Nos. 19-840, 19-1019

IN THE

Supreme Court of the United States

CALIFORNIA, ET AL.,
***PETITIONERS*,**

v.

TEXAS, ET AL.,
***RESPONDENTS*.**

TEXAS, ET AL.,
***PETITIONERS*,**

v.

CALIFORNIA, ET AL.,
***RESPONDENTS*.**

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

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BRIEF OF *AMICI CURIAE* ALLIANCE OF COMMUNITY HEALTH PLANS AND ASSOCIATION FOR COMMUNITY AFFILIATED PLANS IN SUPPORT OF PETITIONERS IN 19-840

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STATEMENT OF INTEREST[1]

ACHP is a national leadership organization of top-performing health plans and provider organizations. ACHP's members are not-for-profit, community-based, and regional health plans that provide high-quality health coverage and care to nearly 22 million Americans, including 2.6 million Medicare beneficiaries, in 35 states and the District of Columbia.

ACAP is a national trade association representing 76 not-for-profit and community-based health plans in 32 states that provide health coverage to more than 20 million people through Medicaid, Medicare, Marketplace, and other public health coverage programs. ACAP's member health plans primarily participate in the low-margin, Medicaid market and rarely participate in the higher-margin large group employer market. ACAP member health plans that have entered into the individual market provide streamlined coverage for low-income consumers that regularly move between Medicaid and the individual market based on income. Many enrollees to ACAP's member health plans are among the nation's poorest and sickest people who lack access to other health insurance.

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[1] No part of this brief was authored by counsel for any party, and no person or entity has made any monetary contribution to the preparation or submission of the brief other than *amici curiae* and their counsel. Pursuant to Rule 37.3(a), *amici* state that counsel of record for Petitioners and Respondents have consented to the filing of this brief.

Together, ACHP's and ACAP's member health plans ("Member Plans")[2] deliver affordable, high-quality coverage and care for more than 42 million Americans in 40 states and the District of Columbia. As mission-driven organizations, Member Plans have been a strong and stable presence in their communities.

ACHP and ACAP submit this amicus brief to explain how invalidating the entire Affordable Care Act (as Respondents argue) would be catastrophic to Member Plans, their enrollees, and millions of other Americans, at a time in history—the COVID-19 pandemic—when Americans need access to affordable healthcare more than ever.

INTRODUCTION

The nation has spent the past decade adapting to the Affordable Care Act[3] ("ACA"). The ACA made substantial changes to how health insurance is delivered and accessed. Among those changes are provisions that:

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[2] A list of the ACHP and ACAP Member Plans are attached as an appendix hereto.

[3] The Affordable Care Act (the "Act" or the "ACA") is comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010).

- enable consumers to purchase and afford health insurance via advance premium tax credits[4];

- ensure coverage of essential health benefits, such as maternity care, mental health, and substance use disorder services, in individual and small group insurance policies[5];

- prohibit the denial of coverage on the basis of preexisting conditions[6];

- encourage states to expand Medicaid eligibility[7]; and

- improve Medicare benefits and quality, as well as Medicare's financial health.[8]

The ACA is "one of the most consequential laws" in U.S. history. *Sissel v. U.S. Dep't of Health & Human Servs.*, 799 F.3d 1035, 1049 (D.C. Cir. 2015) (Kavanaugh, J., dissenting). And it continues to function almost completely undisturbed by the neutering of the individual mandate by the Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (2017)("TCJA").

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[4] 26 U.S.C. § 36B (ACA Section 1401).

[5] 42 U.S.C. § 18022 (ACA Section 1302).

[6] 42 U.S.C. § 300gg-1, 42 U.S.C. § 300gg-4, 42 U.S.C. § 300gg-3 (ACA Section 1201).

[7] ACA Title II, Subtitle A; 42 U.S.C. § 1396d(y)(1).

[8] 42 U.S.C.§ 18052 (ACA Section 1332).

Respondents the State of Texas, *et. al.*, Mr. Hurley and Mr. Nantz, seek a return to pre-ACA America. Jettisoning the ACA, however, would create chaos, strip millions of Americans of their health insurance, and strain government health and welfare programs in the midst of an unprecedented public health crisis.

In just five months, the COVID-19 pandemic has swept—and continues to sweep—across the country and the world, affecting the lives of every American, and perhaps nearly everyone on earth. As of the filing of this brief, nearly four million cases of COVID-19 have been confirmed worldwide, with over 1.3 million cases confirmed in the U.S. Nearly 80,000 deaths have been caused by the virus in the United States, and nearly 300,000 deaths have been reported across the globe.[9] Millions more Americans have lost their jobs and will lose their employer-sponsored health insurance as a result of the virus, forcing them to seek affordable coverage in the individual market via special enrollment periods enabled by the ACA.[10]

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[9] Worldometer, "COVID-19 Coronavirus Pandemic." (May 8, 2020), *available at* https://www.worldometers.info/coronavirus/.

[10] Joseph Antos and James Capretta, "Blocking Open Enrollment for ACA Insurance is Another Pandemic Mistake." *American Enterprise Institute*, (April 2, 2020) (noting the need to open up the ACA's marketplace exchanges via an even broader and more accommodating special enrollment process for people who lose their jobs and employer-sponsored health insurance due to the pandemic), *available at* https://www.aei.org/health-policy/blocking-open-enrollment-for-aca-insurance-is-another-pandemic-mistake/; *see also* Centers

(continued...)

Now more than ever, Americans need access to a stable healthcare system with high-quality, innovative, and affordable healthcare. Exigencies and the public welfare dictate that the ACA remain intact. Indeed, even the U.S. Attorney General has said he does not think the ACA should be struck down in its entirety.[11] The Court has ample reason to repudiate Respondents' case:

- *First*, individual respondents Mr. Hurley and Mr. Nantz lack standing to challenge a now-toothless individual mandate because it causes them no cognizable injury should they opt to forgo health insurance. *See Babbitt v. United Farm Workers Nat. Union*, 442 U.S. 289, 298 (1979) ("A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement.").

- *Second*, respondents the State of Texas and its fellow state plaintiffs lack standing because they failed to submit any empirical

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for Medicare and Medicaid. "If you lose job-based health insurance." *HealthCare.gov* (Individual coverage obtained via an ACA marketplace is more affordable than using COBRA to continue coverage under the employer-sponsored plan), *available at* https://www.healthcare.gov/have-job-based-coverage/if-you-lose-job-based-coverage/.

[11] Kaitlan Collins, et. al. "Barr urges Trump administration to back off call to fully strike down Obamacare." *CNN* (May 5, 2020), *available at* https://www.cnn.com/2020/05/05/politics/william-barr-obamacare-supreme-court/index.html.

or concrete evidence of injury before the district court. *See Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 420 (2013) (rejecting standing where respondents offered "no concrete evidence" of injury).

- *Third*, the individual mandate remains a valid exercise of congressional power. The law in its current form is a dormant tax, "do[ing] nothing" while reserving the features to operate as tax in the future. *See* JA451 (King, J., dissenting); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012) (upholding individual mandate under Congress's taxing power).

- *Fourth*, even if the mandate itself were unconstitutional, it is severable from the remainder of the ACA, for Congress has given direct evidence of its intent to preserve the ACA without an enforceable mandate: in 2017, it temporarily neutralized the mandate's impact, while retaining the rest of ACA's provisions. *See United States v. Booker*, 543 U.S. 220, 224 (2005) (severability analysis is question of Congress' "likely intent" to preserve a law, despite excising an unlawful portion of it).

Respondents' lack of standing and the individual mandate's constitutionality are sound and convincing legal bases for the Court to reverse the Fifth Circuit, and Member Plans leave it to State Petitioners, the United States House of Representatives, and several of their fellow *amici* to argue these points.

The purpose of this brief is to animate Petitioners' severability argument by showing the catastrophic consequences facing Member Plans and their millions of enrollees should the ACA cease to exist, and explaining how several important ACA reforms continue to function despite an unenforceable mandate.

The Court should reverse the Fifth Circuit in its entirety. But if it were inclined not to, law and circumstances dictate that the remainder of the ACA must stand.

ARGUMENT

Part III explains why the balance of the ACA should remain unscathed even if the Court agrees that the individual mandate is no longer constitutional. We begin, though, in Part I with a description of the important features of the ACA that, if constitutionally invalid, would be devastating to Member Plans and their millions of enrollees. Part II then examines the even greater disastrous consequences COVID-19 would cause in the absence of the ACA.

I. INVALIDATING THE ENTIRETY OF THE ACA WOULD BE CATASTROPHIC TO THE WELFARE OF MEMBER PLANS AND THEIR ENROLLEES.

The ACA transformed the lives and welfare of millions of people, including those covered by the ACHP and ACAP Member Plans. The ACA's expanded access to affordable care with meaningful benefits has furthered the core mission of not-for-profit community health plans to reduce costs,

improve health outcomes, and deliver high-quality care. The ACA not only guarantees access to affordable healthcare for millions of Member Plans' enrollees, it has prompted Member Plans to innovate on behalf of those enrollees—to improve the quality of that care by way of innovative payment models, integrated care delivery, and other quality improvement activities.

Invalidating the ACA would eliminate that access to affordable care. Vitiation of the ACA, as Respondents request, would increase the number of uninsured, strain the healthcare delivery system's ability to withstand massive amounts of uncompensated care, result in delays in necessary care, and result in substantially worse health outcomes for Americans.[12]

The ACA reforms described below underline the importance of not invalidating the entire ACA even if the individual mandate is deemed unconstitutional.

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[12] *See* David Blumenthal, M.D. and David Squires, "Estimating the Affordable Care Act's Impact on Health." *The Commonwealth Fund* (Aug. 12, 2015) (describing how the ACA has improved health outcomes in America), *available at* https://yale.app.box.com/s/mhmds0etbz1k37wixfisag75crcudfab/file/524214153121.

A. Invalidating the ACA's advance premium tax credit will cause millions, including many of Member Plans' enrollees, to lose coverage.

Before the ACA, Americans who did not have health insurance through their employer but who otherwise did not qualify for Medicare or Medicaid lacked options for affordable, comprehensive coverage.[13] Insurance policies in this "non-group" market were often too expensive for Americans to afford, so many opted to forgo insurance altogether.[14] Inevitably, these individuals would get sick, go to the emergency room or a physician's office, and then not be able to pay for it. And by having forgone regular preventive care or management of chronic conditions, many of these individuals presented with more acute conditions than they otherwise would have, increasing the cost of care and the strain on the healthcare system.

The ACA sought to disrupt this paradigm, in part, through an advance premium tax credit. *See* 26 U.S.C. § 36B; *see also King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (noting "the Act seeks to make

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[13] *See* Adam Looney and Kathryn Martin, "One in Five 2014 Marketplace Consumers was a Small Business Owner or Self-Employed," *U.S. Department of the Treasury* (Jan. 12, 2017), *available at* https://www.treasury.gov/connect/blog/pages/one-in-five-2014-marketplace-consumers-was-a-small-business-owner-or-self-employed.aspx.

[14] Sabrina Corlette, *et. al*., "The ACA's Effect on The Individual Insurance Market." *HealthAffairs* (March 2020), *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01363.

insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line"). The tax credit is designed to incentivize people who lack employer-sponsored insurance to purchase individual policies by defraying the costs of those policies.

Approximately 9.3 million Americans—87 percent of all marketplace exchange enrollees—in 2019 received the tax credit to help make their coverage more affordable.[15] Over one million enrollees of ACHP Member Plans receive the tax credit, as do approximately 580,000 of ACAP Member Plans' enrollees. Indeed, more than 92% of one ACHP Member Plan's enrollees rely on the tax credit to afford insurance.

The difference in the effective premium rates for those receiving the tax credit is significant and demonstrates its importance. In 2019, the average premium for Americans purchasing an individual insurance policy off the marketplace exchange without the tax credit was $612 per month; for those that received the tax credit, *it was $87 per month*.[16]

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[15] *Id.*

[16] Centers for Medicare & Medicaid Services, *Health Insurance Exchanges 2019 Open Enrollment Report* (Mar. 25, 2019), *available at* https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report.

The individual health insurance market is very price sensitive.[17] Millions of Member Plans' enrollees rely on the tax credit each year. For example, an ACAP Member Plan in Harris County, Texas, estimates that 80,000 out of its 89,000 on-marketplace enrollees rely on the tax credit to afford insurance. Member Plans' benefit from the tax credit, in part, because it enables more people to enroll, broadening the risk pool and helping to keep premiums more affordable. ACHP Member Plans' enrollment numbers for individual insurance products has more than doubled since the ACA's implementation.

Invalidating the ACA, and with it, invalidation of the advance premium tax credit, would result in millions losing coverage due to an inability to afford premiums. This would be the case both for those individuals who lose the benefit of the tax credit and for some individuals priced out of coverage given a worsening risk pool. In 2015, as this Court deliberated its decision in *King v. Burwell,*[18] studies estimated that invalidation of the tax credit as applied to the 34 states who at the time had not established state-managed marketplaces would increase the number of uninsured by approximately

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[17] Paul Houchens, *et al*., *Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act*, 17 Society of Actuaries (Mar. 2020).

[18] *See King*, 135 S. Ct. at 2496 (upholding the availability of the tax credit in states that had a federal marketplace exchange).

9 million people.[19] The number is sure to be even higher if the Court were to invalidate the ACA wholesale.

A return to a time with no tax credit will make insurance unaffordable for millions, drastically increase uncompensated care provided by hospitals, result in fewer consumers purchasing insurance, and shrink risk pools.

B. Invalidating the ACA's coverage requirements for persons with pre-existing conditions puts the healthcare of the nation's most vulnerable at risk.

The ACA protects the nation's sickest Americans by making it unlawful for private insurers to discriminate against prospective enrollees with preexisting conditions in the sale and pricing of health insurance.[20] Pre-existing conditions include many different ailments—some of the most common being high blood pressure, behavioral-health disorders, heart conditions, diabetes, and cancer.[21] And, as detailed below, ACHP and ACAP

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[19] Evan Saltzman and Christine Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces." *Rand Health Quarterly* (July 15, 2015) at 2, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158240/.

[20] 42 U.S.C. § 300gg-1, 42 U.S.C. § 300gg-4, 42 U.S.C. § 300gg-3.

[21] U.S. Dep't of Health & Human Servs., Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Ac*t, ASPE ISSUE BRIEF 1 (Jan.

(continued...)

Member Plans have developed innovative programs to manage their enrollee's preexisting conditions.

The ACA made it illegal for an insurer to deny an individual coverage based on preexisting health status or to charge that individual more than a similarly situated individual without the preexisting condition. *See* 42 U.S.C. § 300gg-1, 42 U.S.C. § 300gg-4, 42 U.S.C. § 300gg-3. These reforms have opened the doors to affordable, quality health coverage for millions of Americans, who previously could not purchase or afford health insurance, including many of the Member Plans' enrollees.[22]

The ACA prompted Member Plans to do more, and to do it more effectively. To this end, Member Plans have implemented chronic condition case management and other quality improvement activities to meet the needs of persons with previously devastating chronic conditions.

For example, four ACAP Member Plans have developed programs to improve services for their beneficiaries suffering from Hepatitis C. These programs include the implementation of rapid case management, care coordination, and engagement

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5, 2017), *available at* https://aspe.hhs.gov/pdf-report/health-insurance-coverage-americans-pre-existing-conditions-impact-affordable-care-act.

[22] U.S. Dep't of Health & Human Servs., (footnote 21 *supra*) (noting analysis that found that, "between 2010 and 2014, the share of Americans with pre-existing conditions who went without health insurance all year fell by 22 percent, a drop of 3.6 million people").

with members on the importance of treatment adherence. One ACHP Member Plan also altered treatment protocols for Hepatitis C to shorten the length of treatment and cure people faster, resulting in almost $300,000 in savings per patient. Those savings mean that, for every two patients treated, treating a third is free. Since 2018, the Member Plan has treated more than 2,000 Hepatitis C patients and achieved a 97.5% cure rate.

Four other ACAP Member Plans have developed programs to better coordinate care for substance-abuse patients. These programs encourage a comprehensive, case management approach tailored to each patients' needs and an emphasis on analyzing data to monitor a patient's medical needs and progress, and to coordinate care.[23]

Similarly, another ACHP Member Plan launched an Integrated Substance Use Disorder and Community Collaborative Initiative, designed to increase screening and treatment for substance use disorders and engage patients any time they touch the delivery system. This initiative, launched in response to the opioid epidemic, has ensured timely and appropriate care has been delivered to more than 1,500 individuals and counting. The ACA helped make these innovations a life-saving reality.

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[23] Association for Community Affiliated Plans, "Resource Guide: Improving Care Management for Individuals with Substance Use Disorder." *ACAP*, at 2 (Aug. 2018), *available at* https://www.communityplans.net/wp-content/uploads/2018/09/Improving_Care_Management_for_SUD.pdf

Invalidating the ACA would sweep these crucial programs away, and most Americans don't want this to happen: the ACA's pre-existing condition reforms have achieved widespread support across the political spectrum, and for good reason.[24] A recent report by the Kaiser Family Foundation finds that, as of January 2020, approximately 54 million Americans have a pre-existing health condition "that would have been deniable in the pre-ACA individual market."[25] For these individuals, a return to a pre-ACA world means a world where fear abounds that they will lose or be denied coverage just because they are sick—or for other individuals, that they will be unable to afford coverage because of change to the risk pool.[26]

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[24] Kaiser Family Foundation Health Reform, "Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act." *Kaiser Family Foundation* (Jan. 3, 2020) (noting that "Majorities say it is 'very important' to them that the ACA provisions prohibiting insurance companies from denying coverage (72%) or charging sick people more (64%) remain in place if the ACA is ruled unconstitutional," and noting further the bipartisan support for preexisting-condition reforms), *available at* https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/.

[25] *Id.*

[26] U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, (describing study from 2011 that found that "54 percent of people with individual market insurance were worried that their insurer would drop their coverage if they got really sick"), *available at*

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One of ACHP's and ACAP's Member Plans' core values is to help improve the lives of their communities, especially the sickest and most in need. Striking down the ACA would frustrate that vital mission.

C. Invalidating the ACA's Medicaid expansion would strip health coverage away from those who cannot afford commercial insurance.

Medicaid is a federally funded program administered by the states that provides coverage to the nation's poorest and most vulnerable populations.

Before the ACA, Medicaid was generally limited to low-income families with children, qualified pregnant women, and the aged, blind, or disabled. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 541-42 (2012) (noting same). Eligibility for Medicaid across various states required most participants to have incomes below 100%—and in some instances well-below 100%—of the federal poverty line.[27]

(continued...)
https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting.

[27] Kaiser Family Foundation, "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Line." *KFF* (Timeframe: Jan. 1, 2020), *available at* https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-

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The ACA enabled states to increase their Medicaid program offerings. *See* 42 U.S.C. § 1396a(10)(A)(i)(VIII); 42 U.S.C. § 1396d(y). For those states that opt into this "Medicaid expansion," they must expand Medicaid coverage for most low-income adults with income levels at or below 138% of the federal poverty level.[28] This expansion eliminates the "coverage gap" between traditional Medicaid eligibility and qualifications for federal subsidies to purchase coverage through the marketplace exchanges.

As of early 2020, 37 states and the District of Columbia are participating in the ACA's Medicaid expansion.[29] Medicaid expansion is vitally important to the mission of ACHP's and ACAP's Member Plans. Indeed, the work of several Member Plans includes not only provision of expanded Medicaid coverage to enrollees, but attendant to that, investments in various innovative programs that help the homeless

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[28] Nicole Craffitz-Wortz *et al.*, "Association of Medicaid Expansion with Opioid Overdose Mortality in the U.S." *JAMA Network* (2020), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2758476.

[29] Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision." *KFF* (timeframe March 13, 2020), *available at* https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

and poverty-stricken—all with the intent of reducing poverty, improving health, and reducing healthcare costs.[30]

ACHP and ACAP Member Plans enroll over four million and 17 million individuals in their Medicaid managed care plans, respectively. These numbers are more than double their levels from 2010, before the ACA was implemented.

Medicaid expansion has increased access to healthcare for the nation's poorest and most vulnerable Americans. For example, in FY 2018, there were more than 15 million Medicaid expansion enrollees nationwide.[31] As of April 2019, 72.4 million Americans are enrolled in Medicaid or the Children's Health Insurance Program.[32] Correspondingly, the number of uninsured has

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[30] Association for Community Affiliated Plans, "Bridging the Health and Housing Gap." *ACAP* (Nov. 2017) *available at* https://www.communityplans.net/research/housing-gap/; *see also* Kaiser Permanente, "$200M for Our Fight Against Homelessness," *available at* https://about.kaiserpermanente.org/who-we-are/fast-facts/at-a-glance/200-million-fight-homelessness.

[31] Kaiser Family Foundation, "Medicaid Expansion Enrollment." *KFF* (FY 2018), available at https://www.kff.org/health-reform/state-indicator/medicaid-expansion enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[32] Medicaid & CHIP Payment & Access Comm'n, "Medicaid enrollment changes following the ACA." *MACPAC*, *available at* https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/.

declined, "The sharp declines in uninsured rates among the low-income population in expansion states are widely attributed to gains in Medicaid coverage."[33]

One study by the Center on Budget and Policy Priorities has found that Medicaid expansion has saved at least 19,000 lives.[34] Medicaid expansion is traceable to increases in people getting regular check-ups, having their prescriptions filled, and diagnosing severe illnesses, such as cancer, earlier. Evidence also shows that it decreases people skipping medications due to cost and going without a primary care physician.[35]

Medicaid expansion further requires enhanced coverage requirements for mental health and substance-use disorders.[36] Another study has concluded that Medicaid expansion is attributable to

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[33] Larisa Antonisse *et al.*, "The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review." Kaiser Family Foundation, (Mar. 28, 2018), *available at* https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaidexpansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/.

[34] Matt Broaddus and Aviva Aron-Dine, "Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds." *Ctr. On Budget & Policy Priorities*, (Nov. 6, 2019), *available at* https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds.

[35] *Id.*

[36] *Id*.

decreases in total opioid deaths in the United States.[37]

Medicaid expansion has had a stabilizing effect on hospitals and other providers—particularly in rural areas—and has resulted in improved access to healthcare services. A Health Affairs study determined that Medicaid expansion prevents hospital closures because it reduces uncompensated care for poor, uninsured individuals.[38]

Many ACHP and ACAP Member Plans who provide Medicaid managed care benefits to beneficiaries also provide coverage through the exchanges, enabling continuity of care and consistency in coverage for beneficiaries who transition from Medicaid to private insurance available via the exchanges.

The elimination of the Medicaid expansion program would mean the loss of healthcare coverage for millions that have gained it through the ACA's initiative. Most of these individuals will not be able to afford coverage in the commercial market, and as a consequence, will forgo coverage altogether. No coverage means fewer individuals seeking preventive care and filling necessary prescription medications, leading to sicker populations, increases in emergency

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[37] Nicole Craffitz-Wortz *et al.*, (footnote 28 *supra*).

[38] Richard C. Lindrooth, *et. al.*, "Understanding the Relationship Between Medicaid Expansions and Hospital Closures." *Health Affairs* Vol 37, No. 1 (January 2018), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

room visits, and increases in the rate of uncompensated healthcare services. This would, in turn, disrupt the healthcare system, impair the insurance market, and increase costs for all Americans.

D. Invalidating the ACA will strain the Medicare budget and set back initiatives to enhance the quality of healthcare for older Americans.

Medicare currently provides healthcare coverage for over 60 million people who are either at least 65 years old or disabled.[39] The ACA has 165 provisions related to Medicare and creates Medicare programs and alternative payment arrangements that reduce costs and improve the quality of healthcare. *See, e.g.* 42 U.S.C. § 1395jjj and 1395cc-4. These Medicare enhancements have enabled ACHP's and ACAP's Member Plans to provide Medicare benefits at lower costs to their enrollees.

The ACA created the Center for Medicare and Medicaid Innovation ("CMMI"). CMMI develops healthcare delivery and payment models to improve quality of care to Medicare and Medicaid beneficiaries and reduce costs.[40] CMMI "has

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[39] Juliette Cubanski *et al.*, "The Facts on Medicare Spending and Financing," *Kaiser Family Foundation* (Aug. 20, 2019), *available at* https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.

[40] Kaiser Family Foundation, "'What is CMMI?' and 11 other FAQs about the CMS Innovation Center." *KFF* (Feb. 27, 2018), *available at* https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/.

launched over 40 new payment models, involving more than 18 million patients and 200,000 healthcare providers."[41] Through CMMI, a number of states are also engaged in multi-payer delivery and payment reforms that include a focus on population health and recognize the role of social determinants, *i.e.*, the conditions in which people are born, work, and live.

The bulk of CMMI's innovative payment models operate as part of the Medicare program and include accountable care organizations, bundled payments, and medical homes.[42] These models' goal is to steer Medicare spending away from fee-for-service to alternative payment arrangements that are more cost effective and better serve the healthcare needs of Medicare beneficiaries.

One example of how these innovative models have reduced costs and improved quality of care is the Enhanced Primary Care ("EPC") program, a patient-centered medical home, implemented by an ACHP Member Plan. The EPC Engagement Team worked directly with practices on performance improvement and cost savings, including more affordable prescription drug options. Between 2010 and 2014, quality scores for EPC sites rose from 71% to 77%, while quality scores for non-EPC sites rose from 65% to 68%. Likewise, the EPC program realized millions of dollars in cost-savings that have

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[41] *Id.*

[42] *Id.*

been re-invested into the practices that improved quality, efficiency and patient satisfaction scores.

Another example of the ACA's critical Medicare reforms is the Medicare Shared Savings Programs. The Medicare Shared Savings Programs is a new payment model that CMMI is testing in the market. The program permits the formation of accountable care organizations ("ACOs")—groups of doctors and hospitals—that take responsibility for the care of a Medicare patient and get to share in the financial savings or losses for the care of that patient depending on the achievement of certain healthcare quality and cost benchmarks.[43]

In July 2019, about one-sixth of all Medicare beneficiaries—10.9 million people—were receiving care from a provider participating in the Medicare Shared Savings Program.[44] Many others receive care from providers participating in another alternative payment model.[45] ACHP Member Plans use these and other types of innovative payment and delivery

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[43] Kaiser Family Foundation, "An Overview of Medicare." *KFF* (Feb. 13, 2019), *accessed in* May 2020, *available at* https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/.

[44] Centers for Medicare and Medicaid Services, "Shared Savings Program Fast Facts – As of July 1, 2019," *accessed in* May 2020, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-2019-fast-facts.pdf.

[45] Centers for Medicare and Medicaid Services, "About the CMS Innovation Center," *accessed in* May 2020, *available at* https://innovation.cms.gov/About/.

models to achieve higher quality, more cost-effective care. This, in turn, allows them to meet the needs of more people in their communities.

The implementation of these programs has benefited Medicare considerably by reducing its spending.[46] The Congressional Budget Office estimates that programs launched by CMMI will save the federal government $34 billion from 2017-2026.[47]

The ACA's Medicare reforms have benefited not just Medicare's budget but its beneficiaries as well. The ACA mandates that certain preventive services are available to Medicare beneficiaries without cost-sharing. Tens of millions of Medicare beneficiaries, including Member Plans' enrollees, take advantage of these free preventive services, ultimately leading to earlier diagnoses and less costly treatments.[48]

Programs through CMMI and the ACA-created Federal Coordinated Health Care Office (the "Medicare-Medicaid Coordination Office") have also enabled Member Plans to develop specialized programs that tackle the acute needs of certain

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[46] Juliette Cubanski, *et al*. (footnote 39 *supra*).

[47] Kaiser Family Found., "'What is CMMI?'" and 11 other FAQs about the CMS Innovation Center." (footnote 40 *supra*).

[48] Centers for Medicare & Medicaid Services, "Nearly 12 million people with Medicare have saved over $26 billion on prescription." *CMS.gov*. (Jan. 13, 2017), *available at* https://www.cms.gov/newsroom/press-releases/nearly-12-million-people-medicare-have-saved-over-26-billion-prescription-drugs-2010.

vulnerable populations.[49] For example, in 2019 there were more than 12.2 million people concurrently enrolled in both Medicare and Medicaid (referred to as "dual-eligibles").[50] Dual-eligible persons typically have higher rate of chronic health conditions and risk of worse outcomes than persons in either Medicare or Medicaid.[51]

The Medicare-Medicaid Coordination Office was created to provide higher quality, better coordinated, integrated service delivery, and easier to access healthcare for dual-eligibles.[52] To do so, the Medicare-Medicaid Coordination Office has used demonstration projects under the Financial Alignment Initiative to test better ways to integrate care and improve outcomes.[53] The Financial Alignment Initiative helps Member Plans satisfy the needs of dual-eligibles.[54] ACAP Member Plans enroll more than 30% of all dual-eligible persons in

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[49] 42 U.S.C. § 1315b(d) (ACA Section 2602).

[50] Medicare-Medicaid Coordination Office, FY 2019 Report to Congress at 3 *available at* https://www.cms.gov/files/document/mmco-report-congress.pdf

[51] *Id*.

[52] *Id*. at 7.

[53] *Id*. at 9; https://innovation.cms.gov/innovation-models/financial-alignment; 42 U.S.C. § 1315a (ACA Section 3021); *see also* https://www.macpac.gov/subtopic/financial-alignment-initiative/

[54] Centers for Medicare and Medicaid Services, "Financial Alignment Initiative for Medicare-Medicaid Enrollees." *CMS.gov*. (Apr. 9, 2020), *available at* https://innovation.cms.gov/innovation-models/financial-alignment

the demonstration. This initiative and the Medicare-Medicaid Coordination Office are vital to the mission of ACAP Member Plans and have spawned better care for dually eligible Americans.

For example, over 10,000 enrollees of one ACAP Member Plan are dually eligible for Medicare and Medicaid and suffer from a behavioral health diagnosis. This Member Plan estimated that as many as 70 percent of its members suffering from behavioral health issues lacked a suitable care option. These enrollees did not need the intensive, restrictive care that comes with admission to a psychiatric hospital, but they also needed care that was more intensive than that generally offered in an outpatient setting. In response to this dilemma, the Plan—through coordination and approval of CMMI—created its own crisis stabilization unit program, which offers a level of care somewhere between a psychiatric hospital and outpatient setting. The program uses a renovated house and an unused hospital wing to meet these patients' needs. The program is made possible through the ACA.

Another ACAP Member Plan developed a pilot program to help members transition out of institutions and into the community and avoid unnecessary institutionalizations. As part of the program, 34 Members receive intense case management, housing assistance services, and medical care. The Member Plan partnered with a care management agency and a housing agency to create the pilot program, which also leverages the Member Plan's relationships with other community organizations, including: affordable supportive housing providers; county agencies; hospital and

nursing facility discharge planners and social workers; and a network of community Residential Care Facilities for the Elderly.

Since the ACA's inception, Medicare has received healthier enrollees when they become Medicare-eligible because the ACA's other reforms make healthcare more accessible to Americans under the age of 65. "Beneficiaries with continuous health insurance coverage for approximately 6 years before enrolling in Medicare were more likely than those without prior continuous insurance to report being in good health or better by nearly 6 percentage points during the first 6 years in Medicare."[55]

Invalidating the ACA will result in wiping away these and other enhancements to Medicare which have benefitted the federal government's budget and the millions of beneficiaries served by the program. A Congressional Budget Office report from 2016 estimated that a full repeal of the ACA would increase Medicare spending in the years to come by billions of dollars, pushing it faster to the brink of insolvency.[56] It would also lead to higher Medicare

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[55] U.S. Government Accountability Office, "Medicare: Continuous Insurance Before Enrollment Associated with Better Health and Lower Program Spending." *GAO* (Dec. 2013) at 9 (finding that the previously uninsured had 35% more program spending in the first year of Medicare enrollment than those who continuously had insurance for six years), *available at* https://www.gao.gov/assets/660/659753.pdf.

[56] Juliette Cubanski, *et. al.*, "What are the Implications of Repealing the Affordable Care Act for Medicare Spending and Beneficiaries," *Kaiser Family Foundation* (Dec. 13, 2016), *available at* https://www.kff.org/health-reform/issue-brief/what-

(continued...)

premiums, deductibles, and cost-sharing for the program's beneficiaries.[57]

A world without the ACA means accelerated financial peril for Medicare and the loss of critical healthcare benefits for older Americans.

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In 2017, the Congressional Budget Office estimated that the number of uninsured in the United States would increase by 32 million over the span of a decade if the ACA were repealed.[58] Millions more uninsured is the last thing the country needs during the midst of a global pandemic.

II. ACCESS TO AFFORDABLE HEALTHCARE MADE POSSIBLE THROUGH THE ACA IS A CRUCIAL PUBLIC GOOD, ESPECIALLY DURING A GLOBAL PANDEMIC.

The Court affords "great weight to the decisions of Congress." *Rostker v. Goldberg*, 453 U.S. 57, 64 (1981) (quoting *Columbia Broadcasting System, Inc. v. Democratic Nat'l Comm.*, 412 U.S. 94, 102 (1973)). And Congress's decision on the ACA, despite the mountain of legal challenges over the last decade,

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[57] *Id.*

[58] Congressional Budget Office, "H.R. 1628 Obamacare Repeal Reconciliation Act of 2017." *CBO* (July 19, 2017) at 1, *available at* https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

has been to preserve the law. The virtues of deferring to legislative judgments are no more important than in national emergencies and crises of public health. *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 398 (1937) (noting that "the Legislature is primarily the judge of the necessity of [its] enactment[s]"); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905); *accord Holder v. Humanitarian Law Project*, 561 U.S. 1, 34 (2015) (noting that the judiciary defers to Congress when considering "weighty interests of national security").

Seldom has an event in human history so pervasively altered the everyday lives of people than the COVID-19 pandemic. On March 13, 2020, President Trump declared the pandemic a national emergency,[59] following which 42 states, the District of Columbia, and Puerto Rico issued shelter-at-home orders in efforts to stop the virus's spread.[60]

As of the filing of this brief, the virus has infected a reported 1.3 million Americans, but the true number is purported to be much larger. It has killed nearly 80,000 in this country, and nearly

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[59] "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," *The White House* (March 13, 2020), *available at* https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

[60] Marisa Fernandez, "More states issue stay-at-home orders as coronavirus crisis escalates." *AXIOS*, (Apr. 6, 2020), *available at* https://www.axios.com/states-shelter-in-place-coronavirus-66e9987a-a674-42bc-8d3f-070a1c0ee1a9.html.

300,000 worldwide.[61] Over 20 million Americans lost their jobs in April alone, largely due the economic shutdown that the virus has caused.[62] And an estimated 35 million are projected to lose their employer-sponsored health insurance during the course of the outbreak.[63]

One study estimates $42 billion dollars in uninsured hospitalization costs for COVID-19 patients, and this is *despite the enhanced access to affordable care and coverage provided by the ACA*.[64] A world infected by COVID-19 where the ACA did not exist would see even higher uninsured hospitalization costs caused by the virus.

Contrary to Respondents' goal, governments and health plans are actively trying to *enhance*

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[61] Worldometer, "COVID-19 Coronavirus Pandemic." (May 8, 2020) (footnote 9 *supra*).

[62] Heather Long and Andrew Van Dam, "U.S. unemployment rate soars to 14.7 percent, the worst since the Depression era." *The Washington Post*, (May 8, 2020) available at https://www.washingtonpost.com/business/2020/05/08/april-2020-jobs-report/.

[63] Keya Vakil, "35 Million Americans Could Lose Employer-Sponsored Health Insurance, Report Finds." *Courier*, (Apr. 6, 2020), *available at* https://couriernewsroom.com/2020/04/06/35-million-americans-could-lose-employer-sponsored-health-insurance-report-finds/.

[64] Kaiser Health News, "Treating Uninsured Could Cost Hospitals $42B, And As Layoffs Increase That Number Could Soar." *KHN* (Apr. 8, 2020), *available at* https://khn.org/morning-breakout/treating-uninsured-could-cost-hospitals-42b-and-as-layoffs-increase-that-number-could-soar/.

access to care during this unprecedented time, *not contract* it.[65] As part of his national emergency proclamation, President Trump directed his administration to begin permitting the use of "Section 1135 waivers" under the Social Security Act, making it easier to enroll people in Medicaid, Medicare, and the State Children's Health Insurance programs.[66] Health plans and insurers, including Member Plans, have exceeded statutory requirements to waive cost-sharing for COVID-19 diagnostic testing and some have elected to waive cost-sharing also for COVID-19 treatment and extended benefits for telemedicine (including treatment unrelated to COVID-19 to support social distancing and shelter-in-place orders).[67]

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[65] *See, e.g.*, U.S. Chamber of Commerce, "Coalition Letter to Congressional Leadership Urging Swift Action to Protect Americans' Health Care Coverage." (Apr. 28, 2020) (asking Congress to expand access to coverage for those who are losing their jobs due to the COVID-19 outbreak), *available at* https://www.uschamber.com/letters-congress/coalition-letter-congressional-leadership-urging-swift-action-protect-americans.

[66] "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," *The White House* (footnote 59 *supra*).

[67] Alliance of Community Health Plans, "Blog-Community Health Plans Take Action on COVID-19." *ACHP* (Apr. 2020), *available at* https://achp.org/blog-community-health-plans-take-action-on-covid-19/; Association for Community Affiliated Plans, "Resources on COVID-19 (Coronavirus)." *ACAP*, *available at* https://www.communityplans.net/research/resources-on-covid-19-coronavirus/.

Given their strong focus on community health and wellbeing, it is no surprise that ACHP and ACAP Member Plans have done even more to support their members, providers, and communities during the pandemic. For example, several ACHP and ACAP Member Plans have made charitable donations to address food insecurity, childcare, counseling, support to community non-profits, and COVID-19 treatment and prevention efforts for the homeless.[68] Each of these activities supports the ACA's twin goals of increasing access to and affordability of healthcare. One ACAP Member Plan has even pledged to halt coverage terminations due to nonpayment through at least June 2020.

Now more than ever the Nation needs Americans monitoring their health and seeking appropriate treatment when they become ill. Abolishing the ACA would have the opposite effect. It would strip coverage from millions, create financial disincentives for many Americans to seek proper healthcare, increase uncompensated care at hospitals treating the virus, reduce funding to the Centers for Disease Control and Prevention, and severely undermine measures to control the virus's spread.[69] The consequences could be devastating.

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[68] *Id*.

[69] Robert Greenwald, "Insight – Just When It's Most Critical, Republicans Seek End of Affordable Care Act." *Bloomberg Law* (Apr. 23, 2020), *available at* https://news.bloomberglaw.com/us-law-week/insight-just-when-its-most-critical-republicans-seek-end-of-affordable-care-act.

Congress neutered the individual mandate through its passage of the TCJA, but it determined to keep the rest of the ACA in place. Now is hardly the time for the courts to get in the business of second guessing that legislative choice.[70] Eliminating the ACA—a pillar of the American healthcare system—during the ongoing public health crisis would make a nation already stricken by chaos even more chaotic.[71] And, as discussed below, such a result would be inconsistent with the Court's severability jurisprudence.

III. EVEN IF THE COURT WERE TO FIND THE INDIVIDUAL MANDATE UNCONSTITUTIONAL, IT IS SEVERABLE FROM THE ACA.

The individual mandate is constitutional because it is, in current form, a dormant tax that "does nothing" while reserving the features to operate as tax in the future. See JA451 (King, J., dissenting); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 564-566 (2012). But even if the Court were to find the mandate unconstitutional, it is

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[70] Joseph Antos and James Capretta, "Blocking Open Enrollment for ACA Insurance is Another Pandemic Mistake." (footnote 10 *supra*) (describing the utility and necessity of the ACA to combat the pandemic).

[71] Bowen Garret and Anuj Gangopadhyaya, "How the COVID-19 Recession Could Affect age." *Urban Institute* (May 2020) (noting how unemployment may rise to 15 to 20 percent by June, and as many as 25 to 43 million could lose their employer-based health insurance), *available at* https://www.rwjf.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html.

severable from the remainder of the ACA—which remains a viable and functional law.

The issue of severability is one of congressional intent. *See United States v. Booker*, 543 U.S. 220, 265 (2005) (describing the inquiry as focused on the "likely intent" of Congress "in light of" the court's decision). The Court must discern what Congress would have had done had it known the Court would hold the inactive mandate unconstitutional. *Id.* The question of intent focuses on the enacting Congress—in this case the Congress that enacted the TJCA—and asks: if Congress would have known of the neutered mandate's constitutional infirmity, would it still keep the rest of the ACA? *See, e.g., Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006).

The law presumes that Congress would prefer a statute stand subject to excision of its unconstitutional parts rather than see the entire statute fail. *See generally Executive Benefits Ins. Agency v. Arkison*, 573 U.S. 25, 36-37 (2014); *accord Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984). Uncertainty relating to congressional intent militates in favor of keeping the remainder of the law intact. *See Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (recognizing a presumption in favor of severability).

As explained above and in Petitioners' brief, the Congress that enacted the TCJA decided to neutralize the individual mandate by zeroing out its tax, but it also decided to leave the remainder of the

ACA in place. There can be no better evidence from the enacting Congress that it would keep the rest of ACA despite an unconstitutional mandate, *because it did in fact leave the rest of the ACA intact without an enforceable mandate*.

But even if this powerful—if not dispositive—evidence of congressional intent did not exist, there is another jurisprudential proxy for congressional intent that the Court can look to for resolving the severability question: the Court asks whether the remaining statutory scheme can continue to function with the unconstitutional provision excised? In other words, is the balance of the statute *operable* absent the stricken provision? *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) ("Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently").

Our lived reality dictates that the answer is "yes": there has been no tax penalty for Americans failing to buy coverage since tax year 2019, yet the ACA has continued to function.

The ACA's individual marketplace reforms continue to function. Despite facing no penalty, nearly as many Americans enrolled for coverage on the marketplaces in 2019 and 2020, as in 2018. Approximately 11,444,141 Americans enrolled in a marketplace ACA health plan in 2019, and 11,409,447 did the same in 2020; whereas

11,750,175 people enrolled in 2018.[72] The difference in enrollment over the three years has been *de minimis*. Marketplace enrollment at Member Plans has remained steady, and they expect it to steadily rise in the coming years. For example, ACHP Member Plans' on-marketplace enrollment has been: 1,642,340 in 2018, 1,686,085 in 2019, and 1,440,787 in 2020. Likewise, ACAP Member Plans' on-marketplace enrollment has been: 812,224 in 2018, 727,560 in 209, and 719,643 in 2020.

Individual mandate aside, the advance premium tax credits and the reductions and limitations on cost-sharing incentivize people to participate in the market, and these reforms have protected against a steep fall-off in participation. *See* Congressional Budget Office "Options for Reducing the Deficit: 2017-2026," *CBO* at 237 (Dec. 2016) (recognizing that the effects of repealing the individual mandate "would be mitigated somewhat by other factors—including the marketplace subsidies (which make health insurance less costly and more attractive to younger and healthier enrollees who are eligible for those subsidies) and the annual open-enrollment periods in the nongroup market (which reduce the incentive for people to wait until they become ill to obtain coverage).").

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[72] Kaiser Family Foundation, "Marketplace Enrollment, 2014-2020, *KFF,* (Timeframe 2018, 2019, 2020), *available at* https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

In November 2017, the Congressional Budget Office analyzed the effects of repealing the individual mandate and found that the "[n]on group insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." *See* Congressional Budget Office, "Repealing the Individual Health Insurance Mandate: An Updated Estimate." *CBO* at 1 (Nov. 2017). That analysis and prediction has proven to be largely accurate since the tax became dormant last year.

The ACA's Medicaid expansion reforms continue to function. Medicaid accounted for the coverage of 70,609,251 individuals in 2019, with 37 states and the District of Columbia having implemented the ACA's Medicaid expansion program.[73] Utah and Idaho adopted and implemented Medicaid expansion in 2020; Nebraska adopted Medicaid expansion in 2019 and is set to implement it in October of this year.[74]

States continue to expand Medicaid under the ACA despite the effective absence of a mandate. And for Member Plans in particular, total Medicaid enrollment is on the rise. ACHP Member Plans' Medicaid coverage grew from 907,937 covered lives to 2,124,434 covered lives following expansion. Similarly, ACAP Member Plans' Medicaid coverage

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[73] Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions: Interactive Map." *KFF* (March 13, 2020), *available at* https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

[74] *Id.*

rose from 7,970,101 covered lives to 17,175,480 covered lives in 2019.

The ACA's Medicare reforms continue to function. The Center for Medicare and Medicaid Innovation has launched "over 40 new payment models, involving more than 18 million patients and 200,000 healthcare providers" since its inception.[75] The ACA's alternative payment models and delivery systems continue to slow the growth in Medicare spending, providing much needed relief to this vital program for older Americans.[76]

The ACA also continues to reduce costs for approximately 60 million Medicare beneficiaries by requiring free coverage for certain preventative screenings and eliminating the Part D prescription drug coverage gap.[77] These reforms empower Medicare beneficiaries to access services and potentially catch dangerous and costly medical conditions earlier, allowing Member Plans to more effectively manage care, mitigate risks, and improve the lives of their Medicare beneficiary members.

Despite an inactive mandate, Medicare and its beneficiaries are still enjoying the many improvements brought to the Medicare program by the ACA.

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[75] Kaiser Family Foundation, "'What is CMMI?' and 11 other FAQs about the CMS Innovation Center." (footnote 40 *supra*).

[76] Juliette Cubanski *et al.*, (footnote 39 *supra*).

[77] Kaiser Family Foundation Health Reform, "Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act." (footnote 24 *supra*).

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History shows that the individual mandate, while no doubt preferred by the ACA's promoters in Congress, is not necessary to the ACA's ability to function as a whole. The idea that the ACA cannot operate without the mandate is empirically false and belied by experience.

CONCLUSION

The Court should reverse the Fifth Circuit's decision in its entirety. But should the Court reach the issue of severability, it should hold that the individual mandate is severable from remainder of the ACA.

Respectfully submitted,

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APPENDIX

LIST OF MEMBER HEALTH PLANS

ACHP's Member Plans include: Aultcare (Ohio), AvMed (Fla), Capital District Physicians' Health Plan (N.Y.), CommunityCare (Okla.), Dean Health Plan (Wisc.), Fallon Health (Mass.), Geisinger Health Plan (Penn.), Group Health Cooperative of South Central Wisconsin (Wisc.), Harvard Pilgrim Health Care (Mass.), Health Alliance (Ill.), Health Alliance Plan (Mich.), HealthPartners (Minn.), Independent Health Plan (N.Y.), Kaiser Permanente (Calif.), Martin's Point Health Care (Maine), Pacific Source Health Plans (Ore.), Presbyterian Health Plan (N.M.), Priority Health (Mich.), Sanford Health Plan (S.D.), Scott & White Health Plan (Texas), Security Health Plan (Wisc.), SelectHealth (Utah), UCare (Minn.), and UPMC Health Plan (PA).

ACAP's Member Plans include: Affinity Health Plan (N.Y.), Alameda Alliance for Health (Calif.), Alliance Health (N.C.), AlohaCare (Hawaii), AmeriHealth Caritas Delaware (Del.), AmeriHealth Caritas District of Columbia (D.C.), AmeriHealth Caritas Louisiana (La.), AmeriHealth Caritas North Carolina (N.C.), AmeriHealth Caritas New Hampshire (N.H.) AmeriHealth Caritas Pennsylvania (Penn.), Amida Care (N.Y.), Banner University Health Plans (Ariz.), Blue Cross Complete of Michigan (Mich.) Boston Medical Center HealthNet Plan (Mass.), CalOptima (Calif.), Cardinal Innovations Healthcare (N.C.), CareOregon (Ore.), CareSource Ohio (Ohio), CenCal Health (Calif.), Central California Alliance For Health (Calif.), Children's Community Health Plan (Wisc.), Children's Medical Center Health Plan (Texas), Commonwealth Care Alliance (Mass.), Community

Care Plan (Fla.), Community First Health Plans (Texas), Community Health Choice (Texas), Community Health Group (Calif.), Community Health Network of Connecticut (Conn.), Community Health Plan of Washington (Wash.), Community Health Options (Maine), Common Ground Healthcare Cooperative (Wisc.) Contra Costa Health Plan (Calif.), Cook Children's Health Plan (Texas), CountyCare (Ill.), Denver Health (Colo.), Driscoll Health Plan (Texas), El Paso First Health Plans (Texas), Elderplan | HomeFirst (N.Y.), Gateway Health Plan (Penn.), Geisinger Health Plan (Penn.), Gold Coast Health Plan (Calif.), Hamaspik Choice (N.Y.), Health Partners Plans (Penn.), Health Plan of San Joaquin (Calif.), Health Plan of San Mateo (Calif.), Health Services for Children with Special Needs (D.C.), Hennepin Health (Minn.), iCircle Care (N.Y.), Inland Empire Health Plan (Calif.), Kern Family Health Care (Calif.), Keystone First (Penn.), L.A. Care Health Plan (Calif.), Maryland Community Health System (Md.), Maryland Physicians Care (Md.), MDwise (Ind.), Montana Health CO-OP (Mont.), Mountain Health Co-Op (Idaho), My Choice Family Care (Wisc.), Nascentia Health (N.Y.), Neighborhood Health Plan of Rhode Island (R.I.), Parkland Community Health Plan (Texas), Partnership Health Plan of California (Calif.), Partners Behavioral Health Management (N.C.), Prestige Health Choice (Fla.), Priority Partners (Md.), San Francisco Health Plan (Calif.), Santa Clara Family Health Plan (Calif.), SelectHealth of South Carolina (S.C.), Sendero Health Plans (Texas), Texas Children's Health Plan (Texas), University of Utah Health Plans (Utah), UPMC for You (Penn.), VillageCareMAX (N.Y.), Virginia Premier Health Plan (Va.), VNSNY

CHOICE Health Plans (N.Y.), Well Sense Health Plan (N.H.).