No. 19-840

In the
Supreme Court of the United States

STATE OF CALIFORNIA, ET AL.,
Petitioners,

v.

STATE OF TEXAS, ET AL.,
Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

The Catholic Health Association of the United States (CHA) is the national leadership organization for the Catholic health ministry in the United States. Consisting of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. One in seven hospital patients in the United States receives care in a Catholic hospital, and those hospitals serve a high percentage of poor, low income, and underinsured Americans. *See* Catholic Health Ass'n, *Catholic Health Care in the United States Fact Sheet*, (Jan. 2015), https://tinyurl.com/chausa2015.

Amicus' mission is informed and motivated by the Catholic Church's teachings on the dignity of the human person and the sanctity of human life. These values are the foundation of its commitment to the moral dimensions of health care. They direct the Catholic health ministry to care for the sick and dying and to insist on accessible and affordable health care for all. Catholic social teaching recognizes a right to access to health care. This right is based on the inherent dignity of each individual, created in the image and likeness of God. Each person has the right to live and to the "means necessary for the proper development of life," including medical care. Pope

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[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than amicus and its counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for all parties have consented to the filing of this brief.

John XXIII, *Pacem in Terris*, no. 11 (Apr. 11, 1963). In Catholic social thought, rights are accompanied by responsibilities. It is the responsibility of the members of society to work together to establish a system that gives all of its members access to a reasonable standard of health care.

Amicus is motivated by the Church's call for preferential options for the poor. A just society must prioritize meeting the needs of its most vulnerable members, such as those with physical, mental, spiritual and economic challenges. *Catechism of the Catholic Church*, ¶¶ 1033, 2044, 2048 (6th ed. 1994), https://tinyurl.com/catech1994. Indeed, the Catholic health ministry seeks to distinguish itself by serving and advocating "for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees." U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, at 11 (5th ed. 2009), https://tinyurl.com/usccbdirect. As a consequence, Catholic hospitals are more likely to provide public health and specialty services, mental health, substance abuse, and trauma services, despite the often negative financial implications. Catholic Health Ass'n, *Advocacy Agenda: 2019–2020 (116th Congress)*, https://tinyurl.com/chaassoc (last visited on May 12, 2020). This reflects *amicus*' view that health care knowledge and skill is, for the most part, not proprietary; it belongs to society, and its citizens

entrust it to medical professionals to be used for the common good. *See* Pope Benedict XVI, *Caritas in Veritae* (2009), https://tinyurl.com/carinve.

In advancing its mission, the Catholic health ministry has witnessed firsthand the devastating impact of the lack of affordable health insurance and health care on vulnerable members of our society. CHA therefore advocated for the passage of the Patient Protection and Affordable Care Act (ACA), which expands health care coverage to those without it in all 50 states and decreases the cost to society of providing health care. CHA filed an *amicus curiae* brief in a prior challenge to the ACA in this Court, and signed an *amicus curiae* brief in this case when the Court was considering the petition for *certiorari*. While continuing to support the positions advanced by the National Hospital Associations in this case, CHA files this brief because it is uniquely positioned to explain how its Catholic identity and the Catholic teachings that motivate its work inform its positions.

SUMMARY OF ARGUMENT

In the decade since its enactment, the ACA has made strides toward addressing the two problems it sought to mitigate—that millions of Americans lacked sufficient health coverage or any way to pay for it, and hospitals that provided emergency and other medical care to the uninsured or underinsured incurred billions of dollars in uncompensated care costs. Through its expansion of Medicaid, guaranteed issue requirements (relating largely to pre-existing conditions), and subsidies to purchase insurance, the ACA has enabled more than 20 million Americans to obtain affordable health care.

Another of the original provisions of the ACA is known as the "individual mandate," which gave Americans the choice between obtaining a minimum level of health insurance or paying an alternative tax penalty. Congress in 2017, however, amended the law to set the alternative tax penalty at zero, leaving the rest of the ACA intact. The Fifth Circuit found that this targeted, minimal amendment violated the Constitution by leaving the language of a mandate in place while removing any practical mechanism to enforce it.

This decision is wrong. Congress acted within its authority in amending the amount due under Section 5000A(c) while leaving in place the overall statutory mechanism of an alternative tax penalty. But even if the zeroed out alternative tax renders Section 5000A(c) an invalid exercise of Congress's taxing powers because a zero tax is no tax at all, then the mandate in Section 5000A(a) is similarly no mandate at all. Without any compulsion to purchase health insurance, the ACA as amended is a valid exercise of Congress's Commerce Clause powers. The lower court's contrary ruling runs afoul of the well-established canon that, if fairly possible, federal courts have a duty to construe a statute to save it.

Even if the Court finds the amended Section 5000A unconstitutional, it must find it severable from the rest of the ACA. Discerning Congress's intent by examining what it actually did, it is clear Congress intended only to alter one section of an exceptionally complicated law. Contemporaneous legislative statements by the amendment's supporters reflect the intent that Congress was effectively rendering the

minimum coverage provision unenforceable while preserving every other provision of the ACA. The Court must apply the presumption in favor of severability and uphold the rest of the law.

Striking down the whole of the ACA, the alternative to a severability ruling if Section 5000A is unconstitutional, would cause devastating, irreparable harm to millions of vulnerable Americans and the health care providers who serve them. The pain of repeal will be borne by some of the most vulnerable in our society—those with pre-existing medical conditions, pregnant women, racial minorities, and the poor. Without available, affordable, meaningful insurance options, vulnerable individuals and families will not be able to purchase coverage and will seek the only care available to them—more often than not, this is expensive emergency care. Absent insurance, the costs of this care go uncompensated. These costs fall most heavily on "safety net" hospitals—many of which are associated with CHA and its member hospitals and care centers—that prioritize caring for this population. Striking down the ACA will thus jeopardize Catholic health care's ability to carry out this mission.

ARGUMENT

I. Section 5000A Remains Constitutional Although the Alternative Tax is Set to Zero.

The Court has already ruled that Section 5000A as originally enacted, rather than imposing a command to purchase health insurance, instead presents

individuals with a lawful choice between buying health insurance and being subject to an alternative tax. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 & n.11 (2012) (*NFIB*). Congress' 2017 amendment to subsection (c) of Section 5000A merely reset the amount of the alternative tax to zero. It did nothing to change any other parts of Section 5000A—specifically, subsections (a) and (b), which set this lawful choice between obtaining minimum health insurance or being subject to an alternative tax. Indeed, had Congress also eliminated Section 5000A(b), which establishes the "shared responsibility payment" alternative to obtaining health insurance, then only a mandate to purchase health insurance would have remained. But Congress was well aware of *NFIB*'s ruling that such a construction would exceed its authority, and it left intact the shared responsibility payment requirement.

On the face of the statute, then, Congress did not exceed its authority in amending the amount due under Section 5000A(c). The lower court's contrary rulings also run afoul of the well-established canon that federal courts "have a duty to construe a statute to save it, if fairly possible." *Id.* at 574 (Roberts, C.J.).

1. Section 5000A has three pertinent subsections that work together to effectuate the "individual mandate" of the ACA: subsection (a) provides that "an applicable individual shall" obtain a minimum level of health insurance; subsection (b) provides that, in the alternative, individuals have the choice to pay a tax to the IRS rather than obtain health insurance; and subsection (c) sets the amount of the alternative tax payment.

The Court in 2012 upheld the constitutionality of the whole of Section 5000A. In *NFIB*, although five justices interpreted subsection (a), in isolation, to be an unconstitutional command to purchase health insurance, *id.* at 547-61, a different majority held that Section 5000A, as a whole, provided a lawful choice between obtaining health insurance and paying an alternative tax, *id.* at 568. In so doing, the Court was "choosing between competing plausible interpretations of a statutory text, resting on the reasonable presumption that Congress did not intend the alternative which raises serious constitutional doubts." *Clark v. Martinez*, 543 U.S. 371, 381 (2005). The Court's interpretation that, as a whole, Section 5000A provides a lawful choice and not an unlawful command was therefore a "means of giving effect to congressional intent, not of subverting it." *Id.* at 382.

2. In 2017, Congress made a focused change to the ACA. As part of the Tax Cuts and Jobs Act (TCJA), Congress reduced to zero the amount of the alternative tax imposed by Section 5000A(c), effective January 1, 2019. Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). That amendment, however, did not modify the fundamental structure enacted by the ACA, nor did it substantively change any of its hundreds of other provisions. Indeed, the TCJA did nothing to change any other parts of Section 5000A—specifically, subsections (a) and (b), which set this lawful choice between obtaining minimum health insurance or being subject to an alternative tax. Presently, individuals retain the choice whether to purchase or forego health insurance. If they choose to forego it, presently, the alternative tax they would owe under Section 5000A(b) is set to zero dollars,

rendering any supposed mandate to purchase insurance toothless. In retaining the statutory structure and only modifying the amount of penalty (albeit to a level where it has no practical effect today), it is difficult to imagine that Congress intended to change the overall meaning of the ACA. Indeed, nothing about the TCJA purports to or could prohibit a future Congress from further amending the statute to increase the tax.

3. Federal courts "have a duty to construe a statute to save it, if fairly possible." *NFIB*, 567 U.S. at 574 (Roberts, C.J.). "This canon is followed out of respect for Congress, which we assume legislates in the light of constitutional limitations." *Rust v. Sullivan*, 500 U.S. 173, 191 (1991). As noted above, the Court previously invoked this canon in *NFIB* when it construed Section 5000A as a whole as offering a lawful choice between purchasing health insurance and paying a tax, *see* 567 U.S. at 574 & n.11, even though Section 5000A(a) by itself might "more naturally" be read "as a command to buy insurance," *id.* at 574 (Roberts, C.J.).

The case for doing so here is even clearer. Indeed, there is no reason for the Court to presume anything other than that in 2017, Congress was well aware of the Court's decision in *NFIB* only 5 years earlier. The TCJA did nothing to upend the relationship between subsections (a)-(c) of Section 5000A, or the overall structure of Section 5000A; instead, it functionally suspended the payments for individuals who choose not to purchase health insurance, while leaving the structure in place such that a later Congress could reinstate them. As Judge King below observed, there

is nothing unconstitutional about a law that functionally requires an individual to do nothing. *Texas v. United States*, 945 F.3d 355, 405 (5th Cir. 2019) (King, J., dissenting).

Finally, to the extent that it might be thought that a zero tax is not really a tax at all, it would follow that Section 5000A is not a mandate at all either. To this end, the Senate Majority Leader's statement that the TCJA would "repeal [the ACA's] *individual mandate tax* so that low- and middle-income families are not forced to purchase something they either don't want or can't afford," 163 Cong. Rec. S8153 (daily ed. Dec. 20, 2017) (emphasis added), lends support to the interpretation that Congress only intended to do away with the one potentially constitutionally problematic section of the ACA, and otherwise leave the statute untouched.

Accordingly, concluding here that the amended ACA is not a valid exercise of Congress's Tax Clause authority would now mean that the ACA, as amended, is a valid exercise of Congress's Commerce Clause authority. That is because there is no doubt that Congress may provide health insurance subsidies and adopt the other provisions of the ACA pursuant to the Commerce Clause. The defect the Court identified in *NFIB* was that Congress *mandated* that individuals take the affirmative act of purchasing insurance. 567 U.S. at 549 (Roberts, C.J.) (finding Section 5000A violates the Commerce Clause by "compel[ling] individuals not engaged in commerce to purchase an unwanted product"). It necessarily follows that, if a tax of zero is not a tax because people can safely ignore

it, then for the same reason it is not an unconstitutional mandate.

II. If Unconstitutional, the Amended Section 5000A is Severable from the Rest of the ACA.

1. Congress enacted the ACA in 2010 "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 519. Congress was reacting to two related problems— millions of Americans lacked sufficient health coverage or any way to pay for it, and hospitals that provided emergency and other medical care to the uninsured or underinsured incurred billions of dollars in uncompensated care costs. Prior to the ACA, the Department of Health and Human Services calculated that uninsured Americans accounted for nearly one-fifth of the total trips to hospital emergency rooms, which in 2006 equated to more than 20 million visits. Press Release, U.S. Dep't of Health & Human Servs., *New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits* (July 15, 2009). In 2008, those visits led to the provision of $86 billion in health care services. Jack Hadley et al., Kaiser Family Found., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, & Incremental Costs,* at 66 (Aug. 2008), https://tinyurl.com/uninsured2008. Although some uninsured patients were able to pay for a portion of the care they received, much of the costs were passed along to hospitals—in particular, hospitals, like many in the Catholic health ministry, that serve a substantial share of vulnerable patients. Inst. of Med., *America's Health Care Safety Net: Intact*

but Endangered (The National Press, 2000). Congress designed the ACA to address these related issues.

The ACA is a complex law with hundreds of provisions. This "series of interlocking reforms [was] designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). Over time, however, the understanding of the relative importance of its various provisions has changed with experience. At enactment, the ACA was thought to have three primary components that were to work in concert to achieve its goals. First, the ACA prohibits insurance companies from denying coverage or charging higher premiums based on a person's medical condition or history. 42 U.S.C. §§ 300gg–300gg-4. Second, the ACA provides subsidies through premium tax credits and cost-sharing reduction payments, making coverage and the use of that coverage affordable. *See* 26 U.S.C. § 36B; 42 U.S.C. §§ 18071, 18081–18082; *see also King*, 135 S. Ct. at 2487. And third, the ACA's "individual mandate" poses a choice for individuals who are not covered by an employer's insurance policy to purchase minimum coverage or pay an alternative tax. 26 U.S.C. § 5000A.

In addition to these three components, the ACA did much more. Among other things, it created exchanges on which qualified individuals can purchase health insurance, *see* 42 U.S.C. §§ 18021(a)(1)(B), 18031–18044; it expanded the Medicaid program in participating States, *id.* § 1396a(a)(10)(A)(i)(VIII); and mandated that employers with 50 or more full-time employees provide health insurance to their employees, *see* 26 U.S.C. § 4980H. It further called for important public health initiatives, such as one for the

early detection of cancer. *See* Lindsay Sabik et al., *The ACA and Cancer Screening and Diagnosis*, 23 The Cancer Journal 151 (2017), https://tinyurl.com/tacsd. And it requires every tax exempt hospital in the country to work with public health and groups representing vulnerable persons to assess community health needs, plan how to address the most significant community health needs, and report on progress. 26 U.S.C. § 501(r)(3).

The overall statutory scheme has been a ringing success and has enabled millions more Americans to obtain health insurance. As of early 2017, there were 28.1 million uninsured in the United States, "20.5 million fewer . . . than in 2010." Robin A. Cohen et al., Nat'l Ctr. for Health Statistics, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2017,* at 1 (Aug. 2017), https://tinyurl.com/nchsestim.

Perhaps surprisingly to the Congress that initially enacted the ACA, the individual mandate bears less responsibility for this overall success than other provisions that operate independently from Section 5000A. According to one study, subsidies accounted for 41% of 2014's coverage gains that could be attributed to the ACA's major provisions, while the individual mandate's effects were negligible. *See* Molly Frean et al., *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. Health Econ. 72, 80–81 (2017). The rest of these gains came from the Medicaid program, with 29% of the total attributable to enrollment due to increased awareness by those already eligible, but not yet enrolled—such as

children—and the other 30% attributable to the ACA's Medicaid expansion. *See id.* "The relative magnitudes of the changes for each policy were quite similar in 2015." *Id.* at 81; *see also* Ctr. on Budget and Policy Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), https://tinyurl.com/chartaca.

In passing the 2017 amendment to the ACA, Congress was thus aware of the ACA's successes, as well as the relative lack of importance of the alternative penalty to obtaining them. As discussed above, the amendment changed only the amount of the alternative penalty codified in Section 5000A(c), and did not change the structure of the overall law. Indeed, legislative statements at the time made clear that what Congress was doing was effectively rendering the minimum coverage provision unenforceable while preserving every other provision of the ACA. For instance, supporters of the amendment emphasized that the TCJA would not "change any of the subsidies," 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017) (statement of Sen. Toomey); that it would "take nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage," 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017) (statement of Sen. Scott); that "[n]o one" would be "forced off of Medicaid or a private health insurance plan," 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) (statement of Sen. Capito); and that it would do "nothing to alter Title [I]" of the ACA, "which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits," Senate Finance Comm. Open Exec. Session to Consider an Original Bill

Entitled the "Tax Cuts and Jobs Act" (Nov. 15, 2017), at 286 (statement of Chairman Hatch).

2. Courts must "refrain from invalidating more of [a] statute than is necessary." *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion); *see also id.* at 653 ("[T]he presumption is in favor of severability."). If a court holds a statutory provision unconstitutional, it must ask whether "the legislature [would] have preferred what is left of its statute to no statute at all." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006); *see Denver Area Ed. Telecomms. Consortium, Inc. v. FCC,* 518 U.S. 727, 767 (1996) (plurality opinion) ("Would Congress still have passed § 10(a) had it known that the remaining provisions were invalid?" (internal quotation marks and brackets omitted)). It must also consider "whether the statute will function in a *manner* consistent with the intent of Congress." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987). The remainder of the statute is *presumptively* severable unless the resulting statutory "scheme [would] sharply differ[ ] from what Congress contemplated." *Murphy* v. *NCAA*, 138 S. Ct. 1461, 1482 (2018). Here, Congress in 2017 plainly expressed its preference for an ACA without an enforceable minimum coverage provision over no ACA at all.

The best way to "determine[ ] what Congress would have done" is "by examining what it did." *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 560 (2001) (Scalia, J., dissenting). This case is straightforward. The TCJA reduced to zero the amount of the alternative tax imposed by Section 5000A. As Judge King observed in dissent below, the amendment

"declawed the coverage requirement without repealing any other part of the ACA." *Texas*, 945 F.3d at 416 (King, J., dissenting). Congress' intent, as demonstrated by the minimal change in the statute and contemporaneous statements of its supporters, was that the balance of the ACA "should survive in the absence" of an enforceable minimum coverage provision. *Alaska Airlines,* 480 U.S. at 687.

III. Judicial Repeal of the ACA would Wreak Devastating Consequences on the Patients and Communities *Amicus'* Members Serve.

Eliminating the ACA would wreak devastating and disproportionate harm to society's marginalized populations, particularly low-income families, as well as to the health care providers who serve them. *Amicus* and its members prioritize caring for this population, a mission grounded in Catholic Social teaching, which recognizes both a right to health care to protect life and uphold human dignity and a particular responsibility to give priority to the poor and vulnerable in society. *Catechism of the Catholic Church,* ¶¶ 1033, 2044, 2048 (6th ed. 1994), https://tinyurl.com/catech1994. Indeed, the Catholic health ministry seeks to distinguish itself by serving and advocating for those people whose social conditions put them at the margins of our society and make them particularly vulnerable. Striking down the ACA will have a devastating impact on those who receive health care coverage as a result of the ACA's expansion of Medicaid and health exchange tax subsidies. It will also disproportionately impact the vulnerable, such as those who are elderly, pregnant or have pre-existing health conditions.

1. Since the ACA's passage, more than 20 million people, who otherwise would not, have been able to obtain insurance. Ctr. on Budget and Policy Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), https://tinyurl.com/chartaca). Most of these newly insured individuals come from "working families," and "[a]bout 63 percent [of the uninsured in 2011] were in households with incomes under $50,000." Charles R. Babcock, *Uninsured Americans Get Hit With Biggest Hospital Bills*, Bloomberg, Mar. 11, 2013. The majority of this expansion is due primarily to the ACA's Medicaid expansion to low-income adults, as well as ACA policies making it easier for eligible people to enroll. Ctr. on Budget and Policy Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), https://tinyurl.com/chartaca. By one count, Medicaid enrollment increased by 14.7 million between 2013 and April 2019, which represents a "26.1% increase over the baseline." Medicaid and CHIP Payment and Access Comm'n, *Medicaid Enrollment Changes Following the ACA*, https://tinyurl.com/macpacaca (last visited May 11, 2020). Of that increase, almost 12.5 million are individuals who would not have been eligible absent the ACA's Medicaid expansion. Kaiser Family Found., *Medicaid Expansion Enrollment* (FY 2018), https://tinyurl.com/expansion18 (*see* Total: Expansion Group – Newly Eligible Enrollment). The individual mandate is indeed not the primary driver of the gains. Ctr. on Budget and Policy Priorities, *Chart Book: Accomplishments of Affordable Care Act* (Mar. 19, 2019), https://tinyurl.com/chartaca (noting approximately half the gains are attributable to a *combination* of "ACA policies such as subsidies for individual market coverage, reforms to the individual

insurance market, letting young adults stay on their parents' plans, and the individual mandate requiring most people to have coverage or pay a penalty").

The pain of total repeal will be borne by some of the most vulnerable in our society, among them those with pre-existing conditions, pregnant women, racial minorities, and the poor. For instance, between 23 and 51 percent of non-elderly Americans are thought to have a pre-existing condition that could result in them being denied coverage (or only offered it at significantly higher rates than for others) as was the case before the ACA. Issue Brief, U.S. Dep't of Health & Human Servs., *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017), https://tinyurl.com/dohhsaspe. Further, prior to the ACA, "gender rating" for coverage meant women paid an estimated $1 billion more per year than men for health coverage. Samantha Kahn, Wharton Pub. Policy Initiative, *The End of Gender Rating: Women's Insurance Under the ACA* (Aug. 2015), https://tinyurl.com/genderrating. And repeal of ACA would jeopardize the progress made on lowering maternal mortality. Adam Searing & Donna Cohen Ross, Georgetown Univ. Health Policy Inst., *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* (May 2019), https://tinyurl.com/maternalaca. In addition, since the passage of the ACA, insurance coverage has increased significantly for all racial/ethnic groups. Because coverage increased more for non-Hispanic blacks and Hispanics than for non-Hispanic whites, previous disparities in coverage have decreased. Thomas C. Buchmueller & Helen G. Levy, *The ACA's*

Impact On Racial And Ethnic Disparities In Health Insurance Coverage And Access To Care, 39 Health Affairs 395, 401 (2020). And as noted above, millions of Americans have been able to utilize newfound access to non-emergency healthcare thanks to the ACA's Medicaid expansions.

Without available, affordable, meaningful insurance options, vulnerable and lower income individuals and families will not be able to purchase coverage and will seek the only care available to them—more often than not, this is expensive emergency care. In addition to being extremely costly, exclusively using emergency rooms is not an effective substitute for regular treatment: "[d]elaying or forgoing needed care can lead to serious health problems, making the uninsured more likely to be hospitalized for avoidable conditions." The Kaiser Comm'n on Medicaid & the Uninsured, *The Uninsured & the Difference Health Insurance Makes*, at 2 (Sept. 2010), https://tinyurl.com/kffcommn. A recent study shows that that, among those who have obtained insurance due to ACA reforms, there are "[l]arge increases in the share of low-income adults getting regular check-ups and other preventive care, and large decreases in the share without a personal physician or usual source of care." Matt Broaddus & Aviva Aron-Dine, Ctr. On Budget and Policy Priorities, *Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds* (Nov. 2019), https://tinyurl.com/cbppmedicaid (citing Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA 1501 (2016)). Regular check-ups and preventive care are

crucial in controlling costs—they decrease the number of emergency room visits, help patients avoid delayed detection and treatment of disease, as it is often more costly to treat a later-stage disease, and help limit the effect of compounding health problems, such as diabetes, which results in longer and more costly treatment.

Given its experience serving these communities, the Catholic health ministry has observed how low-income populations face extremely difficult choices when it comes to the allocation of their limited resources. Repealing the ACA will only harm patients, hospitals, and the overstressed health care system. *See* Sarah M. Miller, Robert Wood Johnson Found., *The ACA Helps Correct Incentives for Patients to Use the Health Care System Inefficiently* (Aug. 2013), https://tinyurl.com/acarwjf2013.

2. Losing insurance coverage imposes costs more broadly than just on the millions who will now, again, need to find a way to pay for health care. Press Release, U.S. Dep't of Health & Human Servs., *New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits* (July 15, 2009) (noting that the uninsured made more than 20 million trips to hospital emergency rooms in 2006). The cost of care for the uninsured gets passed on to hospitals, insurance companies, employers, and other individuals.

After years of increases before the ACA, the uncompensated care rate began to fall after its reforms went into effect. *See* Am. Hosp. Ass'n, *Fact Sheet: Uncompensated Hospital Care Cost* (Jan. 2020), https://tinyurl.com/rcwcrxw. Even so, in 2018,

hospitals provided $41.3 billion in uncompensated care. And a recent study estimated that, if the ACA were repealed, "providers' share of uncompensated care would increase 109.2 percent" over a five-year period, even assuming that "governments would be willing to fund uncompensated care at pre-ACA levels." Matthew Buettgens et al., Urban Inst., *The Cost of ACA Repeal*, at 8 (June 2016), https://tinyurl.com/costrepeal.

These costs fall most heavily on "safety net" hospitals—many of which are associated with the Catholic health ministry[2]—that serve a significant share of uninsured, Medicaid, and other vulnerable patients. Inst. of Med., *America's Health Care Safety Net: Intact But Endangered* (The National Press, 2000). For instance, one study showed that for these safety net hospitals, uncompensated care costs can amount to more than 20% of total operating costs. Changes in Health Care Financing & Org., *Challenges Facing the Health Care Safety Net* (Feb. 2008), https://tinyurl.com/hcfochallenges. In 2016 alone, even with the ACA in effect, Catholic hospitals provided over $10 billion in uncompensated care. This number would only increase with repeal and come at the cost of important investments in their ability to better serve vulnerable populations. For instance, a recent study of safety net institutions in states that expanded Medicaid following the ACA shows that they have used the subsequent "increase in reimbursement to hire new clinical staff, open new health centers and clinics, buy new equipment, and

[2] Indeed, Catholic hospitals are more dependent on public payers (Medicare and Medicaid) than other hospitals.

improve existing facilities." Adam Searing & Jack Hoadley, Georgetown Univ. Health Policy Inst., *Beyond the Reduction in Uncompensated Care: Medicaid Expansion is Having a Positive Impact on Safety Net Hospitals and Clinics*, at 4 (June 2016), https://tinyurl.com/hlthpolicy.

The increased costs associated with treating uninsured or underinsured individuals prevents hospitals from more completely fulfilling their missions. The effects of these costs are most strongly felt in facilities, such as Catholic hospitals, that strive as part of their mission to serve especially vulnerable populations. Simply put, the more resources Catholic safety net hospitals must devote to providing emergency and other medically necessary care to uninsured people, the fewer resources they have to address the many other significant and unmet needs of their communities, such as assisting with housing insecurity, Mike Butler, *Homelessness: Our $15 Million Investment in Affordable Housing for the Poor and Vulnerable*, Providence Blog, https://tinyurl.com/providblog, and ensuring adequate nutrition, Catholic Health Ass'n, *Ministry Examples*, https://tinyurl.com/ministry-examples (last visited May 11, 2020).

Indeed, one of the many reasons CHA supported passage of the ACA was that the law promised to add more people to the insurance rolls, which should have the effect of offsetting decreases in reimbursement. *See* Sr. Carol Keehan, President and CEO, CHA, Remarks at Cleveland City Club, *Next Steps for the Affordable Care Act* (Aug. 17, 2012), https://tinyurl.com/charemarks (noting that, in

supporting the ACA, hospitals accepted $155 billion in Medicaid reimbursement cuts as part of a legislative compromise under which the ACA also provided coverage to tens of millions of newly insured persons). This reform, in turn, freed up resources for hospitals to perform more health care services for low income and otherwise vulnerable populations and the communities the CHA's member institutions serve. These concerns are particularly sensitive now, with the COVID-19 pandemic showing the importance of keeping our health care system, especially hospitals that serve the poor and vulnerable, financially healthy and able to provide critical health care services in times of crisis. Repealing the ACA jeopardizes all of this.

In short, a decision from this Court striking down the whole of the ACA would wreak havoc on the U.S. health care system and irreparably harm hospitals and vulnerable Americans. Congress could not have intended this result when it amended only a single piece of the ACA.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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