No. 19-840

In the Supreme Court of the United States

CALIFORNIA, ET AL., *Petitioners*,
v.
TEXAS, ET AL., *Respondents.*

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

Brief of *Amici Curiae* American Medical Association, American Academy of Allergy, Asthma and Immunology, Aerospace Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Cardiology, American College of Emergency Physicians, American College of Medical Genetics and Genomics, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Radiation Oncology, American College of Radiology, American Psychiatric Association, American Society of Gastrointestinal Endoscopy, American Society of Hematology, American Society of Metabolic and Bariatric Surgery, Endocrine Society, GLMA: Health Professionals Advancing LGBTQ Equality, Renal Physicians Association, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology in Support of Petitioners

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INTEREST OF *AMICI CURIAE*

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state and in every medical specialty.

The remaining *amici*, listed on the cover of this brief, are associations of physicians and other health care professionals with areas of specialized medical knowledge and expertise. They are all represented in the AMA House of Delegates. *Amici* and their member physicians are committed to seeing that all Americans have access to affordable, quality medical care.[1]

SUMMARY OF ARGUMENT

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), a landmark piece of legislation that aimed to reshape the health care industry that accounts for roughly one-fifth of our

[1] *Amici* file this brief with the consent of all parties. No one other than *Amici* and their counsel authored any part of this brief or monetarily funded its preparation.

nation's economy.[2] Given the nature of this task, the resulting statute was enormous, consisting of over 900 pages of text, with its Table of Contents alone spanning 16 pages of single-spaced type.[3] Unfortunately, like many complex and nuanced policies, it became the victim of over-simplification in order to oppose its passage and implementation. As a result, the Plaintiffs have attempted to reduce this law, which touches every corner of the health care delivery system, to one issue. They purport to tie the fate of the entire ACA to the so-called 'individual mandate' – 26 U.S.C. § 5000A's instruction to either purchase health insurance or pay a tax.

The Plaintiffs and Federal-Defendants invite the Court to unravel the legislative process and now do what Congress would not: invalidate the entire ACA. *Amici* adopt the arguments of the U.S. House of Representatives and the several Intervenor states, headed by California, that § 5000A should remain constitutional, as a tax or otherwise, following passage of the 2017 Tax Cuts and Jobs Act. However, if the Court should decide that § 5000A is no longer constitutional, *amici* urge the Court to give proper weight to the 2017 Congress's decision to leave the rest of the ACA intact.

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[2] National Health Expenditure Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

[3] https://www.hhs.gov/sites/default/files/patient-protection.pdf. Its provisions were codified in diverse parts of the U.S. Code. *See* http://uscode.house.gov/table3/111_148.htm (table, ACA (Pub. L. 111-148) to U.S. Code).

When one provision of a statute is held unconstitutional, the portions that are not themselves unconstitutional are presumed to survive—unless (a) Congress clearly intended them to be inseparable or (b) they cannot function independently. *Free Ent. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010). Instead of relying on this established presumption, the Fifth Circuit majority questioned the appropriateness of the court's role in performing a severability analysis.[4]

Severability analysis, at its core, requires that the court read and understand the law at issue in order to make some judgment on how it might function, should the court remove the offending portion. *See, generally, United States v. Booker*, 543 U.S. 220, 258 (2005). Understandably, this could be a daunting task when it comes to a law as complex and far-reaching as the ACA. But it is not complicated here, since the 2017 Congress did not show any intention of effecting the rest of the ACA when it made changes to § 5000A.

Instead, both lower courts overcomplicated the matter. The district court demonstrated that it had not, in fact, carefully read the then-current ACA, and instead, relied on inaccurate characterizations of what the law must contain.[5] The Fifth Circuit, though it had the authority to perform a *de novo* review of the district court's analysis, chose not to, and instead, mused that

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[4] *Texas v. United States*, 945 F.3d 355, 395-97 (5th Cir. 2019).

[5] *See*, *e.g.*, "The ACA also lays out hundreds of minor provisions, spanning the Act's 900-plus pages of legislative text, that complement the above-mentioned major provisions and others." *Texas v. United States*, 340 F. Supp. 3d 579, 587 (N.D. Tex. 2018).

perhaps some of the ACA might be severable and some might not. The Fifth Circuit instructed the district court to go through the law in its entirety and explain which parts of the law should stand and which should not.

Unfortunately, the fate of the health care system now hangs in the balance. During what has now become a national health emergency, *amici*'s members and their patients will bear the burden of a near-certain collapse. Accordingly, *amici* demonstrate that those provisions of the ACA other than § 5000A, including those provisions Plaintiffs and Federal-Defendants contend are inextricably linked to § 5000A, are independent and therefore severable.

Finally, the ACA is currently serving as the backbone of the safety-net for the millions of Americans facing sudden unemployment due to the present pandemic. *Amici*, as members of the workforce primarily responding to the current crisis, respectfully request that the Court consider the implications of invalidating the ACA in the midst of the current health crisis. Given the enormous consequences of striking down the ACA in its entirety, *amici* have participated in this case from the start (making standing, merits, and severability arguments).[6] The stakes have only increased since this Court granted *certiorari*.

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[6] *See* Brief for American Medical Association, *Texas v. United States*, 340 F. Supp. 3d 579, 585 (N.D. Tex. 2018) and Brief for American Medical Association, *Texas v. United States*, 945 F.3d 355, 369 (5th Cir. 2019).

ARGUMENT

I. When One Provision of a Statute Is Unconstitutional, the Other Provisions Survive Unless It Is Evident that Congress Would Not Otherwise Have Enacted Them or that They Are Incapable of Functioning Independently.

This Court has been reluctant to strike down entire statutes when one provision was held to be unconstitutional. For example, in invalidating certain provisions of the Sarbanes-Oxley Act, the Court summarized the established severability analysis:

> "Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem," severing any "problematic portions while leaving the remainder intact." ... Because "[t]he unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions," ... the "normal rule" is "that partial, rather than facial, invalidation is the required course."

Free Ent. Fund v. Pub. Co. Accounting Oversight Bd., 561 U.S. 477, 508 (2010) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328–29 (2006); *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932); and *Brockett v. Spokane Arcades, Inc.,* 472 U.S. 491, 504 (1985)).

Thus, in deciding whether the remaining portions of a statute survive when one part is invalid, courts must consider two questions:

- Is it evident that Congress would not have enacted those portions without the invalid part?
- Is it evident that the remaining portions cannot function independently?

Absent such evidence, the court "must sustain" the remaining portions. *Free Ent. Fund*, 561 U.S. at 509. And "the presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion).

The first question asks "[w]ould the legislature have preferred what is left of its statute to no statute at all?", *Ayotte*, 546 U.S. at 330, but the legislature's preference may be presumed rather than express. To be sure, some statutes expressly state that if a portion is held invalid, the other provisions will remain valid. This Court has emphasized, however, that "[t]he absence of a severability clause" is just "silence" and "does not raise a presumption against severability." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 686 (1987); *see also, e.g.*, *New York v. United States*, 505 U.S. 144, 186-87 (1992) (explicit severability clause is unnecessary); *United States v. Jackson*, 390 U.S. 570, 585 n.27 (1968) ("the ultimate determination of severability will rarely turn on the presence or absence of [a severability] clause"). Notably, both the Senate

and House legislative drafting manuals instruct that such clauses are unnecessary.[7]

In sum, a court "must refrain from invalidating more of the statute than is necessary." *United States v. Booker*, 543 U.S. 220, 258 (2005) (internal quotation marks and citation omitted) (severing and excising invalid mandatory sentencing provision from remainder of sentencing act, when "[m]ost of the statute is perfectly valid"). Thus, "the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." *Alaska Airlines*, 480 U.S. at 685; *see also United States v. Jackson*, 390 U.S. at 585 (when part of an act is held invalid, the rest remains operative "'[u]nless it is evident that the legislature would not have enacted those provisions'" without the invalid part) (quoting *Champlin Ref. Co. v. Corp. Comm'n,* 286 U.S. 210, 234 (1932)).

Indeed, in previously reviewing the ACA, the Court stressed that "we have a duty to construe a statute to save it, if fairly possible." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012) (*NFIB*). While striking down the ACA's essentially mandatory Medicaid expansion, it noted:

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[7] *See* U.S. Senate Office of Legislative Counsel, Legislative Drafting Manual, § 131 (Feb. 1997) (https://law.yale.edu/system/files/documents/pdf/Faculty/SenateOfficeoftheLegislativeCounsel_LegislativeDraftingManual%281997%29.pdf); U.S. House of Representatives Office of Legislative Counsel, House Legislative Counsel's Manual on Drafting Style, § 328 (Nov. 1995) (https://legcounsel.house.gov/HOLC/Drafting_Legislation/draftstyle.pdf).

> The question here is whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion. Unless it is "evident" that the answer is no, we must leave the rest of the Act intact. ... We are confident that Congress would have wanted to preserve the rest of the Act. ... [W]e do not believe Congress would have wanted the whole Act to fall, simply because some may choose not to participate. The other reforms Congress enacted, after all, will remain "fully operative as a law," ... and will still function in a way "consistent with Congress' basic objectives in enacting the statute." ... Confident that Congress would not have intended anything different, we conclude that the rest of the Act need not fall in light of our constitutional holding.

Id. at 587 (quoting *Champlin,* 286 U.S. at 234, and *Booker*, 543 U.S. at 259). The same is true here.

II. Congress Did Not Intend Its Action Regarding § 5000A to Invalidate Any Other Provision of the ACA.

The question before this Court is not whether, as the district court believed, the Congress that enacted the ACA in 2010 regarded the mandate as essential to the functioning of the Act as a whole. Rather, the question is what the Congress that eliminated the payment for violation of the individual mandate in 2017 thought about severability. *See Pierce v. Underwood*, 487 U.S. 552, 566–67 (1988) (the views of

one session of Congress do not control legislation passed by another Congress); *United States v. Sw. Cable Co.,* 392 U.S. 157, 170 (1968) (same).

Whether the individual mandate was severable from the rest of the ACA, as the Act stood in 2010, was squarely addressed by the Eleventh Circuit in *Florida v. U.S. Dep't of HHS*, 648 F.3d 1235, 1320–22 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom. NFIB v. Sebelius*, 567 U.S. 519 (2012). There, the court ruled: "Excising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.' As our exhaustive review of the Act's myriad provisions in . . . demonstrates, the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance." 648 F.3d at 1321–22. This reasoning is even stronger today.

Notably, when Congress removed the tax on noncompliance with the individual mandate, it gave absolutely no indication that it intended to invalidate any other provision of the ACA. Indeed, proponents of the bill to change the tax stressed that the change would leave other provisions intact. As just some examples, in the Senate Finance Committee hearing Senator Toomey (R-PA) stated:

> There are no cuts to Medicaid. There are no changes to the program. There are no reimbursement differences. There are no disqualifications for people to participate. None of that. We are simply saying if you cannot afford these ill designed plans, with respect to

> your family anyway, you are not going to have to pay this penalty.

Continuation of the Open Executive Session to Consider an Original Bill Entitled the Tax Cuts and Jobs Act Before the S. Comm. on Fin., Senate, 115th Congress, Nov. 15, 2017. Senator Shelly Moore Capito (R-WV) also stated:

> No one is being forced off of Medicaid or a private health insurance plan by the elimination of the individual mandate. By eliminating the individual mandate, we are simply stopping penalizing and taxing people who either cannot afford or decide not to buy health insurance plans.

163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017).

Even more fundamentally, the 2017 Congress's choice to leave intact all of the other provisions of the ACA when it modified the law regarding the individual mandate strongly evidences that Congress did not regard those other provisions as dependent on disincentives to compliance with the mandate.

It is hardly surprising that the 2017 Congress did not intend the remainder of the ACA to be invalidated if § 5000A was subsequently found unconstitutional. Wholesale invalidation of the ACA would have a devastating impact on physicians, patients, and the American health care system. It would undo "[h]istoric gains in health insurance coverage ... achieved since

the implementation of the [ACA]."[8] But for the ACA, 27% of adults age 18–64 (53.8 million people)—and 44% of those age 55–64—would have been denied insurance in the individual market due to a preexisting condition.[9] Invalidating the ACA now "would adversely affect virtually all Americans, regardless of the type of health care coverage they have."[10] And there is no evidence that the 2017 Congress intended to alter the constitutionality of the ACA.

III. The Remainder of the ACA Is Separate and Independent of the Individual Mandate and Should Remain in Force.

A. The Key Health Care Provisions of the ACA Are Not Functionally Dependent on the Individual Mandate.

Review of the key health care provisions of the ACA confirms that the remainder of the law can function independently of the individual mandate. The following

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[8] Dep't of HHS, ASPE Issue Brief, "Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage" (Sept. 29, 2016) (https://aspe.hhs.gov/system/files/pdf/207946/ACA HistoricIncreaseCoverage.pdf).

[9] Kaiser Family Foundation, "Pre-Existing Condition Prevalence for Individuals and Families" (Oct. 04, 2019) (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/).

[10] Timothy S. Jost, "Court Decision to Invalidate the Affordable Care Act Would Affect Every American," *To the Point* (Dec. 17, 2018) (https://www.commonwealthfund.org/blog/2018/court-decision-invalidate-affordable-care-act-would-affect-every-american).

examples, though not exhaustive, demonstrate the wide range of independent provisions within the ACA.

1. Premium Subsidies and Cost-Sharing Reduction Provisions

For eligible individuals and families with incomes between 100% and 400% of the Federal Poverty Level (FPL), the ACA also provides for premium credits to purchase insurance through health insurance exchanges established pursuant to the Act. 26 U.S.C. § 36; *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). For those with incomes between 100% and 250% of the FPL, the ACA provides for cost-sharing subsidies to reduce their out-of-pocket costs (e.g. deductibles, copayments, coinsurance) and annual cost-sharing limits if they select a silver plan. 42 U.S.C. § 18071. The mandate is severable from these provisions.

As Senator Hatch explained:

> Let us be clear, repealing the tax does not take anyone's health insurance away. No one would lose access to coverage or subsidies that help them pay for coverage unless they chose not to enroll in health coverage once the penalty for doing so is no longer in effect.

Senate Finance Committee, Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" (Nov. 15, 2017) at 106, 286. These provisions offer the ability to purchase health care insurance to persons who might otherwise be unable. They are in no way dependent on the legislative change to the individual mandate.

2. Preventive Services, Essential Heath Benefits, and Related Provisions

The ACA requires non-grandfathered group and non-group plans to cover certain preventive health services on a first-dollar basis (with no cost sharing). *See* 42 U.S.C. § 300gg-13. It creates incentives for use of Medicare preventive services; eliminates co-insurance; and provides for Medicare coverage of annual risk assessments, wellness visits, and personalized prevention plans, with incentives for healthy lifestyle. Notably, this provision became effective in 2011, while the mandate did not become effective until 2014. This fact alone demonstrates that the two provisions are not dependent on one another. In any event, specifying coverage for preventive services is not so related to the mandate that the mandate cannot be severed.

Similarly, the ACA requires compliant plans in the small-group and individual markets to include coverage of ten categories of essential health benefits, including hospitalization, outpatient medical care, maternity care, mental health and substance abuse treatment, prescription drugs, habilitative and rehabilitative services, and pediatric dental and vision services. *See* 42 U.S.C. § 18022. In 2013, before the ACA essential-health-benefits requirements took effect, 75% of non-group health plans did not cover maternity care, 45% did not cover substance use disorder treatment, and

38% did not cover mental health services.[11] Other ACA provisions are inextricably linked to the essential health benefits provisions, including 42 U.S.C. § 300gg-11 (which prohibits plans from placing annual and lifetime limits on the dollar value of benefits), and 42 U.S.C. § 18022 (requiring non-grandfathered plans to limit cost sharing for essential health benefits covered in-network).

All of these provisions are independent of § 5000A. They came into effect in 2010, 2011, and 2013—before the mandate became effective. Substantively, it is difficult to see how specifying which benefits compliant plans must cover could depend on the enforcement provisions of the individual mandate.

3. Voluntary Medicaid Expansion Provisions

The ACA provides for federal funding of states' expansion of Medicaid to include adults with incomes up to 138% of the FPL—the federal government paying 100% of the cost of the expansion initially, phasing down to 93% in 2019 and 90% beginning in 2020. 42 U.S.C. §§ 1396a, 1396d(y). The 2012 *NFIB* decision held it unconstitutional to compel states to expand Medicaid, but states could still voluntarily expand

[11] http://files.kff.org/attachment/Issue-Brief-Potential-Impact-of-Texas-v-US-Decision-on-Key-Provisions-of-the-Affordable-Care-Act.

Medicaid and receive federal funding support under the ACA.[12]

After the *NFIB* decision, each state may decide whether it wants to expand its Medicaid program as provided for in the ACA—and thereby receive the enhanced federal matching rate offered by Congress to encourage the Medicaid expansion. Thirty-six states and the District of Columbia have chosen to expand their Medicaid programs in accordance with the ACA.[13] It would be disastrous for these states if the federal funding supports were now removed.[14] And there is absolutely no reason to believe that modification of § 5000A has anything to do with those payments.

4. Accountable Care Organizations Provisions

The ACA requires HHS to establish a shared savings program, under which "accountable care organizations" (ACOs) share in cost savings if they meet certain criteria for managing and coordinating care for Medicare fee-for-service beneficiaries. 42 U.S.C. § 1395jjj. This provision promotes accountability for patient populations, coordination of services, and

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[12] *See NFIB*, 567 U.S. at 585–86 ("In light of the Court's holding [on Medicaid expansion], the Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion. That fully remedies the constitutional violation we have identified.").

[13] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[14] *Nat'l Fed'n of Indep. Bus. v. Sebelius,* 567 U.S. 519, 585 (2012).

investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

Nothing suggests that Congress intended the ACO provisions, effective in 2012, to depend on the existence of the later-effective mandate—or that the 2017 removal of the tax on non-compliance with the mandate was intended to undo the ACO provisions. Indeed, Senator Scott said that the 2017 bill did not affect "any actual health feature." 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017).

5. Pre-existing Conditions Provisions

Under Title I of the ACA, non-grandfathered plans are prohibited from discriminating against individuals based on their health status. 42 U.S.C. § 300gg-4. In the non-group, small-group, and large-group market, insurers must guarantee coverage. 42 U.S.C. § 300gg-1. Further, health plans are prohibited from applying preexisting condition exclusions (42 U.S.C. § 300gg-3), and rescission of coverage is prohibited (42 U.S.C. § 300gg-12). Insurers in the non-group and small-group market must use community rating (i.e., they may not vary premiums based on health status, gender, or any other factor, except age (up to 3:1), geography, and family size). 42 U.S.C. § 300gg. These are vital health care protections.

The district court wrongly concluded that these provisions are inextricably intertwined with the removal of the tax on non-compliance with the mandate. First, it is not evident that the 2017 Congress intended these provisions to fall when it enacted the Tax Cuts and Jobs Act (TCJA). On the contrary, many

congressional leaders voiced support for the law's pre-existing condition protections even as they voted for the TCJA. For example, Senator Hatch said "nothing [in the bill] impacts Obamacare policies like coverage for preexisting conditions" and "[t]he bill does nothing to alter Title I of Obamacare, which includes all of the insurance mandates and requirements related to preexisting conditions." Similarly, Senator Scott said "our bill … does not have a single letter in there about preexisting conditions." 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017). Most telling of all, when Congress changed the tax rate to zero, it did not repeal the pre-existing-conditions, guaranteed-issue, and community-rating provisions, and other key consumer protections in Titles I and II of the ACA.

Second, the pre-existing-conditions, guaranteed-issue, and community-ratings provisions are capable of functioning even with the tax/penalty rate changed to zero. The CBO did not forecast a "death spiral," but rather that non-group markets would remain stable.[15] The tax credit structure helps promote this market stability, as premiums for the benchmark second-

[15] In November 2017, before enactment of the December 2017 TCJA, the CBO reported that "[i]f the individual mandate penalty was eliminated but the mandate itself was not repealed"—which is what the 2017 Congress did—"[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." CBO, "Repealing the Individual Health Insurance Mandate: An Updated Estimate" (Nov. 2017) at 1 (https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf).

lowest-cost silver plan are tied to a percentage of income.[16]

B. Innumerable ACA Provisions Are Not Related to Private Health Insurance and Are Independent of the Individual Mandate.

As the Eleventh Circuit's "exhaustive review" and its Appendix A showed, "the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance," and "[e]xcising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.'" *Florida v. HHS*, 648 F.3d at 1321–22 (and Appendix A, *id.* at 1365-71). Those remaining provisions include the following:

1. Additional Coverage-Related and Consumer Protection Provisions

- **Special patient protections** (42 U.S.C. §§ 300gg-9–300gg-28), includes the right to select a primary care provider (or pediatrician) from any available participating primary care provider; eliminates prior authorization or increased cost-sharing for emergency services (whether in-network or out-of-network); direct access to ob/gyn care; the right not to be dropped from coverage for participating in approved clinical trials for life-threatening diseases; eliminates denial of coverage for routine patient costs;

[16] "The amount of the tax credit … is equal to the difference between the individual or family's premium cap and the cost of the benchmark silver plan." https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/.

right to internal appeals of coverage determinations and claims.

- **Dependent coverage up to age 26** (42 U.S.C. § 300gg-14). Provides coverage for approximately 2.3 million young adults, effective 2010 (preceding the mandate's 2014 effective date).

- **Behavioral health parity** (42 U.S.C. § 1396u-7). Requires Medicaid coverage of mental-health and substance-use-disorder services at parity with other Medicaid medical benefits for adults in Medicaid expansion programs and other adults under Medicaid Alternative Benefit Packages.

- **Medical loss ratio** (42 U.S.C. § 300gg-18). Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs, and provide consumer rebates if medical loss ratio is less than 85% for large-group-market plans and 80% for individual and small-group markets. Became effective in 2010, with rebates beginning in 2011, while mandate became effective in 2014.

- **Consumer information and transparency** (42 U.S.C. § 300gg-15). Requires non-grandfathered health plans to summarize coverage in plain language, and to report transparency data (e.g., number of claims submitted and denied).

- **Health insurance exchanges** (42 U.S.C. §§ 18031-18044). Creates marketplaces for qualified health plans (QHPs) meeting specific criteria; exchanges must certify that QHPs meet ACA requirements, provide subsidies to eligible individuals, operate a website for application and comparison of

health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators. Marketplace operation does not depend on a mandate, but ACA-compliant plans sold on the marketplaces may be more expensive without a mandate.

- **Premium rate reviews** (42 U.S.C. § 300gg-94). Creates a process for review/justification of health plan premium increases. States must report to HHS on premium-increase trends and recommend whether to exclude plans from the exchange for unjustified premium increases. Gives states grants to support premium-increase review and approval. Effective plan year 2010, with HHS monitoring premium increases (in and outside exchanges) beginning plan year 2014.

- **Waiting periods** (42 U.S.C. § 300gg-7). Requires no-more-than-90-day waiting periods on eligibility for employer health benefits (e.g., for new hires).

- **Risk adjustment** (42 U.S.C. §§ 18061–18063). Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees.

- **Simplification of enrollment processes** (42 U.S.C. §§ 1395cc, 1396a, 1397gg). Requires states to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges.

- **Non-discrimination** (42 U.S.C. § 18116). Building on federal civil rights laws, prohibits discrimination based on race, color, national origin, sex,

age, or disability in certain health programs or activities. May include gender identity and pregnancy status (by regulation).

2. Key Medicare-Related Provisions (ACA Title III).

- **Center for Medicare and Medicaid Innovation** (CMMI) (42 U.S.C. § 1315a). Establishes the CMMI to test care models that improve quality and slow Medicare cost growth rate, including programs promoting greater efficiencies and timely access to outpatient services by not requiring physician/ professional referrals or involvement in creating care plan. Effective in 2011, before the mandate.

- **Medical home pilot program** (42 U.S.C. § 1396w-4). Establishes independence-at-home demonstration program to bring primary-care services into the home for highest-cost Medicare beneficiaries with multiple chronic conditions. Shared savings available to health teams for achieving quality outcomes, patient satisfaction, and cost savings. Allows NPs and PAs to lead home-based primary care teams.

- **Medicare Advantage** (MA) (42 U.S.C. §§ 1395eee, 1395w-21, 1395w-23, 1395w-24, 1395w-27a). Requires HHS to transition to fiscal neutrality between regular Medicare fee-for-service and MA plans. Benchmarks vary from 95% of regular Medicare spending in high-cost areas to 115% in low-cost areas.

- **Medicare data release provision/qualified entity program** (42 U.S.C. § 1395kk). Requires HHS to provide Medicare claims data to qualified entities,

for public provider performance reports, subject to safeguards ensuring validity and reliability of the data. Physicians/providers can review data before public reports, with the right to appeal and correct errors. Data is non-discoverable and inadmissible without consent of provider/supplier.

- **Medicare "doughnut hole"** (42 U.S.C. § 1395w-102(b). Reduces the coverage gap for Medicare prescription drug benefits over time, 2010–2020.

3. Other Key Provisions.

- **Access to Therapies** (42 U.S.C. § 18114). Prohibits HHS from promulgating regulations that interfere with access to medical care or the information patients receive from their providers.

- **Biosimilar pathway** (42 U.S.C. §§ 262, 284m, 35 U.S.C. § 271, 28 U.S.C. § 2201, 21 U.S.C. §§ 355, 355a, 355c, 379g). Gives FDA immediate authority to establish an abbreviated pathway to approve biosimilars for market, introducing more competition in the pharmaceutical marketplace. Effective in 2010, preceding and unrelated to the mandate.

- **Electronic funds transfers** (EFT) (42 U.S.C. 1320d–2). Requires adoption of EFT operating rules for health care payment and remittance advice by July 1, 2012, effective by January 1, 2014. Also requires health care providers to comply with EFT standard for Medicare payments by January 1, 2014.

- **Graduate Medical Education** (GME) (42 U.S.C. § 294g). Authorizes redistribution of 65% of

unused GME residency slots to qualifying hospitals to address physician shortages, especially in rural/underserved areas (eff. July 1, 2011). Creates greater flexibility to count training in outpatient settings and didactic/scholarly activities toward GME payments (eff. July 1, 2010, applicable to previous cost reporting periods). Preserves GME positions from closed hospitals and directs HHS to establish a process to redistribute medical residency slots from qualifying closed hospitals (eff. 2010 for 2010–11).

- **Health disparities** (42 U.S.C. § 1396w-5). Requires qualified health plans to reduce health disparities by using language services, community outreach, and cultural competency trainings.

- **Health outcomes** (42 U.S.C. § 300gg-17). Requires HHS to develop guidelines for health insurers to report on initiatives to improve health outcomes by care coordination and chronic disease management, prevent hospital readmissions, improve patient safety, and promote wellness and health.

- **Health plan identifier** (42 U.S.C. § 1320d-2). Requires adoption of unique health plan identifier system.

- **HHS national health care quality strategy and plan** (42 U.S.C. § 280j). Provides resources to develop national strategy for performance improvement, quality measures and best practices, data aggregation, and public reporting of performance information.

- **Loan forgiveness** (42 U.S.C. § 292s). Requires medical students who receive federal loan funds to

practice in primary care until the earlier of 10 years or loan repayment.

- **Long-term care** (42 U.S.C. §§ 293k-1, 1396a, 1396d, 1396p). Improves the nation's long-term care system, including new options for states to offer home and community-based services, to increase non-institutional long-term care services.

- **Medicaid drug rebate percentage** (42 U.S.C. 1396r-8). Increases Medicaid drug rebate for most brand-name drugs to 23.1% and increased Medicaid rebate for non-innovator multiple-source drugs to 13%. Extends drug rebate program to Medicaid MCOs.

- **National Health Service Corps** (NHSC) (42 U.S.C. § 254g). Authorizes increased funding for NHSC scholarship and loan repayment program, allows part-time service and teaching time to qualify toward the NHSC service requirement, and increases the annual NHSC loan repayment amount from $35,000 to $50,000 in 2010.

- **National prevention and health promotion strategy and other prevention provisions** (42 U.S.C. §§ 280*l* et seq., 300gg et seq., 300u-10, 300u-11, 1396a, 1396d, 1396r-8, 1396o, 1396o-1). Develops a national prevention and health promotion strategy that sets specific goals for improving health. Creates a prevention and public health investment fund, providing $7 billion in funding from 2010 through 2015, and $2 billion for each fiscal year after 2015, to expand and sustain funding for prevention and public health programs. Permits insurers to create incentives for health promotion and disease prevention practices

through significant premium discounts and encourages employers to provide wellness programs and premium discounts for participating employees. Covers only proven preventive services and provides incentives to Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women. Includes food labeling requirements.

Contrary to the view of the district court, these are not "minor provisions" *Texas v. United States*, 340 F. Supp. 3d 579, 587 (N.D. Tex. 2018). They are important congressional enactments providing tremendous benefits for the American people. Most significantly, they are entirely independent of § 5000A.

IV. Invalidating the ACA Would Throw the U.S. Health Care System Into Crisis, and Doing so in the Midst of a Pandemic Would Risk Collapse.

Invalidating provisions that have expanded access to health insurance coverage such as the guaranteed-issue and community rating provisions—or the *entire* ACA—would have a devastating impact on doctors, patients, and the American health care system in normal times. However, striking down the ACA at a time when the system is struggling to respond to a pandemic that has infected nearly 1.4 million Americans and killed more than 80,000[17] at the time of

[17] Centers for Disease Control, "Cases in the U.S.", (last visited May 11, 2020) https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

this writing would be a self-inflicted wound that could take decades to heal.

Even if these were the best of times, the consequences of any form of invalidation of the ACA would eliminate the "[h]istoric gains in health insurance coverage have been achieved since the implementation of the Affordable Care Act."[18] The ACA's "nationwide protections for Americans with pre-existing health conditions" have allowed 53.8 million people to obtain affordable health insurance.[19]

The ACA has also been vital in reducing health care costs and bolstering financial security for Americans. For example, "Medicaid expansion improve[d] the financial security of the newly insured (for example, by reducing the amount of debt sent to a collection agency by an estimated $600-$1000 per person gaining Medicaid coverage)."[20] And, "[h]ad premiums increased since 2010 at the same mean rate as the preceding decade, the mean family premium for employer-based coverage would have been almost $2600 higher in 2015." *Id.*

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[18] Department of Health and Human Services, ASPE Issue Brief, *Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage* (September 29, 2016) (available at: https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf).

[19] KFF, "Pre-Existing Condition Prevalence for Individuals and Families" (Oct. 04, 2019) (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/).

[20] Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, 316(5) JAMA 525-532 (2016), *available at* https://jamanetwork.com/journals/jama/fullarticle/2533698.

Sacrificing these reforms would leave millions without much-needed insurance and in a financially worse position. A March 2019 Urban Institute analysis ("State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA")[21] concluded that,

> if the entire law were eliminated and pre-ACA Medicaid expansion waivers were reinstated . . . the number of uninsured people in the US would increase to 50.3 million, an increase of 65.4 percent or 19.9 million people. Medicaid and CHIP enrollment would fall by 15.4 million people through the elimination of the ACA's Medicaid expansion. Reduced Medicaid eligibility would increase uninsurance among the low-income population.
>
> The total number of people with private nongroup insurance (ACA compliant and noncompliant) would drop 35.4 percent (6.9 million people), compared with having the ACA in place.

And, if states were unable to reinstate their pre-ACA Medicaid expansion waivers, "up to 1.3 million more people could become uninsured . . . , increasing national uninsurance under repeal by *21.2 million people*." *Id*. (emphasis added).

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[21] https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state.pdf. *See also* the Urban Institute's June 2018 analysis, "The ACA Remains Critical for Insurance Coverage and Health Funding, Even without the Individual Mandate" (https://www.urban.org/sites/default/files/publication/98634/aca-remains-critical_2001873_0.pdf).

But these are not the best of times. Health care in the United States is at a precipice. Due to the current pandemic, millions of Americans have become suddenly unemployed at historic rates.[22] And for most of those newly unemployed, they have also lost their employer-sponsored health insurance at a time when it is extremely likely they will need it.[23] The ACA provides relief in the form of Medicaid or subsidized coverage through the ACA-created exchanges. Depending on the plan, this coverage could be much more affordable than COBRA coverage.

Without the ability to pay for health care, uncompensated care costs will rise. In December of 2019, the Urban Institute estimated that "the amount of uncompensated care sought by the nonelderly population would nearly double from about $61.3 billion to $111.4 billion, if the ACA had been overturned at the start of 2019."[24] Hospitals and other entities are already under financial strain because of the need to cancel elective procedures, which provide a majority of their operating revenue.[25] Uncompensated care costs would exacerbate

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[22] Justin Wolfers, *The Unemployment Rate is Probably 13 Percent*, NYT (Apr. 3, 2020) https://www.nytimes.com/2020/04/03/upshot/coronavirus-jobless-rate-great-depression.html.

[23] Urban Institute, *How the COVID-19 Recession Could Affect Health Insurance Coverage,* https://www.rwjf.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html?cid=xem_other_unpd_ini:quick%20strike_dte:20200504_des:quick%20strike

[24] https://www.urban.org/sites/default/files/publication /101361/implications_of_the_fifth_circuit_court_decision_in_texas_v_united_states_final_121919_v2.pdf.

[25] John T. Fox, *Commentary: Healthcare's looming financial implosion*, MODERN HEALTHCARE, (Mar. 20, 2020), https://www.modernhealth

the strain on health care delivery even more than currently exists.

Patients who have chosen to obtain health insurance through non-ACA short-term, limited duration insurance (STLDI) plans now face uncertainty around whether COVID-19 related treatment or hospitalization will be covered, precluded as a pre-existing condition, or capped.[26] These sorts of caps or limits offer unfortunate previews of what could become the new normal if the ACA is invalidated. The cost to treat COVID-19 related hospitalization could be nearly $35,000, which would overwhelm the average citizen.[27]

Amici know better than anyone that "[m]edicine has long operated under the precept of *Primum non nocere*, or 'first, do no harm.'" *Manuel v. City of Joliet*, 137 S. Ct. 911, 929 (2017) (Alito, J., dissenting) ("'[F]irst, do no harm'—is a good rule of thumb for courts as well."). They respectfully submit that this Court should do the same.

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care.com/opinion-editorial/commentary-healthcares-looming-financial-implosion.

[26] Christine Linke Young & Kathleen Hannick, *Misleading marketing of short-term health plans amid COVID-19*, BROOKINGS INST., (Mar. 24, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/.

[27] Abigail Abrams, *Total Cost of Her Treatment: $34, 927.43,* TIME, (Mar. 19, 2020), https://time.com/5806312/coronavirus-treatment-cost/.

CONCLUSION

Amici respectfully request that this Court reverse the Fifth Circuit's decision, uphold the constitutionality of the ACA, and avoid furthering the current state of crisis our health care system faces.

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