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,

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, Fort Worth Division
No. 4:18-cv-167

BRIEF OF HCA HEALTHCARE, INC. AS *AMICUS CURIAE* IN SUPPORT OF INTERVENOR DEFENDANTS-APPELLANTS AND REVERSAL

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 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.

Parties:

With two exceptions, the Plaintiffs-Appellees, Defendants-Appellants, Intervenor Defendants-Appellants, and Intervenors are governmental parties and therefore neither they nor their counsel are listed here per Rule 28.2.1.

Plaintiffs-Appellees include two non-governmental parties:

1. John Nantz, represented by Robert E. Henneke and Darren Lee McCarty, Esq.

2. Neill Hurley, represented by Robert E. Henneke and Darren Lee McCarty, Esq.

Amicus Curiae on this Brief:

Amicus HCA Healthcare, Inc. is a publicly traded company. It has no parent company and no publicly held corporation holds more than 10% of its stock.

Counsel for Amicus Curiae on this Brief:

HCA Healthcare, Inc. is represented by Robert A. Waterman and Kathryn Hays Sasser (who are employees of HCA) and David M. Zionts and Paige M. Jennings of COVINGTON & BURLING LLP.

Respectfully submitted,

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STATEMENT OF INTEREST AND INTRODUCTION

HCA Healthcare, Inc. ("HCA") is the largest non-governmental health care provider in the United States.[1] HCA owns and operates 179 acute care hospitals, 142 ambulatory and outpatient surgery centers, 86 free-standing emergency rooms, 130 urgent care centers, and 1,120 physician clinics. In 2018, HCA and its 38,000 affiliated medical staff physicians, 94,000 nurses, and 276,000 employees provided care to patients in connection with 8.8 million emergency room visits, 1.5 million surgeries, and 2 million inpatient admissions.

The patients cared for by HCA are significantly impacted by the Patient Protection and Affordable Care Act of 2010 ("ACA"). In 2018 alone, more than 400,000 individuals who obtained insurance coverage through the ACA's American Health Benefit Exchanges (the "Exchanges") sought health care from HCA facilities. *See* 42 U.S.C. § 18031. HCA gathers and maintains extensive information about the care it delivers, and its experience sheds considerable light on the practical operation of the ACA. In 2015, when previous litigants unsuccessfully sought to invalidate the ACA's subsidies in many States, *see King v. Burwell*, 135 S. Ct. 2480 (2015), HCA shared its relevant experience with the Supreme Court. *See* Br. of

[1] This brief is submitted pursuant to Fed. R. App. P. 29(a) and Fifth Circuit Rule 29. All parties have consented to the submission of this brief. Pursuant to Fed. R. App. P. 29(a)(4)(E), no counsel for a party authored this brief in whole or in part, and no person other than the amici or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

HCA Inc. as Amicus Curiae in Support of Respondents and Affirmance, *King v. Burwell*, 2015 WL 365002 (Jan. 28, 2015).

The ACA now faces a comprehensive and troubling attack. While Congress has considered and rejected multiple proposals to repeal the ACA in its entirety, the 115th Congress succeeded in amending one ACA provision as part of a comprehensive tax reform bill. That amendment reduced the tax penalty for failing "to maintain minimum essential coverage" to zero. 26 U.S.C. § 5000A. On the basis of that change, Plaintiffs argue that the "minimum essential coverage" provision of the ACA is now unconstitutional *and* that the entirety of the ACA is not severable and so must be invalidated as well.

In this brief, HCA addresses the question of severability. Even assuming Plaintiffs are correct that they have standing and that the ACA's minimum essential coverage provision is unconstitutional, the question of severability of the remainder of the ACA turns on "legislative intent." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006). Courts generally strive not to invalidate more of a law than necessary, unless it is "evident that Congress would not have enacted those provisions" absent the unconstitutional provision. *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018). Here, far from it being "evident," it is simply not credible to conclude that Congress intended the zeroing out of a tax penalty to cause the entire Act to collapse.

HCA will not repeat the many compelling arguments that have already been offered for this conclusion. *See* Opening Br. of State Defs. 33–47; Opening Br. of Intervenor U.S. House of Reps. 41–56. Rather, HCA seeks to again assist the Judiciary by sharing what it has learned as the nation's largest non-governmental health care provider about the practical operation of the Act. To this end, HCA has published an analysis of its ACA-related data and information, which forms the basis of the material presented in this brief. *See* HCA, *Analysis of HCA Data Relevant to Aspects of the Affordable Care Act* ("HCA Report") (March 2019), *available at* https://hcahealthcare.com/util/documents/2019/2019-Analysis-of-HCA-Data-Relevant-to-Affordable-Care-Act.pdf [hereinafter HCA Report].

HCA's experience with its patients demonstrates the many and important ways in which the ACA is operating as intended. And it refutes any suggestion that Congress intended the entirety of the ACA to be unraveled, simply because of a change to a tax penalty.

ARGUMENT

I. HCA's Data Show That The ACA Is Functioning As Intended.

Congress intended the ACA to achieve critical public policy goals, and HCA's data show that the ACA is operating as Congress intended:

- *Personal Responsibility*: Congress wanted individuals who did not previously pay for health care to be personally and financially responsible for that care.

HCA's data demonstrate that patients with ACA coverage, unlike most uninsured patients, make payments to cover some of the cost of their health care.

- *Encouraging Care in Appropriate Settings*: Congress sought to reduce the usage of emergency rooms ("ERs") by uninsured patients, and to encourage all patients to use more efficient forms of care. HCA's data show that patients with ACA coverage use ERs significantly less than uninsured patients.
- *Women's Access to Health Care*: Congress intended to address the particular challenges faced by women seeking affordable insurance and accessing needed health care. HCA's data indicate that women are benefitting from the availability of ACA coverage and have improved access to medically necessary care.
- *Protecting the Previously Insured*: Congress also sought to improve coverage for the previously insured. A majority of the patients who have ACA coverage and for whom HCA has data previously had some form of insurance coverage. This population would find it *substantially more* difficult than before the ACA to obtain coverage if the statute is invalidated in its entirety.

HCA's data help illuminate the basic severability issue in this case. Even if this Court were to conclude that the ACA's minimum essential coverage provision is now unconstitutional due to the reduction of the tax penalty to zero, Congressional

intent controls the severability of that provision. The "touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature." *Ayotte*, 546 U.S. at 330. The remainder of the ACA is constitutionally valid and is capable of "functioning independently," and must remain in place consistent with Congress's objectives in enacting the law. *Booker v. U.S.*, 543 U.S. 220, 258–59 (2005).

A. Patients Are Taking Personal And Financial Responsibility For Their Health Care.

One of the problems Congress sought to address with passage of the ACA was the reality that individuals who cannot purchase insurance often become "free riders," accessing care in emergency rooms that they cannot and do not pay for. The costs of this "uncompensated care" are passed on throughout the economy. HCA's data indicate that the ACA diminished this free-rider problem and increased the percentage of patients who now take personal and financial responsibility for their health care.

In 2018, 93% of HCA's uninsured patients paid nothing for the health care services they received at HCA's facilities. HCA Report at 6. That percentage remains virtually unchanged among HCA's uninsured patients, even if the

calculation considers only uninsured patients with incomes above 200% of the federal poverty level. *Id.* at 2, 6.[2]

By contrast, in a majority of cases, HCA patients who have ACA coverage pay towards their cost-sharing obligations, which can include deductibles or co-payments. *Id.* at 6. While health insurers are required to provide free preventive services (*e.g.*, cancer screenings), Exchange plans often require patients to pay *something* towards even medically necessary ER visits. HCA's patients in ACA plans who make cost-sharing expenditures pay on average $513 out-of-pocket for their health care at HCA facilities. *Id.*

This level of cost-sharing can be significant for Exchange patients. Nationally, over 80% of Exchange enrollees qualify for income-based subsidies.[3] For example, a patient making $30,350 per year (or just over 250% of the 2018 federal poverty level for a single person) would qualify for subsidized premiums through an Exchange (but not cost-sharing subsidies). A $513 payment for health care would represent more than 20% of her pre-tax monthly income.

Congress concluded that individuals should pay for a share of their health care costs in this way, balanced with a regime of subsidies for both premiums and cost-

[2] Under its charity care policy, HCA does not require payment from qualifying uninsured patients whose incomes are at or below 200% of the federal poverty level.

[3] Office of Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *ASPE Research Brief, 2019 Health Plan Choice and Premiums in Healthcare.gov States* 9 (Oct. 26, 2018), *available at* https://tinyurl.com/yyd2fadr (noting that from plan years 2014 through 2018, between 84 and 87% of enrollees qualified for advance premium tax credits).

sharing obligations so as not to make the burden too great. This requirement was a way to promote personal and financial responsibility and smarter health care choices, as well as to encourage the use of less expensive modes of care.

Fostering personal responsibility and reducing uncompensated care were basic goals of the ACA. An express statutory reason for pursuing near-universal coverage was to reduce the $43 billion in annual uncompensated care that the uninsured passed on to insured families (as of 2008). 42 U.S.C. § 18091(2)(F); *NFIB v. Sebelius*, 567 U.S. 519, 547–48 (2012) (op. of Roberts, C.J.). Members of Congress explained that the ACA was intended to "promote personal responsibility," 155 Cong. Rec. 23,370 (Oct. 1, 2009) (Sen. Mark Begich), and reduce the shifting of uncompensated care costs. *See* 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (Rep. Tim Ryan) ("[I]t is cheaper for us as a country, since we are all already paying for [the uninsured] anyway through higher insurance premiums, it is cheaper for everybody if we give them an insurance card and make them pay something. No more free riders. Everyone is going to have to pay something.").

In designing the subsidies for coverage on the Exchanges, Congress was similarly attuned to the importance of individuals maintaining a personal, financial stake in their health care. Thus, Congress included income-based caps on the premium subsidies available to low-income individuals. 26 U.S.C. §§ 36B(b)(2), (b)(3)(A)(i). Moreover, for even the lowest income individuals eligible for

subsidies, cost-sharing assistance was designed so that it would not completely eliminate an individual's obligation to pay a portion of the total cost of their health care through co-payments and deductibles. 42 U.S.C. § 18071(c).

Of course, Congress conceived of the tax penalty for not maintaining health insurance as one way to promote "individual responsibility." ACA tit. I, subtit. F, pt. I. But as reflected above, that was just one provision among many addressing the twin issues of personal responsibility and uncompensated care. And in practice, the amount of the tax penalty – even before its reduction to zero – was seen as "too low" to make a significant difference in individual health insurance decisions.[4]

With or without the tax penalty, many Americans have access to subsidized coverage on the Exchanges and will not have to revert to being uninsured and requiring uncompensated care. Based on HCA's data for 2018, subsidized coverage on the Exchanges achieves what Congress intended: it causes individuals to take personal and financial responsibility for their health care, balanced with protections to make sure medical needs do not lead to financial ruin. Once covered by an Exchange plan, they pay out of pocket a portion of their health care costs, and they avoid generating significant uncompensated costs that ultimately are borne by businesses and insured individuals. If the ACA were invalidated, millions of

[4] Avalere Health, *Individual Mandate Penalty May Be Too Low to Attract Middle-Income Individuals to Enroll in Exchanges* (Apr. 24, 2015), https://tinyurl.com/yy6whjx6.

individuals (including those who were previously insured, *see infra* pp. 16–19) would likely lose coverage and no longer be able to continue to take a measure of personal and financial responsibility for their health care.[5]

In sum, numerous statutory provisions and the overall statutory structure of the ACA confirm that Congress wanted individuals seeking health care to have personal and financial responsibility for that care. Significant progress has been made towards that statutory objective – but the district court's indiscriminate severability analysis would eliminate these advances. That result cannot be squared with any plausible account of congressional intent.

B. HCA's Exchange Patients Use Emergency Rooms At Dramatically Reduced Rates, And Have Better Access To Outpatient Services.

Congress intended the ACA to tackle the problem of uninsured patients using ERs for non-emergency health care. HCA's data show that the ACA has in fact measurably reduced ER visits for the newly insured and likewise increased the use of non-emergency, but medically necessary, outpatient services.

[5] A study by the Urban Institute concluded that full repeal of the ACA would result in 24 million more people becoming uninsured than if the ACA were left intact. MATTHEW BUETTGENS ET AL., THE COST OF ACA REPEAL 3 (June 2016), *available at* https://tinyurl.com/yczx557k [hereinafter COST OF ACA REPEAL].

In order to assess the ACA's effects on ER usage, HCA measured the ratio of ER visits to inpatient admissions.[6] HCA Report at 7. In 2018, uninsured patients visited ERs approximately ten times for every inpatient admission. *Id.* By contrast, individuals covered by Exchange plans visited ERs approximately three times for every inpatient admission. *Id.* Thus, HCA's data indicate that uninsured patients are about 300% more likely than those covered by Exchange plans to rely on ER care.

HCA also has measured improved access to medically necessary outpatient services, again using inpatient admissions as a control. These data similarly suggest that the ACA is having its intended effect. In 2018, uninsured patients made non-ER outpatient visits to HCA facilities approximately 0.7 times for every inpatient admission. *Id.* By contrast, individuals covered by ACA plans made outpatient visits to HCA facilities 3.2 times for every inpatient admission. *Id.* HCA's data reflect that the likelihood that an individual will access outpatient care increases nearly 2.5 times when he or she has coverage through the ACA.

Thus, at the same time that patients covered by Exchange plans rely less on the ER, they receive more outpatient care than uninsured patients, including care (such as chemotherapy) that is not typically available in the ER. Care is thus being

[6] Because inpatient admissions generally are unavoidable, insured and uninsured patients tend to require inpatient services at a similar rate. This makes inpatient admissions a useful "control" against which to compare ER use and outpatient visits.

provided to patients covered by Exchange plans in more appropriate and cost-effective settings.

This striking reduction of ER usage and expansion of outpatient care in HCA facilities is a predictable result of affordable coverage through the ACA. Uninsured patients may wait until they are seriously ill to seek care because they cannot afford to pay for primary care.[7] And when they do fall ill, they typically visit ERs and pay nothing towards the cost of their care. *Supra* pp. 5–6. Patients with ACA coverage, by contrast, take responsibility for a share of their costs, *supra* pp. 6–7, and have both the ability and a financial incentive to seek timely and medically necessary outpatient care, and to avoid ER visits for care which could be provided in a more efficient, less expensive setting.

These changes in the way patients access health care were core objectives of the ACA. Overuse of ERs and delayed access to appropriate care were, as Congress expressly found, symptoms of the problem of the uninsured: "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008," which "increas[ed] family premiums by on average over $1,000 a year." 42 U.S.C. §

[7] *See, e.g.*, Nat'l Ctr. for Health Statistics, U.S. Dep't Health and Human Servs., *Health, United States, 2017*, tbl. 63, *available at* https://tinyurl.com/y5yfpo38 (as of 2016, over 27% of the uninsured delayed or did not seek medical care due to cost compared with 7.4% of privately insured).

18091(2)(F). Indeed, the goal of reducing ER usage and increasing more efficient forms of care is manifest throughout the ACA.[8]

Members of Congress echoed this central goal of "preventing [the uninsured] from depending on expensive emergency services in place of regular health care." 155 Cong. Rec. 33,024 (Dec. 22, 2009) (Sen. Patrick Leahy). The pre-ACA increase in the number of Americans who were "not . . . able to afford insurance" meant they were "going to show up at hospital emergency rooms," which "costs a lot." 155 Cong. Rec. 29,762 (Dec. 8, 2009) (Sen. Barbara Boxer); *see also* 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (Rep. Tim Ryan) ("[W]e have 30 million-plus people in the United States of America who have no preventive care at all, dumped into our emergency rooms, much sicker than they need to be."). Members of Congress emphasized the importance of patients receiving non-emergency care in the most appropriate setting so that they could avoid more expensive emergency and inpatient care. *See* 155 Cong. Rec. 23,038 (Sept. 30, 2009) (Rep. Jason Altmire) ("[W]e need to get [people] their health care in the most appropriate, cost-efficient setting . . . .").

[8] *See, e.g.*, 42 U.S.C. § 18022(b)(1)(I) (requiring coverage for "[p]reventive and wellness services and chronic disease management" as an Essential Health Benefit); *id.* § 300gg–13(a) (requiring plans to cover certain preventive health services free of cost-sharing); *id.* § 300gg–17(a) (requiring the development of health plan reporting requirements related to care coordination, disease management, medical homes, and preventing hospital readmissions); *id.* § 1395cc–5(a) (requiring the Secretary to test an outcome-based health care delivery model to be judged, *inter alia*, on its success in "reducing emergency room visits"); *id.* § 256a–1 (requiring the Secretary to establish "community health teams" that, *inter alia*, ensure "access to the continuum of health care services in the most appropriate setting").

HCA's experience shows that the ACA is having its intended effect of reducing ER usage and increasing medically necessary outpatient care. The likely result of invalidating the statute in its entirety is that many patients covered by Exchange plans will join or rejoin the ranks of the uninsured, and revert to the patterns of ER use that Congress sought to counteract. In fact, as discussed below, many individuals who are now covered by Exchange plans and who *were* previously insured would likely lose access to affordable coverage if the district court decision is affirmed. *See infra* pp. 16–19.

In this respect too, the district court's blanket conclusion of non-severability cannot be squared with any plausible account of legislative intent. Plaintiffs' position would not only frustrate the legislative aim of reducing ER usage and increasing the use of more appropriate and efficient forms of care, it would actually make matters worse than they were before the ACA. This simply could not have been Congress's aim.

C. Women Comprise Two-Thirds Of HCA Patients On The Exchanges And Receive Care That Might Otherwise Be Unavailable To Them.

Another core goal of the ACA was to ensure that women are able to meet their health care needs. Based on HCA's data, those needs are being met far more than they were prior to the ACA.

Approximately 66% of HCA's patients with ACA coverage are women, outnumbering men nearly two to one. HCA Report at 5. Women enrolled in Exchange plans access health care in greater numbers in part because in the relevant (*i.e.*, pre-Medicare) age range – up to 65 – women are at greater risk for certain health issues, such as a cancer.[9] Consistent with this fact, HCA's data show that a remarkable 82% of the oncology services provided at HCA facilities to patients with ACA coverage is for women. *Id.* at 9.

Ultrasounds illustrate how women with ACA coverage are better able to access needed health care. If a woman has a breast lump or mass or an abnormal mammogram, it is common for a physician to order an ultrasound to determine if there is a benign cyst or malignancy, and whether a biopsy is needed for diagnosis.[10] These breast ultrasounds are not, however, available in ERs, the primary site of care for many uninsured women. The result: HCA's patients who have ACA coverage are close to *four times* more likely to obtain an ultrasound for a breast lump, mass, or abnormal mammogram than a woman who is uninsured. *Id.* at 4. This improved

[9] For example, in 2017, cancer was the leading cause of death among women in the 35–54 age group, with breast cancer accounting for the largest number of cancer deaths; there are also approximately 3.1 million breast cancer survivors in the United States. *See* Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Statistics, *Underlying Cause of Death 1999–2017*, on CDC WONDER Online Database, https://tinyurl.com/y6x4tau2; Am. Cancer Soc'y, *How Common Is Breast Cancer?*, https://tinyurl.com/y99xr5ls (last revised Jan. 8, 2019).

[10] Johns Hopkins Medicine, *Breast Ultrasound*, http://tinyurl.com/mkvfg2s (last visited Mar. 18, 2019); *see also* Am. Coll. of Radiology, *ACR Practice Parameter for the Performance of a Breast Ultrasound Examination* 2 (Revised 2016, Resolution 38), *available at* https://tinyurl.com/y5rt4ryk; Regina J. Hooley et al., *Breast Ultrasonography: State of the Art*, 268 Radiology 642, 643 (Sept. 2013) ("Ultrasonography . . . has become an indispensable tool in breast imaging.").

access to such an important diagnostic tool for women at risk for breast cancer would likely be reversed if the ACA is invalidated.

Without access to affordable coverage, patients will also face reduced access to treatment options for urgent but chronic conditions, such as cancer. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals must provide stabilizing treatment for "emergency" medical conditions, but need not provide non-emergency care, such as chemotherapy and radiation.[11] Although Medicaid may provide some coverage for women diagnosed with breast or cervical cancer, such coverage varies by state and often is limited to certain programs for low-income individuals for which many current Exchange enrollees will not qualify. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); *id.* § 1396a(aa). Without coverage, some women may turn to the already-strained resources of public hospitals, where there may be long waits for appointments.[12] As a result, the invalidation of the ACA would adversely affect all patients, but especially women who need treatment for life-threatening diseases like cancer.

Congress, in enacting the ACA, was acutely concerned with the health care needs of women. For example, the ACA bans gender-based premium rate

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[11] 42 U.S.C. § 1395dd; *see also* Aaron Carroll, *Why emergency rooms don't close the health care gap*, CNN, May 7, 2012, http://tinyurl.com/p6wqd3t.

[12] Laurie E. Felland & Lucy Stark, *Local Public Hospitals: Changing with the Times*, Ctr. for Studying Health Sys. Change, Research Brief No. 25, at 1–2 (Nov. 2012), *available at* https://tinyurl.com/yyl984as (citing "inadequate capacity" and "long waits").

discrimination that previously made quality insurance coverage less affordable for women. 42 U.S.C. § 300gg. In requiring health plans to cover all "Essential Health Benefits," Congress directed HHS to "take into account the health care needs of diverse segments of the population, including women." *Id.* § 18022(b)(4)(C). Moreover, Congress required health plans to make numerous preventive services available for free, specifically mentioning the preventive care needs of women. *Id.* § 300gg–13(a)(1), (4).[13] Similarly, Congress prohibited health plans from requiring prior authorizations or referrals for in-network obstetrical or gynecological care. *Id.* § 300gg–19a(d)(1).

HCA's data reveal that women make up nearly two-thirds of its patients with ACA coverage, a substantial increase from the uninsured population. The data show, moreover, that this coverage gives women better access to medically necessary care. Once again, Congress could not possibly have intended to unravel this achievement simply because a tax penalty was reduced to zero.

D. A Substantial Share Of HCA's Patients On The Exchanges Were Previously Insured, And Would Be At Risk Of Becoming Uninsured If Appellees Prevail.

The ACA was intended to improve access to quality, affordable health care for uninsured individuals *as well as* for individuals who previously had insurance.

[13] *See also* HealthCare.gov, *Preventive health services for women*, https://tinyurl.com/zwkyskm (last visited Mar. 18, 2019) (listing 38 preventive health services for women that plans must offer without cost-sharing).

Invalidating the ACA is likely to make it even more difficult for previously insured individuals to obtain insurance.

The previously insured account for 65% of HCA Exchange patients for whom relevant data are available. HCA Report at 4. This is consistent with national surveys concluding that up to two-thirds of all Exchange enrollees were previously insured.[14]

This large group of previously insured Americans will face an extremely difficult situation if the ACA is invalidated, since most benefit from subsidized coverage which would no longer be available. For example, a waitress living in Houston, Texas has a mean annual income of approximately $24,400, or around 200% of the federal poverty level for a single person (the national median, $20,820, is even lower).[15] Currently, she can obtain a "silver" plan on the state's federally-facilitated Exchange, with premium subsidies reducing her monthly payment to

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[14] *See* Press Release, *New Survey: After First ACA Enrollment Period, Uninsured Rate Dropped from 20 Percent to 15 Percent; Largest Declines Among Young Adults, Latinos, and Low-Income People*, The Commonwealth Fund (July 10, 2014), *available at* http://tinyurl.com/k4xuyd2 (37% of Exchange enrollees previously insured); Liz Hamel et al., *Survey of Non-Group Health Insurance Enrollees*, Henry J. Kaiser Family Found. (June 19, 2014), *available at* http://tinyurl.com/q6wc56r (43% of Exchange enrollees previously insured); Katherine Grace Carman & Christine Eibner, *Survey Estimates Net Gain of 9.3 Million American Adults with Health Insurance*, RAND Corp. (Apr. 8, 2014), http://tinyurl.com/lwo2dze (two-thirds of Exchange enrollees previously insured); *see also* Amit Bhardwaj et al., *Individual market: Insights into consumer behavior at the end of open enrollment*, McKinsey & Co. (May 8, 2014), *available at* http://tinyurl.com/q366knz (three-quarters of individual market enrollees previously insured, but data not limited to Exchanges).

[15] *See* Bureau of Labor Statistics, *Occupational Employment and Wages, May 2017: 35-3031 Waiters and Waitresses*, *available at* https://tinyurl.com/yywcb8ls (last modified Mar. 30, 2018).

$127 per month (with a $5,350 deductible), or $245 per month (with no deductible). However, *unsubsidized* coverage under the least expensive "bronze" plan would cost her $274 per month – more than 13% of her pre-tax income – *and* she would be responsible for a $6,400 deductible.[16] Faced with significant medical needs, her combined premiums and deductibles could result in out-of-pocket payments of almost $10,000, or 40% of her pre-tax income. This is not affordable coverage. *Cf.* 26 U.S.C. § 5000A(e)(1) (classifying an individual for whom coverage costs more than 8% of income as one who "cannot afford coverage"). And if the law is invalidated in its entirety, it is not clear what type of unsubsidized, non-Exchange individual market could even emerge, particularly because many states have since enacted health insurance reforms intended to conform with the ACA.[17]

HCA's patients with Exchange coverage (and millions of other Americans) will be affected by this case regardless of whether they had insurance coverage prior to the ACA. Not only will previously uninsured individuals once again be without coverage options, but the substantial share of HCA's Exchange patients who *were* previously insured will likely not have access to any well-functioning insurance

[16] All of the figures in this paragraph are based on searches of HealthCare.gov conducted on March 26, 2019, for a 35-year-old, non-smoking applicant. These numbers, of course, reflect current market conditions, in which there is a diverse risk pool.

[17] National Conference of State Legislatures, *2011-2014 Health Insurance Reform Enacted State Laws Related to the Affordable Care Act* (updated June 17, 2014), https://tinyurl.com/yyrq4q7m.

market to fall back on.[18] Congress, in expressly designing the ACA to "achieve near-universal coverage," 42 U.S.C. § 18091(2)(D), could not have intended that the gains realized over the more than eight years in which ACA coverage has been available would be suddenly erased because of a change to a single provision.

II. Congress Would Not Have Intended To Reverse All Of The Progress That Has Been Made In Carrying Out The ACA's Objectives.

The only provision of the ACA alleged in this case to be unconstitutional is the "requirement to maintain minimum essential coverage." 26 U.S.C. § 5000A(a). The Supreme Court previously held that this provision imposes a tax, not a true mandate, and is constitutional on that basis. *NFIB*, 567 U.S.at 574. Plaintiffs now allege that a later Congress's reduction of the amount of that tax to zero somehow renders the $0 tax penalty unconstitutional.

On its own, the constitutional question that Plaintiffs pose has no practical import: it is the difference between no requirement, and a requirement backed up by a penalty of nothing. Quite transparently, the purpose of this litigation is not to invalidate the now-toothless provision Plaintiffs actually challenge, but to leverage this alleged constitutional infirmity to bring down the entire ACA.

That is the opposite of how severability works. This Court must "strive" to "sever [the Act's] problematic portions while leaving the remainder intact." *Ayotte*,

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[18] *See* COST OF ACA REPEAL, *supra* n.5 (noting that full repeal of the ACA would result in nearly 20% of Americans being uninsured, as compared with 17.6% in 2013).

546 U.S. at 329. Invalidation of the rest of the statute is proper *only* if the Court concludes that this is "what Congress would have intended in light of the Court's constitutional holding." *Booker*, 543 U.S. at 246. Indeed, it must be "*evident*" that Congress would have wanted the rest of the Act to fall. *Murphy*, 138 S. Ct. at 1482.

The briefs of the State Defendants and the U.S. House of Representatives show that it is undeniable that this is not what Congress would have intended. HCA, on the basis of its substantial experience as the largest non-governmental health care provider in the nation, adds only the following: Congress passed the ACA to reduce uncompensated care and foster personal responsibility, and *on the ground that is what is happening*. Congress passed the ACA to channel patients away from the emergency room and towards more efficient and appropriate forms of care, and *on the ground that is what is happening*. Congress passed the ACA to remedy the particular challenges women have faced in receiving the health care they need, and *on the ground that is what is happening*. Congress passed the ACA to ensure there would be a functioning individual insurance marketplace capable of covering millions of Americans, and *on the ground that is what is happening*.

It is not remotely plausible – much less "evident" – that Congress would have intended for all of this progress in achieving the objectives it enacted into law to be reversed, because of the amendment of a single provision.

CONCLUSION

For the foregoing reasons, as well as the reasons set forth in the briefs of Intervenor Defendants-Appellants and the Intervenor U.S. House of Representatives, the decision of the district court should be reversed.

Respectfully submitted,

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April 1, 2019

CERTIFICATE OF SERVICE

I hereby certify that, on April 1, 2019, I electronically filed the foregoing with the Clerk of this Court using this Court's CM/ECF system. Participants in this case who are CM/ECF users, or represented by CM/ECF users, are hereby served by CM/ECF.

/s/ David Zionts
David Zionts

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATIONS

I, David Zionts, do hereby certify that the foregoing brief of amicus curiae:

1) Complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) and of the Rules of this Court because it contains 5,058 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f) and the Rules of this Court, as calculated by the word-processing system used to prepare the brief; and

2) Complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally-spaced typeface using Microsoft Office Word in 14-point, Times New Roman font.

/s/ David Zionts
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