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**UNITED STATES DISTRICT COURT**

**NORTHERN DISTRICT OF CALIFORNIA**

State of California, et al.,

Plaintiffs,

v.

Donald J. Trump, et al.,

Defendants.

Case No. 17-cv-05895-VC

**AMICUS CURIAE BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, THE FEDERATION OF AMERICAN HOSPITALS, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AND THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IN SUPPORT OF NEITHER PARTY**

## STATEMENT OF INTEREST

The American Hospital Association represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 43,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Association of American Medical Colleges is a not-for-profit association representing all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

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## STATEMENT OF ISSUES AND RELEVANT FACTS

The Affordable Care Act has helped millions of uninsured Americans buy comprehensive health insurance. But paying premiums every month is only the first step. Plans often include "cost-sharing" provisions that require patients to pay certain sums before benefits kick in or a percentage of the plan's cost for services. And these cost-sharing payments pose a risk to lower-income patients, who are the ones most likely to rely on the Affordable Care Act's insurance exchanges for coverage. Insurance is not helpful if a patient cannot afford the cost-sharing payments required when she actually seeks health care.

Congress knew that. It therefore built into the Affordable Care Act cost-sharing subsidies whereby insurers would reduce the out-of-pocket costs for low-income patients and the government would reimburse insurers for the value of the reduction. Without cost-sharing reductions, patients' physical and financial health would suffer. Even with the reductions, high cost-sharing obligations can cause patients to forgo needed treatment and devastate their finances. And without the cost-sharing subsidies provided for by the Affordable Care Act, some patients could lose their coverage altogether, triggering a "death spiral" in the exchanges, as the value of the cost-sharing subsidies is shifted back into higher premiums, which in turn drives healthier patients to different insurance options and leaves only the sickest patients behind, still further increasing premiums and driving more patients off the exchanges.

Hospitals, too, will find it harder to achieve their missions. Hospitals already provide billions in uncompensated care to patients who cannot pay their bills and who have no other source of payment. An end to the cost-sharing subsidies will force hospitals to shoulder an even greater burden, reducing and in some cases eliminating operating margins, and making it harder for them to serve their patients and communities. Congress in the Affordable Care Act cut funding for uncompensated care at hospitals in the expectation that hospitals would make up the difference through exchange-insured patients. But if hospitals must bear the burden of uncompensated care from an increasing number of uninsured or underinsured patients, the balance Congress struck in the Act will be upset.

All of this suggests that the cost-sharing subsidies provided for under the Act should

continue to be made. Congress meant for the Act to create exchanges where lower-income patients could purchase affordable insurance that they could actually use. Without the subsidy payments, government expenditures under the Act will increase, which would be in tension with the Act's goals.

## ARGUMENT

### I. ENDING THE COST-SHARING SUBSIDIES WILL HURT PATIENTS AND HINDER HOSPITALS' PATIENT-FOCUSED MISSIONS.

#### A. Cost-Sharing Reductions Keep Patients' Healthcare Costs Manageable.

1. The Affordable Care Act has been called a "three legged stool" of health reform. Mark Seidenfeld, *Tax Credits on Federally Created Exchanges*, 99 Minn. L. Rev. Headnotes 101, 101 (2015). The first leg—guaranteed issue and community rating—ensures that all Americans can obtain insurance without facing increased rates because of pre-existing conditions. *See King v. Burwell*, 135 S. Ct. 2480, 2486 (2015). The second leg—the individual mandate—requires most Americans to obtain health insurance, preventing the adverse selection that can occur when only the sick sign up. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2623 (2012). And the third—subsidies—reduces the cost of health insurance for lower-income individuals who might not otherwise be able to afford it. *See King*, 135 S. Ct. at 2494. Taken together, the Affordable Care Act "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market." *Id.* at 2485.

*King* upheld the tax credits that the Act provides to help individuals afford exchange plan premiums. But the cost-sharing subsidies at issue in this case are also essential. Patients who earn up to 250% of the federal poverty level—$30,150 for individuals and $61,500 for a family of four[1]—and who purchase a "silver" level plan on the health-insurance exchanges are eligible for cost-sharing reductions that reduce their out-of-pocket healthcare costs. The Commonwealth Fund, *Essential Facts About Health Reform Alternatives: Eliminating Cost-Sharing Reductions*, at 1 (Apr. 28, 2017).[2]

Cost-sharing reductions come in two forms. First, insurers reduce the copayments or

[1] HealthCare.gov, *Federal Poverty Level (FPL)*, https://goo.gl/BnfS2P.
[2] *Available at* https://goo.gl/pxYjLA.

coinsurance that patients pay for particular covered services, such as office visits. Gary Claxton and Nirmita Panchal, Kaiser Family Found., *Cost-Sharing Subsidies in Federal Marketplace Plans* (Feb. 11, 2015) (*Cost-Sharing Subsidies*).[3] Second, insurers cap the total out-of-pocket costs patients must pay per year. Matthew Rae et al., Kaiser Family Found., *Impact of Cost-Sharing Reductions and Out-of-Pocket Limits* (Mar. 22, 2017) (*Impact of Reductions*).[4] For those earning under 200% of the federal poverty level, out-of-pocket costs are capped at $2,350 for single coverage and $4,700 for family coverage. *Id.* For those earning between 200% and 250% of the federal poverty level, out-of-pocket costs are capped at $5,700 for single coverage and $11,400 for family coverage. *Id.* In 2017, more than 7 million patients—58% of those enrolled in exchange plans—qualified for cost-sharing reductions that make it more affordable for them to use their coverage. Ctrs. for Medicare & Medicaid Servs., *Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016 – January 31, 2017* (March 15, 2017).[5]

2. Cost-sharing reductions and limits on out-of-pocket expenses protect the sickest and highest-cost individuals "who need the benefits of insurance the most." Loren Adler and Paul Ginsburg, The Brookings Inst., *Health Insurance as Assurance: The Importance of Keeping the ACA's Limits on Enrollee Health Costs* (Jan. 17, 2017).[6] As insurers struggle to keep premiums down, they increasingly shift costs to patients in the form of higher deductibles—the amount that must be paid before insurance coverage kicks in—and increased coinsurance—the percentage of the provider's fee the patient must pay even after insurance kicks in. Carolyn Y. Johnson, *Americans Are Shouldering More and More of Their Health-Care Costs*, Wash. Post (June 27, 2016).[7]

The average silver plan enrollee without cost-sharing subsidies faces a deductible as high as $3,609. *Impact of Reductions*, *supra*. But with cost-sharing reductions, a qualifying silver

[3] *Available at* https://goo.gl/6gzo44.
[4] *Available at* https://goo.gl/PcEcuX.
[5] *Available at* https://goo.gl/nMO32R.
[6] *Available at* https://goo.gl/V0FBlQ.
[7] *Available at* https://goo.gl/AK2h78.

plan enrollee may pay deductibles on average as low as $809. *Id.* Cost-sharing reductions thus generally make exchange plans equivalent to employer-sponsored plans for patients with similar incomes. Munira Z. Gunja, *et al.*, The Commonwealth Fund, *Americans' Experiences With ACA Marketplace Coverage: Affordability and Provider Network Satisfaction* 5 (July 2016).[8] And cost-sharing reductions "can result in thousands of dollars of savings for individuals and families who have significant medical events or ongoing medical needs." *Cost-Sharing Subsidies*, *supra*.

Cost-sharing reductions thus prevent out-of-pocket costs from putting health care out of reach for lower-income Americans who dutifully pay their premiums each month. Almost half of all adults say they could not cover an emergency expense costing $400 or more, and would have to borrow or sell something to meet it. Bd. of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2016* 10 (May 2017).[9] And households eligible for cost-sharing reductions have on average just over $300 in liquid assets. Gary Claxton, *et al.*, Kaiser Family Found., *Consumer Assets and Patient Cost Sharing* 3 (Feb. 2015).[10]

For these patients, finding the money for even the Affordable Care Act's capped out-of-pocket obligations is a stretch. One-fifth of insured patients report difficulty paying their medical bills. Margot Sanger-Katz, *Even Insured Can Face Crushing Medical Debt, Study Finds*, N.Y. Times (Jan. 5, 2016).[11] Of that one-fifth, 63% had to tap all or most of their savings, 42% took on an extra job or had to work more hours, 14% moved or took in roommates, and 11% were forced to rely on charity. *Id.* And insured patients with high-deductible plans—private plans similar to exchange plans without cost-sharing reductions—delayed or avoided preventative care because of concerns about out-of-pocket costs. Rachel Dolan, *Health Policy Brief: High-Deductible Health Plans*, Health Affairs (Feb. 4, 2016).[12]

Even for insured patients, then, out-of-pocket costs are a form of "financial toxicity" that "can diminish quality of life and impede delivery of the highest quality care." S. Yousuf Zafar

[8] *Available at* https://goo.gl/e9augP.
[9] *Available at* https://goo.gl/uIZyze.
[10] *Available at* https://goo.gl/mNUov3
[11] *Available at* https://goo.gl/mMbPzg.
[12] *Available at* https://goo.gl/cWbme5.

and Amy P. Abernethy, *Financial Toxicity, Part I: A New Name for a Growing Problem*, 27(2) Oncology 80–149 (2013).[13] Patients with higher out-of-pocket costs are less likely to adhere to treatment plans and to fill needed prescriptions, and may even forgo needed treatment. *Id.* The Affordable Care Act's cost-sharing reductions thus protect patients' physical health as well as their financial health.

3. If insurers cannot receive government reimbursement for the value of cost-sharing reductions, they may not eliminate those cost-sharing reductions, but they will have to make up the cost somehow—and that somehow is likely to be increased premiums. One study found that eliminating federal reimbursement of cost-sharing reductions would increase premiums for silver plans by $1,040 on average for all patients, not just those receiving cost-sharing reductions. Linda J. Blumberg and Matthew Buettgens, Urban Inst., *The Implications of a Finding for the Plaintiffs in* House v. Burwell 8 (Jan. 2016) (*Implications*)[14]; *cf. King*, 135 S. Ct. at 2493-94 (citing a similar study by Blumberg and Buettgens). And that jump comes on top of next year's estimated double-digit percentage increase in exchange-plan premiums, which likely would have been even greater if insurers had been able to account fully for the lost subsidies. *See* Rabah Kamal, et al., Kaiser Family Found., *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges* (Aug. 10, 2017);[15] Timothy Jost, Health Affairs, *Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets* (Oct. 13, 2017).[16]

These increases, in turn, may well drive patients out of the Affordable Care Act's exchanges. By one estimate, ending the subsidies would drive more than 1 million patients to drop marketplace coverage, finding it more economical to purchase coverage elsewhere. *Implications*, *supra*, at 1. And that would leave only low-income patients—who are most dependent on subsidies and who are more likely to be sicker and to consume more health care—remaining on silver plans. *Id.* at 6; Jeffrey Young, *Obamacare Enrollees Are Sick And They're*

[13] *Available at* https://goo.gl/WPc4Fi.
[14] *Available at* https://goo.gl/719TXR
[15] *Available at* https://goo.gl/zHCqbo.
[16] *Available at* https://goo.gl/QR4T4j.

*Getting A Lot Of Health Care*, The Huffington Post (Mar. 30, 2016) (exchange enrollees tend to be sicker than most patients).[17]

Exchange plans work like all other insurance and count on a diverse population of patients—some who are healthier and some who are sicker—which allows plans to spread risk and costs among their entire pool of insureds. *See* Nat'l Ass'n of Ins. Comm'rs, *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act* 1 (2011).[18] Removing federal reimbursement of cost-sharing subsidies raises the specter of an exchange "death spiral," where the flight of healthier, wealthier patients from the exchanges will raise premiums for those who remain, which will drive even more healthier, wealthier patients from the exchanges, which will again raise premiums for those who remain, and so on. *See* Larry Levitt and Gary Claxton, Kaiser Family Found., *Insurance Markets in a Post-King World* (Feb. 25, 2015) (describing the mechanisms of a death spiral).[19] Ending the cost-sharing subsidies risks the very integrity of the Affordable Care Act's exchanges. *See* Larry Levitt et al., Kaiser Family Found., *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments* (Apr. 25, 2017) ("Many insurers might react to the end of subsidy payments by exiting the ACA marketplaces.").[20] Moreover, because the end to the subsidies was announced shortly before the annual enrollment period for the exchanges, the full impact on insurer participation in exchanges may not be visible until next year.

### B. Ending the Cost-Sharing Subsidies Will Make It Harder For Hospitals To Serve Their Patients And Their Communities.

Hospitals do their part to lessen the burden on patients struggling with cost-sharing payments and health care costs generally. Hospitals provide tremendous amounts of uncompensated care to lower-income patients—$35.7 billion in 2015 alone.[21] A significant part of that—over $10 billion—comes from writing off cost-sharing payments from insured patients.

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[17] *Available at* https://goo.gl/fK3HRO.
[18] *Available at* https://goo.gl/9SVKj1.
[19] *Available at* https://goo.gl/MQvR82.
[20] *Available at* https://goo.gl/9Wzwrp.
[21] Am. Hosp. Ass'n, *Uncompensated Care Cost Fact Sheet* 3 (Dec. 2016), *available at* https://goo.gl/QbFLhU.

Stephanie Armour, *Patients Pay Before Seeing Doctor as Deductibles Spread*, Bloomberg (Oct. 13, 2013).[22] Hospitals accept the price of some uncompensated care as the cost of doing business and as a way to relieve financial stress on poorer patients. But the increase in uncompensated care that will result if federal reimbursement for cost-sharing payments is eliminated will make it harder for hospitals to serve their patients and their communities.

1. Uncompensated care—including uncompensated care for insured patients who cannot pay their out-of-pocket obligations—was expected to fall as more patients became insured through the Affordable Care Act and received cost-sharing reductions. Sean D. Hamill, *Hospitals Show Some Benefit from ACA*, Pittsburgh Post-Gazette (July 24, 2016).[23] And on average it has. *Id.*; *see also Uncompensated Care Cost Fact Sheet*, *supra*, at 3 (showing a decrease in uncompensated care as a percentage of hospitals' total expenses since the Affordable Care Act's enactment in 2010).

But averages conceal the significant challenges that hospitals—especially rural hospitals—face in serving lower-income insured patients. Rural hospitals often serve States that opted out of the Affordable Care Act's Medicaid expansion, and these hospitals have seen increasing uncompensated care costs as a result of the "coverage gap" affecting patients too wealthy for pre-Affordable Care Act Medicaid programs but too poor to take full advantage of the Act's exchange plans. Kristin L. Reiter, *et al.*, *Uncompensated Care Burden May Mean Financial Vulnerability for Rural Hospitals in States That Did Not Expand Medicaid*, Health Affairs, Oct. 2015, at 1721, 1725; Rachel Garfield and Anthony Damico, Kaiser Family Found., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 5-6 (Oct. 2016).[24]

Without federal reimbursement of cost-sharing subsidies, these problems will compound. Patients will either lose coverage and be unable to pay for needed care or face higher premiums and have fewer funds available to pay their cost-sharing obligations. Either way, the bottom line

[22] *Available at* https://goo.gl/ayuhua.
[23] *Available at* https://goo.gl/wYBdo6.
[24] *Available at* https://goo.gl/BiP9MU.

is the same: Lower- and middle-income patients will find it harder to pay their medical bills, leaving hospitals with greater uncompensated-care burdens, and therefore with fewer resources available for free care, financial assistance, fee-reduction programs, and other benefits to make and keep their communities healthy.

Already, hospitals are feeling financial stress as they realize that many newly insured patients from the Affordable Care Act that they were counting on to reduce uncompensated-care burdens may have plans with deductibles so high that their insurance is illusory. As one hospital executive explained, "When someone has a really high deductible, effectively they're still uninsured, and most people . . . don't have $5,000 lying around to pay their bills." John Lauerman, *Bad Debt Is the Pain Hospitals Can't Heal as Patients Don't Pay*, Bloomberg (Feb. 23, 2016).[25] And this stress has started showing up in hospitals' bottom lines. The Minnesota Hospital Association's members have seen one subset of uncompensated care spike by 20% to $425 million in 2016, with 39 members—most of them rural—operating at a loss. *Id.* Eliminating federal reimbursement for cost-sharing reductions threatens to make these problems worse and to spread them to even more hospitals.

2. These financial risks come at a time when hospitals can ill afford them. In the Affordable Care Act, Congress cut—in two different ways—the payments hospitals receive to care for Medicare and Medicaid patients. First, Congress cut Medicare and Medicaid Disproportionate Share Hospital, or "DSH," payments. 42 U.S.C. § 1395ww(r) (Medicare); *id.* § 1396r-4(f)(7) (Medicaid). DSH payments provide assistance to hospitals that serve large numbers of low-income patients, *see Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S. Ct. 817, 822 (2013), and are the largest form of federal funding for uncompensated care, *see* Kaiser Family Found., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (May 30, 2014).[26] Together, the Act's reductions in Medicare and Medicaid DSH payments will cut federal support for uncompensated care by an estimated $36.1 billion through the end of the decade. *See* Am. Hosp. Ass'n, *Summary of 2010 Health Care Reform Legislation* 34-35 (Apr.

[25] *Available at* https://goo.gl/XHy3GO.
[26] *Available at* https://goo.gl/bF3k0O.

19, 2010).[27] And following the Affordable Care Act's passage, the Medicaid DSH reductions have been both extended and significantly increased. *See* Peter Cunningham, *et al.*, Kaiser Family Found., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes* 6 (June 2016).[28] CMS has proposed $43 billion in further cuts to DSH from fiscal year (FY) 2018 through FY 2025. 82 Fed. Reg. 35,155, 35,170 (July 28, 2017).

Second, Congress cut payments to hospitals by reducing the Medicare inflation adjustment and the "market basket" rates used annually to adjust Medicare payments. 42 U.S.C. § 1395ww(b)(3)(B). The program's chief actuary estimated that these cuts will cost hospitals another $233 billion over 10 years. Richard S. Foster, Ctrs. for Medicare & Medicaid Servs., *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Apr. 22, 2010).[29]

The cuts—a combined total of some $269 billion in a single decade—drastically reduce hospitals' payments for treating Medicare and Medicaid patients. That is particularly significant because even before the cuts, Medicare and Medicaid did not fully cover hospitals' costs of care. Hospitals in 2015 spent $57.8 billion providing care to Medicare and Medicaid patients for which the hospitals were not reimbursed. American Hosp. Ass'n, *Underpayment by Medicare and Medicaid Fact Sheet* (Dec. 2016).[30]

Congress thought hospitals could survive these cuts because they would receive offsetting revenues. Lawmakers believed the newly freed-up monies would fund subsidies like cost-sharing reductions; the subsidies would help more people buy and use insurance; and the influx of insured patients would reduce—though not eliminate—the billions of dollars a year that hospitals spend providing uncompensated care. *See* 42 U.S.C. § 18091(2) (congressional findings). As President Obama explained: "As health reform phases in, the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered." L.D. Hermer & M. Lenihan, *The Future of Medicaid Supplemental Payments: Can They Promote*

[27] *Available at* https://goo.gl/vBafWp.
[28] *Available at* https://goo.gl/Drpozl.
[29] *Available at* https://goo.gl/RQ8Ld2.
[30] *Available at* https://goo.gl/TvPkmb.

*Patient-Centered Care*? 102 Ky. L.J. 287, 294 n.37 (2013) (quoting press reports). The inflation and market-basket adjustments had a similar impetus. See John Reichard, *Biden Announces Deal With Hospitals to Cut Medicare, Medicaid Payments By $155 Billion*, CQ Healthbeat (July 8, 2009).[31] But without federal reimbursement of cost-sharing reductions, hospitals will have to shoulder the Act's funding cuts *and* an uncompensated-care burden similar to what they carried before the Act. That is a one-two punch from which hospitals and their communities cannot easily recover.

## II. CONGRESS COULD NOT HAVE INTENDED THESE RESULTS.

Congress could not have intended these harms to patients and hospitals. Congress's goal in the Affordable Care Act was "[t]o ensure that health coverage is affordable." S. Rep. No. 111-89, at 4 (2009). Cost-sharing reductions were an essential aspect of that affordability; lower-income patients should not have to pay for health coverage that they cannot afford to use.

That purpose informs the merits of the appropriations question raised by this case. The Supreme Court noted before that the Affordable Care Act is "far from a *chef d'oeuvre* of legislative draftsmanship." *King*, 135 S. Ct. at 2493 n.3 (citation omitted); *id.* at 2492 ("The Affordable Care Act contains more than a few examples of inartful drafting."). And the Court therefore has interpreted the Act in light of Congress's stated goals of creating functional, affordable exchanges offering comprehensive insurance to qualifying lower-income patients. *Id.* at 2493 ("We cannot interpret federal statutes to negate their own stated purposes.") (quoting *N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405, 419-420 (1973)). This Court should interpret the Act with these goals in mind.

Allowing the cost-sharing subsidies to be terminated also would lead to paradoxical results. If the cost-sharing subsidies were to end, the government would spend even more money than it currently does. Eliminating federal reimbursement of cost-sharing reductions will increase the price of silver exchange plans. *Supra* at 5-6. And because tax credits for all patients are pegged to the cost of silver plans, the available credits for those enrolled in exchange plans will increase. *Implications*, *supra*, at 5. That would cost the government over $3.6 billion more than

[31] *Available at* https://goo.gl/HoAwVU.

if the cost-sharing subsidies were left as is. *Id.* at 8. And this $3.6 billion additional expense is authorized by the Affordable Care Act; there is a standing appropriation to pay for premium-support subsidies. This spending increase suggests that ending the cost-sharing subsidies may be in tension with the Affordable Care Act's purposes and goals.

## CONCLUSION

The Court should decide this appeal in light of the foregoing principles.

Dated: October 21, 2017

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