remain in it on a continuing basis.[16] Underwriting also reduces incentives that might otherwise lead healthy individuals to postpone obtaining coverage until an illness or condition requires treatment.[17] In States that do not allow premiums to be priced according to individuals' expected costs of medical care, the individual market can attract a disproportionate number of persons with higher expected costs, thereby raising average premiums for all participants in the market and making coverage less affordable for younger, healthier people.[18]

B. If PPACA's Individual Mandate Requirement Is Stricken And The Market Reforms Stand, Adverse Selection And Cost-Shifting Will Reduce Access to Affordable Coverage

PPACA enacts new federal regulation of the health insurance market through two key policies: (1) comprehensive market reforms in Section 1201 that change how premiums are priced and coverage is offered, and (2) an individual mandate provision in Section 1501 requiring all qualifying Americans to obtain

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adjusted community rating system, which limits insurers' ability to set premium prices according to applicants' health status and other demographic factors. *See* Linehan, *Underwriting in the Non-Group Health Insurance Market* at 6.

16 *See* Snook & Harris, *Adverse Selection* 2.

17 *See id.* at 2-3.

18 Linehan, *Underwriting in the Non-Group Health Insurance Market* 8.

health care coverage or pay a penalty.[19] Section 1201 of the Act requires insurers to issue and renew health care coverage for applicants and enrollees who pay the premium ("guarantee issue" and "guaranteed renewability"),[20] prohibits pre-existing condition exclusions,[21] forbids insurers from basing coverage eligibility on health status and related factors (*e.g.*, presence of a disability),[22] and prohibits insurers from imposing waiting periods longer than 90 days before an enrollee's coverage takes effect.[23] Significantly, the Act also institutes a modified "community rating" system, which precludes insurers from pricing policies according to health status and other types of information relating to an applicant's claims history, and limits premium variations based on applicants' ages, gender,

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[19] The individual mandate in Section 1501 provides that, beginning on January 1, 2014, all U.S. citizens and legal residents must purchase coverage or pay a penalty for failing to do so. There are exceptions to this requirement, including for those who cannot meet a specified affordability threshold and for undocumented aliens, incarcerated individuals, and those with religious objections. The penalty for failing to maintain coverage initially will be the greater of a flat annual fee of $95 or one percent of income in 2014. By 2016, this will increase to the greater of a flat annual fee of $695 or 2.5 percent of income. *See* PPACA § 1501(b), 26 U.S.C. § 5000A. Some have maintained that the mandate may not impose a large enough penalty, especially in the early years, to foster the level of compliance that some studies have projected would be necessary to the mandate's effectiveness in combating adverse selection. Stewart, *Ghost of "Adverse Selection" Looms Over Health Care Reform*, Capitol Weekly (Jan. 6, 2011).

[20] *See* PPACA § 1201, 42 U.S.C. §§ 300gg-1, 300gg-2.

[21] *See* PPACA § 1201, 42 U.S.C. § 300gg-3.

[22] *See* PPACA § 1201, 42 U.S.C. §§ 300gg-1, 300gg-4.

[23] *See* PPACA § 1201, 42 U.S.C. § 300gg-7.

geographic locations, or tobacco use.[24] In addition, all participants within a given risk pool pay the same premium for the same coverage.[25]

The insurance market reforms in Section 1201 will fundamentally alter the way insurers spread risk and price premiums in the individual market. As discussed above, health insurance plans in most States currently adjust for adverse selection by using underwriting and rating practices to encourage individuals to enter the market before they are likely to require significant medical care. The Section 1201 market reforms will eliminate the use of many of these tools and require insurers to issue coverage to anyone who can pay the premium. If premiums are set based on the average expected costs for an insurer's whole pool, as PPACA requires, participation will become relatively more attractive for individuals with higher expected health care costs, and less attractive for individuals with lower expected health care costs.[26] As a result, imposing these

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[24] *See* PPACA § 2701, 42 U.S.C. § 300gg; *see also* Chaikind et al., Congressional Research Service, *Private Health Insurance Provisions in PPACA (P.L. 111-148)* 12, (Apr. 15, 2010).

[25] *See* Kaiser Family Foundation, *How Private Health Coverage Works* 11; Linehan, *Underwriting in the Non-Group Health Insurance Market* 6.

[26] *See* Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010). ("[The Congressional Budget Office] and [Joint Committee on Taxation] estimate that, relative to current law, the elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people. As a result, in the absence of a mandate, those who enroll would be less healthy, on average, than those enrolled with a mandate.").

reforms without an individual mandate would lead to even more adverse selection and cost-shifting, resulting in higher average costs for those who remain insured and making coverage even less attractive to those with lower expected costs.

II. ECONOMIC EVIDENCE AND REAL-WORLD EXPERIENCE ILLUSTRATE THE POTENTIAL CONSEQUENCES OF SEPARATING THE MANDATE FROM PPACA'S INSURANCE MARKET REFORMS

A. Actuarial And Economic Evidence Indicates That Without An Individual Mandate, PPACA's Insurance Market Reforms Would Create Instability In The Individual Market

Economic evidence indicates that implementing market reforms without an individual mandate would create instability in the marketplace. The projected consequences for the individual market are indicative. Although the assumptions and projections may vary from study to study, the common theme in the economic and actuarial literature is that premiums increase and coverage rates fall when insurance market reforms are enacted without an individual mandate. For example, the Congressional Budget Office has predicted that increased adverse selection in the individual market would raise premiums for new policies by approximately 15 to 20 percent.[27] Similarly, while the Act is projected to expand coverage to 32 million previously uninsured individuals, only an estimated 8 million of the currently uninsured would obtain coverage if the Act contained no

[27] *Id.*

mandate.[28] And instead of the $42.3 billion decline in uncompensated care predicted to occur under the Act, costs of care for the uninsured will continue to shift to the rest of society.[29]

Economic evidence also shows that implementing the Act's insurance market reforms without an individual mandate would not reduce the problem of adverse selection. To the contrary, the law would have just the opposite effect, potentially creating a self-reinforcing "premium spiral." As explained above, the insurance market reforms in Section 1201 preclude some of the underwriting practices that insurers have found necessary to achieve premium predictability and stability in the individual market. *See supra* pp. 9-10, 12. Under the new regulatory regime, coverage will be available to all Americans without regard to pre-existing conditions, including those in need of expensive medical treatment. Without an enforceable requirement that everyone obtain health care coverage, healthy people will thus have an incentive to forego buying health insurance until they expect to need medical care, knowing that they cannot be excluded for any pre-existing condition and that their premiums cannot be increased due to their health status. As a result, the insurance pool would likely consist of individuals

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[28] *See* Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, New Eng. J. Med. (Feb. 23, 2011).

[29] *See* Buettgens et al., *While The Individual Mandate Matters: Timely Analysis of Immediate Health Policy Issues* 7 (Dec. 2010).

with higher health care costs, and premiums in turn would be relatively higher. Higher premiums would lead many healthier, younger individuals to opt out, and the risk pool would continue to skew toward relatively sicker individuals, which in turn would drive up the community-rated premium and chase even more relatively healthy people out of the risk pool.[30]

B. States' Experiences Show That Enacting Insurance Market Reforms Without An Individual Mandate Can Disrupt The Health Insurance Market

Available evidence confirms that market reforms, such as guarantee issue and community rating requirements, can have harmful, unintended consequences if implemented without a requirement that individuals purchase health insurance and participate in the pooling of risk. During the 1990s, eight States took such a path. Although there are no perfect models for what would happen on the national level—particularly because the insurance markets, laws, and, accordingly, outcomes in each State vary—history shows that enactment of community rating and guarantee issue laws without an individual coverage requirement generally contributed to destabilization of individual markets, increases in premiums, and declines in enrollment. This experience, in turn, indicates how the district court's decision to invalidate the individual mandate, but uphold the market reforms, could adversely affect the individual market.

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[30] *See* Reinhardt, *The Case for Mandating Health Insurance*, N.Y. Times, Oct. 23, 2009.

The story of health insurance reform in Maine illustrates the potential consequences of enacting insurance market reforms without an individual mandate. In 1993, Maine enacted guarantee issue and modified community rating reforms for its individual market, allowing limited price variation only for age, occupation or industry, and geographic location.[31] Insurers participating in the individual market were also required to offer two plans—"basic" and "standard"—that met minimum coverage requirements. According to a report issued by the state Bureau of Insurance analyzing the ensuing problems in Maine's individual market, the "market for individual HMO coverage" as of January 2001 "appear[ed] to be in a death spiral."[32] Premiums for indemnity coverage increased significantly, with the leading carrier in the market forced to double its rates from the time the reforms had taken effect.[33] As premiums increased, coverage rates fell because fewer people could afford to purchase coverage in the individual market.[34] Although other factors may have also contributed to the deterioration of affordability and availability, state regulators determined that the modified community rating

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31 *See Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance* 5 (May 30, 2007).

32 Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market* 4 (Jan. 22, 2001); *see also id.* at 3 ("It is now clear that the future viability of the individual health insurance market in Maine is at serious risk.").

33 *See id.* at 4.

34 *See id.*

requirement "result[ed] in the risk pool having a higher average age and therefore higher costs."[35]

Recent reports indicate that the individual market in Maine has not improved. One study commissioned by the state's Bureau of Insurance noted in 2007 that premiums were continuing to "escalate[] rapidly, making coverage unaffordable for many."[36] As of 2006, the average deductible for a policy sold in Maine's individual market was approximately $7,000.[37] And as of December 2010, Maine's Superintendent of Insurance noted that only "two insurance companies … are actively offering insurance coverage in the individual market."[38]

The individual market in New Jersey similarly deteriorated after insurance reforms were enacted without an individual mandate. In 1993, New Jersey implemented the Individual Health Coverage Plan, which required guarantee issue and renewal and pure community rating of individual health policies.[39] One study examining the impact of New Jersey's reforms found that, as of 2004, the

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35 *Id.* at 10.

36 *Reform Options for Maine's Individual Health Insurance Market* 5.

37 *Id.*

38 Letter from Kofman, Maine Superintendent of Insurance, to Secretary Sebelius, HHS, Attachment at 2 (Dec. 16, 2010); *see also Reform Options for Maine's Individual Health Insurance Market* 15.

39 *See* Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 Health Affairs 167, 167 (2004).

individual market was "heading for collapse."[40] More than half of enrollees had left the individual market between 1995 and 2001, and premiums had increased two or three times from their early levels.[41] Although it may be difficult to draw precise causal links between the market reforms and subsequent market deterioration, the trend in the early 2000s suggested "a marketwide adverse-selection death spiral spurred by open enrollment and pure community rating."[42] Recognizing that legislative changes were necessary to stabilize the market, the New Jersey legislature in 2001 began enacting a series of further reforms.[43] One such measure, the Basic and Essential Health Plan, provided a "bare bones" option for coverage at lower prices for younger, healthier enrollees in the individual market.[44] From that measure's implementation in 2003 through 2009, enrollment in New Jersey's individual market increased by 32 percent.[45]

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40 *Id.* at 168.

41 *Id.*

42 *Id.* at 169.

43 Parente & Bragdon, Manhattan Institute, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured* 6 (Sept. 2009); Turnbull et al., *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Short Case Studies of Six States* 20 (Feb. 2005). In July 2008, the New Jersey legislature passed additional reforms of the individual market. *See* 2008 N.J. Laws 38.

44 Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 20.

45 Parente & Bragdon, *Healthier Choice* 6.

In Kentucky, concerns about the potential effects of adverse selection contributed to significant destabilization of the individual market. Within two years of enacting comprehensive insurance market reforms in 1994—including guarantee issue and modified community rating requirements—more than 40 insurers ended their participation in Kentucky's individual market before the reforms went into full effect, with only two insurers remaining to sell new policies in the individual market.[46] Responding to the collapse of the individual market and fearing that many residents across the State no longer had coverage options,[47] the Kentucky legislature began repealing the insurance reforms in 1996, eliminating many of the reforms' core provisions, including guarantee issue and modified community rating in 1998.[48]

The deterioration of the individual market also led the New Hampshire legislature eventually to repeal its reforms of the individual health insurance

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[46] Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Pol. Pol'y & L. 133, 152 (2000). Approximately 23 of these insurers were holding more than 100 individual policies but stopped selling new coverage when the reforms were enacted. Holding only a few or no policies, the rest of the insurers left Kentucky's individual market altogether. *See id.*; *see also* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 7.

[47] Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. Health Pol. Pol'y & L. 175, 194 (2000); Kirk, 25 J.Health Pol. Pol'y & L. at 152.

[48] *See* Kirk, 25 J.Health Pol. Pol'y & L. at 158; *see also* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 7 ("The 1998 reforms were meant to attract carriers back into the market and reduce rates for the healthy enrollees of existing carriers.").

market. In 1994, the State enacted reforms that included guarantee issue, modified community rating, and limits on pre-existing condition exclusions.[49] Between 1994 and 2000, the number of carriers participating in the individual market dropped from twelve to two.[50] And the two insurers that remained offered individual policies at higher prices.[51] In 1997, the New Hampshire Insurance Department "observed … market changes that seemed to be characteristic of a market-wide antiselection spiral."[52] The Department more recently described the experience in the 1990s as "a collapse of [New Hampshire's] individual market."[53] In 2001, the New Hampshire legislature repealed the guarantee issue requirement and allowed insurers once again to use medical underwriting for policies sold in the individual market.[54]

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49 Feldvebel & Sky, *A Regulator's Perspective on Other States' Experiences*, 25 J. Health Pol. Pol'y & L. 197, 198 (2000).

50 *Id.* at 197, 199.

51 *Id.* at 199.

52 Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16. J. Ins. Reg. 399, 401 (Summer 1998) (citing New Hampshire Insurance Department, *An Analysis of the Nongroup Market with Recommendations for Change* (Oct. 27, 1997)).

53 Letter from Sevigny, Commissioner, Insurance Department, The State of New Hampshire, to Secretary Sebelius, HHS (Jan. 6, 2011).

54 National Association of Health Underwriters, *Analysis of State-Level Health Insurance Market Reforms* 11-12 (Oct. 2005).

Similarly, volatility in the individual market led the State of Washington to repeal the comprehensive insurance market reforms it had passed in 1993.[55] The 1993 reforms included a guarantee issue provision, a phased-in community rating requirement, and limits on pre-existing condition exclusions, including a significantly shorter time period during which an insurer could rely on an applicant's history to make an exclusion determination.[56] Although the legislation also included plans for an individual mandate requirement, the requirement never took effect, as the legislature instead rolled back the mandate and many of the other reforms in 1995.[57] It is difficult to determine whether and to what extent the reforms alone caused the individual market to deteriorate, but evidence shows that prices rose and coverage fell significantly soon after the 1993 passage of the reform package. One study reported that some premiums in the individual market rose by as much as 78 percent during the three years following enactment of the original reforms.[58] Coverage also fell, with enrollment in the individual market

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55 *See* Nichols, 25 J. Health Pol. Pol'y & L. at 192 ("Kentucky, and to a lesser but still serious extent Washington, clearly had the worst experiences with implementing and sustaining individual market reforms.").

56 Kirk, 25 J. Health Pol. Pol'y & L. at 136-137.

57 *Id.* at 138; *see also* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 15.

58 Suderman, *The Lesson of State Health-Care Reforms*, Wall St. J., Oct. 15, 2009 (citing study presented at the 1999 annual meeting of the Association for Health Services Research).

falling by 25 percent during the same time period.[59] In addition, insurers suffered significant financial losses. Policy analysts reported that the six biggest insurance carriers in Washington's individual market lost somewhere between $48 and $58 million in 1995.[60] The remaining insurance market reforms were repealed in 2000.[61] Since then, the state legislature has enacted new measures aimed at stabilizing the market and encouraging carriers to return to Washington's individual market, including a 2001 law that allows insurers to refer their costliest applicants to a high-risk pool and permits plans to impose a nine-month waiting period for coverage of pre-existing conditions.[62] Today, there are five insurance companies participating in the individual market, compared to the two that remained before the 1993 reforms were repealed.[63]

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59 *Id.* Enrollment in Washington's individual market fell from just over 218,000 people in 1993 to approximately 134,000 in 2000. *See* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 16.

60 Ramsey, *Cause of Hemorrhaging Health Plans For Individuals Debated*, Seattle-Post Intelligencer, Feb. 10, 1997 (citing January 1997 report by Washington State Health Care Policy Board); *see also* Ramsey, *State Reforms Are Costly to Health Insurers*, Seattle-Post Intelligencer, Apr. 16, 1997.

61 Kirk, 25 J. Health Pol. Pol'y & L. at 145; *see also* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 15.

62 Robert Wood Johnson Foundation, *Issue Brief: Recognizing Destabilization in the Individual Health Insurance Market* 4 (July 2010).

63 Stark, Washington Policy Center, *Overview of the Individual Health Insurance Market in Washington State* (Jan. 2011).

Although the volatility in New York's individual market was not as significant as in Washington, New York experienced deterioration in both availability and cost of individual coverage after the legislature enacted a comprehensive market reform package in 1993. Within five years after enactment of the reform measures, enrollment in the individual market fell between 38 and 50 percent according to one report, indicating "significant adverse selection" in the market.[64] In addition, premium rates "increased substantially … due to adverse selection," making it difficult for individuals with lower medical costs to obtain affordable coverage.[65] One analyst also found that "reform resulted in the demise of comprehensive indemnity products and the withdrawal of all commercial indemnity insurers" from the individual market.[66] The New York legislature has not significantly changed the reform laws since their 1993 enactment, and the individual market remains "very expensive" with "a high average age."[67] More recent data indicate that the decline in enrollment in New York has been severe. One recent study noted that although the portion of the total non-elderly population enrolled in the individual market nationwide grew between 1994 and 2007, the

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64 Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 76, 87 (2000).

65 *Id.* at 97-98.

66 *Id.* at 97.

67 Parente & Bragdon, *Healthier Choice* 4-5.

individual market in New York had "nearly disappeared" in that same time period, with the portion of New York's non-elderly population covered by individual insurance dropping by 96 percent between 1994 and 2009.[68] The same study estimated that if New York's community rating and guarantee issue requirements were repealed, the price of individual coverage could potentially fall by as much as 42 percent.[69]

Although results in Vermont's individual market have been mixed compared to other States following enactment of comprehensive market reforms, studies reveal some evidence of adverse selection taking place. Vermont's 1992 reform package required guarantee issue and a community rating system.[70] Following reform, enrollment in the individual market initially surged and then fell, and premiums rose, though by a smaller margin than some had predicted.[71] Between 1994 and 1996, premiums in the individual market increased an average of 16 percent per year, but held steady during 1997.[72] Some state-specific factors may have mitigated the impact of the reforms in Vermont, including state laws that

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68 *Id.* at 5; *see also id.* at 6 ("If its rate of participation were as high as the average U.S. state's (5.5 percent of the non-elderly population), New York's market would be 27 times its current size and have 91,000 policyholders today[.]").

69 *Id.* at i (Executive Summary).

70 Hall, *An Evaluation of Vermont's Reform Law*, 25 J. Health Pol. Pol'y & L. 101, 101 (2000).

71 *Id.* at 107, 114-115, 121.

72 *Id.* at 115.

allowed insurers to utilize measures to counteract adverse selection, the demographics of the population in Vermont, and the availability of generous public programs.[73] More recent data, however, suggest a negative trend, with a December 2006 analysis conducted for state regulators indicating that the individual health insurance market in Vermont "seems to be performing badly: the number of people buying coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing."[74] Responding to these concerns, Vermont enacted a comprehensive health reform bill in 2006, part of which directs the State to recommend options for improving the individual market.[75]

Finally, Massachusetts provides an example of a State enacting new measures after reforms passed in the 1990s were followed by disruption in the health insurance market. In 1996, the Massachusetts legislature passed reforms, including guarantee issue of at least one of three types of benefits packages, a prohibition on pre-existing condition exclusions and waiting periods, and a

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73 *Id.* at 129.

74 Wicks, *The Individual Market in Vermont: Problems and Possible Solutions* 15 (Dec. 2006) (prepared for Vermont Department of Banking, Insurance, Securities and Health Care Administration).

75 *See* Besio, *Vermont Health Care Reform: Five-Year Implementation Plan* 3 (Dec. 1, 2006); *see also id*. at 10 ("[T]he Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation.").

modified community rating system.[76] After these reforms were implemented, premiums rose and coverage rates fell, with enrollment in the individual market falling from approximately 135,300 people in 1996 to just over 55,200 in 2000.[77] In 2000, the Massachusetts legislature began modifying these provisions,[78] culminating with passage of a comprehensive health reform bill in 2006 intended to achieve near-universal coverage.[79] The 2006 reform package maintained some of the measures passed a decade earlier, including guarantee issue and modified community rating, and contained numerous new requirements, including an individual mandate that requires every qualifying Massachusetts resident over the age of 18 to purchase health insurance.[80]

CONCLUSION

As experiences in these eight States indicate, implementing insurance market reforms, such as guarantee issue and community rating, without an individual mandate may lead to an increase in adverse selection and, accordingly,

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[76] Kirk, 25 J. Health Pol. Pol'y & L. at 161; *see also* Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 11.

[77] Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 13; Kirk, 25 J. Health Pol. Pol'y & L. at 167-168.

[78] Turnbull et al., *Insuring the Healthy Or Insuring the Sick?* 13.

[79] Long, *On the Road to Universal Coverage: Impact of Reform In Massachusetts At One Year*, Health Affairs, w270, w270 (June 3, 2008).

[80] McDonough et al., *Massachusetts Health Reform Implementation: Major Progress and Future Challenges*, Health Affairs, w288, w291 (June 3, 2008).

raise premium prices, reduce coverage rates, and destabilize individual markets. Although the States' experiences have varied, and although numerous factors undoubtedly affect how the market operates, the common trend across these States bears out what basic actuarial and economic concepts predict: Market reforms that are not coupled with an individual mandate are likely to lead to disruption and instability in the health insurance market.

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March 7, 2011

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I hereby certify that the foregoing Brief For America's Health Insurance Plans As Amicus Curiae In Support Of Neither Party complies with the type-volume limitation of Rule 32(a)(7)(B)(ii) because the brief contains 6,210 words, excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii), as measured by the word count feature of the word processing system used to prepare this brief. I further certify that the foregoing Brief complies with the typeface requirements of Rule 32(a)(5) and the typestyle requirements of Rule 32(a)(6) because this brief has been prepared in a proportionally spaced typeface in 14-point Times New Roman.

s/ Randolph D. Moss
RANDOLPH D. MOSS

March 7, 2011

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I hereby certify that on March 7, 2011, I caused the foregoing Brief For America's Health Insurance Plans As Amicus Curiae In Support Of Neither Party to be electronically filed with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the Court's CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system. Eight paper copies are also being filed with the Clerk of the Court by overnight courier.

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March 7, 2011

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