No. 16-635

In the Supreme Court of the United States

AMERICAN FREEDOM LAW CENTER, ET AL.,
PETITIONERS

v.

BARACK H. OBAMA, PRESIDENT OF THE
UNITED STATES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, imposed new regulatory requirements on health insurance issuers and adopted an individual-coverage provision that generally requires individuals to maintain health coverage or pay a tax penalty. The question presented is:

Whether the court of appeals correctly held that petitioners lack standing to challenge a transitional policy temporarily delaying the enforcement of certain provisions of the ACA against health insurance issuers and a policy providing a hardship exemption from the individual-coverage requirement for individuals whose coverage was cancelled and who found other coverage unaffordable.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 821 F.3d 44. The opinion and order of the district court (Pet. App. 18-39) is reported at 106 F. Supp. 3d 104.

JURISDICTION

The judgment of the court of appeals was entered on May 13, 2016. A petition for rehearing was denied on August 10, 2016 (Pet. App. 40-41). The petition for a writ of certiorari was filed on November 7, 2016. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, generally requires individuals to maintain health coverage or

pay a tax penalty. *King* v. *Burwell*, 135 S. Ct. 2480, 2486 (2015) (citing 26 U.S.C. 5000A). The ACA provides, however, that no tax penalty shall be imposed on an individual who for any month is determined by the Department of Health and Human Services (HHS) to have suffered a hardship with respect to the ability to obtain qualifying coverage. 26 U.S.C. 5000A(e)(5).

Other ACA provisions impose new requirements on health insurance issuers, including requiring fair premiums, 42 U.S.C. 300gg, guaranteeing the availability of coverage, 42 U.S.C. 300gg-1, guaranteeing the renewability of coverage, 42 U.S.C. 300gg-2, prohibiting exclusions based on preexisting conditions, 42 U.S.C. 300gg-3, prohibiting discrimination based on health status, 42 U.S.C. 300gg-4, and requiring coverage of essential health benefits, 42 U.S.C. 300gg-6.

Several of those insurance market reforms were scheduled to take effect for plan years beginning on or after January 1, 2014. 42 U.S.C. 300gg note. Before that date, some insurance issuers notified customers that they would be terminating plans that did not comply with the market reforms. C.A. App. 43. Many of the affected individuals and small businesses could obtain coverage through the health insurance Exchanges established under the ACA. *Ibid.* But even with the federal premium tax credits available to eligible individuals and the small business health care tax credits available to eligible small employers, some consumers found that new coverage would be more expensive than their prior coverage. *Ibid.* HHS was concerned that those consumers might be dissuaded from immediately transitioning to new coverage. *Ibid.*

Accordingly, HHS announced a transitional policy under which it would not enforce certain ACA market

reforms against health insurance issuers in the small-group and individual markets that continued to offer coverage that would otherwise have been cancelled because it did not comply with those market reforms, provided that the issuers met certain conditions. C.A. App. 43-45. HHS encouraged state insurance regulators to adopt the same transitional policy. *Id.* at 45.[1] The transition period was ultimately extended to cover policies renewed on or before October 1, 2017, provided that all covered policies end by December 31, 2017.[2] The transitional policy "applies solely to health insurance providers, which are given the option of temporarily providing non-ACA-compliant plans." Pet. App. 5. It "does not apply to individuals," who are still required to comply with the ACA's requirement to maintain health coverage or pay a tax penalty unless they qualify for an exemption. *Ibid.*

HHS also issued a bulletin reminding consumers of their options if their policies were cancelled, including the option to buy another policy on an Exchange and the potential availability of federal premium tax credits. C.A. App. 47. The bulletin advised consumers that, if their policies were cancelled and they found other policies unaffordable, they would be eligible for

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[1] The ACA's market reforms were enacted as amendments to the Public Health Service Act, 42 U.S.C. 201 *et seq.*, which gives States primary responsibility to regulate health insurance issuers. 42 U.S.C. 300gg-22(a)(1). HHS has enforcement authority if it determines that a State has failed to substantially enforce one or more of the relevant provisions against issuers in the State. 42 U.S.C. 300gg-22(a)(2).

[2] HHS, *Extended Transition to ACA-Compliant Policies* (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf.

a hardship exemption under 26 U.S.C. 5000A(e)(5). C.A. App. 47-48.

2. Petitioners are the American Freedom Law Center (AFLC), a nonprofit organization, and Robert Muise, AFLC's senior counsel. Pet. App. 5. Muise receives health coverage through the AFLC group health plan, which is insured by Blue Cross of Michigan (Blue Cross). *Ibid.* Blue Cross did not choose to offer any small group plans under the challenged transitional policy, but instead informed AFLC that it would "be transitioning [AFLC] into a reform-compliant plan." C.A. App. 60; see *id.* at 40-41. Petitioners allege that AFLC's plan complies with the ACA's market reforms. *Id.* at 35. And because Muise has health coverage, he does not owe a tax penalty under the individual-coverage provision. *Id.* at 34.

Petitioners filed this suit asserting that the transitional and hardship exemption policies exceed HHS's authority and violate principles of equal protection. Pet. App. 6-7. In an attempt to establish standing, petitioners asserted that Blue Cross increased AFLC's premiums as a result of the challenged HHS policies and would lower AFLC's premiums if those policies were enjoined. *Ibid.* To support that assertion, petitioners submitted a declaration from Muise stating that AFLC's premiums increased by 57% for the 2014 plan year. C.A. App. 36. Petitioners also submitted a June 2014 rate filing by Blue Cross that requested a 2.7% rate increase for 2015 small group plans and stated that "[s]ignificant drivers of the rate change include * * * [l]ower than anticipated improvement of the ACA compliant market level risk pool in 2014 and 2015 due to the market being allowed to extend pre-ACA non-grandfathered plans into

2016." *Id.* at 80. In March 2015, however, Blue Cross submitted a new rate filing stating that there would be a 3.3% *decrease* for policies issued between July 1, 2015, and December 31, 2015. Pet. App. 6. That filing identified the "significant drivers" of the decrease as "2014 trend results coming in much lower than anticipated" and "shifts in market risk assumptions after the allowance by the government for carriers to extend offerings of pre-reform plans." *Ibid.* (brackets and citation omitted).

3. The district court dismissed petitioners' suit for lack of standing. Pet. App. 18-37. The court concluded that petitioners had fallen "woefully short of meeting their burden" to demonstrate that their alleged injury was caused by the challenged policies or that it would be redressed by the relief they sought. *Id.* at 28. Among other things, the court noted that "health insurance premiums fluctuate for myriad reasons, ranging from the particular terms of coverage to various other actuarial factors." *Id.* at 33 n.2. The court further explained that petitioners' theory of standing rested on the actions of third parties not before the court, and that petitioners had not established any of the links of the causal chain linking their claimed injury to the challenged policies. *Id.* at 28-29.

4. The court of appeals affirmed. Pet. App. 1-15. The court noted that standing is "substantially more difficult to establish" where, as here, it "depends on the unfettered choices made by independent actors not before the courts." *Id.* at 8 (internal quotation marks omitted) (quoting *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 562 (1992)). And the court held that even assuming that petitioners had suffered a concrete injury in fact in the form of higher insurance

premiums, they had failed to show that the transitional policy caused that injury. *Id.* at 9.

The court of appeals noted that the "only evidence" petitioners offered to demonstrate causation was Blue Cross's 2014 rate filing, which included as a reason for its planned rate increase the fact that the overall risk pool for ACA-compliant plans was smaller than anticipated. The court rejected petitioners' reliance on that rate filing for two independent reasons. First, the court concluded that "it is unclear whether the rate increase discussed in Blue Cross's filing applied to [petitioners'] health care plan at all." Pet. App. 9. The court explained that the filing requested an *average* rate increase of 2.7%, but specified that rate changes would "vary slightly by product and plan," with rates for some plans not increasing at all. *Id.* at 9-10. The court explained that because petitioners had failed to identify which plan Blue Cross transitioned them to, the court was "left to guess" whether it was one of the plans for which Blue Cross requested a rate increase. *Id.* at 10.

Second, the court of appeals found that even though Blue Cross's 2014 filing appeared to show that the rates for some plans were increasing, its 2015 filing showed that the rates for the same plans *decreased*. Pet. App. 10. The court noted that petitioners sought to rely on "basic economic principles" to show a direct link between a supposed reduction in the ACA-compliant risk pools and the alleged increase in petitioners' premiums. *Ibid.* But the court explained that petitioners failed to substantiate the asserted connection and noted that Blue Cross's rate filings demonstrate the complexity of health insurance premiums. The court explained that, "as Blue Cross's

two rate filings reveal, the effect of various factors, including the size of risk pools, on health insurance pricing is far from 'basic.'" *Ibid.* The court added that petitioners had "made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the Transitional Policy." *Id.* at 10-11. The court concluded that this was a "major missing link" in petitioners' chain of causation. *Id.* at 11.

The court of appeals also held that petitioners lacked standing to assert their equal-protection challenges. Pet. App. 13-15. The court explained that Muise cannot demonstrate any injury attributable to the hardship exemption because he has qualifying insurance and therefore has no need for the exemption. *Id.* at 14. And the court held that petitioners' claim of standing to challenge the transitional policy was foreclosed by its decision rejecting a similar claim in *Cutler* v. *HHS*, 797 F.3d 1173 (2015), cert. denied, 136 S. Ct. 877 (2016).

5. The court of appeals denied rehearing en banc. Pet. App. 40-41. Judges Brown and Kavanaugh would have granted the petition. *Id.* at 41.

ARGUMENT

Petitioners renew their contention (Pet. 9-19) that they have Article III standing. The court of appeals correctly rejected that argument, and its decision does not conflict with any decision of this Court or of another court of appeals. To the contrary, the court applied long-settled principles of Article III standing to the particular facts of this case. No further review is warranted.

1. The court of appeals correctly held that petitioners lack Article III standing. To establish the "irreducible constitutional minimum of standing," petitioners had to show that their asserted injury is "fairly . . . traceable to the challenged action of the defendant, and not . . . the result of the independent action of some third party not before the court," and that it is "likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 560-561 (1992) (brackets and internal quotation marks omitted). And where, as here, "the plaintiff is not himself the object of the government action or inaction he challenges, standing * * * is ordinarily substantially more difficult to establish." *Id.* at 562 (citation and internal quotation marks omitted).

a. Petitioners have abandoned the principal argument on which they relied below—*i.e.*, that Blue Cross's 2014 rate filing shows that increases in their insurance premiums are traceable to the transitional policy. Instead, petitioners now assert (Pet. 14-17) that "basic laws of economics" establish their standing. Specifically, they contend (Pet. 15) that because insurance premiums are set based on risk pools and the ACA was intended to move healthy people into the risk pools to lower insurance premiums, "any regulation that has the effect of reducing th[e] risk pool will necessarily have an adverse effect on premiums."

Petitioners' theory rests on speculation as to how other individuals, employers, and insurance issuers might react if the transitional policy were enjoined. To show that enjoining the transitional policy would decrease AFLC's premiums, petitioners would need to establish (1) that some small employers in Michigan

are currently enrolled in plans that were extended pursuant to the transitional policy; (2) that if the transitional policy were enjoined, those small employers would switch to comprehensive plans offered by Blue Cross, rather than purchasing comprehensive plans from their current health insurance issuers or from one of the many other health insurance issuers in Michigan; (3) that the addition of those employers' employees to Blue Cross's small group risk pool would make the pool less risky; and, (4) that Blue Cross would, as a result, lower AFLC's premiums.

As the district court explained, petitioners have not provided factual allegations or evidence to substantiate "*any* of the links in th[is] causal chain." Pet. App. 28. The court of appeals likewise noted that petitioners have a "major missing link" in their chain of causation because they "have made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the Transitional Policy." *Id.* at 11.

Blue Cross's rate filings further undermine petitioners' attempt to invoke "basic laws of economics" to make up for their lack of specific factual allegations or evidence. As the court of appeals explained, those filings show that "the effect of various factors, including the size of risk pools, on health insurance pricing is far from 'basic.'" Pet. App. 10. Indeed, Blue Cross's 2015 rate filing directly contradicts petitioners' theory: That filing states that "shifts in market risk assumptions" due to the transitional policy led to a *decrease* in Blue Cross's rates. *Id.* at 6 (brackets omitted).

b. The court of appeals also correctly held that petitioners do not have standing to assert their equal protection claims. Pet. App. 13-15. Muise appears to claim that he was denied equal treatment with respect to the hardship exemption, but he cannot demonstrate any injury attributable to that exemption because he has insurance "and thus is not subject to the penalty in the first place (such that the exemption would be of no benefit to him)." *Id.* at 14.[3]

The court of appeals was likewise correct to reject petitioners' claim that they have standing to assert an equal-protection challenge to the transitional policy because that policy allowed other employers and individuals to maintain non-ACA compliant coverage. As the court explained in rejecting the same claim in *Cutler* v. *HHS*, 797 F.3d 1173, 1183-1184 (2015), cert. denied, 136 S. Ct. 877 (2016), petitioners' alleged injury is not fairly traceable to the transitional policy and would not be redressed by invalidating that policy. "The transitional policy applies evenhandedly across the United States, so if [petitioners] cannot obtain the insurance [they] desire[] and others can, that is because [Blue Cross] cancelled [their] policy"—not because of any action by the government. Pet. App. 14-15 (quoting *Cutler*, 797 F.3d at 1183-1184).

2. Petitioners err in asserting (Pet. 11, 15-17) that the court of appeals' decision conflicts with this Court's decisions in *General Motors Corp.* v. *Tracy*,

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[3] Petitioners assert (Pet. 18-19) that Muise has standing because he is subject to the individual-coverage provision, which requires him to maintain health coverage or pay a tax penalty. But petitioners have not challenged the individual-coverage provision or suggested that Muise wishes to avail himself of an exemption so that he could forgo health coverage without paying a tax penalty.

519 U.S. 278 (1997), and *Clinton* v. *City of New York*, 524 U.S. 417 (1998). In *General Motors*, the Court held that a purchaser of natural gas had standing to challenge a state tax imposed on sales by out-of-state suppliers because the purchaser was "liable for payment of the tax." 519 U.S. at 286. In *Clinton*, the Court held that the recipients of a targeted tax benefit had standing to challenge the cancellation of that benefit because they had "concrete plans to utilize" the benefit and were "engaged in ongoing negotiations" for a transaction that would utilize it. 524 U.S. at 432. Both cases thus involved causal chains far less speculative than the one petitioners assert here.

3. Petitioners do not contend that the decision below conflicts with any decision by another court of appeals. Instead, they assert (Pet. 11, 14-17) that the court of appeals' decision in this case conflicts with its own prior decisions. Even if petitioners were correct, such an intra-circuit conflict would not warrant this Court's review. See *Wisniewski* v. *United States*, 353 U.S. 901, 902 (1957) (per curiam).

In any event, no intra-circuit conflict exists. The two decisions on which petitioners rely addressed questions of "competitor standing" and held that plaintiffs had standing to challenge policies that "intensified the competition for a share in a fixed amount of money," *Sherley* v. *Sebelius*, 610 F.3d 69, 74 (D.C. Cir. 2010), or that allowed "unfair competition" by the plaintiffs' direct competitors, *International Ladies' Garment Workers' Union* v. *Donovan*, 722 F.2d 795, 810 (D.C. Cir. 1983) (*ILGW*). This is not a competitor-standing case, and the chain of causation on which petitioners rely is far more speculative than those found sufficient in *Sherley* and *ILGW*. See *United*

Transp. Union v. *ICC*, 891 F.2d 908, 912 n.7 (D.C. Cir. 1989) (characterizing *ILGW* as a "competitor standing" case and observing that it does not require a court to credit "allegations founded solely on [a] complainant's speculation"), cert. denied, 497 U.S. 1024 (1990).

Furthermore, even if the facts at issue here were otherwise comparable to those in *Sherley* and *ILGW*, this case would still be distinguishable because the purported basic economic principles on which petitioners rely are contradicted by evidence—specifically, by Blue Cross's 2015 rate filing, which directly contradicts petitioners' theory about the effect of the transitional policy on their insurance premiums. Pet. App. 6, 10-11.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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