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Before the House of Representatives Energy & Commerce Committee

Subcommittee on Oversight & Investigations

"The ACA's Cost Sharing Reduction Program: Ramifications of the Administration's Decision on the Source of Funding for the CSR Program."

July 8, 2016

Thank you, Chairman Murphy and Ranking Member Degette, and members of the Subcommittee, for providing this opportunity to participate in this hearing.

I am Senior Counsel to the Constitutional Accountability Center, a public interest law firm, think tank, and action center dedicated to realizing the progressive promise of the text and history of the Constitution. I helped draft an *amicus curiae* brief which CAC filed with the District Court for the District of Columbia in *House of Representatives v. Burwell*, on behalf of Democratic Leader Pelosi and other leading members of the House Democratic Caucus.[1] Our brief supports the Administration's determination that it has authority to fund the Affordable Care Act cost-sharing provisions at issue in that case and in this hearing. Here is why.

As both the Subcommittee members and we on the other side of the witness table are well aware, the cost-sharing-reductions program at issue in the hearing was designed and has in practice operated as an integral component of the Affordable Care Act. It is essential to the ACA's extension of access to health insurance and health care to 20 million Americans who previously lacked coverage. However, members of the

[1] Brief of *Amici Curiae* Members of Congress in Support of Defendants' Motion for Summary Judgment, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2016 WL 2750934 (D.D.C. May 12, 2016), *available at* http://theusconstitution.org/sites/default/files/briefs/House_v_Burwell_Brief_Final.pdf.

majority party in the House of Representatives allege that the Administration's payments to implement this program are unlawful, on the ground that Congress has not appropriated funds to support those payments. They have filed a lawsuit seeking to strip the funding for that benefit, despite the fact that millions of ACA beneficiaries depend on the CSR subsidies for access to health care. In May of this year, a federal District Court for the District of Columbia upheld the House's challenge. Earlier this week, on July 6, the Administration filed in the D.C. Circuit its notice of appeal from the District Court's decision.

In my view, the Administration's implementation of the CSR program is lawful, and the House's complaint, and this District Court decision, have got the applicable law wrong. ACA opponents contend that there is no appropriation for the cost-sharing reductions, even though, as they concede, 31 U.S.C. § 1324 provides a permanent appropriation for the premium tax credits. With respect, this assertion is at odds with the ACA's plan for reforming and restructuring individual insurance markets, the mechanisms Congress designed to effectuate that plan, textual provisions defining those mechanisms and how they are intended to operate, and multiple other provisions of the Act which would make no sense under these ACA opponents' interpretation. The Administration has determined that the premium tax credits and cost-sharing reductions are commonly funded by the permanent appropriation in 31 U.S.C. § 1324. That interpretation suffers from none of the above fatal deficiencies, and enables the Act to operate as Congress intended, vastly expanding – as Congress also intended – the number of Americans who can enjoy the security of affordable access to health insurance and health care.

Just one year ago, in *King v. Burwell*, the Supreme Court rejected a similarly perverse "interpretation," contrived – in the words of its architects – to "drive a stake through the heart" of the ACA. In that case, Chief Justice John Roberts, writing for a six-justice majority, held, in terms that plainly bear on the interpretive question at issue here:

> "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter. Section 36B can fairly be read consistent with what we see as Congress's plan, and that is the reading we adopt."

One year later, ACA opponents have mounted what amounts to a rerun of the same strategy for undermining a law they have not been able to invalidate or repeal – as if *King*, and the well-established precedents and other authorities on which it was based, had never happened. Once again they brandish an a-contextual, hyper-literalist "interpretation", ignoring the statute as a whole, crafted to "undo" the statutory design, and yield results inconsistent with the ACA's plan for improving health insurance markets – precisely the sort of scenario that the Court in *King* ruled out. The Administration's interpretation of the pertinent provisions of the ACA and the IRC fits the law's design and avoids such self-defeating results. It is correct, and, I believe, will be so held, as Judge Collyer's decision is appealed to higher courts.

The basis for the House's position to the contrary is that Section 1401 of the ACA, which prescribes the tax credits, specifically references, and amends, 31 U.S.C. §1324, as a permanent source of funding, whereas there is no such reference in Section 1402, which addresses the CSR subsidies. Revealingly, the House's brief in support of its motion for summary judgment before Judge Collyer literally did not cite

King at all. Judge Collyer herself dismissed the Supreme Court's decision as "inapposite." It's not hard to understand why these opponents need for *King* to go away. The CSR subsidies operate as a package with the premium assistance tax credits, for lower-earning persons eligible for the tax credits, providing those comparatively lower income individuals with complementary assistance necessary to enable them to purchase health care products and services covered by their insurance.[2] The CSR part of that package is no less essential than the tax credits component.

No one doubts that the premium tax credits and the cost-sharing reductions are integrally related, and that both are critical to what the Supreme Court characterized, in *King v. Burwell,* as the ACA's "series of interlocking reforms designed to expand coverage in the individual health insurance market." The ACA "bars insurers from taking a person's health into account when deciding whether to sell health insurance or how much to charge"; it "generally requires each person to maintain insurance coverage or make a payment to the [IRS]"; and it "gives tax credits to certain people to make insurance more affordable." These three reforms, the Court made clear, "are closely intertwined"; the first reform would not work without the second, and the second would not work without the third.[3]

The text and structure of the ACA make clear that the cost-sharing reductions and the premium tax credits are both integrally-connected to each other and to the "interlocking reforms" adopted by the law. Indeed, the ACA's text makes the two

[2] Premium assistance tax credits are available to persons purchasing insurance through ACA-sanctioned state-level exchanges who earn between 100% and 400% of the Federal Poverty Level (FPL). Cost-sharing subsidies are available to persons eligible for premium assistance tax credits and whose incomes are between 100% and 250% of the FPL.

[3] *King v. Burwell*, 135 S. Ct. 2480, 2485, 2487 (2015).

complementary mechanisms components of a single "program," in which eligibility for the CSR component is predicated on eligibility for the tax credit component, which the Act directs the Government to "establish," to ensure unified advance payments of both components. Pursuant to this program, the Secretary of the Treasury must "make[] advance payment" of both premium tax credits and cost-sharing reductions "in order to reduce the premiums payable by individuals eligible for such credit," and to "establish a program under which . . . advance determinations are made . . . with respect to the income eligibility of individuals . . . for the premium tax credit . . . and the cost-sharing reductions," and "make[] advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit." ACA § 1412 (42 U.S.C. §§ 18082(a), 18082(a)(1), 18082(a)(3), §18082(c), 18071(f)(2)). As the Department of Justice explained in its final brief in the District Court, "Within this integrated program, both portions of the advance payments, including the advance cost-sharing reduction payments at issue here, are 'refunds due from' Section 36B within the meaning of 31 U.S.C. § 1324(b) because both are compensatory payments made available through the application of Section 36B, which sets forth conditions necessary to qualify for cost-sharing reductions as well as premium tax credits." In the same vein, the Act (in the above-cited section) defines the term "applicable State health subsidy program" as "the program under this title for the enrollment of qualified health plans offered through an Exchange, including the premium tax credits under section 36B of Title 26 and cost-sharing reductions under section 1402."

As the text of the ACA makes clear, an integral component of the statute's "interlocking system" for achieving its goal of near-universal coverage is its package of subsidies for ensuring that lower income individuals and families can afford to participate – premium assistance tax credits and cost-sharing reduction payments, that reduce the costs of both health insurance and of health care purchased with that insurance. 26 U.S.C. § 36B; 42 U.S.C. §§ 18071, 18082. Under the terms of the ACA, the premium tax credits "*shall* be allowed" for individuals with household incomes from 100% to 400% of the federal poverty line to help them purchase insurance, 26 U.S.C. § 36B(a), (c)(1)(A) (emphasis added), and insurance issuers "*shall* reduce the cost-sharing under the plan" for individuals with household incomes from 100% to 250% of the federal poverty level to help them defray the costs of health care purchased with that insurance (*i.e*., expenses such as co-payments and deductibles), 42 U.S.C. § 18071(a)(2) (emphasis added); 45 C.F.R. § 155.305(g). Congress also gave insurance issuers a legal right to payment from the federal government for the amount of those mandatory cost-sharing reductions. The law provides that "the Secretary *shall* make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added); *id.* § 18082(c)(3).

As with the premium assistance tax credits unsuccessfully challenged in *King v. Burwell,* the House leadership's narrow interpretation of CSR funding authority would similarly generate, as the Justice Department explained to the District Court, a "cascading series of nonsensical and undesirable results that" would follow "if the Act did not allow the government to comply with the statutory directive to reimburse . . . insurers for the cost-sharing reductions"). Two such bizarre results are especially worth

noting. As detailed in an *amicus curiae* brief filed on behalf of fifteen economic and health policy scholars (including the Director of the Congressional Budget Office from 2009 through 2015), if not reimbursed by the government for reducing cost-sharing expenses incurred by their beneficiaries, insurers will raise premiums for all affected plans – namely, the "silver" plans the Act specifies as required for eligibility for CSR subsidies. Those higher premiums would apply to *all* such silver plans, including those covering individuals not eligible for CSR benefits, *and even individuals not insured through the exchanges at all.* Any such individuals who have opted to purchase such plans would have an incentive either to buy cheaper and less protective plans, or, possibly, to purchase more protective "gold" plans, which, paradoxically, could become less expensive than silver plans, or such persons would drop coverage altogether. Obviously, such results would flout the "market improvement" design of the ACA.

Second, even more nonsensical, these scholars explain, "the amount of the premium tax credits offered to subsidized enrollees would increase ***across the board.***"[4] As a result, federal expenditures would increase – and from the same fund – the permanent appropriation provided by 31 U.S.C. §1324 – from which the House leadership's interpretation purports to save taxpayer dollars.[5] A December 2015 issue brief issued by the Department of Health & Human services summarized the "net result" of that perverse interpretation:

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[4] Brief *Amici Curiae* for Economic and Health Policy Scholars In Support of Defendants, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2016 WL 2750934 (D.D.C. May 12, 2016), *available at* http://premiumtaxcredits.wikispaces.com/file/view/4552756-2--24176.pdf/569554697/4552756-2--24176.pdf.

[5] Linda J. Blumberg & Matthew Buettgens, *The Implications of a Finding for the Plaintiffs in* House v. Burwell, Urb. Inst. (Jan 26, 2016), http://www.urban.org/research/publication/implications-finding-plaintiffs-house-v-burwell

> . . . [R]ather than directly reimbursing insurers for the CSRs they are required to provide, the federal government would cover the cost . . . through a larger [premium tax credit]. . . [which would be paid to] all PTC recipients [not just CSR recipients]. . . . [T]his approach would be . . . *billions of dollars higher annually* than it would otherwise be. Thus, federal deficits would be higher . . . than the current structure in which the federal government directly reimburses insurer costs for CSRs."[6]

Because these mandatory payments were so critical to the effective operation of the ACA, Congress did not leave the funds for their payment to the vicissitudes of the annual appropriations process. Instead, Congress provided for their payment out of a permanent appropriation via 31 U.S.C. § 1324. At the time Congress was debating and enacting the ACA, this understanding was shared on a bipartisan basis. During the debate, some members expressed concern that these permanently appropriated subsidies would not be subject to the Hyde Amendment, which under certain circumstances limits the use of annually-appropriated funds to pay for abortions.[7] To address those concerns, Congress adopted a provision to apply such funding restrictions to the subsidies that were permanently appropriated in the law, and in doing so, it made explicit that premium tax credits *and* cost-sharing reductions were the subject of permanent appropriations.[8]

Since the ACA's enactment, Congress has not used its ample legislative powers to reverse or even to defund the Administration's implementation of the CSS subsidy

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[6] *Potential Fiscal Consequences of Not Providing CSR Reimbursements,* ASPE Issue Brief, Department of Health & Human Services (December 1. 2015), https://aspe.hhs.gov/sites/default/files/pdf/156571/ASPE_IB_CSRs.pdf

[7] *See, e.g.*, 155 Cong. Rec. S12660 (daily ed. Dec. 8, 2009) (Sen. Hatch) ("this bill is not subject to appropriations").

[8] *See* 42 U.S.C. § 18023(b)(2)(A) ("If a qualified health plan provides coverage of [abortions for which public funding is prohibited], the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services: (i) The credit under section 36B of Title 26 . . . (ii) Any cost-sharing reduction under section 18071 of this title . . . .").

program – even though it has done just that with respect to other aspects of the Administration's ACA implementation, as members of this subcommittee well know. "Congressional appropriators have used a number of legislative options available to them through the appropriations process in an effort to defund, delay, or otherwise address implementation of the ACA." C. Stephen Redhead & Ada S. Cornell, Congressional Research Service, R44100, *Use of the Annual Appropriations Process to Block Implementation of the Affordable Care Act (FY2011-FY2016)*, at 5 (2016), https://www.fas.org/sgp/crs/misc/R44100.pdf. Among other things, House appropriators "repeatedly have added limitations," provisions "that restrict the use of funds provided by the bill." *Id.*; *see id.* (noting that limitations either "cap[] the amount of funding that may be used for a particular purpose or . . . prohibit[] the use of any funds for a specific purpose"). They have also added "several reporting and other administrative requirements regarding implementation of the ACA," including "instructing the HHS Secretary to establish a website with information on the allocation of [specified] funds and to provide an accounting of administrative spending on ACA implementation." *Id.* at 6. But, as far as I know, no ACA opponent has yet so much as drafted, let alone taken steps to enact, proposed legislation to overrule the Administration's determination that it has authority to fund the ACA's mandate to provide CSR subsidies.

On the contrary, post-enactment congressional action has *confirmed* that Section 1324 provides a permanent appropriation for the advance payments that the ACA directs the Secretary make to insurers for the cost-sharing subsidies. For fiscal year 2014, both houses passed an appropriations bill that conditioned the payment of cost-sharing reductions (and premium tax credits) on a certification by HHS that the

Exchanges verify that applicants meet the eligibility requirements for such subsidies.[9] To comply with this provision, HHS subsequently certified to Congress that the Exchanges "verify that applicants for advance payments of the premium tax credit and cost-sharing reductions are eligible for such payments and reductions." Because there was no yearly appropriation for the payments, it would have made no sense for Congress to enact such a law if, as plaintiff now argues, Congress believed that there was no permanent appropriation available to fund the payments.

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In sum, the Administration has appropriately and lawfully acted to ensure access to affordable health insurance and health care for the 6.4 million individuals currently receiving cost-sharing reductions – who represent 57% of the 11.1 million consumers receiving health insurance coverage through the exchange market-places across the nation. Withdrawing funding for that lifeline would flout the design of the ACA and the textual provisions which establish that design – which is why this latest effort to undermine the health reform law is no more likely to succeed than its predecessor attempts have.

[9] Continuing Appropriations Act, 2014, Pub. L. No. 113-46, Div. B, § 1001(a) (2013).