No. 19-10011

IN THE

United States Court of Appeals for the Fifth Circuit

STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

and

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

Intervenor Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Texas,
No. 4:18-CV-167
Hon. Reed Charles O'Connor

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AMERICA'S ESSENTIAL HOSPITALS, AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF INTERVENOR DEFENDANTS-APPELLANTS

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SUPPLEMENTAL STATEMENT OF INTERESTED PARTIES

Pursuant to Fifth Circuit Rule 29.2, the undersigned counsel of record certifies that the following listed persons and entities, in addition to those already listed in the parties' briefs, have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

1. *Amici curiae on this brief*:

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   Federation of American Hospitals

   The Catholic Health Association of the United States

   America's Essential Hospitals

   Association of American Medical Colleges

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/s/ Sean Marotta
Sean Marotta

April 1, 2019

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INTEREST OF AMICI CURIAE

The American Hospital Association, Federation of American Hospitals, The Catholic Health Association of the United States, America's Essential Hospitals, and the Association of American Medical Colleges respectfully submit this brief as amici curiae.[1]

The American Hospital Association represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 health care leaders who belong to its professional membership groups. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. The Federation's members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Dedicated to

[1] All parties have consented to the filing of this brief. We certify that this brief was not authored in whole or part by counsel for any of the parties; no party or party's counsel contributed money for the brief; and no one other than amici and their counsel have contributed money for this brief.

a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised 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. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life and advocates for a health care system that is available and accessible to everyone, paying special attention to the poor and vulnerable.

America's Essential Hospitals is the national association representing more than 325 hospitals and health systems that provide a disproportionate share of the nation's uncompensated care and are dedicated to providing high-quality care for all, including underserved and low-income populations. Filling a safety net role in their communities, its member hospitals offer a full range of services to meet community needs, including specialized services that would otherwise be unavailable (for example, trauma centers, emergency psychiatric facilities, and burn care), public health services, mental health services, substance abuse services, specialty care services, and wraparound services such as transportation and

translation to ensure that patients can access the care being offered. Many also provide training for physicians and other health care professionals.

The Association of American Medical Colleges is a not-for-profit association representing all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Amici's members are deeply affected by the Nation's health care laws, particularly the Affordable Care Act ("ACA"). *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. That is why they have filed amicus briefs in support of the law in the Supreme Court, the courts of appeals, and courts across the Nation. Amici write to offer guidance, from hospitals' perspectives, on the legal issue in this case and the harmful impact that upholding the District Court's decision striking down the law would have on the American health care system and all who depend on it to keep them well and to care for them when they are ill.

SUMMARY OF ARGUMENT

In the years since its enactment in 2010, the ACA has made substantial progress toward its goal of improving Americans' access to quality health care. More Americans have health insurance coverage because of the ACA's many reforms, such as the Medicaid expansion, the guaranteed-issue requirements, and the creation of state insurance exchanges. And the ACA's wide range of programs that encourage innovation in patient care have improved the quality of American health care.

Congress recognized this progress when it made a targeted change to the ACA's reforms in 2017. Armed with the knowledge that the ACA's health insurance coverage gains can be traced to multiple provisions of the law, and that the ACA's individual mandate had contributed less than originally expected, it decided that the mandate no longer needed to be enforced for the ACA's reforms to continue. And so Congress zeroed out the penalty associated with the mandate, kept the mandate in place, and left the rest of the ACA's many provisions undisturbed.

Despite this, the District Court declared the mandate invalid and inseverable from the rest of the ACA, on the premise that the Congress that merely amended the ACA to eliminate the mandate's penalty would prefer no ACA at all to an ACA without a mandate. That premise finds no support in law, logic, or experience. As

to the law, there is no evidence that the ACA cannot "function[] independently," *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987), of the penalty-free mandate. Instead, the evidence before Congress in 2017 showed that repealing the mandate *and* eliminating the penalty would have roughly the same effect on coverage as eliminating just the penalty. That suggests that the amending Congress would be, at most, indifferent as to whether the mandate remained in place, not that it viewed the penalty-free mandate as somehow essential to the rest of the ACA. As to the logic, Congress in 2017 considered several options for addressing the ACA, ranging from a complete repeal to the elimination of the mandate penalty. It chose the option that *least* disturbed the ACA's reforms. Congress's choice is therefore incompatible with a conclusion that this Congress would have preferred no ACA to one without the penalty-free mandate it left in place. And as to the experience, the available evidence shows that Congress was correct to conclude that the ACA can function without the individual mandate, which strongly suggests that it can also function without any residual effects of the now penalty-free mandate.

If left in place, the District Court's wholesale judicial repeal of the ACA will have disturbing consequences. It would drag this country back into the world before the ACA, removing millions from the insurance rolls. And without coverage, Americans suffer. Those without insurance coverage forgo basic

medical care, making tem more difficult to treat when they do seek care. This not only hurts patients; it has severe consequences for the hospitals that care for them. Hospitals will bear a greater uncompensated-care burden, which will force them to reallocate limited resources and compromise their ability to provide needed services.

The judicial repeal of the ACA will have long-term consequences as well. The ACA put in place numerous programs designed to finance and foster innovative programs to address our most pressing health care needs, such as the opioid crisis and providing more home health care to support the country's aging population. These programs should not be cut off before they realize their full potential. The harmful effects that removing these programs would have on communities further confirm that Congress could not have intended for the entire ACA to fall with the mandate.

This Court should reverse.

ARGUMENT

The District Court's ruling accomplished a judicial repeal of the Affordable Care Act. If upheld, it will unwind eight years of progress under the ACA's broad set of reforms. And if upheld, it will cause tens of millions of patients to lose their health insurance, returning them to the ranks of the long-term uninsured and putting their health at risk.

This repeal may serve Plaintiffs' idiosyncratic health-policy preferences. But for the rest of the country, which has benefitted from expanded health-insurance coverage, the birth of a stable individual-insurance market, an expanded Medicaid safety net, and many other protections, it would be disastrous. It would result in more Americans going without basic medical care and more Americans waiting to seek care until they are seriously ill, placing their health at greater risk and making it harder to treat their conditions successfully.

Nothing in law or logic supports the District Court's reasoning or requires this result. The individual mandate, as amended, is constitutional. *See* Intervenor-Defs.' Br. at 35–40. But even if this Court disagrees, it should still reverse the District Court's untenable conclusion that the current individual mandate "is essential to and inseverable from" the rest of the ACA. *See* ROA.2665 (internal quotation marks omitted).

Timing, as the saying goes, is everything. When Congress enacted the ACA in 2010, it wrote on a blank slate. It viewed the individual mandate and its accompanying penalty as an important component of its reforms to this Nation's health care system. But when Congress revisited the Act in 2017, it had the benefit of seven years of experience. In light of that experience, it knew that the individual mandate was less important than the rest of the package of reforms, and so it zeroed out the penalty associated with non-compliance. That is, it decided

that the individual mandate was not "essential" to the ACA's reforms and did not need to be enforced. Congress' choice to eliminate the penalty attached to the mandate but to go no further is as clear a sign of congressional intent as a court could hope for.

The District Court's order threatens to upend health care in America, harming patients and the hospitals and physicians they rely on. Nothing requires that result. This Court should not affirm a judicial repeal of the ACA that Plaintiffs sought only after they failed to secure a legislative one.

I. THE INDIVIDUAL MANDATE IS SEVERABLE FROM THE REST OF THE ACA.

If this Court holds that the individual mandate without a penalty is unconstitutional, it must then decide whether the provision can be excised from the rest of the ACA, "essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). The "normal rule" is "that partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985). The remainder "must" be sustained "unless it is evident that" it is "incapable of functioning independently" of the mandate or that, in light of the text and historical context, Congress "would have preferred no [Act] at all to" an ACA without the mandate. *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010) (internal alterations and quotation marks omitted).

The District Court's conclusion that Plaintiffs had cleared that high hurdle was wrong. The ACA can function independently of any hortatory effect of a penalty-free mandate. And there is no evidence that the 2017 Congress that removed the penalty would have preferred no ACA at all to an ACA without the penalty-free mandate. Indeed, Congress' repeated, unsuccessful attempts to enact a broader repeal are evidence that it did not prefer a broader—much less a full—repeal.

1. The ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). It worked. 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), *available at* https://tinyurl.com/nchsestimate. But it did not work exactly as planned.

When enacted, the ACA's major provisions related to the individual insurance market were often referred to as a three-legged stool. The guaranteed-issue and community-rating provisions formed the first leg, prohibiting insurers from discriminating on the basis of preexisting or other conditions, such as claims history and gender. *See* 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4; *see also National*

Fed'n of Indep. Bus. v. Sebelius ("NFIB"), 567 U.S. 519, 547–548 (2012). Subsidies through premium tax credits and cost-sharing reduction payments formed the second leg, 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 the individual mandate formed the third, expanding the risk pool to the healthy and the sick alike by requiring people to maintain coverage and penalizing those who did not. *See* 26 U.S.C. § 5000A; *see also NFIB*, 567 U.S. at 548.

Taken together, the idea was that these reforms would achieve "near universal" health insurance coverage. 42 U.S.C. § 18091(2)(D). The guaranteed-issue and community-ratings provisions would make sure that coverage was widely available. The subsidies would make sure that coverage was generally affordable and that patients would have access to the services they needed, including those offered by hospitals. And the mandate would make sure that everyone purchased insurance, expanding the risk pool and making the ACA's mandates financially viable for insurers.

2. But the ACA is more than the metaphorical stool. It created health-insurance exchanges to serve the individual and small-group health insurance markets, through which qualified people can purchase health-insurance plans that provide a basic set of essential benefits. *See* 42 U.S.C. §§ 18021(a)(1)(B), 18031–

18044. It expanded the Medicaid program, permitting adults in participating States with incomes of up to 133% of the federal poverty level to obtain coverage. *See id.* § 1396a(a)(10)(A)(i)(VIII); *see also NFIB*, 567 U.S. at 548, 586–588 (plurality op.) (severing requirement that States participate in Medicaid expansion). It mandated that employers with 50 or more full-time employees provide health insurance to their employees. *See* 26 U.S.C. § 4980H. And it contains hundreds of other provisions. To continue the analogy, then: The ACA has "several other 'legs' that are critical to supporting the ACA regime." Gillian E. Metzger, *Agencies, Polarization, and the States*, 115 Colum. L. Rev. 1739, 1773 (2015).

Moreover, the ACA's three legs did not contribute equally to the expansion of coverage in the individual market. The individual mandate has had a smaller effect than expected. One study found that 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).[2] The rest of these

[2] Among the factors that explain the low impact of the mandate is the number of people exempt from it—24% in the 2015 tax year. *See* Alexandra Minicozzi, Unit Chief, Cong. Budget Office, Presentation at the 2017 Annual Meeting of the American Academy of Actuaries: *Modeling the Effects of the Individual Mandate on Health Insurance Coverage* 2 (Nov. 14, 2017), *available at* https://tinyurl.com/cbopresentation.

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.

Even then, the gains directly attributable to the ACA's coverage provisions accounted for 60% of the total increase in 2014. That is, some of the increase in coverage could not be traced directly to these ACA provisions but instead stemmed from other factors. Those factors include decreased unemployment, and a corresponding increase in employer-sponsored coverage and the affordability of individual coverage; the increased attractiveness of insurance due to the "guaranteed issue requirements"; and the "simplification of purchasing coverage due to the creation of the exchanges." *Id.*

A Kaiser Family Foundation poll—its latest poll before the elimination of the mandate's penalty took effect—found that few people who purchased health insurance through the individual market viewed the individual mandate as a "major reason" for their decision to obtain coverage. *See* Ashley Kirzinger et al., Kaiser Family Found., *Kaiser Health Tracking Poll-March 2018: Non-Group Enrollees* (Apr. 3, 2018), *available at* https://tinyurl.com/mandatepoll. They instead identified "protecting against high medical bills (75 percent)," "peace of mind (66

percent)," and "an ongoing health condition (41 percent)." *Id.* The availability of affordable and effective health insurance—not a government mandate—drives patients to purchase coverage. *See id.* ("[N]ine in ten non-group enrollees say they intend to continue to buy their own insurance even with the repeal of the individual mandate."). Although some Americans may choose to roll the dice on their health and finances, most *want* to have affordable insurance for themselves and their families.

3. By the time congressional attention turned to repeal in 2017, policymakers knew that the individual mandate had not been coverage's main driver. Unsurprisingly, studies that analyzed congressional repeal proposals showed that repealing the mandate would have a much smaller impact on coverage than repealing other provisions.

The Congressional Budget Office (CBO) examined the effects on coverage of repealing nearly all of the ACA's insurance reforms. *See* CBO, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* 2 (Jan. 2017), *available at* https://tinyurl.com/cborepealjan17. It estimated that near-complete repeal would lead to 32 million people losing health insurance over a ten-year period. *See id.* at 1. That is, the number of uninsured individuals would be *higher* than before the ACA.

The CBO also examined the effects of a more-targeted repeal effort aimed just at the individual mandate. It found that repealing the mandate and its penalty would increase the uninsured by only 13 million through 2027. *See* CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* 1, 3 (Nov. 2017) ("*CBO Mandate Repeal Estimate*"), *available at* https://tinyurl.com/cbomandate.[3] And the CBO's estimate was an upper bound. Others estimated that the increase in uninsured from repealing the mandate would be substantially lower, closer to four or five million over ten years. *See* Dylan Scott, *CBO: 13 Million More Uninsured if You Repeal Obamacare's Individual Mandate*, Vox (Nov. 8, 2017, 4:50 PM), *available at* https://tinyurl.com/voxestimate (discussing critics of this estimate who argue the coverage decrease will be lower); Dan Mangan, *Killing Obamacare Mandate Won't Cut Number of Insured—Or Budget Deficit—As Much As Predicted, Analysis Says*, CNBC (Nov. 17, 2017, 3:32 PM), *available at* https://tinyurl.com/cnbcestimate (describing a S&P Global Ratings Analysis report that estimated the decrease in coverage at four to five million by 2027); *see also* Christine Eibner & Evan Saltzman, RAND Corp., *How Does the ACA Individual Mandate Affect Enrollment and Premiums in the Individual Insurance Market?* 3

[3] Thirteen million newly uninsured due to a repeal of the individual mandate and its penalty is a large number, to be sure. But it is significantly less than the *32 million* that would lose coverage under a complete repeal like the District Court's.

(2015), *available at* https://tinyurl.com/randestimate (estimating an 8 million increase in uninsured). Indeed, the CBO itself has said its initial estimate was too high by one-third. *See* CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, at 20 (May 2018) ("*CBO 2018 Subsidies Report*"), *available at* https://tinyurl.com/cbosubsidies2018.

The CBO also found little-to-no difference in the effect on coverage between a wholesale repeal of the mandate and Congress's eventual choice of repealing the mandate *penalty*, but not the mandate itself. The CBO considered exactly this question and concluded that "[i]f the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be *very similar*." *CBO Mandate Repeal Estimate*, at 1 (emphasis added). That is because "with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law." *Id.* In other words, repealing the individual mandate's penalty would reduce the number of insured, *see supra* p. 14 & n.3, but going *further* and repealing the mandate itself would not cause any significant additional decrease in coverage.

All of this suggests two things. First, when Congress repealed the mandate penalty, it was aware of the effects the repeal would have on health care coverage, and it found them tolerable. That is, it knew that while some would lose coverage,

that number was far smaller than the number that would lose coverage if other reforms—such as the subsidies and the Medicaid expansion—were also repealed. And second, when Congress repealed the mandate penalty, it was indifferent to whether individuals complied with the penaltyless mandate. *See, e.g.*, 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) (statement of Sen. Capito) ("If you opt not to purchase, which I hope you would not, your government shouldn't be taxing you . . . .").

4. The current individual mandate is therefore severable from the rest of the ACA. Neither common sense nor empirical evidence support the notion that the rest of the ACA is "incapable of functioning independently," *Alaska Airlines*, 480 U.S. at 684, without the penalty-free mandate. Quite the opposite. As the *CBO Mandate Repeal Estimate* makes clear, now that the penalty backing the mandate has been repealed, excising the penaltyless individual mandate will have minimal effects on coverage. Common sense therefore compels the conclusion that the ability of the ACA's remaining provisions to function does not depend on whatever small amount of coverage will result from keeping the current penalty-free mandate in place.

Nor is it at all "evident" that the amending Congress would have preferred completely unwinding all of the ACA over eliminating only the penalty-free individual mandate. Reaching that conclusion would require accepting the

implausible premise that Congress would have preferred to forgo *all* of the ACA's gains in the scope and quality of coverage rather than to sacrifice only whatever minimal effect on coverage the penalty-free individual mandate may have. No evidence supports that premise; rather, when Congress zeroed out the penalty and left the choice to obtain coverage up to consumers, it signaled its willingness to tolerate a world where the mandate had no, or only minimal, effect.

Congress's contemporaneous failure to repeal other, major ACA provisions provides further confirmation that it did *not* prefer a full-scale repeal. Before the individual mandate's penalty was repealed in 2017, Congress considered, and rejected, a flurry of more far-reaching ACA-related proposals. The American Health Care Act of 2017, to take just one example, would have repealed the Medicaid expansion and ACA's subsidies, eliminated the penalties associated with the individual and employer mandates, and relaxed or permitted waivers of the ACA's community-rating and essential-benefits provisions. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017). The bill would have increased the number of uninsured by 23 million by 2026. *See* CBO, *Cost Estimate for H.R. 1628: American Health Care Act of 2017*, at 4 (May 2017), *available at* https://tinyurl.com/cboaha2017. And after many attempted amendments, the bill died in the Senate. *See* Kim Soffen & Kevin Schaul, *Which Health-Care Plans The Senate Rejected (And Who Voted 'No')*, Wash. Post (July 28, 2017, 2:25 AM),

available at https://tinyurl.com/wapoamendments. That shows that in 2017, Congress chose to enact a single, more-surgical amendment to the ACA that was limited in scope after expressly considering and rejecting broader cuts. In severability terms, Congress's decision to reject an evisceration of the ACA suggests that its preference would have been for an ACA without the penalty-free mandate rather than for no ACA at all.

The District Court should not have given the Plaintiffs a judicial repeal of the entire ACA through the backdoor of severability after they could not get it through Congress. If Plaintiffs are unhappy with the ACA, their remedy lies with the political branches, not the federal courts.

5. In order to find the mandate inseverable, the District Court reasoned that because Congress removed the penalty, but not the individual mandate itself, it viewed the mandate as essential. *See* ROA.2662-2664. But the District Court did not grapple with the reality that Congress knew, *see supra* p. 15, that a penalty-free mandate would not materially affect coverage. The 2017 Congress viewed the toothless mandate as all but *irrelevant*, not essential.

The District Court next stated that because Congress did not amend the findings that had been enacted alongside the original mandate, it must have agreed that those findings remained just as true with respect to the penaltyless mandate. *See* ROA.2663-2664. That Congress left those findings in place sheds no light on

the severability issue here. To start, those findings appear in a provision that speaks to the mandate's "effects" on interstate commerce; they did not address severability. 42 U.S.C. § 18091(2) (titled "Effects on the national economy and interstate commerce"); *see also id.* § 18091(1) (stating that the individual mandate, as enacted, "is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in [§ 18091(2)]"). Moreover, the findings referred to the mandate *as enacted*, that is, to the mandate backed by a penalty. *See id.* § 18091(1) (referring to the "individual responsibility requirement *provided for in this section*" (emphasis added)). The findings were not reenacted when the penalty was removed. Thus even if the findings spoke to severability in 2010, they say nothing about the severability of the amended individual mandate at issue here.

More fundamentally, how Congress saw the interconnectedness of the various ACA provisions in 2010 does not inform how Congress saw the interconnectedness of the various ACA provisions in 2017. Congress reassessed the necessity of the penalty-backed mandate in 2017 and concluded that it could remove that penalty without fundamentally compromising the rest of the ACA. *See, e.g.*, *CBO 2018 Subsidies Report*, at 2 (in the wake of the penalty repeal, "[t]he nongroup health insurance market [will be] stable in most areas of the country over the next decade."). Congress can—and did—change its mind in light

of the evidence developed since it first passed the Act. Congress cannot be tied forever to a single, unchanging view of the ACA.

II. AFFIRMING THE DISTRICT COURT'S SEVERABILITY HOLDING—AND PERMITTING A JUDICIAL REPEAL OF THE ACA—WOULD HARM PATIENTS AND THE HOSPITALS THEY RELY ON FOR CARE AND TREATMENT.

Affirming the District Court's order would cause millions of Americans to lose their health coverage, inflicting on them all the harms that come with being uninsured. Low-income families, those least able to cope with these harms, would be hardest hit. Affirming its order would also have severe consequences for the hospitals and physicians that provide care to all Americans, which would be forced to shoulder a greater uncompensated-care burden. And it would end the ACA's important programs aimed at fostering innovative solutions to our most pressing health care problems, preventing them from reaching their potential. These consequences are further proof that Congress could not have intended for the entire ACA to fall with the mandate.

1. A wholesale judicial repeal of the ACA would eliminate the coverage gains made since 2010. An Urban Institute study found that a complete repeal would leave 24 million uninsured over a five-year period. *See* Matthew Buettgens et al., Urban Institute, *The Cost of ACA Repeal* 1, 3 (June 2016) ("*ACA Repeal*"), *available at* https://tinyurl.com/uirepeal. Indeed, a full repeal would result in *more* Americans being uninsured in 2021 than were uninsured in 2013 when the ACA's

coverage provisions were first going into effect. *See id.* at 2–3 (finding that "53.5 million people" would be uninsured compared to "47.5 million" due to an increase in health care costs over time and the repeal of the dependent-coverage provision). Other studies agree. *See* Dobson DaVanzo & Assocs. LLC, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals* 3 (Dec. 2016), *available at* https://tinyurl.com/aharepeal ("22 million people by 2026"); CBO, *Cost Estimate for H.R. 1628: Obamacare Repeal Reconciliation Act of 2017*, at 1, 10 (July 19, 2017), *available at* https://tinyurl.com/cbo1628 ("27 million in 2020").

These are not abstract numbers. They mean that more people will go without basic medical care and will wait to seek care until they are more seriously ill and more difficult and costly to successfully treat. Those who have health care coverage "are more likely to have a regular source of care," such as a general practitioner. *See* American Hosp. Ass'n, *The Importance of Health Coverage* 2 (Apr. 2018), *available at* https://tinyurl.com/aha2018. Regular access to care translates to regular access to prescription drugs, to early diagnosis and treatment, to preventative mental health care, to well-care child-care visits, and to many other benefits. *See id.* In short, if patients have regular access to care, they have better health and better outcomes. *See id.*; *see also* Board of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2017*, at 23 (May 2018) ("*Economic Well-Being*"), *available at* https://tinyurl.com/2018fed

("Among the uninsured, 42 percent went without medical treatment due to an inability to pay, versus 25 percent among the insured.").

These harms will fall on those least able to afford them. The Urban Institute study estimated the total non-elderly health care spending would be "$88.1 billion lower without the ACA." *ACA Repeal* at 7. These health-care dollars would be diverted away from those with the least. "More than two-thirds of the reduction in health care spending would come from reducing care delivered to those in families with incomes below 200 percent of" the federal poverty level. *Id.* And "[a]lmost all of the rest" would come from a loss of care among "those with incomes between 200 and 400 percent of" the federal poverty level. *Id.* These numbers likely do not paint the full picture, because they assume that governments and private health care providers would be able to "return to pre-ACA rates of spending on uncompensated care," an assumption for which there is no guarantee. *Id.*[4]

[4] This brief focuses on the effect a judicial repeal of the ACA would have on insurance coverage. But the ACA is not a mere coverage statute; it enacted a broad range of health care reforms. Eliminating those reforms will, among many other things, limit the *quality* of the coverage those who remain covered will have. *See, e.g.*, Kaiser Family Found., *Potential Impact of* Texas v. U.S. *Decision on Key Provisions of the Affordable Care Act* (Dec. 2018), *available at* https://tinyurl.com/kffrepeal (listing protections for pre-existing conditions, requirements to provide essential health benefits, the prohibition of coverage limits, and consumer protection provisions).

2. A sharp increase in uninsured and underinsured patients also would harm hospitals' ability to serve those populations. Hospitals provide tremendous amounts of uncompensated care—care for which the hospital receives no payment at all—to lower-income patients. After years of increases before the ACA, the uncompensated care rate began to fall after its reforms went into effect. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 3 (Jan. 2019), *available at* https://tinyurl.com/ahauncompensated2019. Even so, in 2017, hospitals provided $38.4 billion in uncompensated care. *Id.*

The District Court's severability holding repealing the ACA would sharply increase the amount of uncompensated care that hospitals would need to provide. The Urban Institute 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." *ACA Repeal*, at 8. If they were unwilling or unable to do so, "the increase in the burden on providers would be higher." *Id.* These burdens will undermine hospitals' finances, causing some to curtail services or to close altogether, and will undermine hospitals' efforts to redirect funds to community-based prevention and treatment to lower costs and improve outcomes.

Just as with patients, this increase in uncompensated care will not be shared equally among hospitals. Rural hospitals, for example, already face resource

shortfalls. These hospitals serve an aging, poorer, and declining population, one already with "high uninsured rates and a payer mix dominated by Medicare and Medicaid." *See* Jane Wishner et al., Kaiser Family Found., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* 1 (July 2016), *available at* https://tinyurl.com/kffrural. Because of this, rural hospitals' closure rate is already on the rise: "From 2013 through 2017, 51 rural hospitals closed (67 if we include rural areas of metropolitan counties)." Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare and the Health Care Delivery System* 47 (June 2018) (citation omitted), *available at* http://tinyurl.com/mpacreportjune18; *see also* Cecil G. Sheps Ctr. for Health Servs. Research, Univ. of North Carolina at Chapel Hill, *102 Rural Hospital Closures: January 2010 – Present*, http://tinyurl.com/uncclosure (last visited Mar. 30, 2019) (listing 17 rural hospitals in Texas and five in Mississippi as having closed since 2010). A sharp rise in the number of uninsured—especially as the Medicaid expansion disappears—means this already struggling low-income population will be less able to afford their medical bills, leaving these rural hospitals with greater uncompensated-care burdens that they may not be able to shoulder, putting them at greater risk for closing.

The same is true of "safety-net" hospitals, those that serve the highest proportion of low-income and uninsured patients. Safety-net hospitals have

benefited the most from the ACA's reforms, especially Medicaid expansion. *See* David Dranove et al., The Commonwealth Fund, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal* 4 (May 2017), *available at* https://tinyurl.com/tcfuncompensated. Among hospitals, these safety-net hospitals will be hit the hardest by the ACA's repeal. *See id.* at 6.

3. The District Court's severability holding would also halt progress made toward improving the kinds of care available to Americans. The ACA is more than a mere health-insurance statute; it enacted many programs designed to address this country's most pressing health care needs. *See supra* p. 22 n.4; *see also* ACA, tit. III, subtitle A, 124 Stat. at 353–415 (titled "Transforming the Health Care Delivery System"). If the ACA falls, these programs fall with it, and the progress the programs have will halt.

The ACA established the Center for Medicare & Medicaid Innovation within the Centers for Medicare & Medicaid Services. The Innovation Center tests new ways of paying for and delivering care, with an eye toward improving the quality of care Americans receive. *See* 42 U.S.C. § 1315a. It has funded and supported a broad range of programs aimed at improving access to, and the quality of, health care.

One of the Innovation Center's programmatic focuses is the opioid crisis. *See* U.S. Dep't of Health & Human Servs., *Determination That a Public Health Emergency Exists* (Oct. 26, 2017), *available at* https://tinyurl.com/phcrisis. Several programs aimed at combatting the opioid crisis, such as the Maternal Opioid Misuse model, which aligns and coordinates the care of pregnant and post-partum Medicaid patients addicted to opioids. *See* Press Release, Centers for Medicare & Medicaid Servs., *CMS Model Addresses Opioid Misuse Among Expectant and New Mothers* (Oct. 23, 2018), *available at* https://tinyurl.com/yyzpo238; Centers for Medicare & Medicaid Servs., *Integrated Care for Kids (InCK) Model* (Aug. 23, 2018), *available at* https://tinyurl.com/cmsickids.

Beyond these targeted innovations, the ACA contains a broad range of programs that address substance use disorders (SUDs). *See* Amanda J. Abraham et al., *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, 107 Am. J. Pub. Health 31, 31 (2017) (listing "coverage expansions, regulatory changes requiring coverage of SUD treatments in existing insurance plans, and requirements for [parity for] SUD treatments"). And "although the epidemic continues, it would arguably be worse without these reforms." *Id.*; *see also* Matt Broaddus et al., Ctr. on Budget & Policy Priorities, *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest*

Data Show 1 (Feb. 28, 2018) (explaining that many uninsured coping with opioid-use disorders have gained coverage).

Home health care delivery is another example. "Without a home- and community-based benefit in Medicare, the majority of individuals with physical or cognitive limitations will face difficulty obtaining needed care or incur financial burdens." Karen Davis et al., Commonwealth Fund, *Designing a Medicare Help at Home Benefit: Lessons from Maryland's Community First Choice Program* 2 (June 2018) ("Maryland CFC"), *available at* https://tinyurl.com/marylandcfc. To develop solutions to address this problem, the ACA gave States the option of providing home and community-based services and support in their Medicaid state plans without going through a burdensome waiver process. *See* 42 U.S.C. § 1396n(k); *see also* 42 U.S.C. § 1396a (setting out the requirements for the plan a State must submit in order to receive Federal matching funds for Medicaid services). The early experience in States that have implemented this option has been promising. In Maryland, for example, the program has increased the care patients receive and has led to the recruitment of a qualified workforce to provide services. *See Maryland CFC* at 7. The program "has the potential to support independent living longer and achieve savings." *Id.*

If the District Court's order is affirmed, the progress made by these programs and the many others authorized in the ACA will come to an end. The

ACA's promotion of state-level innovation provides state and federal policymakers alike with valuable data and experience with which to craft the next generation of health care reforms. If the ACA is repealed by court order, these potential gains in the quality of patient care, and the opportunity to scale those gains across the country, will end with it.

* * *

In sum, affirming the judicial repeal of the ACA that the Plaintiffs obtained from the District Court will harm the patients that depend on the ACA, harm the hospitals that serve them, and harm the ongoing progress in health care innovation. This all shows that Congress could not have intended the rest of the ACA to fall with the mandate. Congress's overall goal in the ACA was to "[t]o ensure that health coverage is affordable." S. Rep. No. 111-89, at 4 (2009). A result that eliminates the ACA, where health coverage would be out-of-reach, is directly contrary to that goal. As between an ACA without the mandate and no ACA at all, the evidence is clear that Congress would not have preferred the latter. After all, courts do not "interpret federal statutes to negate their own stated purposes." *King*, 135 S. Ct. at 2493 (internal quotation marks omitted). This Court should follow that commonsense teaching here and reverse the District Court's order declaring the individual mandate unconstitutional and declaring the rest of the ACA inseverable from the mandate.

CONCLUSION

The District Court's judgment should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 6,464 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

/s/ Sean Marotta
Sean Marotta

CERTIFICATE OF SERVICE

I certify that on April 1, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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