IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al.,

Plaintiffs,

v.

UNITED STATES OF AMERICA, et al.,

Defendants,

and

CALIFORNIA, et al.,

Intervenors-Defendants.

Case No. 4:18-cv-00167-O

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF INTERVENOR-DEFENDANTS

MELINDA REID HATTON
MAUREEN MUDRON
LAWRENCE HUGHES
AMERICAN HOSPITAL ASSOCIATION
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, D.C. 20001

Counsel for American Hospital Association

CATHERINE E. STETSON
SEAN MAROTTA
KIRTI DATLA*
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

** Admitted only in Texas; supervised by firm members*

Counsel for Amici Curiae

(Additional counsel listed on inside cover)

Additional counsel:

KATHLEEN TENOEVER
ERIN RICHARDSON
FEDERATION OF AMERICAN HOSPITALS
750 Ninth Street, N.W.
Suite 600
Washington, D.C. 20001

Counsel for Federation of American Hospitals

LISA J. GILDEN
Vice President, General Counsel
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
1875 Eye Street, N.W.
Suite 1000
Washington, D.C. 20006

Counsel for The Catholic Health Association of the United States

IVY BAER
FRANK R. TRINITY
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
655 K Street, N.W.
Suite 100
Washington, D.C. 20001

Counsel for Association of American Medical Colleges

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES:

STATUTES:

TABLE OF AUTHORITIES—Continued

Page

LEGISLATIVE MATERIALS:

OTHER AUTHORITIES:

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

INTEREST OF AMICI CURIAE

The American Hospital Association, Federation of American Hospitals, The Catholic Health Association of the United States, and Association of American Medical Colleges respectfully submit this brief as amici curiae.

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 of the Catholic health ministry, representing the largest not-for-profit provider of health care services in the nation. The Catholic health ministry is comprised of more than 2,200 hospitals, nursing homes, long-term care facilities, health care systems, sponsors, and related organizations serving the full continuum of health care across our nation. CHA's Vision for U.S. Health Care calls for health care to be available and accessible to everyone, paying special attention to poor and vulnerable individuals. 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 151 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 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Amici's members are deeply affected by the Nation's health care laws, particularly the Affordable Care Act ("ACA"). *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. That is why they have filed amicus briefs in support of the law in the Supreme Court, the courts of appeals, and courts across the Nation. *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480 (2015); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012); *U.S. House of Representatives v. Azar*, No. 16-5202 (D.C. Cir. 2018). Just as in those cases, amici write to offer guidance, from hospitals' perspective, on the harmful impact that striking down the law would have on the American health care system.

ARGUMENT

The Court should be clear about what Plaintiffs seek: The judicial repeal of the Affordable Care Act. Plaintiffs thus propose unwinding the last eight years of progress, throwing tens of millions off of the insurance rolls and returning them to the ranks of the long-term uninsured, who have demonstrably worse health outcomes. The ACA's repeal may serve Plaintiffs' idiosyncratic health-policy preferences. But for the rest of the country, which has

received from the Act expanded health-insurance coverage, a stable individual-insurance market, and an expanded Medicaid safety net, a judgment for Plaintiffs would be disastrous. If Plaintiffs prevail, more Americans will go without basic medical care and more Americans will wait to seek care until they are more seriously ill and more difficult to successfully treat.

Nothing in law or logic requires that result. Timing, as the saying goes, is everything. When Congress enacted the Affordable Care Act in 2010, it wrote on a blank slate. It viewed the individual mandate and its accompanying penalty as an important component of the reforms the Act would make to this Nation's health-insurance system. When Congress revisited the Act in 2017 with the benefit of seven years of experience, it decided that the individual mandate was ultimately less important to the project of ensuring access to coverage than the rest of the package of reforms, and so it zeroed out the penalty associated with non-compliance.

As the State Intervenors explain, even the mandate as amended is still a tax and the mandate is therefore still constitutional. *See* Intervenor-Defs.' Opp. at 17–20 (ECF No. 91 at 29–32). But if the Court rules that the individual mandate is unconstitutional without a monetary penalty, then it should conduct its severability analysis under the Act as it stands today. And as it stands today, the individual mandate is severable from the rest of the Act. After all, when Congress had the choice before it in 2017, it explicitly chose to zero out the penalty attached to the mandate and do nothing else. That is as clear a sign of Congressional intent as the Court could hope for.

Ruling otherwise and striking down the entire ACA would devastate this Nation's health care system, its patients, and the hospitals they rely on for care. Nothing requires that catastrophic result. This Court should decline to give Plaintiffs the result they seek—repeal of the entire ACA—judicially when they could not secure it through the political process.

I. The Current Individual Mandate is Severable From the Rest of the ACA.

If the Court concludes that the individual mandate without a penalty for noncompliance does not pass constitutional muster, the Court then must determine whether the provision can be excised from the rest of the ACA, which is "essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). The "normal rule" is "that partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985). The remainder of the ACA "must" be sustained "unless it is evident that" it is "incapable of functioning independently" of the mandate or that, in light of the text and historical context, Congress "would have preferred no [Act] at all to" an ACA without the mandate. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010) (internal alterations and quotation marks omitted).

Plaintiffs cannot clear that high hurdle. Any hortatory effect that the current individual mandate may have is not necessary to sustain the ACA. And there is no evidence that the Congress that removed the penalty backing the mandate would have preferred no ACA to an ACA without an already penaltyless mandate. Indeed, its unsuccessful attempts to enact a broader repeal is evidence that Congress did not prefer a broader—much less a full—repeal. The mandate is therefore severable from the remainder of the ACA.

1. The ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). It worked. As of early 2017, there were 28.1 million uninsured in the United States, "20.5 million fewer . . . than in 2010." Robin A. Cohen et al., Nat'l Ctr. for Health Statistics, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January – March 2017*, at 1 (Aug. 2017), *available at* https://tinyurl.com/nchsestimate. But it did not work exactly as planned.

When the ACA was enacted, its major provisions were often referred to as a three-legged stool. The guaranteed-issue and community-rating provisions formed the first leg, prohibiting insurers from discriminating against Americans on the basis of preexisting or other conditions, such as claims history, gender, and, to a certain extent, age. *See* 42 U.S.C. §§ 300gg, 300gg-3, 300gg-4; *see also Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 567 U.S. 519, 547–548 (2012). Subsidies through premium tax credits and cost-sharing reduction payments formed the second leg, making coverage and the use of that coverage feasible for Americans who would otherwise be unable to afford it. *See* 26 U.S.C. § 36B; 42 U.S.C. §§ 18071, 18081–18082; *see also King*, 135 S. Ct. at 2487. And the individual mandate formed the third leg, expanding the risk pool to the healthy as well as the sick by requiring people to maintain coverage and penalizing those who did not. *See* 26 U.S.C. § 5000A; *see also NFIB*, 567 U.S. at 548.

Taken together, the hope was that these reforms would achieve "near universal" health insurance coverage. 42 U.S.C. § 18091(2)(D). The guaranteed-issue and community-ratings provisions would make sure that coverage was widely available. The subsidies would make sure that coverage was generally affordable and that patients would have access to the health care services they needed, including those offered by hospitals. And the mandate would make sure that everyone purchased insurance, expanding the risk pool and making the ACA's mandates financially viable for insurers.

2. This conventional understanding of the ACA has proven incomplete in two ways. It does not recognize the many other reforms that the ACA put into place, or their contribution to expanded coverage. And, in practice, the three legs have not been equally effective.

The ACA did much more than just three things. It created health-insurance exchanges to serve the individual and small-group health insurance markets, through which qualified people

can purchase health-insurance plans that provide a basic set of essential benefits. *See* 42 U.S.C. §§ 18021(a)(1)(B), 18031–18044. It expanded the Medicaid program, permitting adults with incomes of up to 133% of the federal poverty level to obtain coverage under the program. *See id.* § 1396a(a)(10)(A)(i)(VIII); *see also NFIB*, 567 U.S. at 548, 586–588 (plurality op.) (severing requirement that States participate in Medicaid expansion). It mandated that employers with fifty or more full-time employees provide health insurance to their employees. *See* 26 U.S.C. § 4980H. And it contains hundreds of other provisions. To continue the analogy, then: The ACA has "several other 'legs' that are critical to supporting the ACA regime." Gillian E. Metzger, *Agencies, Polarization, and the States*, 115 Colum. L. Rev. 1739, 1773 (2015).

Moreover, the ACA's three legs did not contribute equally to the expansion of coverage in the individual market. As it turns out, to date, the individual mandate has had a smaller effect than expected. One study found that the subsidies accounted for 41% of 2014's coverage gains that could be attributed to the ACA's major provisions, while the individual mandate's effects were negligible.[1] *See* Molly Frean et al., *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. Health Econ. 72, 80–81 (2017). The rest of these gains came from the Medicaid program, with 29% of the total attributable to enrollment due to increased awareness by those already eligible, but not yet enrolled—such as children—and the other 30% attributable to the ACA's Medicaid expansion. *See id.* "The relative magnitudes of the changes for each policy were quite similar in 2015." *Id.* at 81.

[1] Among the factors that explain the low impact of the individual mandate is the number of people exempt from it—24% in the 2015 tax year. *See* Alexandra Minicozzi, Unit Chief, Cong. Budget Office, Presentation at the 2017 Annual Meeting of the American Academy of Actuaries: *Modeling the Effects of the Individual Mandate on Health Insurance Coverage* 2 (Nov. 14, 2017) ("*CBO Presentation*"), *available at* https://tinyurl.com/cbopresentation.

Even then, all of the gains that could be attributed to the ACA together accounted for only 60% of the total increase in 2014 coverage gains. That is, some of the increase in coverage could not be traced directly to the ACA's reforms aimed directly at increasing coverage but instead stemmed from other factors. The study attributed those gains to other factors, including decreased unemployment, decisions to purchase insurance due to "the social effect of the individual mandate," the increased attractiveness of insurance due to the "guaranteed issue requirements," and the "simplification of purchasing coverage due to the creation of the exchanges." *Id.*

A recent Kaiser Family Foundation poll adds to the explanation for why the individual mandate has proven less important than originally expected. It found that few people who purchase health insurance through the individual market viewed the individual mandate as a "major reason" for their decision to obtain coverage. *See* Ashley Kirzinger et al., Kaiser Family Found., *Kaiser Health Tracking Poll-March 2018: Non-Group Enrollees* (Apr. 3, 2018), *available at* https://tinyurl.com/mandatepoll (finding that only a third of enrollees identified the individual mandate as one of the major reasons they obtained health insurance). They instead identified "protecting against high medical bills (75 percent) and peace of mind (66 percent)" as well "an ongoing health condition (41 percent)," of their own or of a family member. *Id.* This suggests that the availability of affordable and effective health insurance—not a government mandate—drives patients to purchase coverage. *See CBO Presentation*, at 14 (pointing out that "knowledge about the benefits of having health insurance, subsidies, and the enrollment process;" a decrease in "the stigma associated with Medicaid;" and "persistence" effects may keep individuals enrolled in health insurance without a mandate). For good reason: Although

some Americans may wish to roll the dice on their health and finances, most *want* to have affordable insurance for themselves and their families.

3. By the time congressional discussion turned to whether to repeal the ACA or to repeal various provisions in 2017, it was clear that the individual mandate had not been the main driver of the drop in the uninsured as was originally expected. Unsurprisingly then, the studies of these legislative proposals showed that repealing the individual mandate would have a much smaller impact than repealing other provisions.

For example, in the run-up to the amendment, the Congressional Budget Office examined the effects on coverage of repealing nearly all of the ACA's reforms. The bill under review would have repealed all of the ACA's major reforms in two phases. The first would have repealed the employer and individual mandates and the second would have repealed the Medicaid expansion and the subsidies. *See* Cong. Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* 2 (Jan. 2017), *available at* https://tinyurl.com/cborepealjan17. The Congressional Budget Office estimated that under this near-complete repeal of the ACA, 32 million people would lose health insurance over a ten-year period. *See id.* at 1. That is, the number of uninsured individuals would be *higher* than before the ACA.

The Congressional Budget Office also examined the effects of a more-targeted repeal effort aimed just at the individual mandate and estimated a much smaller decrease in coverage. It concluded that a wholesale repeal of the individual mandate—of both the requirement and the penalty—would not undo the gains attributable to the rest of the ACA. It estimated that a wholesale repeal of the individual mandate would reduce the number of insured by 4 million in 2019, and by 13 million through 2027. *See* Cong. Budget Office, *Repealing the Individual*

Health Insurance Mandate: An Updated Estimate 1, 3 (Nov. 2017) ("*CBO Mandate Repeal Estimate*"), *available at* https://tinyurl.com/cbomandate. Thirteen million newly uninsured would be a blow to the health care system, to be sure. But they are significantly fewer than the *32 million* that would lose coverage under a complete repeal like the one that Plaintiffs propose. *See id.* And 13 million was an outer bound. Other reports estimated that the increase in uninsured as a result of the mandate's repeal would be substantially lower, closer to four or five million over ten years. *See* Dylan Scott, *CBO: 13 Million More Uninsured if You Repeal Obamacare's Individual Mandate*, Vox (Nov. 8, 2017, 4:50 PM), *available at* https://tinyurl.com/voxestimate (discussing critics of this estimate who argue the coverage decrease will be lower); Dan Mangan, *Killing Obamacare Mandate Won't Cut Number of Insured—Or Budget Deficit—As Much As Predicted, Analysis Says*, CNBC (Nov. 17, 2017, 3:32 PM), *available at* https://tinyurl.com/cnbcestimate (describing a S&P Global Ratings Analysis report that estimated the decrease in coverage from a repeal of the individual mandate at four to five million by 2027); *see also* Christine Eibner & Evan Saltzman, RAND Corp., *How Does the ACA Individual Mandate Affect Enrollment and Premiums in the Individual Insurance Market?* 3 (2015), *available at* https://tinyurl.com/randestimate (estimating an 8 million increase in the number of uninsured).[2]

The Congressional Budget Office also saw little-to-no difference between a wholesale repeal of the mandate and Congress's eventual choice of repealing the mandate penalty but not the mandate. It considered exactly this question and concluded that "[i]f the individual mandate

[2] Indeed the Congressional Budget Office recently agreed that its initial estimate was too high. *See* Cong. Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, at 20 (May 2018) ("*CBO 2018 Subsidies Report*"), *available at* https://tinyurl.com/cbosubsidies2018 ("CBO and JCT estimate the reduction in health insurance coverage is about one-third smaller than the agencies previously estimated.").

penalty was eliminated but the mandate itself was not repealed, the results would be *very similar*." *CBO Mandate Repeal Estimate*, at 1 (emphasis added). That is because "with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law." *Id.*

All of this suggests two things. First, when Congress repealed the mandate penalty, it was aware of the effects the repeal would have on health care coverage, and it found those effects tolerable. That is, it knew that while some would lose coverage, that number was far smaller than the number that would lose coverage if other reforms—such as the subsidies and the Medicaid expansion—also were repealed. And second, when Congress repealed the mandate penalty, it was indifferent to whether individuals complied with the penaltyless mandate. *See, e.g.*, 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) (statement of Sen. Capito) ("If you opt not to purchase, which I hope you would not, your government shouldn't be taxing you, and that is what has happened."). That is, whether someone chose to purchase health insurance was up to her, but that personal choice had no bearing on the overall functioning of the rest of the ACA's reforms.

4. The upshot is that the current individual mandate is clearly severable from the rest of the ACA. There is no evidence—either common sense or empirical—that the rest of the ACA is "incapable of functioning independently," *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987), without the penalty-free mandate. Quite the opposite. As the *CBO Mandate Repeal Estimate* makes clear, now that the penalty backing the mandate has been repealed, excising the penaltyless individual mandate will have minimal effects on coverage. Common sense therefore suggests that the remaining provisions of the ACA's operation do not depend on whatever small

change in coverage will result from the difference between the current mandate-without-a-penalty and no mandate at all. Nor is it at all "evident" that the amending Congress would have preferred ending the ACA project altogether over ending only the current individual mandate. Reaching that conclusion would require accepting the implausible premise that Congress would have preferred to forgo *all* of ACA's gains in the quality and quantity of coverage rather than to lose out on only whatever minimal effect on coverage the amended individual mandate will have. No evidence supports that premise; rather, when Congress zeroed out the penalty and thus left the coverage choice entirely up to consumers, it signaled a clear willingness to tolerate a world where the mandate had no, or only minimal, effect.

Congress's contemporaneous failure to repeal other, major ACA provisions provides further confirmation that it did *not* prefer a full-scale repeal. Before the individual mandate's penalty was repealed in 2017, Congress considered, and rejected, a flurry of more far-reaching ACA-related proposals. The American Health Care Act of 2017, to take one example, would have repealed the Medicaid expansion, repealed ACA's subsidies, eliminated the penalties associated with the individual and employer mandates, and relaxed or permitted waivers of the ACA's community rating and essential benefits provisions. *See* American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017). The bill would have increased the number of uninsured by 23 million in 2026. *See* Cong. Budget Office, *Cost Estimate for H.R. 1628: American Health Care Act of 2017*, at 4 (May 2017), *available at* https://tinyurl.com/cboaha2017. After many attempted amendments, the bill died in the Senate. *See* Kim Soffen & Kevin Schaul, *Which Health-Care Plans The Senate Rejected (And Who Voted 'No')*, Wash. Post (July 28, 2017, 2:25 AM), *available at* https://tinyurl.com/wapoamendments. This shows that Congress chose to enact a single, more surgical amendment to the ACA after expressly considering and rejecting

broader cuts to the ACA. In severability terms, Congress's decision to reject an evisceration of the ACA suggests that its preference would have been for an ACA without the amended individual mandate rather than for no ACA at all.

Plaintiffs should not be allowed to get through this Court—repeal of the entire ACA through the backdoor of severability—what they could not get through Congress. And make no mistake: This case is but one of a multi-front battle that Plaintiffs are waging against the ACA. If the Plaintiffs are unhappy with the ACA, their remedy lies with the political branches, not this Court.

5. The plaintiffs' only response is to head back in time, to 2010, and examine the intent of Congress with respect to the ACA *as enacted*. They point to congressional findings enacted alongside the original mandate, which they read to express a congressional view that the individual mandate is so integral to the ACA that, for severability purposes, the ACA cannot survive without it. *See* PI Mot. at 31 (ECF No. 40 at 41) (discussing basis for the original findings relating to the individual mandate); *see also* Federal Defs.' Resp. at 13–16 (ECF No. 92 at 18–21) (relying on the original findings to assert that the guaranteed-issue and community-rating provisions are inseverable from the penaltyless mandate). But those findings shed no light on the severability issue here. To start, those findings appear in a provision that speaks to the mandate's "effects" on interstate commerce; they did not address severability. 42 U.S.C. § 18091(2) (titled "Effects on the national economy and interstate commerce"); *see also id.* § 18091(1) (stating that the individual mandate, as enacted, "is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in [§ 18091(2)]"). What is more, the findings expressly dealt with the mandate *as enacted*, that is, to the mandate backed by a penalty. *See id.* § 18091(1) (referring to the "individual

responsibility requirement *provided for in this section*" (emphasis added)). The findings were not reenacted when the penalty was removed. Thus even if the findings spoke to severability in 2010, they say nothing about the severability of the amended individual mandate at issue here. And, for the reasons just discussed, the amended mandate is plainly severable.

More fundamentally, how Congress saw the interconnectedness of the various ACA provisions in 2010 does not inform how Congress saw the interconnectedness of the various ACA provisions in 2017. As the above analysis shows, Congress reassessed the necessity of the penalty-backed mandate in 2017 and concluded that it could remove that penalty without fundamentally compromising the rest of the ACA. *See, e.g.*, *CBO 2018 Subsidies Report*, at 2 (concluding recently that, in the wake of the penalty repeal, "[t]he nongroup health insurance market [will be] stable in most areas of the country over the next decade"). Congress can—and did—change its mind in light of the evidence developed since it first passed the Act. Plaintiffs cannot tie Congress forever to a single, unchanging view of the ACA. Neither should the Court.

II. Accepting the Plaintiffs' Severability Argument—and Striking Down the ACA—Would Devastate Patients and the Hospitals They Rely on for Care.

Make no mistake about what Plaintiffs seek: The wholesale judicial repeal of the ACA. That would have devastating consequences, kicking millions of Americans off of coverage and inflicting on them all the harms that come with being uninsured. These harms would fall on the low-income families least able to cope with them. And a judicial repeal would have severe consequences for America's hospitals, which would be forced to shoulder the greater uncompensated-care burden that the ACA's repeal would create. These consequences further show that Congress could not have intended the entire ACA to fall with the mandate.

1. Striking down the Act would eliminate the coverage gains made since 2010. An Urban Institute study found that a complete repeal would leave 24 million uninsured over a five-

year period. *See* Matthew Buettgens et al., Urban Institute, *The Cost of ACA Repeal* 1, 3 (June 2016) ("*ACA Repeal*"), *available at* https://tinyurl.com/uirepeal. Indeed, a full repeal would result in *more* Americans being uninsured in 2021 than were uninsured in 2013 when the ACA's coverage provisions were first going into effect. *See id.* at 2–3 (finding that "53.5 million people or 19.4 percent of the population" would be uninsured compared to "47.5 million . . . in 2013, representing 17.6 percent of the population" due to an increase in health care costs over time and the repeal of the dependent-coverage provision). Other studies agree. *See* Dobson DaVanzo & Assocs. LLC, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals* 3 (Dec. 2016), *available at* https://tinyurl.com/aharepeal ("If the ACA is repealed, we estimate that the number of uninsured would increase by 22 million people by 2026."); Cong. Budget Office, *Cost Estimate for H.R. 1628: Obamacare Repeal Reconciliation Act of 2017*, at 1, 10 (July 19, 2017), *available at* https://tinyurl.com/cbo1628 (estimating the effect of repealing many of the ACA's major provisions as increasing the number of uninsured by "27 million in 2020").

These are not abstract numbers. They mean that more people will go without basic medical care and will wait to seek care until they are more seriously ill and more difficult to successfully treat. Those who have health care coverage "are more likely to have a regular source of care," such as a general practitioner. *See* Am. Hosp. Ass'n, *The Importance of Health Coverage* 2 (Apr. 2018), *available at* https://tinyurl.com/aha2018. Regular access to care translates to regular access to prescription drugs, to early diagnoses and treatments, to preventative mental health care, and to well-care child care visits. *See id.* All of this means that if people have regular access to care, they have better health and better outcomes when they do face illness or a medical condition. *See id.*; *see also* Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2017*, at 23 (May 2018) ("*Economic*

Well-Being"), *available at* https://tinyurl.com/2018fed ("Among the uninsured, 42 percent went without medical treatment due to an inability to pay, versus 25 percent among the insured.").

Decreased access to health care coverage also devastates the finances of the under- and uninsured. Four out of ten adults say that they could not cover an emergency expense costing $400 or more, and would have to borrow or sell something to meet it. *See Economic Well-Being*, at 21. "Out-of-pocket spending for health care is a common unexpected expense that can be a substantial hardship for those without a financial cushion." *Id.* at 23. Even with the ACA's reforms, over 20% of adults faced an unexpected medical bill they were unable to pay in 2017, and 37% of those who reported medical expenses in 2017 still have unpaid debt from those bills. *See id.*; *see also* S. Yousuf Zafar and Amy P. Abernethy, *Financial Toxicity, Part I: A New Name for a Growing Problem*, 27(2) Oncology 80, 81 (2013) (even for insured patients, out-of-pocket costs are a form of "financial toxicity" that "can diminish quality of life and impede delivery of the highest quality care.").

All of these harms will fall on those least able to afford them. The Urban Institute study estimated the total non-elderly health care spending would be "$88.1 billion lower without the ACA." *ACA Repeal*, at 7. These health-care dollars would be diverted away from those with the least. "More than two-thirds of the reduction in health care spending would come from reducing care delivered to those in families with incomes below 200 percent of" the federal poverty level. *Id.* And "[a]lmost all of the rest" would come from a loss of care among "those with incomes between 200 and 400 percent of" the federal poverty level. *Id.* These numbers may not even paint the full picture, as they assume that governments and private health care providers would be able to "return to pre-ACA rates of spending on uncompensated care," an assumption for which there is no guarantee. *Id.*

2. A sharp increase in uninsured and underinsured patients also would harm the hospitals that serve those communities. Hospitals do their part to lessen the burden on patients struggling with health care costs, in part by providing tremendous amounts of uncompensated care—care for which the hospital receives no payment at all—to lower-income patients. After years of steady increases before the ACA, the uncompensated care rate began to fall after its reforms went into effect. *See* Am. Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 2 (Dec. 2017), *available at* https://tinyurl.com/ahauncompensated. Even so, in 2016, hospitals provided $38.3 billion in uncompensated care. *See id.* at 3.

Striking down the ACA would sharply increase the amount of uncompensated care that hospitals would need to provide. The Urban Institute study estimated that, if the ACA were repealed, "providers' share of uncompensated care would increase 109.2 percent" over a five-year period, assuming that "governments would be willing to fund uncompensated care at pre-ACA levels." *ACA Repeal*, at 8. If they were unwilling or unable to do so, "the increase in the burden on providers would be higher." *Id.* These increases will stretch some hospitals' finances to the breaking point, causing some to curtail services or to close altogether, and will undermine efforts to redirect funds to community-based prevention and treatment to lower costs and improve outcomes.

Just as with patients, this increase in uncompensated care will not be shared equally among hospitals. Rural hospitals, for example, already face significant challenges in serving lower-income insured patients. These hospitals serve an aging, poorer, and declining population, one already with "high uninsured rates and a payer mix dominated by Medicare and Medicaid." *See* Jane Wishner et al., Kaiser Family Found., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* 1 (July 2016), *available at*

https://tinyurl.com/kffrural. Rural hospitals' closure rate is already on the rise. *See id.* at 2. A sharp rise in the number of uninsured—especially as the Medicaid expansion disappears—means an already struggling population will be less likely to pay their medical bills, leaving these hospitals with greater uncompensated-care burdens and at greater risk for closure.

The same is true of "safety-net" hospitals, those that serve the highest proportion of low-income and uninsured patients. Safety-net hospitals have benefited the most from the ACA reforms, especially the Medicaid expansion. *See* David Dranove et al., The Commonwealth Fund, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal* 4 (May 2017), *available at* https://tinyurl.com/tcfuncompensated. These same safety-net hospitals, then, will be hit the hardest by its repeal. *See id.* at 6 ("[E]liminating the Medicaid expansions and restoring [the pre-ACA system of payments to hospitals with a disproportionate share of Medicare and Medicaid patients] will reintroduce systematic disparities in hospital uncompensated care burdens.").

3. In short, granting Plaintiffs the relief they seek will devastate both the patients that depend on the ACA and the hospitals that serve them. And that is yet another reason why Congress could not have intended the rest of the ACA to fall with the mandate. Congress's overall goal in the ACA was to "[t]o ensure that health coverage is affordable." S. Rep. No. 111-89, at 4 (2009). Plaintiffs' approach, where health coverage would not just be unaffordable, but out-of-reach, is directly contrary to that goal. As between an ACA without the mandate and no ACA at all, Congress cannot reasonably be found to have preferred the latter. After all, courts do not "interpret federal statutes to negate their own stated purposes." *King*, 135 S. Ct. at 2493 (internal quotation marks omitted). The Court should follow that sound teaching here and deny Plaintiffs' motion.

CONCLUSION

For the foregoing reasons, Plaintiffs' motion should be denied.

Respectfully submitted,

/s/ Catherine E. Stetson
CATHERINE E. STETSON
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

SEAN MAROTTA
KIRTI DATLA*
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

** Admitted only in Texas; supervised by firm members*

Counsel for Amici Curiae

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