No. 19-840 & 19-1019

In The
Supreme Court of the United States

THE STATE OF CALIFORNIA, ET AL.,

Petitioners,

v.

THE STATE OF TEXAS, ET AL.,

Respondents.

THE STATE OF TEXAS, ET AL.,

Cross-Petitioners,

v.

THE STATE OF CALIFORNIA, ET AL.,

Cross-Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF HCA HEALTHCARE, INC. AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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May 2020

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INTEREST OF AMICUS CURIAE

HCA Healthcare, Inc. ("HCA") is the largest non-governmental healthcare provider in the United States.[1] HCA owns and operates 186 hospitals and more than 2,000 care sites, including 104 freestanding emergency rooms ("ERs"), 170 urgent care clinics, 123 surgery centers, over 1,200 telehealth sites, 96 cancer services centers, and more than 1,300 physician practices. In 2019 alone, HCA facilities provided healthcare services in connection with more than 34 million patient encounters, including approximately 9.2 million ER visits and 220,000 newborn deliveries.

The Patient Protection and Affordable Care Act of 2010 ("ACA") has profoundly affected the lives and health of millions of Americans, including those who seek care from HCA facilities. For example, hundreds of thousands of times a year, HCA facilities provide care to patients covered by health insurance purchased through the ACA-created American Health Benefit Exchanges ("Exchange patients" and "Exchanges," respectively). *See* 42 U.S.C. § 18031.

HCA gathers and maintains extensive data about that care, and HCA shared its data and experience with this Court in 2015, when previous litigants sought to invalidate the ACA's subsidies in many

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[1] Pursuant to Rule 37.6, the *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* or its counsel made any monetary contributions intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), all parties have given consent to the filing of this brief or provided blanket consent to the filing of timely *amicus* briefs.

States. *See King v. Burwell*, 135 S. Ct. 2480 (2015); *see also* Br. of HCA Inc. as Amicus Curiae in Support of Respondents and Affirmance, *King v. Burwell*, 2015 WL 365002 (Jan. 28, 2015).

As it did five years ago, HCA believes that its on-the-ground perspective and experience may be informative to the Court, underscoring what the ACA has meant for HCA's patients, as well as the doctors, nurses, and other healthcare providers who care for them. Indeed, notwithstanding Congress's decision to reduce to zero the tax penalty for individuals who forgo health insurance, the ACA has continued to operate as intended in key respects, as HCA's experience helps illustrate.

HCA has published an analysis of data related to the care provided at its facilities in every year from 2014 (the first year in which the Exchanges were operating) through 2019 (the first year in which the tax penalty was reduced to zero). *See* HCA Healthcare, *Analysis of HCA Data Relevant to Aspects of the Affordable Care Act* ("HCA Report") (May 2020), *available at* http://www.HCAHealthcare.com/ACAReport. This information and analysis form the basis of the material presented in this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress enacted the ACA ten years ago, with the objectives of expanding access to health insurance, enhancing consumer protections, reorienting the health care system around preventative care and wellness, and curbing rising health care costs. *See* Pub. L. No. 111–148, 124 Stat. 119, 119–128 (2010). As this Court

recently recognized, the ACA's most basic goal has been achieved: it has "expanded healthcare coverage to many who did not have or could not afford it." *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315 (2020). With the COVID-19 pandemic causing unemployment to soar, the availability of health insurance under the ACA is more important than ever.

HCA's experience shows how patients have relied on the ACA's reforms even beyond this broad expansion of coverage. As one of the country's largest health care providers, HCA can attest to the important ways the ACA has been—*and still is*—achieving Congress's goals. Congress intended to shift care, where possible, out of emergency rooms and into more efficient settings—and that is what has happened. Congress intended to address the gender inequality that has plagued our health care system and help women gain access to needed care—and that is what has happened. Congress intended a greater portion of Americans to take personal responsibility and maintain an individual stake in their care decisions—and, again, that is what has happened.

The plaintiffs in this case seek to unwind all of this progress toward Congress's objectives. They argue that due to a 2017 amendment, the ACA now includes an unconstitutional mandate—albeit an unenforceable one—to purchase health insurance. Even if that were right, the drastic remedy of invalidating the entire statute would not follow. "Generally speaking, when confronting a constitutional flaw in a statute, [the Court] tr[ies] to limit the solution to the problem, severing any problematic portions while leaving the

remainder intact." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010) (citation omitted). As the Chief Justice wrote for the Court in *Free Enterprise Fund*, when a statute "remains fully operative as a law" with the unconstitutional provision "excised," the Court "*must* sustain its remaining provisions." *Id.* at 509 (emphasis added) (citation omitted).

Since the mandate to purchase insurance is already toothless, there is no need to speculate as to whether the remainder of the ACA can operate without it. Congress *decided* in 2017 that the ACA could remain "fully operative as a law" without any enforceable requirement to maintain insurance. And the ACA has, in fact, continued to operate as intended. HCA's data and on-the-ground experience confirm this reality. Despite the lack of any federal penalty for failing to purchase insurance, HCA saw an increase in visits by Exchange patients and continues to see the ACA's objectives being fulfilled.

On a straightforward application of the Court's severability precedents, the ACA cannot be invalidated. Any other result would be contrary to this Court's admonishment to "respect the role of the Legislature, and take care not to undo what it has done." *King*, 135 S. Ct. at 2496.

ARGUMENT

I. The Affordable Care Act Has Helped HCA's Patients Access Needed Care And Fulfilled Other Important Congressional Objectives.

Congress enacted the ACA to achieve critical public policy goals. Foremost, of course, was the objective of expanding health insurance coverage for the American people. *See* 42 U.S.C. § 18091(2)(D) (citing the Act's goal of "achiev[ing] near-universal coverage"); Affordable Care Act, Tit. I, Subtit. E, 124 Stat. 213 (indicating the statute's goal of providing "[a]ffordable [c]overage [c]hoices for [a]ll Americans"). No one disputes that the ACA has been successful in this respect. *See Me. Cmty. Health Options*, 140 S. Ct. at 1315.

HCA has seen firsthand how the ACA has revolutionized the health care system. Each year from 2014 through 2019, HCA facilities provided care to Exchange patients during hundreds of thousands of visits. *See* HCA Report at 5. Approximately 200,000 of these visits were by Exchange patients who had received care at HCA facilities *without* insurance in 2012 or 2013. *See id.* at 4. That is, HCA's data show that these patients were uninsured before the ACA was implemented, but afterwards had insurance through the Exchanges. And these numbers reflect only those Exchange patients who visited HCA facilities in a specific two-year period while uninsured; no doubt many others did not seek care, some of them precisely because they lacked insurance.

Congress also had more granular and complementary objectives beyond simply expanding coverage. These included encouraging care in the most appropriate and efficient settings, expanding access to needed care for women, and making it possible for more people to take personal financial responsibility for their care. HCA's data show that, in the years after the ACA was enacted, these goals were being met. And progress on these fronts is continuing, as HCA's data through 2019 demonstrate.

A. HCA's Exchange Patients Used Emergency Rooms At Dramatically Reduced Rates, And Had Better Access To Outpatient Services.

HCA's data show that, in the years since the Exchanges began to operate in 2014, the ACA measurably reduced ER visits for the newly insured and likewise increased the use of non-emergency, but medically necessary, outpatient services.

To assess the ACA's effects on ER usage, HCA measured the ratio of ER visits to inpatient admissions. HCA Report at 9–11. Because inpatient admissions generally are unavoidable, insured and uninsured patients tend to require inpatient services at a similar rate. This makes inpatient admissions a useful "control" against which to compare ER use and outpatient visits.

In the years from 2014 through 2019, uninsured patients visited HCA facilities' ERs approximately ten times for every inpatient admission. *Id.* at 9. By contrast, Exchange patients visited HCA facilities' ERs

approximately three times for every inpatient admission. *Id.* In other words, according to HCA's data, Exchange patients were about *three times less likely* than the uninsured to access care through ERs. *See id.*

HCA also recorded improved access to medically necessary outpatient services, again using inpatient admissions as a control. In 2014 through 2019, uninsured patients made non-ER outpatient visits to HCA facilities around 0.8 times for every inpatient admission. *See id.* By contrast, over that same period, Exchange patients made non-ER outpatient visits to HCA facilities between 2.3 to 3.2 times for every inpatient admission. *Id.* HCA's data thus reflect a *tripling* of the likelihood that an individual will access outpatient care if he or she has coverage through the ACA. *See id.*

These numbers tell a powerful story and are the predictable result of the ACA's expansion of affordable insurance coverage. Due to the increased availability of insurance, Exchange patients simultaneously were able to rely *less* on ER care, and to receive *more* medically necessary outpatient care. This includes care, such as chemotherapy, that is not typically available in an ER setting. Uninsured individuals, by contrast, may wait until they are seriously ill to seek care because they cannot afford to pay for primary care.[2] And when they do fall ill, they typically visit ERs and pay

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

nothing toward the cost of their care, passing that cost onto the rest of the health care system. *See infra* pp. 13–16.

Colonoscopies, typically an outpatient procedure, illustrate the difference the ACA makes. HCA's data show that, for patients aged 55 to 64, those with Exchange coverage are approximately *six times* more likely to receive a screening or diagnostic colonoscopy than those who are uninsured. *See* HCA Report at 14. Access to a colonoscopy literally can be a matter of life and death—according to one study, "receipt of a screening colonoscopy was associated with a 67% reduction in the risk of death from any colorectal cancer."[3]

The changes that HCA has seen in the way patients access health care were core objectives of the ACA. *See supra* pp. 5–6. Overuse of ERs and delayed access to appropriate care were, as Congress expressly

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[3] Chyke A. Doubeni et al., *Effectiveness of Screening Colonoscopy in Reducing the Risk of Death from Right and Left Colon Cancer: A Large Community-based Study*, 67 Gut 291, 291 (Oct. 12, 2016), *available at* https://tinyurl.com/yay644u9; *see also* Charles J. Kahi et al., *Colonoscopy and Colorectal Cancer Mortality in the Veterans Affairs Health Care System: A Case–Control Study*, 168 Annals of Internal Med. 481 (Apr. 3, 2018), *available at* https://tinyurl.com/y7mfe6wx (concluding that receipt of a colonoscopy was associated with significant reductions in mortality from colorectal cancer among veterans); Ryota Niikura et al., *Colonoscopy Reduces Colorectal Cancer Mortality: A Multicenter, Long-term, Colonoscopy-based Cohort Study*, 12 PLoS One 9 (Sept. 28, 2017), *available at* https://tinyurl.com/y9rtm78q (concluding that colorectal cancer mortality decreased significantly among patients who received a colonoscopy without colorectal cancer diagnosis compared with the general population).

found, symptoms of the problem of unaffordable insurance: "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008," which "increas[ed] family premiums by on average over $1,000 a year." 42 U.S.C. § 18091(2)(F). Indeed, the goal of reducing ER usage and increasing more efficient forms of care is manifest throughout the ACA.[4] Members of Congress echoed this vital goal of "preventing [the uninsured] from depending on expensive emergency services in place of regular health care." 155 Cong. Rec. 33,024 (Dec. 22, 2009) (Sen. Patrick Leahy). The pre-ACA increase in the number of Americans who were "not . . . able to afford insurance" meant they were "going to show up at hospital emergency rooms," which "costs a lot." 155 Cong. Rec. 29,762 (Dec. 8, 2009) (Sen. Barbara Boxer); *see also* 156 Cong. Rec. H1801 (daily ed. Mar. 20, 2010) (Rep. Tim Ryan) ("[W]e have 30 million-plus people in the United States of America who have no preventive care at all, dumped into our emergency rooms, much sicker than they need to be."). Members of Congress emphasized the importance of patients receiving non-emergency care in the most appropriate setting so

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

they could avoid more expensive emergency or inpatient care. *See* 155 Cong. Rec. 23,038 (Sept. 30, 2009) (Rep. Jason Altmire) ("[W]e need to get [people] their health care in the most appropriate, cost-efficient setting . . . .").

HCA's experience shows that the ACA has had its intended effect of reducing ER usage and increasing access to medically necessary outpatient care, including potentially life-saving cancer screenings. Invalidating the statute in its entirety is likely to cause many Exchange patients to join or rejoin the ranks of the uninsured, to revert to the patterns of ER use that Congress sought to counteract, and to have diminished access to the type of preventative care Congress wanted to make more available.

B. Women Received Care That Might Otherwise Be Unavailable To Them.

Another core goal of the ACA was to ensure that women are able to meet their health care needs. Based on HCA's data, in the years 2014 through 2019, those needs were being met far more than they were prior to the ACA.

In the years 2014 through 2019, approximately two-thirds of visits to HCA facilities by patients with ACA coverage were made by women. HCA Report at 5. Women covered by Exchange plans accessed health care in greater numbers in part because in the relevant (*i.e.*, pre-Medicare) age range—up to 65—women are at greater risk for certain health issues, such as

cancer.[5] Consistent with this fact, HCA's data show that, from 2014 through 2019, approximately 80% of the oncology services provided at HCA facilities to patients with ACA coverage were for women. *See id.* at 12.

The specific case of ultrasounds illustrates how women with ACA coverage were better able to access needed health care. If a woman has a breast lump or mass or an abnormal mammogram, it is common for a physician to order an ultrasound to determine if there is a benign cyst or malignancy, and whether a biopsy is needed for diagnosis.[6] These breast ultrasounds are not, however, available in ERs, the primary site of care for many uninsured women. The result: from 2014 through 2019, women with ACA coverage were *between three and four times more likely* to obtain an ultrasound for a breast lump, mass, or abnormal

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[5] For example, in 2017, cancer was the leading cause of death among women in the 35 to 54 age group, with breast cancer accounting for the largest number of cancer deaths; there are more than 3.5 million breast cancer survivors in the United States. *See* Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics, *Underlying Cause of Death, 1999–2018*, on CDC WONDER Online Database, https://tinyurl.com/y6x4tau2; Am. Cancer Soc'y, *How Common Is Breast Cancer?*, https://tinyurl.com/y99xr5ls (last revised Jan. 8, 2020).

[6] Johns Hopkins Medicine, *Breast Ultrasound*, http://tinyurl.com/mkvfg2s (last visited May 8, 2020); *see also* Am. Coll. of Radiology, *ACR Practice Parameter for the Performance of a Breast Ultrasound Examination* 2 (Revised 2016, Resolution 38), *available at* https://tinyurl.com/y5rt4ryk; Regina J. Hooley et al., *Breast Ultrasonography: State of the Art*, 268 Radiology 642, 643 (Sept. 2013) ("Ultrasonography . . . has become an indispensable tool in breast imaging.").

mammogram than women who were uninsured. HCA Report at 13 (data for women aged 35 to 54).

Without access to affordable insurance, women would be left with reduced access to treatment options for urgent but chronic conditions, such as cancer. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), hospitals must provide stabilizing treatment for "emergency" medical conditions, but not non-emergency care, such as chemotherapy and radiation.[7] Although Medicaid may provide some coverage for women diagnosed with breast or cervical cancer, such coverage varies by state and often is limited to certain low-income programs for which many current Exchange patients do not qualify. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); *id.* § 1396a(aa). Without coverage, some women may turn to the already-strained resources of public hospitals, where there may be long waits for appointments.[8] As a result, the invalidation of the ACA would adversely affect all patients, but especially women who need treatment for life-threatening diseases like cancer.

This is plainly contrary to the intent of Congress, which was acutely concerned with the health care needs of women. For example, the ACA bans gender-based premium rate discrimination that previously

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[7] 42 U.S.C. § 1395dd; *see also* Aaron Carroll, *Why Emergency Rooms Don't Close the Health Care Gap*, CNN (May 7, 2012), http://tinyurl.com/p6wqd3t.

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

made quality insurance coverage less affordable for women. 42 U.S.C. § 300gg. In requiring health plans to cover all "Essential Health Benefits," Congress directed the Department of Health and Human Services to "take into account the health care needs of diverse segments of the population, including women." *Id.* § 18022(b)(4)(C). Moreover, Congress required health plans to make numerous preventive services available for free, specifically mentioning the preventive care needs of women. *Id.* §§ 300gg–13(a)(1), (4).

HCA's experience in providing care to women covered by the ACA's Exchanges shows in granular fashion how these important congressional objectives would be harmed by the law's invalidation.

C. Exchange Enrollees Took Personal And Financial Responsibility For Their Health Care.

Another of the problems Congress sought to address with the ACA was the reality that individuals who cannot purchase insurance often become "free riders" by necessity, visiting ERs to access needed care that they cannot and ultimately do not pay for. As Congress expressly found, the costs of this "uncompensated care" are passed on throughout the economy, including in the form of higher premiums for people with insurance. *See* 42 U.S.C. § 18091(2)(F). HCA's data indicate that, over the last six years, the ACA diminished this free-rider problem and increased the percentage of patients who now take personal and financial responsibility for their health care.

In approximately 90% of cases over the period from 2014 to 2019, uninsured patients paid nothing for

health care services they received at HCA's facilities. *See* HCA Report at 7. By contrast, during that same time period, in a majority of cases Exchange patients paid toward their out-of-pocket obligations, which included deductibles or cost-sharing. *See id.* at 8. While health insurers are required to provide free preventive services (*e.g.*, cancer screenings), Exchange plans often require patients to pay something toward even medically necessary ER visits. Between 2014 and 2019, HCA patients who were covered by an ACA plan and who made cost-sharing expenditures paid an average of at least $543 out-of-pocket for their health care. *Id.*

This level of cost-sharing is significant for Exchange patients. Nationally, more than 80% of Exchange enrollees qualified for income-based subsidies.[9] For example, a patient making $31,500 per year (or just over 250% of the 2019 federal poverty level for a single person) would qualify for subsidized premiums through an Exchange (but not cost-sharing subsidies). A $543 payment for health care would represent more than 20% of her pre-tax monthly income.

In designing the subsidies for coverage on the Exchanges, Congress was attuned to the need for individuals to maintain a personal, financial stake in their health care. Thus, Congress included income-based caps on the premium subsidies available to low-

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

income individuals. 26 U.S.C. §§ 36B(b)(2), (b)(3)(A)(i). Moreover, for even the lowest-income individuals eligible for subsidies, cost-sharing assistance was designed so that it would not completely eliminate a patient's obligation to pay a portion of the total cost of her health care through copayments and deductibles. 42 U.S.C. § 18071(c).

Of course, Congress conceived of the tax penalty for not maintaining health insurance as one way to promote "individual responsibility." ACA tit. I, subtit. F, pt. I. But as reflected above, that was just one provision among many addressing the interrelated issues of personal responsibility and uncompensated care. And in practice, the amount of the tax penalty—even before its reduction to zero—was seen as "too low" to make a significant difference in individual health insurance decisions.[10]

With or without the tax penalty, many Americans have maintained their subsidized coverage on the Exchanges rather than reverting to being uninsured and requiring uncompensated care. Based on HCA's data, subsidized coverage on the Exchanges achieves what Congress intended: it causes individuals to take personal and financial responsibility for their health care, but also allows those individuals to avoid financial ruin caused by or related to their medical needs. Once covered by an Exchange plan, individuals pay out of pocket for a portion of their health care costs, and they avoid generating significant uncompensated

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

costs that ultimately would be borne by businesses and insured individuals.

If the ACA were invalidated, millions of individuals would likely lose coverage and no longer be able to take a measure of personal and financial responsibility for their health care.[11] Those still able to purchase insurance in the individual market may be forced to spend significantly more, both because they would no longer have access to the subsidies that assist the majority of those enrolled in ACA plans, and because individual health plans likely would provide significantly fewer benefits with greater out-of-pocket costs.[12]

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In sum, HCA's experience shows that significant progress has been made toward Congress's objectives in enacting the ACA. Invalidating that law on the basis of a flawed severability analysis would eliminate

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[11] A study by the Urban Institute concluded that full repeal of the ACA would result in up to 21.2 million people becoming uninsured. LINDA J. BLUMBERG, ET AL., URBAN INST., STATE-BY-STATE ESTIMATES OF THE COVERAGE AND FUNDING CONSEQUENCES OF FULL REPEAL OF THE ACA 2–3 (Mar. 2019) ("STATE-BY-STATE ESTIMATES"), *available at* https://tinyurl.com/y86r6vvj; *id.* at 6 (noting that many people with current or past health problems will no longer be able to purchase insurance at any price due to the elimination of guaranteed issue requirements).

[12] *Id.* at 6 ("Without the ACA's federal tax credits to attract many healthy people into the nongroup insurance market, . . . those enrolling in private nongroup coverage after repeal would likely have policies that cover significantly fewer benefits and require more out-of-pocket spending for services, similar to nongroup coverage before ACA implementation.").

these advances. That result cannot be squared with any plausible account of congressional intent.

II. The ACA Has Continued To Achieve Congressional Objectives Even Without An Enforceable Penalty For Failing To Maintain Minimum Coverage.

In the years since the law was enacted, Congress repeatedly considered and rejected proposals to repeal the ACA.[13] Instead, Congress acted narrowly and incrementally, merely reducing to zero the ACA's shared responsibility tax penalty that previously had been imposed on individuals who chose not to purchase ACA-compliant health insurance. *See* Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017); *see also* 26 U.S.C. §§ 5000A(a), (b)(1), (c). As of January 1, 2019, there was no federal consequence for not purchasing such health insurance. *See* Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

At the time Congress considered this amendment, the Congressional Budget Office forecasted that reducing the tax penalty to zero would not destabilize the individual insurance market.[14] That prediction has borne out. Even with the elimination of the tax

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[13] *See generally* C. Stephen Redhead & Janet Kinzer, Cong. Research Serv., *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act* at 1 (Feb. 7, 2017).

[14] Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate 1 (Nov. 2017), *available at* https://tinyurl.com/yaz9xxld.

penalty, the Exchanges have continued to function. In fact, more insurers participated in the Exchanges in 2019 than in 2018, and premium increases were lower in 2019 than in 2018.[15] Approximately 11.4 million people—25% of them new enrollees—selected Exchange plans for the year 2020.[16] While the rate of Americans without insurance has been increasing somewhat since 2016 and continued to do so in 2019, it remains dramatically lower than prior to implementation of the ACA.[17]

The continued health of the Exchanges can be seen in HCA's data as well. Since the Exchanges began to operate in 2014, HCA has seen a steady increase in patients with Exchange coverage, and that trend was not disrupted by the amendment of the ACA. In 2018, when the tax penalty was still in effect, HCA provided care to Exchange patients during 396,639 visits. HCA Report at 5. Had the tax penalty been the linchpin holding the entire ACA together, one might have expected these numbers to plummet once the penalty became $0 for the 2019 plan year. Yet that is not what happened. To the contrary, in 2019, with no financial penalty for declining to purchase health insurance, HCA provided care to Exchange patients during 423,191 visits. *Id.* Thus, not only did visits by Exchange patients to HCA facilities not decline in the

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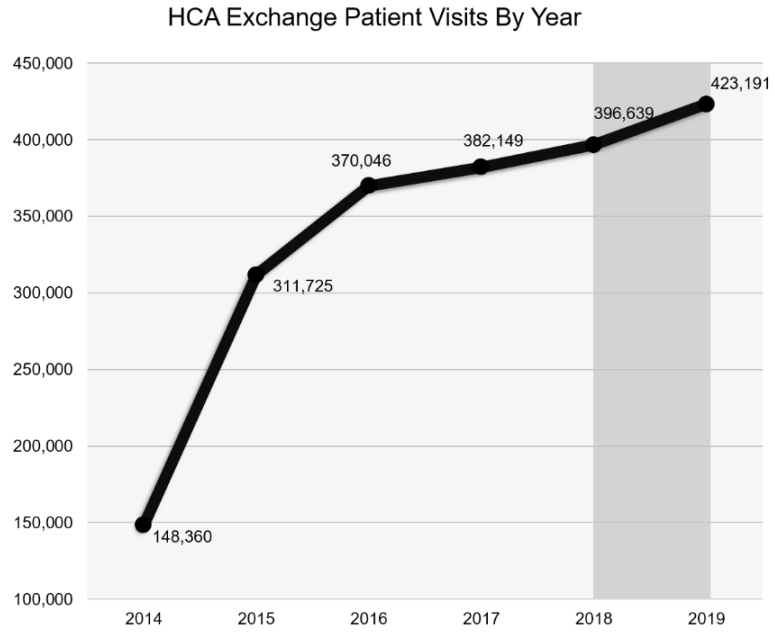
[15] STATE-BY-STATE ESTIMATES, *supra* n.11, at 19.

[16] *See* Ctrs. for Medicare & Medicaid Servs., *Health Insurance Exchanges 2020 Open Enrollment Report* (Apr. 1, 2020), https://tinyurl.com/y7tycsf4.

[17] *See* Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, Gallup (Jan. 23, 2019), https://tinyurl.com/ycbym2mr.

period following the elimination of the tax penalty, they increased by nearly 7%. *Id.*



Indeed, across a range of metrics, the ACA continues to have important effects for patients, with or without a tax penalty for those who choose not to buy insurance. For example, with respect to Congress's goal of tackling the problem of uninsured patients having to resort to ERs for their health care needs, HCA's data for 2019 continue to show significantly less reliance on ERs by Exchange patients, and significantly more access to needed outpatient care, as compared to their uninsured counterparts. *Id.* at 9. These numbers are not meaningfully different than for previous years and show that the ACA is still continuing to meet important congressional objectives.

HCA's data also show that women who were insured through Exchange plans continued to benefit from improved access to needed diagnostic care and treatments in 2019. *See id.* at 12–13. Meanwhile, their uninsured counterparts typically did not have access to this same care. *Id.*

As in years prior, two-thirds of the 2019 visits to HCA facilities by Exchange patients were made by women. *Id.* at 5. HCA's data show that 80% of the oncology services provided to Exchange patients in 2019 were provided to women. *Id.* at 12. And women with ACA coverage who visited HCA facilities in 2019 were 3.56 times more likely to receive an ultrasound for a breast lump, mass, or abnormal mammogram than uninsured women who visited HCA facilities. *Id.* at 13. Again, this data is consistent with HCA's findings from prior years. *See id.* at 5, 12–13. Thus, women have continued to benefit from the ACA's reforms, even without the tax penalty. Again, the ACA is continuing to meet this vital congressional objective notwithstanding the reduction of the tax penalty to zero.

HCA patients have likewise continued to take personal and financial responsibility for their health care, even though the penalty for not purchasing insurance was reduced to zero. In 2019, Exchange patients who made cost-sharing expenditures paid an average of $547.12 toward services at HCA's facilities. *Id.* at 8. This amount was on par with the average out-of-pocket expenditures from 2014 through 2018.

In short, HCA's experience confirms that the ACA can continue—and indeed *has* continued—to achieve

the objectives Congress set out in the law. That has been the case regardless of an enforceable penalty for failing to maintain insurance.

III. The Affordable Care Act Has Operated As Intended Without An Enforceable Individual Mandate, So Under Clear Precedent Any Constitutional Defect Must Be Severed.

The only provision of the ACA that plaintiffs allege is unconstitutional is 26 U.S.C. § 5000A(a). That provision, as this Court has construed it, presents a "choice" between two "lawful" courses of action, *i.e.*, maintaining coverage or paying a tax. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012). In 2017, Congress reduced the amount of this tax to zero. According to plaintiffs, that amendment changed the character of Section 5000A into a true mandate, rendering it unconstitutional. But striking down Section 5000A on this basis would have no practical import: there is real-world no difference between a requirement backed up by a penalty of nothing, and no requirement at all. Quite transparently, the purpose of this litigation was not to invalidate a toothless provision. It was to leverage this alleged constitutional infirmity to bring down the entire ACA. The crux of this case, then, is severability: if Section 5000A is unconstitutional, can it simply be excised from the statute, or must numerous other provisions also be invalidated? This Court's precedents make that an easy question. Section 5000A is readily severed, so it must be, and the rest of the law must be left intact.

The "normal rule" is that severing an offending provision, "rather than facial[] invalidation[,] is the required course." *Free Enter. Fund*, 561 U.S. at 509 (citation omitted); *see also Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329 (2006) ("We prefer . . . to sever [a law's] problematic portions while leaving the remainder intact."). This policy of judicial modesty has been the Court's practice for centuries, going back to *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803), in which "the Court concluded that Section 13 of the Judiciary Act of 1789 was unconstitutional in part," but "did not disturb the remainder of the Judiciary Act." *PHH Corp. v. Consumer Fin. Prot. Bureau*, 881 F.3d 75, 199 (D.C. Cir. 2018) (Kavanaugh, J., dissenting).

Thus, if the rest of the statute remains "fully operative as a law" without the unconstitutional provision, the Court "must sustain its remaining provisions." *Free Enter. Fund*, 561 U.S. at 509. "In order for other [statutory] provisions to fall, it must be *evident* that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018) (emphasis added; cleaned up). Here, then, the plaintiffs need to prove that the ACA *cannot operate* without an unenforceable individual mandate, and that Congress would have preferred *no ACA at all* over one lacking an unenforceable mandate.

Plaintiffs cannot come close to meeting the demanding burden imposed by this Court's precedents. It is obvious that Congress would have preferred an ACA without a mandate over no ACA at all, *because*

that is exactly what it consciously chose: Congress voted to deprive the minimum coverage provision of all practical effect after considering and rejecting a proposal to repeal the entire law. At the time, legislators were clear that the point of the amendment was not to "change anything" about the ACA "except one thing," *i.e.*, the tax penalty for failing to maintain coverage.[18] Indeed, just days before this brief was filed, one Senator who voted for the 2017 amendment called the argument against severability "flimsy": "What they're arguing is that when we voted to get rid of the individual mandate we voted to get rid of Obamacare. I don't know one single senator that thought that."[19]

Congress in 2017 thus made its view clear that the ACA could remain "fully operative as a law" without a mandate to purchase insurance. *Free Enter. Fund*, 561 U.S. at 509. And while that congressional belief alone is dispositive, it turns out that Congress was correct. This is clear from the national data showing that the Exchanges remained stable without any enforceable requirement to purchase insurance. *See*

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[18] 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017) (statement of Sen. Patrick J. Toomey) ("We don't change any of the subsidies. . . . We don't change the rules. We don't change eligibility. We don't change anything except one thing."); *see also* 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017) (statement of Sen. Timothy E. Scott) ("[T]he individual mandate and its effect in our bill take nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage—it does not have a single letter in there about preexisting conditions or any actual health feature [of the ACA].").

[19] Chuck Todd, *Meet the Press with Chuck Todd*, NBCNEWS (May 10, 2020), https://tinyurl.com/ya8t48mf (statement of Senator Lamar Alexander).

supra pp. 17–18. And HCA, on the basis of its substantial experience as the largest non-governmental healthcare provider in the nation, can confirm that the ACA remains fully capable of operating as intended and achieving congressional objectives. *See supra* pp. 18–21.

Congress enacted the ACA, including provisions establishing health insurance Exchanges, to strive for "near-universal coverage," 42 U.S.C. § 18091(2)(D), and Exchange patients are *still* insured and seeking care, penalty or no penalty. Congress intended to channel patients away from ERs and toward more efficient and appropriate forms of care, and that is *still* what is happening, penalty or no penalty. *See supra* p. 19. Congress sought to remedy the particular challenges women have faced in receiving health care, and that is *still* what is happening, penalty or no penalty. *See supra* p. 20. Congress wanted to reduce the burdens on the health system of uncompensated care and foster personal responsibility, and that is *still* what is happening, penalty or no penalty. *See supra* p. 20.

It is not remotely plausible—much less "evident," *Murphy*, 138 S. Ct. at 1482—that Congress would have intended for all of this progress to be reversed, simply because an amendment intended to deprive a single provision of practical effect also made that provision unconstitutional. Whatever the fate of Section 5000A, the Court's well-settled precedents on severability require the rest of the ACA to be left intact. The consequences of a contrary ruling, including to HCA's many patients who rely on the statute, would be devastating.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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May 2020

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