Nos. 19-840, 19-1019

IN THE
Supreme Court of the United States

STATE OF CALIFORNIA, *et al.*,
Petitioners,
v.
STATE OF TEXAS, *et al.*,
Respondents.

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v.
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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF NATIONAL HOSPITAL ASSOCIATIONS AS *AMICI CURIAE* IN SUPPORT OF THE CALIFORNIA STATE COALITION AND HOUSE OF REPRESENTATIVES

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STATEMENT OF INTEREST[1]

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health systems, and

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici curiae*, their members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

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.

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 ("AAMC") is a not-for-profit association representing all 155 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and 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

more than 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.

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Dedicated to 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.

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 briefs in support of the law in this Court and in lower courts across the Nation. *Amici* write to offer guidance, from hospitals' perspectives, on the legal issue in this case and the harmful impact that a ruling striking down the ACA will 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

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

Congress recognized this progress when it amended the ACA in 2017. Understanding that the ACA's health-insurance-coverage gains can be traced back to multiple provisions of the law, and that the ACA's individual mandate had contributed less to the growth than originally expected, Congress decided that the mandate no longer needed to be enforced for the ACA's reforms to continue. And so the mandate was eliminated, but the ACA's many other provisions were left undisturbed.

Despite this, the Fifth Circuit below declared the mandate invalid and avoided the severability issue entirely, instead remanding for the district court to "provide additional analysis" of the ACA's provisions. Pet. App. 3a–4a.[2] It did so even though the question of severability turns on the interpretation of the text and history of the ACA, the kind of question that appellate courts have "no difficulty" answering without guidance from district courts. *Buckley* v.

[2] Citations to "Pet. App." are to the petition appendix in *California* v. *Texas*, No. 19-840.

Valeo, 424 U.S. 1, 108 (1976) (per curiam); *see also Murphy* v. *National Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018).

Law, logic, and experience all counsel in favor of severing the individual mandate. As for the law, the evidence shows the ACA can "function[] independently" of the mandate. *Alaska Airlines, Inc.* v. *Brock*, 480 U.S. 678, 684 (1987). 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, and that the ACA would continue to function without either. As for the logic, Congress in 2017 considered several options for amending the ACA, ranging from a complete repeal to the elimination of the mandate penalty. Congress chose the option that *least* disturbed the ACA's reforms, a decision incompatible with the district court's conclusion that Congress preferred no ACA to one without the mandate. And as for experience, the available evidence, including marketplace enrollment numbers, shows that Congress was correct to conclude that the ACA can function without the individual mandate.

The likely catastrophic effects of a ruling invalidating the ACA confirm that Congress did not intend that result. Judicial repeal would threaten improvements made to the care Americans receive by eliminating innovations, including programs designed to combat substance abuse. It would also roll back coverage gains, leaving many newly insured patients without access to everything from routine checkups and tests to treatment for chronic illnesses and opioid addiction. The increase in uninsured

patients would also strain the resources of hospitals, particularly those that serve low-income and rural populations. And it would do so at a time when a global pandemic is already straining hospitals' ability to provide care at precisely the time when Americans need it the most.

The court of appeals' decision should be reversed.

ARGUMENT

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

Once the Fifth Circuit concluded that the individual mandate without a penalty was unconstitutional, it faced the question 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 [Affordable Care Act] at all to" an Act 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 answer to the severability question here is clear: The ACA functions perfectly well without the 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

mandate. Indeed, Congress's repeated, unsuccessful attempts to enact a broader repeal are evidence that it did not prefer a *full* repeal. Instead of remanding and leaving hospitals and the rest of the country in a continued state of uncertainty, the Fifth Circuit should have declared the mandate severable from the rest of the Act.

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 individual-insurance-market provisions were often referred to as a "three-legged stool." The guaranteed-issue and community-rating provisions formed the first leg, prohibiting insurers from discriminating based on preexisting conditions and claims history. *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-rating 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 the requirement that States participate in the 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 increases in coverage. The individual mandate in particular has had a smaller-than-expected effect. One study found that subsidies accounted for 41% of 2014's coverage gains attributable 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).[3] The rest came from the Medicaid program, with 29% from enrollment due to increased awareness by those already eligible, but not yet enrolled—such as children—and the other 30% from 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 from the ACA's coverage provisions accounted for only 60% of 2014's total increase. That is, a full 40% of the increase in coverage could not be traced directly to these ACA provisions but instead stemmed from other factors. Those factors included decreased unemployment, and a corresponding increase in employer-sponsored cover-

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[3] 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.

age and the ability to afford individual coverage; the increased attractiveness of individual insurance because of 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 before Congress's elimination of the mandate's penalty took effect—found that few who purchased health insurance through the individual market identified the mandate as a "major reason" for their decision. *See* Ashley Kirzinger et al., Kaiser Family Found., *Kaiser Health Tracking Poll-March 2018: Non-Group Enrollees* (Apr. 3, 2018) ("*Kaiser Health Tracking Poll*"), *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.* And in the wake of the penalty's repeal, marketplace enrollments remained mostly steady. *Enrollment in Individual Market Dips Slightly in Early 2019 after Repeal of Individual Mandate Penalty*, Kaiser Family Found. (Aug. 21, 2019), https://tinyurl.com/tzh34sb. The availability of affordable and comprehensive health insurance—not a government mandate—drives patients to buy coverage. *See Kaiser Health Tracking Poll* ("[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."). Most Americans *want* to have insurance for themselves and their families and will make every effort to have it.

3. By the time Congress considered repeal in 2017, policymakers knew that the individual mandate had not been coverage's main driver. Unsurprisingly,

then, studies analyzing 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 coverage effects 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 would be higher than *before* the ACA.

The CBO also examined the effects of repealing just the individual mandate. It found that repealing the mandate and its penalty would increase the uninsured by 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. [4] And the CBO's estimate was an upper bound. Others estimated that repealing the mandate would lead to four or five million new uninsured 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*

[4] Thirteen million newly uninsured is a large number, to be sure. But it is significantly less than the *32 million* that would lose coverage under the complete repeal contemplated by the district court's opinion.

https://tinyurl.com/voxestimate (discussing critics of the CBO's estimate); 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 four to five million new uninsured over ten years); *see also* Christine Eibner & Evan Saltzman, RAND Corp., *How Does the ACA Individual Mandate Affect Enrollment and Premiums in the Individual Insurance Market?* 3 (2015), *available at* https://tinyurl.com/randestimate (estimating an 8 million increase in uninsured). Indeed, the CBO itself eventually conceded that 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), *available at* https://tinyurl.com/cbosubsidies2018.

The CBO also 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. 12 & n.4, 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 knew the effects repeal would have on coverage and found them tolerable. That is, Congress knew that while some would lose coverage, it would be fewer than if other reforms—such as the subsidies and the Medicaid expansion—were also repealed. And second, when Congress repealed the mandate, it was indifferent to whether individuals purchased insurance or not. *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 mandate is therefore severable from the rest of the ACA. Neither common sense nor empirical evidence support the district court's finding that the rest of the ACA is "incapable of functioning independently," *Alaska Airlines*, 480 U.S. at 684, without the mandate. Quite the opposite. As the *CBO Mandate Repeal Estimate* makes clear, repeal of the mandate will have little effect on coverage. Common sense dictates that the functionality of the ACA's remaining provisions does not depend on the mandate.

Nor is it at all "evident" that the amending Congress would have preferred unwinding the ACA over eliminating only the individual mandate. *Public Co. Accounting Oversight Bd.*, 561 U.S. at 509 (internal quotation marks omitted). The district court's conclusion requires 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 the mandate. Yet no evidence supports that premise. Rather, when

Congress zeroed out the penalty and left the choice up to consumers, it signaled its tolerance for a world in which the mandate had no, or only minimal, effect.

Congress's contemporaneous failure to repeal other, major ACA provisions is further confirmation that it did *not* prefer a full repeal. Before repealing the mandate penalty in 2017, Congress considered—and rejected—a flurry of more far-reaching ACA-related proposals. The American Health Care Act of 2017, for example, would have repealed the Medicaid expansion and 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.

The American Health Care Act's failure shows that, in 2017, Congress chose a single, surgical amendment to the ACA after considering and rejecting broader cuts. In severability terms, Congress's conscious decision not to eviscerate the ACA suggests that its preference would have been for an ACA without the mandate rather than no ACA at all. The court of appeals should have therefore concluded

that the mandate is severable from the rest of the ACA.

5. To avoid this conclusion, the court of appeals disregarded basic severability principles. Severability is a question of law, and one that appellate courts frequently review without district-court findings. *See, e.g.*, *Murphy*, 138 S. Ct. at 1484. The key question—what Congress would have done had it faced the issue—turns not on adjudicatory facts, but on the statutory text and legislative history. *See id.* An appellate court is "just as competent" as a district court "[w]hen it comes to analyzing the statute's text and historical context." Pet. App. 99a (King, J., dissenting). And here no interpretive heavy lifting was required. The court of appeals could have "determine[d] what Congress would have done by examining what it did"—zeroing out the individual mandate without repealing anything else. *Legal Servs. Corp.* v. *Velazquez*, 531 U.S. 533, 560 (2001) (Scalia, J., dissenting). The court of appeals thus erred by remanding the severability question to the district court.

II. THE CATASTROPHIC CONSEQUENCES THAT WOULD FOLLOW FROM A JUDICIAL REPEAL OF THE ACA FURTHER SHOW THAT CONGRESS COULD NOT HAVE INTENDED FOR THE ENTIRE ACA TO FALL WITH THE MANDATE.

It is easy to see why Congress would not want the entire ACA to fall with the mandate. As Judge King put it below, "judicial repeal of the ACA would have potentially devastating effects on the national healthcare system and the economy at large." Pet. App. 106a (King, J., dissenting). It 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. Judicial repeal of the ACA would also have severe consequences for the hospitals and physicians meeting the needs of their communities during a global pandemic that is already straining hospital resources. And it would end the ACA's important programs aimed at creating innovative solutions to our most-pressing health care problems. These consequences are further proof that Congress could not have intended for the entire ACA to fall with the mandate.

1. 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., Robert Wood Johnson Found. & Urban Inst., *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 went 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 their conditions will be more difficult and more costly to treat. Those who have health care coverage are more likely to have a regular source of care, such as a general practitioner. *See* Am. Hosp. Ass'n, *The Importance of Health Coverage* 2 (Oct. 2019), *available at* https://tinyurl.com/s45cufg. 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.* When patients have regular access to care, they have better health and better outcomes. *See id.*; *see also* Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2017*, at 23 (May 2018), *available at* https://tinyurl.com/2018fed (42 percent of uninsured went without medical treatment due to cost, versus 25 percent of insured); Benjamin D. Sommers et al., *Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults*, 36 Health Aff. 1119, 1127 (2017) (finding that those with chronic conditions take their medicine more and see their doctor more when they have insurance coverage). And this is especially true for Medicare beneficiaries, who are by definition older and who had coverage for annual wellness visits added by the ACA. *See Affordable Care Act Expands Medicare Coverage for Prevention and Wellness*, Ctr. Medicare Advocacy, https://tinyurl.com/r48nt4f (last visited May 13, 2020).

This expanded coverage yielded public-health benefits as well, such as mitigating the opioid crisis. Expanded coverage under the ACA has made treatment available to those suffering from opioid-use disorder, with residents in Medicaid-expansion States able to access needed treatments in significantly higher numbers than their counterparts in non-Medicaid-expansion States. Lisa Clemans-Cope et al., Urban Inst., *State Variation in Medicaid Prescriptions for Opioid Use Disorder from 2011 to 2018* (Aug. 2019), *available at* https://tinyurl.com/y7tps6m8. Eliminating the Medicaid expansion would take away access to these life-saving interventions. And because Medicaid beneficiaries are disproportionately among those diagnosed with opioid-use disorder, as well as those who overdose from opioid use, repeal would seriously hamper efforts to combat opioid addiction and the suffering it causes for individuals and communities. Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Report to Congress on Medicaid and CHIP*, at 60 (June 2017), *available at* https://tinyurl.com/ycr6wk6m.

The harms of repealing the ACA will fall on those least able to afford them. The Urban Institute study estimated 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 estimates 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.*

2. A sharp increase in uninsured and underinsured patients also would strain hospitals' ability to serve vulnerable populations. Hospitals provide tremendous amounts of uncompensated care—care for which the hospital receives no payment at all—to lower-income patients. *See* Am. Hosp. Ass'n, *Fact Sheet: Uncompensated Hospital Care Cost* (Jan. 2020) ("*Uncompensated Hospital Care Cost*"), *available at* https://tinyurl.com/rcwcrxw.

One way the ACA addressed the uncompensated-care problem was to allow hospitals to enroll patients in Medicaid who are eligible, but not yet enrolled. *See* Allen Dobson et al., *The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals*, Commonwealth Fund (June 28, 2017), https://tinyurl.com/y7kkywkp. That helped to reduce hospitals' uncompensated care by allowing hospitals to collect Medicaid payments for services provided to newly enrolled Medicaid patients. *Id.* And as a result of this and other reforms, after years of increases, hospitals' uncompensated care costs began to fall after the ACA's reforms went into effect. *See Uncompensated Hospital Care Cost*.

Repealing the ACA would sharply increase hospitals' uncompensated-care costs. Even with the ACA, in 2018, hospitals provided $41.3 billion in uncompensated care. *Id.* 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. In the first year after repeal, the Urban Institute estimates that the newly uninsured would seek $88 billion worth of uncompensated care, including $24.6 billion from hospitals alone. Matthew Buettgens et al., Robert Wood Johnson Found. & Urban Inst., *The Impact on Health Care Providers of Partial ACA Repeal Through Reconciliation* 1, 2 (Jan. 2017), *available at* https://tinyurl.com/y9jtof6n. Over the next ten years, uninsured patients would seek more than $296.1 billion in uncompensated hospital care. *See id.* These responsibilities will stress hospitals' finances, potentially causing some to curtail services. It will also make it more difficult for hospitals' to invest funds in community-based prevention and treatment, to lower costs, and to improve outcomes.

Hospitals that serve disproportionately high numbers of low-income patients, including rural hospitals, will be hardest hit. Richard C. Lindrooth et al., *Understanding The Relationship Between Medicaid Expansions And Hospital Closures*, 37 Health Aff. 111 (2018) ("*Medicaid Expansions and Hospital Closures*"). These safety-net hospitals saw the largest reductions in uncompensated care because of the ACA's Medicaid expansion. David Dranove et al., Commonwealth Fund, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal* (May 2017), *available at* https://tinyurl.com/y8e2nv99. Rural hospitals in Medicaid-expansion States especially benefitted, as their finances improved and they were less likely to close. *Medicaid Expansions and*

Hospital Closures, at 115–116 (hospitals in expansion states more than six times less likely to close than hospitals in states that did not expand Medicaid).

Returning to pre-ACA Medicaid eligibility would force many safety-net hospitals to contemplate devastating service cuts. *See* Diane Arnos & Fredric Blavin, *To Weather COVID-19, Rural Hospitals Might Need More Support*, Urban Inst.: Urban Wire: Health and Health Policy (Apr. 6, 2020) ("*To Weather COVID-19*"), https://tinyurl.com/yag52l7x. Because Medicare and Medicaid pay hospitals less than private insurers, hospitals that disproportionately serve Medicare and Medicaid patients have less revenue. Rural safety-net hospitals, in particular, feel this problem acutely because they serve areas with fewer patients, and the patients they do serve tend to be older and to require more-costly care. *See Medicaid Expansions and Hospital Closures*, at 118; *To Weather COVID-19*. Taken together, even the best-managed safety-net hospitals will struggle to cover their costs during the best of times. *See Medicaid Expansions and Hospital Closures*, at 118; *To Weather COVID-19* (estimating that more than 450 rural hospitals are struggling to stay open). Eliminating the Medicaid expansion could push them to cut services or even close their doors—a result that would leave communities without ready access to needed services. *See Medicaid Expansions and Hospital Closures*, at 119.

3. Striking down the ACA would also threaten the progress made toward improving Americans' care. The ACA is more than a health-insurance statute; it enacted many programs designed to address the

country's most-pressing health care needs. *See* ACA, tit. III, subtitle A, 124 Stat. at 353–415 (titled "Transforming the Health Care Delivery System"). If the ACA falls, these programs—and their progress—fall with it.

For example, 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 are directly aimed at combatting the opioid crisis, such as the Maternal Opioid Misuse model, which aligns and coordinates the care of pregnant and postpartum 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 range of programs that address substance use disorders. *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 [substance use disorder] treatments in existing insurance plans, and requirements for [parity for] [substance use disorder] 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), *available at* https://tinyurl.com/ya28h2eb (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 * * *, 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. 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 id.* § 1396a (setting out the requirements for the plan a State must submit in order to receive Federal matching funds for Medicaid services). States' early experience with this option has been promising. In Maryland, for example, the program has increased the care patients receive and has allowed the State to recruit 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 ACA is struck down, the progress made by these programs and the many others authorized by the ACA will end. The ACA's promotion of state-level innovation provides state and federal policy-makers 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.

4. A decision invalidating the ACA would be particularly devastating given the current global-health emergency. COVID-19 has left millions of Americans without jobs and without their employer-provided health insurance. *See* Larry Levitt et al., *Estimated Cost of Treating the Uninsured Hospitalized with COVID-19*, Kaiser Family Found. (Apr. 7, 2020), *available at* https://tinyurl.com/ydbewo8n; Anuj Gangopadhyaya & Bowen Garrett, Robert Wood Johnson Found. & Urban Inst. (Apr. 2020), *Unemployment, Health Insurance, and the COVID-19 Recession*, at 1, *available at* https://tinyurl.com/y6wwbeka (most Americans have health insurance through their job or a family member's job). As unemployment increases, as many as 35 million people may lose their coverage. Health Mgmt. Assocs., *COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State*, at 1 (Apr. 3, 2020), *available at* https://tinyurl.com/ycfmec99.

Meanwhile, in a matter of weeks, the COVID-19 pandemic has "completely upended the financial health of the hospital industry." KaufmanHall,

National Hospital Flash Report (Apr. 2020), *available at* https://tinyurl.com/y9jf4kh9. It has driven up the cost of staffing and basic supplies, *see* Am. Hosp. Ass'n, *Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19* (May 2020) ("*Financial Pressures*"), *available at* https://tinyurl.com/y7cm5tmv; Lydia DePillis & Lisa Song, *In Desperation, New York State Pays Up to 15 Times the Normal Prices for Medical Equipment*, ProPublica (Apr. 2, 2020, 1:20 PM), *available at* https://tinyurl.com/v57wdlh, and put on hold the non-emergency surgeries that hospitals rely on to balance their budgets. *See Financial Pressures*, at 2; *National Hospital Flash Report*. In the first month alone, COVID-related cancellations caused hospitals across the country to lose billions of dollars. *See, e.g.*, Lisa Schencker & David Heinzmann, *Busy, yet struggling: Illinois hospitals lose $1.4 billion a month as coronavirus cancels surgeries*, Chi. Trib. (Apr. 17, 2020), *available at* https://tinyurl.com/y9qwt6pu; Kaitlin Schroeder, *Ohio hospitals: Pandemic leads to $1.27B monthly hit from delayed procedures*, Journal-News (Apr. 13, 2020), *available at* https://tinyurl.com/yc9u9fg2; Associated Press, *Revenue loss triggers furloughs at Montana hospitals*, Lewiston Trib. (Apr. 19, 2020), *available at* https://tinyurl.com/y8o8xm2t (Montana hospitals expected to lose $100 million in first three weeks of pandemic). By the end of June, AHA estimates that COVID-19 will cause American hospitals to lose a total of $202.6 billion. *Financial Pressures*, at 1.

Invalidating the ACA during the COVID-19 pandemic would deal a double blow to hospitals and the patients they serve. By further increasing hospitals' uncompensated-care responsibilities at a time of

unprecedented strain on their resources, the Court would jeopardize hospitals' ability to serve Americans at precisely the moment when hospitals and their professionals are needed most. That result is manifestly *not* what Congress intended when it declined to repeal the ACA.

As Judge King explained below, "[g]iven the breadth of the ACA and the importance of the problems that Congress set out to address, it is simply unfathomable * * * that Congress hinged the future of the entire statute on the viability of a single, deliberately unenforceable provision." Pet. App. 103a (King, J., dissenting). Properly construed, the individual mandate is severable from the rest of the ACA. The Court should say so.

CONCLUSION

For these reasons, this Court should reverse.

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