Nos. 19-840, 19-841

IN THE
Supreme Court of the United States

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

UNITED STATES HOUSE OF REPRESENTATIVES,
Petitioner,
v.
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Respondents.

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

BRIEF *AMICI CURIAE* OF NATIONAL HOSPITAL ASSOCIATIONS IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Hospital Association ("AHA") repre-

[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 were notified of amici curiae's intent to submit this brief at least 10 days before it was due, and all parties have consented to the filing of this brief.

sents 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 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 ("CHA") 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 ("AAMC") 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; 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 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 Af-

fordable 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 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 this Court's failure to immediately review the decision below 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 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 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 it zeroed out the penalty associated with the mandate, kept the

mandate in place, and left the ACA's many other provisions 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 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. *Valeo*, 424 U.S. 1, 108 (1976) (per curiam); *see also Murphy* v. *National Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018).

The Fifth Circuit's decision remanding to the district court for further—likely protracted—proceedings has flung the American healthcare industry into uncertainty. Left without clarity as to whether the entire ACA will be wiped off the books, hospitals and healthcare providers will have to spend the years it will take for this case to wind through the district court, back up to the court of appeals, and again to this Court, questioning whether they should invest in initiatives that rely on the ACA's provisions. The Court should step in—now—to avoid that unnecessary and untenable result.

The Fifth Circuit's decision to remand was all the more unnecessary because answering this severability question should have been easy. Law, logic, and experience all counsel in favor of severing the indi-

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

vidual mandate. 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, and that the ACA would continue to function without either. As for the logic, Congress in 2017 considered several options for addressing 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 a conclusion that it preferred no ACA to one without the penalty-free mandate it left in place. And as for experience, the available evidence, including the marketplace enrollment numbers, 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.

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 [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 answer to the severability question is clear: The ACA functions independently of any hortatory effect a penalty-free mandate may have. 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's repeated, unsuccessful attempts to enact a broader repeal are evidence that it did not prefer a broader—much less a full—repeal. Instead of remanding, leaving *amici* 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 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).[3] The rest of these gains came from the Medi-

[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 Ameri-

caid 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) ("*Kaiser Health Tracking Poll*"), *available at* https://tinyurl.com/mandatepoll. They instead

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can Academy of Actuaries: *Modeling the Effects of the Individual Mandate on Health Insurance Coverage* 2 (Nov. 14, 2017), *available at* https://tinyurl.com/cbopresentation.

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 repeal of the penalty, 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 effective health insurance—not a government mandate—drives patients to purchase 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."). Although some Americans may choose to roll the dice on their health and well-being, 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.[4] 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 Insur-*

[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.

ance Market? 3 (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), *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. It 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. 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 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 penalty-free 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 penalty-free 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 sig-

naled 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 in 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 to the ACA. 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 court of appeals should have concluded that the individual mandate is severable from the rest of the ACA.

5. To avoid this question, the court of appeals disregarded the basic principles guiding severability. Severability is a question of law, and one that appellate courts frequently review without the benefit of 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 facts that could be found in a hearing, but on the interpretation of 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 below could have "determine[d] what Congress would have done by examining what it did"—namely zeroing out the individual mandate without repealing any other portion of the ACA. *Legal Servs. Corp.* v. *Velazquez*, 531 U.S. 533, 560 (2001) (Scalia, J., dissenting). The Court below thus erred by remanding the severability issue 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 not difficult to see why Congress could not have intended a full repeal of the ACA. 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. Such a finding 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 responsibility. And it would end the ACA's important programs aimed at fostering 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. 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 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 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. This is especially true for Medicare beneficiaries, whose annual wellness visits were added by the ACA. *See Affordable Care Act Expands Medicare Coverage for Prevention and Wellness*, Ctr. Medicare Advocacy, https://tinyurl.com/r48nt4f (last visited Jan. 15, 2020). 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).

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.*

2. A sharp increase in uninsured and underinsured patients also would strain 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* Am. Hosp. Ass'n, *Fact Sheet: Uncompensated Hospital Care Cost* (Jan. 2020), *available at* https://tinyurl.com/rcwcrxw. Even so, in 2018, hospitals provided $41.3 billion in uncompensated care. *Id.*

A finding that the individual mandate is not severable from the rest of the ACA would sharply increase the amount of uncompensated care that hospitals would need to provide. In 2018, combined underpayment from Medicare and Medicaid already totalled $76.6 billion. *See* Am. Hosp. Ass'n, *Fact Sheet: Underpayment by Medicare and Medicaid* (Jan. 2020), *available at* https://tinyurl.com/wkb8bry. 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. These responsibilities will

stress hospitals' finances, 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.

A finding that the ACA is not severable would hamper hospitals' ability to invest in the future. In recent years, roughly a third of hospitals have had negative operating margins—meaning they spent more than they took in. *See* Rich Daly et al., *Not-for-Profit Hospitals Hit All-Time-Low Operating Margins: Moody's*, Healthcare Fin. Mgmt. Ass'n (Aug. 30, 2018), https://tinyurl.com/u8l4f5r. And even without the elimination of the ACA, that number is projected to increase to as much as 50 percent in the next five years. *See id.* A judicial ruling invalidating the entire ACA and increasing the rates of uncompensated care would only further erode hospitals' positive margins. Even lower margins will make it so hospitals will, at best, strain to keep pace with new life-sustaining advances in medicine, invest in new payment and delivery models, and keep pace with escalating drug prices.

3. A decision deeming the individual mandate not severable would also threaten 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* 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 made could falter.

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 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 * * *, 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, 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). 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 individual mandate is found to not be severable, the progress made by these programs and the

innumerable others authorized in the ACA will be reversed. 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. As Judge King explained, "[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.

III. ALLOWING THE DECISION BELOW TO STAND BEYOND THIS TERM WILL SOW UNECESSARY CONFUSION IN THE HEALTHCARE SYSTEM, HARMING PATIENTS AND THE HOSPITALS THEY RELY ON FOR CARE AND TREATMENT.

The court of appeals' decision "ensures that no end for this litigation is in sight." Pet. App. 113a (King, J., dissenting). As litigation continues, hospitals, providers, and patients will have no definitive answer to whether the entire ACA will remain on the books when this case ends. That uncertainty will have serious, perhaps irreparable, consequences for hospitals and the patients they serve. In particular, it would destabilize hospitals' ability to make long-term investments. Hospitals must decide which initiatives to fund years in advance. Before making

those investments, hospitals need to know what the legal landscape will look like. For example, hospitals will not know whether they will need to have funds on hand to cover expenses currently covered by the ACA's Medicaid expansion and other insurance reforms. Nor will they know how to operate services, for which funding may no longer be available, whether the innovative delivery system changes they've made will be sustainable, whether the prevention programs they've invested in will be supported or, in some cases, whether they will be able to keep their doors open at all. *See supra*, pp. 19-20. Allowing the decision below to stand beyond this Term would thus "unnecessarily prolong this litigation and the concomitant uncertainty over the future of the healthcare sector." Pet. App. 74a (King, J., dissenting). The Court should step in now to provide certainty for patients as well as hospitals and other entities whose critical operating decisions are inextricably tied to the ACA.

CONCLUSION

For the foregoing reasons and those in the petitions, the petitions should be granted.

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