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

AMICI CURIAE BRIEF OF 36 STATE HOSPITAL ASSOCIATIONS IN SUPPORT OF PETITIONERS

WILLIAM B. SCHULTZ
Counsel of Record
MARGARET M. DOTZEL
NICHOLAS M. DICARLO
ZUCKERMAN SPAEDER LLP
1800 M Street NW
Suite 1000
Washington, DC 20036
(202) 778-1800
wschultz@zuckerman.com
mdotzel@zuckerman.com
ndicarlo@zuckerman.com

Counsel for Amici Curiae

May 13, 2020

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER AUTHORITIES

INTEREST OF AMICI CURIAE

This brief[1] is filed on behalf of 36 state hospital associations,[2] which represent over 5,000 hospitals and health systems that treat tens of millions of patients every year and currently stand on the frontlines of a global pandemic. Amici and their members (hereafter "amici") share an interest in delivering quality, affordable health care, and therefore in the preservation of the Patient Protection and Affordable Care Act (ACA). Since enactment of the ACA, amici have spent substantial resources embracing the law's reforms that have resulted in the delivery of higher-quality, more coordinated care at a lower cost. Amici are submitting this brief because they support the ACA and because reverting back to old delivery models would significantly disrupt amici's operations and patient care.

Although this brief focuses on the delivery of health care services in this country, amici endorse the constitutional and severability arguments presented by petitioners, which demonstrate that the Fifth Circuit wrongly decided this appeal.[3] Amici agree with

---

[1] Pursuant to Rule 37, all parties have provided written consent to the filing of this amici curiae brief. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to its preparation or submission.

[2] The individual associations are described in the Appendix to this brief.

[3] *See* Pet'r States Br. 25–48; U.S. House of Representatives Br. 14–19, 34–50.

petitioners that the ACA's minimum coverage provision, as amended, is constitutional. But if this Court decides otherwise, amici concur that this Court should hold that the rest of the ACA must remain intact. As petitioners have demonstrated, it is clear that the 2017 Congress would have intended that the ACA remain in force if the minimum coverage provision were judicially invalidated. After all, the 2017 Congress thought it was *legislatively* invalidating that provision when it zeroed out the tax for noncompliance. Having observed the ACA work for years—including in hospitals and health systems across the country—the 2017 Congress had expressly rejected legislation that would have repealed the entire ACA which definitively demonstrates its intent that the remaining provisions are severable from the minimum coverage provision.

INTRODUCTION

The Patient Protection and Affordable Care Act[4] made health care available to millions of individuals through insurance subsidies and expansion of the federal Medicaid program. Often overlooked in the controversy regarding those provisions, which occupied just two of ten titles and fewer than 300 pages of the 974-page bill, are the ACA's many other basic health care reforms. These include, for example, amendments to the Indian Health Care Improvement Act, a pathway for approval of generic biologics by the Food and Drug Administration, provisions making Medicare Part D prescription drugs more affordable, the addition of

[4] Pub. L. 111-148, 124 Stat. 119 (2010). All citations to the law are styled as ACA § ___.

nutritional information to restaurant menus, disclosure of drug company gifts to physicians, and the subject of this brief: foundational changes to the way health care services are delivered and paid for.

The ACA's "delivery reforms," which the Fifth Circuit and the district court did not even mention in their opinions, transformed the way hospitals and health systems deliver and are paid for health care. These provisions have promoted innovative, new models of care and have provided substantial investments in the health care workforce. They also addressed prevention and launched new initiatives to improve health care quality. In the ten years since the ACA was enacted, these reforms have made fundamental improvements in the quality and coordination of care, saving billions of federal dollars. They have become integral to the delivery of health care services in the United States.

ARGUMENT

In their attempt to strike down every provision of the ACA, respondents have characterized the Act's major health care delivery reforms as "minor" provisions. This misnomer led the district court to invalidate these important provisions along with the rest of the law because the court considered them "adjuncts of" the requirement that most Americans obtain health insurance coverage or pay a penalty (the "minimum coverage provision"). The Fifth Circuit, to its credit, recognized that the district court's severability analysis was superficial and ordered the district court to conduct the severability analysis with a "finer-toothed comb." Nevertheless, the Fifth Circuit

adopted the district court's faulty taxonomy, labeling scores of critical provisions as "minor" and abdicating its responsibility to rule on the purely legal severability issue. Both courts failed to recognize that the ACA's delivery reforms have transformed the delivery of health care in the United States by providing more integrated, cost-effective care, while maintaining quality. And because there is no basis for concluding that Congress intended those provisions—which were enacted in separate titles and function independently of the ACA's insurance-related provisions—to be inseverable, they, along with the other remaining provisions, should be left intact regardless of how the Court rules on the constitutionality of the minimum coverage provision.

I. THE ACA'S SIGNIFICANT REFORMS THAT MODERNIZED THE DELIVERY OF HEALTH CARE IN THE UNITED STATES WERE IGNORED BY THE DECISIONS BELOW.

The ACA is best known for its provisions that reformed the individual market for private health insurance, including the minimum coverage provision. The law created Health Insurance Marketplaces where individuals may purchase insurance, provided subsidies to help individuals buy insurance, required that insurance policies permit young adults up to age 26 to remain on their parents' health insurance plans, and prohibited insurers from denying coverage ("guaranteed issue") or charging drastically higher rates because of an individual's health status ("community rating"). It is similarly well understood that the ACA incentivized states to expand Medicaid coverage to millions of Americans.

Importantly, the ACA also contained landmark provisions that have made a sea change in health care delivery, coordination, and payment. These reforms have modernized the way hospitals and health systems deliver services. The law also invested in the health care workforce, prioritized wellness and prevention, and launched new initiatives to study and compare health care quality. All these important innovations were swept under the rug in the decisions below and remain in limbo pending this Court's review.

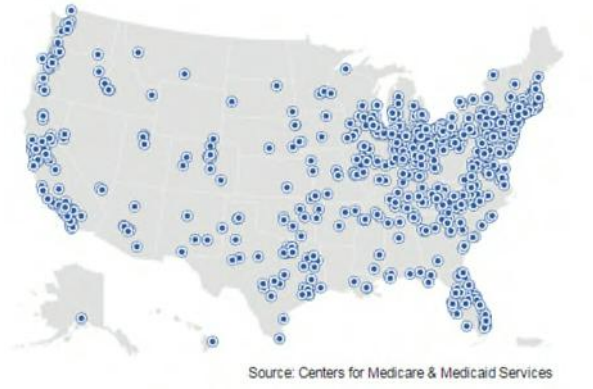
A. The ACA Made Fundamental Changes to the Delivery of Health Care in the United States, Improving Patients' Lives and Saving Tens of Billions of Dollars.

The ACA's reforms include pioneering new models of care that foster better coordination among health care professionals. They also include payments to health systems based on the quality of care provided to Medicare beneficiaries, with less reliance on reimbursement based on each separate hospital and doctor's visit, test, and service provided (the "fee-for-service" model). These paradigm shifts have had ripple effects on hospitals and health systems both because the federal government is the largest payer for health care in the United States and because private insurers often follow the federal government's payment policies.[5]

---

[5] *E.g.*, Tevi D. Troy, *How the Government as a Payer Shapes the Health Care Marketplace*, American Health Policy Institute (2015), http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf.

Leading these reforms is the ACA-created Center for Medicare & Medicaid Innovation (CMMI), which tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries.[6] CMMI has launched over 40 new payment and health care service delivery models, covering more than 18 million patients and 200,000 health care providers across the country.[7] The map below from the Centers for Medicare & Medicaid Services (CMS) shows where in the country health care providers are working with CMMI to test methods for improving the delivery and coordination of care at a lower cost.



According to the Congressional Budget Office, CMMI's programs are projected to reduce federal spending by

---

[6] ACA §§ 3021 & 10306; *see* CMS, *Innovation Models*, http://innovation.cms.gov.

[7] CMS, *CMS Innovation Center: Report to Congress* 1–2 (Dec. 2016), https://innovation.cms.gov/files/reports/rtc-2016.pdf.

as much as $34 billion by 2026.[8] And as predicted, the private market is adopting CMMI alternative payment models.[9]

A CMMI initiative that has had a particularly significant impact on the way hospitals provide care to patients is the Medicare Shared Savings Program for Accountable Care Organizations (ACOs). The Shared Savings Program provides financial incentives to health care providers, including hospitals, primary care physicians, and nursing homes, to join ACOs.[10] The ACO members agree to coordinate and take collective responsibility for the quality and costs of care for a specified patient population. In treating that population, if an ACO meets health care quality thresholds and provides care below a target budget, the provider network splits the savings 50/50 with Medicare. Alternatively, ACOs may split the savings 60/40 if the providers agree in advance to share excess costs with the government in the event their spending exceeds the target budget. A 2017 Office of the Inspector General report found that in the first three years of the program: 428 participating Shared Savings Program ACOs served 9.7 million beneficiaries; most of

---

[8] *CBO's Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation: Hearing Before the H. Comm. on the Budget*, 114th Cong. 3 (2016) (testimony of Mark Hadley, Deputy Director of the Congressional Budget Office). This is the most recent CBO report on the subject.

[9] *See* Health Care Payment Learning & Action Network, *Health Care Payment Learning & Action Network*, https://hcp-lan.org/.

[10] ACA §§ 3022 & 10307; *see* CMS, *Shared Savings Program*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html.

the ACOs reduced Medicare spending compared to their benchmarks, achieving a net spending reduction of nearly $1 billion; and ACOs generally improved the quality of care they provided.[11]

The ACA also established a pilot project to test Medicare bundled payment models called Bundled Payments for Care Improvement (BPCI).[12] Bundling links payments for the multiple services that Medicare beneficiaries receive during a specific episode of care across different settings (including hospitals, physician's offices, and post-acute care providers). Under the initiative, hospitals and other health care providers may enter into payment arrangements that include financial and performance accountability for episodes of care. For example, one model bundles payments for all inpatient hospital services, physician services, post-acute services, and hospital readmission care that a patient receives in connection with a hip or knee replacement.[13] As one Senator described it during Congress's consideration of the ACA, "[i]n effect, instead of paying for each specific service, under

---

[11] HHS Office of the Inspector General, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality*, OEI-02-15-00450 (Aug. 2017), https://oig.hhs.gov/oei/reports/ oei-02-15-00450.pdf.

[12] ACA §§ 3023 & 10308; *see* CMS, *Bundled Payments for Care Improvement (BPCI) Initiative*, https://innovation.cms.gov/initiatives/bundled-payments/.

[13] As a follow-on to BPCI, in 2016 CMMI launched a bundled payment program for hip and knee replacements that is mandatory for hospitals in certain geographic markets. *See* CMS, *Comprehensive Care for Joint Replacement Model*, https://innovation.cms.gov/initiatives/CJR.

bundling there is essentially one payment to reward trying to deliver care in an integrated fashion."[14] Research has shown that bundled payments can align incentives for providers, allowing them to deliver higher-quality, more coordinated care across all specialties and settings. A 2018 report found that participants have responded to the initiative's incentives by reducing Medicare payments while maintaining quality of care.[15] In October 2018, CMMI launched BPCI Advanced, an initiative to test bundling models for 32 additional episodes of care, with nearly 1,300 health systems signed up to participate.[16]

Other ACA "pay-for-performance" reforms tied Medicare payments to the quality of care delivered. A value-based purchasing (VBP) system now pays hospitals for their performance based on quality criteria while treating Medicare beneficiaries, instead of the quantity of procedures performed.[17] Under the VBP program, CMS makes payments to hospitals based on how closely clinical best practices are followed

---

[14] 155 Cong. Rec. S11905, S11910 (daily ed. Nov. 21, 2009) (statement of Sen. Wyden).

[15] The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models 2–4: Year 5 Evaluation & Monitoring Annual Report* (Oct. 2018), https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf.

[16] Press Release, CMS, *CMS Announces Participants in New Value-Based Bundled Payment Model* (Oct. 9, 2018), https://www.cms.gov/newsroom/press-releases/cms-announces-participants-new-value-based-bundled-payment-model.

[17] ACA §§ 3001 & 10335; *see* CMS, *The Hospital Value-Based Purchasing Program*, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/hvbp/hospital-value-based-purchasing.html.

and how well hospitals enhance patients' experience of care during hospital stays over a relevant time period.

The Hospital Readmissions Reduction Program reduces Medicare payments to hospitals with "excessive" readmissions in order to incentivize patient safety and education.[18] Research indicates that the law's incentives are working as intended: readmissions for certain health conditions decreased more rapidly after passage, and improvement was most significant for hospitals with the worst pre-ACA performance.[19] Finally, the ACA established the Hospital-Acquired Condition Reduction Program.[20] The program addresses patient safety by reducing Medicare payments for hospitals that rank in the lowest-performing quartile of hospital-acquired conditions (such as surgical site infections).

Together, these reforms represent the most significant changes to the health care delivery and payment systems in more than 50 years. Some of these health care delivery reform programs have already achieved improvements across a range of measures. Although we expect these programs will continue to be

---

[18] ACA § 3025; *see* CMS, *Hospital Readmissions Reductions Program*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.

[19] *See* Jason H. Wasfy et al., *Readmission Rates After Passage of the Hospital Readmissions Reduction Program: A Pre–Post Analysis*, ANNALS OF INTERNAL MEDICINE, Mar. 7, 2017.

[20] ACA § 3008; *see* CMS, *Hospital-Acquired Condition Reduction Program*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/hac-reduction-program.html.

evaluated and improved, they have already spurred significant investment and innovation among hospitals.

B. The ACA Further Reformed Health Care Delivery by Investing in the Health Workforce, Focusing on Wellness and Prevention, and Creating Health Care Quality Initiatives.

The ACA's reshaping of health care delivery went beyond changing service and payment models. The law also made substantial investments in the health care workforce and in graduate medical education, improved the focus on wellness and prevention, and launched measures intended to study and improve health care quality.

Important to hospitals and health systems, the ACA strengthened the health care workforce. The law established loan repayment programs designed to increase the size of the public health workforce.[21] Hospitals, medical schools, and other entities became eligible for grants to develop, expand, and enhance educational training programs in primary care, nursing, mental and behavioral health.[22] Unused residency training positions were redistributed among teaching hospitals to increase training of primary care physicians and general surgeons, and new positions were added.[23] And the law preserved resident slots within a geographic location when a nearby teaching

---

[21] ACA §§ 5201–10.

[22] ACA § 5301.

[23] ACA § 5503.

hospital closed.[24] Data show that these workforce initiatives are increasing the number of health care providers in underserved and high-need areas, many of whom are currently working to fight the COVID-19 pandemic.[25]

The ACA also initiated a transition of our health system from one that solely treats patients who are sick to one that also focuses on preventing people from becoming sick. The law created the National Prevention, Health Promotion and Public Health Council, chaired by the Surgeon General and composed of the heads of various federal agencies, to lead federal strategy with respect to wellness and prevention in the United States.[26] The ACA also increased access to preventive care in Medicare and Medicaid, including a "Welcome to Medicare" comprehensive physical exam when one enters the Medicare program and annual wellness visits with no cost-sharing, as well as incentives to state Medicaid programs to cover preventive services.[27] The law also created an Office of Women's Health within the Department of Health and Human Services (HHS), to focus on women's health,

---

[24] ACA § 5506.

[25] *See* Shannon Mace & Megan Dormond, *The Impact of the Patient Protection and Affordable Care Act on Behavioral Health Workforce Capacity: Results from Secondary Data Analysis*, Univ. of Mich. Sch. of Public Health, at 13 (Mar. 2018), http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/ACA-Full-Paper_4.16.18-1-1.pdf; *see also* Health Resources & Services Admin., *NHSC Service Commitments: COVID-19*, https://nhsc.hrsa.gov/coronavirus.

[26] ACA § 4001.

[27] ACA §§ 4103 & 4106.

wellness, and prevention.[28] These reforms have led to substantial progress in promoting prevention and public health.[29]

Finally, the ACA launched new initiatives designed to improve health care quality. For example, the law directed the HHS Secretary to design a national quality improvement strategy to elevate priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency.[30] In addition, the ACA established institutions to study health care quality: the Center for Quality Improvement and Patient Safety conducts and supports research on patient safety and health care quality, measurement, reporting and improvement;[31] and the Patient-Centered Outcomes Research Institute conducts comparative clinical effectiveness research to evaluate the effectiveness, risks, and benefits of two or more medical treatments or services.[32]

---

[28] ACA § 3509.

[29] *See* Nadia Chait & Sherry Glied, *Promoting Prevention Under the Affordable Care Act*, 39 ANN. REV. PUBLIC HEALTH 507, 508–12, 519 (2018) (compiling academic research on the ACA's prevention initiatives and concluding that "a great deal of progress was made").

[30] ACA §§ 3011 & 10302–05.

[31] ACA § 3501; *see* Agency for Health Care Research & Quality, *Center for Quality Improvement and Patient Safety*, https://www.ahrq.gov/cpi/centers/cquips/index.html.

[32] ACA §§ 6301–02, as amended by § 10602; *see* Patient-Centered Outcomes Research Institute, *Patient-Centered Outcomes Research Institute*, https://www.pcori.org/.

C. The Decisions Below Failed to Consider the ACA's Transformative Health Care Delivery Reforms.

Rather than grappling with the substantial reforms that Congress adopted in the ACA, including those described above, the district court chose a judicial shortcut around even considering these reforms in the court's severability analysis. Adopting a framework promoted by respondents,[33] the district court divided the provisions of the ACA other than the minimum coverage provision into three tranches. First, the court identified the community-rating and guaranteed issue provisions respecting private health insurance, as meriting separate consideration. Second, the court identified the ACA's remaining "major provisions," as "insurance regulations and taxes," "hospital-reimbursement reductions and other reductions in Medicare expenditures,"[34] the "health-insurance exchanges and their federal subsidies," "the employer responsibility assessment," and "Medicaid expansion."[35] Finally, the court relegated all other provisions to the class of "minor provisions."[36]

---

[33] *E.g.*, Fed. Gov't C.A. Br. 47–48.

[34] Distinct from the delivery reforms, the ACA contained reductions in Medicare and Medicaid reimbursements to hospitals and health systems that contributed over $100 billion in savings to the Medicare Trust Fund. For example, the ACA reduced yearly "market basket" payment increases to hospitals by a "productivity adjustment," reflecting gains in efficiency in the overall economy, and reduced payments to hospitals that serve a "disproportionate share" of indigent patients. ACA §§ 3133 & 10316, 2551 & 10201.

[35] Pet'r App. 174a, 222a–223a.

[36] *Id.* at 174a–175a, 222a–224a.

With this oversimplified classification, the district court avoided consideration of the significance of any provision that it categorized as "minor," including every one of the provisions discussed above. Rather than applying the principles adopted by this Court to determine whether these important provisions are severable from the minimum coverage requirement, which it had ruled unconstitutional, the court simply surmised that "[p]erhaps it is impossible to know which minor provisions Congress would have passed absent the Individual Mandate."[37] The Fifth Circuit correctly found that the district court's severability analysis was "incomplete,"[38] but then failed to rule on severability.

If this Court holds the minimum coverage provision unconstitutional as amended and reaches the severability question, we urge it to reject the preferred rubric of the respondents and the district court that divides the ACA into "major" and "minor" provisions.[39] Such a grouping misclassifies groundbreaking reforms to the delivery of patient care and could lead to a flawed analysis as to severability. As is obvious from even a brief description of the health care delivery reform provisions, these innovations are hardly "minor." Instead they propelled hospitals and health systems to invest substantial resources over the past decade to reform the delivery of health care.

---

[37] *Id*. at 223a–224a.

[38] *Id.* at 65a.

[39] *See* Fed. Gov't C.A. Br. 43–49; Resp. States C.A. Br. 38, 44–50.

II. THE ACA'S DELIVERY REFORMS ARE SEVERABLE BECAUSE THEY ARE WHOLLY INDEPENDENT OF THE MINIMUM COVERAGE PROVISION.

Provisions of a statute must be severed and left intact unless it is "evident that Congress would ***not*** have enacted those provisions which are within its power, independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (emphasis added) (citation omitted); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) (Because the "touchstone" of severability analysis is legislative intent, the Court must ask: "Would the legislature have preferred what is left of its statute to no statute at all?"). Here, there is no basis for concluding that Congress would not have enacted the rest of the ACA absent the minimum coverage provision.[40]

In fact, Congress demonstrated its clear intent to uphold the corpus of the ACA without that provision when it enacted the Tax Cuts & Jobs Act of 2017 (TCJA).[41] In that law, Congress zeroed out the financial penalty for violating the minimum coverage requirement, but it did not repeal a single one of the ACA's other reforms. By leaving the remainder of the

---

[40] At times, this Court has also asked "whether the law remains 'fully operative' without the invalid provisions." *Murphy*, 138 S. Ct. at 1482 (quoting *Free Enter. Fund v. PCAOB*, 561 U.S. 477, 509 (2010)). This question is easily answered by experience: All other ACA provisions—including the delivery reforms described above—have remained fully operative since the tax for violating the minimum coverage provision became $0.

[41] Pub. L. No. 115-97, 131 Stat. 2054 (2017).

ACA in place, Congress answered the key severability question of whether it "preferred what is left of [the ACA] to no statute at all."

Congress did not even debate deleting other ACA provisions when it enacted the TCJA's targeted change. To the contrary, the TCJA's legislative history underscores that Congress meant to leave the ACA's other provisions undisturbed. Congress modified this single provision only after dozens of high-profile votes to repeal the entirety of the ACA had failed.[42] And when Congress did enact the TCJA, one of its principal authors, Senate Finance Committee Chairman Orrin Hatch, avowed that "repealing the tax does not take anyone's health insurance away. . . . The bill does nothing to alter Title I of [the ACA], which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits."[43] Congress certainly did not intend for the TCJA to affect other of the ACA's titles such as the delivery reforms. As petitioners demonstrated, the fact that Congress left the rest of the ACA in place when it eliminated the minimum coverage payment answers the severability question.[44] The remainder of the law must remain.

---

[42] Pet'r States Br. 9, 46–47; U.S. House of Representatives Br. 6, 41.

[43] Transcript of the Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" (Continuation) at 106:10-11, 286:15-18, Before the S. Comm. on Fin., U.S. Senate, 115th Cong. (Nov. 15, 2017)

[44] Pet'r States Br. 36–39; U.S. House of Representatives Br. 40–46.

Congress's intent when it passed the ACA is not relevant to determining the impact of the 2017 law. But if it were, the ACA's text and structure demonstrate that Congress intended to enact delivery reforms independent of the minimum coverage provision. Title I addressed the private health insurance market and contained the minimum coverage provision. Title II provided for Medicaid expansion. But the next three titles reflected Congress's well-documented, independent goal to modernize the health system through the initiatives described above: Title III aimed to "improv[e] the quality and efficiency of health care" by "transforming the health care delivery system"; Title IV focused on "prevention of chronic disease and improving public health"; and Title V invested in the health care workforce.[45]

Respondents are wrong to suggest that Congress codified its intent to not enact the remainder of the ACA without the minimum coverage provision in 42 U.S.C. § 18091, 'Requirement to maintain minimum essential coverage; findings.'"[46] These congressional findings, by their own terms, pertained only to "[t]he individual responsibility requirement provided for in this section" and the private health-insurance market. 42 U.S.C. § 18091(1). In fact, each finding in this section expressly mentioned "health insurance" or the

---

[45] Titles VI (transparency and integrity for federal health programs), VII (access to biologic drugs), VIII (a since-shuttered voluntary long-term care insurance program), and X (a collection of program updates) were also unrelated to the minimum coverage provision.

[46] *See* Resp. States C.A. Br. 42 (asserting that these congressional findings demonstrate that the minimum-coverage provision is "'essential' to the ACA's operation").

"uninsured." As amici have shown, and hundreds of pages of statutory text make clear, congressional intent spanned far wider than merely regulating the private health insurance market.

Debates from Congress's consideration of the ACA further demonstrate that in addition to expanding and improving insurance and Medicaid coverage, Congress independently enacted the ACA to improve the quality of care, reform delivery systems, invest in the health care workforce, and focus on prevention and wellness. Hence, these other provisions are severable and would survive even if this Court struck down some or all of the ACA's private health-insurance provisions.

Indeed, the ACA was the culmination of congressional efforts to modernize health care delivery and reimbursement. In November 2008, Senator Max Baucus, then Chairman of the Senate Finance Committee and one of the principal architects of the ACA, released a white paper outlining the goals for what would become the law. Senator Baucus would later call the white paper "the basis and springboard from which most of the ideas we have been debating, both in the House and in the Senate and on both sides of the aisle, come from."[47] The white paper stated:

> Ensuring access to meaningful health coverage is a fundamental goal of health care reform, ***but there are also other vital priorities we must pursue***.

[47] 155 Cong. Rec. S12836, S12859 (daily ed. Dec. 10, 2009); *see also* 155 Cong. Rec. S13714, S13717 (daily ed. Dec. 22, 2009) ("[B]asically that is the foundation from which almost all ideas in health care reform emanated.").

> Among them is ***the critical need to improve the value of care provided in our health care system***. We must take steps to ensure patients receive higher quality care, and do so in a way that reduces costs over the long-run. In short, the U.S. must get better value for the substantial dollars spent on health care.

(Emphasis added).[48] The white paper further stated that "Congress must dedicate the time and attention to graduate medical education that it deserves."[49] Finally, the Baucus plan called to "immediately refocus our health care system toward prevention and wellness, rather than on illness and treatment."[50]

Congress held over 100 hearings, markups, and legislative meetings before passing the ACA, many of which explored issues distinct from private health insurance. These initiatives included seeking input from hospitals and health systems on ways to modernize the health care delivery system. As Senator Blanche Lincoln, a member of the Senate Finance Committee, summarized:

> We have the best hospitals and doctors, research and technologies in the world. Yet our delivery system is broken. For the last 24 months, the Senate Finance

---

[48] Sen. Max Baucus, *Call To Action: Health Reform 2009*, at 36 (Nov. 12, 2008), https://www.finance.senate.gov/imo/media/doc/finalwhitepaper1.pdf.

[49] *Id.* at 60.

[50] *Id.* at *v*.

> Committee has held hearings and roundtables, summits, all kinds of different deliberative efforts working in partnership with associations that represent providers, advocacy groups on behalf of patients, anybody who would come to the table to talk about how we reform this system and make it better for the constituents we serve, the patients who are the ultimate recipients of the health care system.[51]

Leading up to passage, Members of Congress made countless statements on the House and Senate floor championing the delivery reforms. Below is a representative sample:

- Speaker of the House Pelosi: "The list goes on and on about the health care reforms that are in this legislation," including "creating a healthier America through prevention, through wellness and innovation," and "improv[ing] care and benefits under Medicare."[52]

- Senate Finance Committee Chairman Baucus: "I might mention, too—and this is very important, although we tend to lose sight of it—under this legislation, we provide delivery system reform."[53]

---

[51] 155 Cong. Rec. S12461, S12477 (daily ed. Dec. 5, 2009).

[52] 156 Cong. Rec. H1891, H1896 (daily ed. Mar. 21, 2010).

[53] 155 Cong. Rec. S12019, S12048 (daily ed. Dec. 1, 2009).

- Senator Cantwell: "What we need to do, which is what exactly this bill sets us on a course and path to do, is to pay for value not for volume, to pay physicians on the value they deliver and the outcome of their patients instead of volume. If we did nothing else in health care reform but to change our payment structure to focus on this premise—paying for value and not for volume—then we would be delivering great long-term savings to our health care system."[54]

- Senator Dodd: "[T]he kinds of choices Senator Baucus and [the Senate Finance Committee] made, and the ones we considered in [the Senate Health Education, Labor and Pensions Committee], were ones I believe most of my colleagues believe generally have to be dealt with: the quality of care, strengthening our workforce, dealing with the delivery system, increasing prevention and wellness in this country."[55]

- Senator Kohl: "This bill will also train and expand the health care workforce so they are prepared to care for the growing elderly population. By implementing recommendations from the Institutes of Medicine, we will begin to address the severe shortage we face of direct care workers."[56]

---

[54] 155 Cong. Rec. S11905, S11922 (daily ed. Nov. 21, 2009).

[55] 155 Cong. Rec. S11979, S11995 (daily ed. Nov. 30, 2009).

[56] 155 Cong. Rec. S12355, S12361 (daily ed. Dec. 4, 2009).

- Senator Wyden: "In terms of the real reforms that are in [the] bill, some of the most important have to do with the delivery system—the way American health care is essentially experienced across the land. The fact is that today's delivery system essentially rewards inefficiency. Payments are based on volume rather than quality. . . . [The Senate] bill begins to move in the direction of what we have been doing in our part of the country for some time. [The] bill promotes what are called accountable care organizations. There are also changes in reimbursement."[57]

The titles and reforms highlighted above stand on their own. They are in no way "mere adjuncts of" the minimum coverage provision and the Medicaid expansion—or "mere aids to their effective execution," as respondents suggest.[58] The way in which hospitals and health systems deliver and are paid for treating Medicare beneficiaries is entirely independent of whether individuals pay a penalty for failing to purchase private health insurance. Likewise, the minimum coverage provision's financial penalty has no bearing on teaching hospital residency slots, the National Prevention Strategy, and the institutions that were established to study health care quality. Since there is not a shred of evidence that Congress would have declined to enact these reforms absent the minimum coverage provision, they must remain in force.

---

[57] 155 Cong. Rec. S11905, S11910 (daily ed. Nov. 21, 2009).

[58] *E.g.*, Resp. States C.A. Br. 50.

CONCLUSION

This Court should reverse the Fifth Circuit's decision and hold the minimum coverage provision constitutional. If the Court holds the minimum coverage provision unconstitutional, it should sever that one provision and leave the rest of the ACA intact. Any other ruling would disrupt ten years of innovations that have become enmeshed in the health care landscape, wreak havoc in health care delivery in this country, and subvert the intent of Congress.

Respectfully submitted,

WILLIAM B. SCHULTZ
Counsel of Record
Margaret M. Dotzel
Nicholas M. DiCarlo
Zuckerman Spaeder LLP
1800 M Street, N.W.
Suite 1000
Washington, DC 20036
(202) 778-1800
(wschultz@zuckerman.com)

Counsel for Amici Curiae

May 13, 2020

APPENDIX

DESCRIPTION OF INDIVIDUAL AMICI

Arizona Hospital and Healthcare Association (AzHHA) is Arizona's largest statewide trade association for hospitals, health systems, and affiliated health care organizations. Its hospital members are united with the common goal of improving health care delivery in Arizona.

The Arkansas Hospital Association (ArHA) is a statewide, non-profit trade association that represents 102 member hospitals and health systems and the more-than 41,000 individuals they employ. For 80 years now, ArHA has advocated for initiatives that protect and improve the health of Arkansans by ensuring access to effective, efficient health care. By jeopardizing access to care for approximately 300,000 individuals in the state, the elimination of the Affordable Care Act would have a detrimental impact on the health of Arkansans, on the economic health of the state, and on the continued viability of its hospitals.

The California Hospital Association (CHA) is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the general acute care and psychiatric acute patient beds in California. CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high-quality patient care.

Colorado Hospital Association (CHA) represents more than 100 member hospitals and

health systems throughout Colorado, including urban, rural, critical access and specialty hospitals; and academic, non-profit and tax-paying systems. The Affordable Care Act's provisions impact all Coloradans – nearly six million Americans – and its elimination would have a detrimental impact on their health, on the economic health of the state, and on the continued viability of its hospitals.

The Connecticut Hospital Association (CHA) is a not-for-profit membership organization that represents hospitals and health-related organizations. With more than 140 members, CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are accountable to the community and committed to health improvement.

The Georgia Hospital Association is a non-profit trade association made up of member hospitals and individuals in administrative and decision-making positions within those institutions. Founded in 1929, the Association serves nearly 161 hospitals and health systems in Georgia. Its purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia's citizens.

The Healthcare Association of Hawaii (HAH), established in 1939, is a not-for-profit association that serves as the leading voice of health care on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. HAH's organizational goal to is

to support a healthy Hawaii where every resident of every age has convenient access to appropriate, affordable, high quality care, and where health care providers are reimbursed adequately to deliver that care.

The Illinois Health and Hospital Association (IHA) is a statewide not-for-profit association with a membership of over 200 hospitals and nearly 50 health systems. For over 90 years, the IHA has served as a representative and advocate for its members, addressing the social, economic, political, and legal issues affecting the delivery of high-quality health care in Illinois.

The Iowa Hospital Association (IHA) is a voluntary, not-for-profit membership organization representing all of Iowa's 118 community hospitals, including 82 critical access hospitals. IHA's mission is to support Iowa hospitals in achieving their mission and goals by advocating for member interests at the state and national level, and providing members with valuable education and information resources.

The Kansas Hospital Association (KHA) is a voluntary, non-profit organization existing to be the leading advocate and resource for its members. KHA membership includes 219 facilities, of which 123 are full-service, community hospitals. Founded in 1910, KHA's vision is: "Optimal Health for Kansans."

The Kentucky Hospital Association (KHA) is a non-profit state association of hospitals, related health care organizations, and integrated health care systems statewide. Membership in KHA is voluntary,

and its member entities include 120 hospitals in the Commonwealth of Kentucky. KHA engages in advocacy and representation efforts on behalf of their member hospitals that promote safety, quality, and efficiency in health care. The mission of KHA is to be the leading voice for Kentucky health systems in improving the health of their communities.

The Louisiana Hospital Association (LHA) is a non-profit organization founded in 1926 and incorporated in 1966 for the purpose of promoting the public welfare of the State of Louisiana. The Association's membership is composed of over 150 member institutions, with more than a thousand individual members. Membership consists of hospitals of all kinds, including public, private, non-profit, for-profit, federal, municipal, hospital service district, religious, general, specialty, acute-care, psychiatric, and rehabilitation classifications.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals in Maine including 33 non-profit, general acute-care hospitals, two private psychiatric hospitals, and one acute rehabilitation hospital. In addition to acute care hospital facilities, it also represents 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices.

The Massachusetts Health and Hospital Association (MHA) is a voluntary, not-for-profit organization composed of hospitals and health systems, related providers, and other members with a common interest in promoting the good health of the

people of the Commonwealth of Massachusetts. Through leadership in public advocacy, education, and information, MHA represents and advocates for the collective interests of hospitals and health care providers, and it supports their efforts to provide high-quality, cost-effective, and accessible care.

The Michigan Health & Hospital Association (MHA) is a statewide advocacy organization representing over 170 Michigan health care facilities providing inpatient care including long-term acute care and rehabilitation facilities as well as other specialty hospitals. The MHA represents *all* nonprofit and several for-profit hospitals in the state, advocating on behalf of them and the nearly 10 million people they serve. Established in 1919, the MHA represents the interests of its member hospitals and health systems on key issues and supports their efforts to provide quality, cost-effective and accessible care.

The Minnesota Hospital Association (MHA) is a Minnesota non-profit corporation that represents hospitals in the State of Minnesota, including 142 community-based hospitals and health systems and the physicians employed at those hospitals and health systems. MHA assists Minnesota hospitals in carrying out their responsibility to provide quality health care services to their communities, to promote universal health care coverage, access, and value, and to coordinate the development of innovative health care delivery systems.

The Mississippi Hospital Association (MHA) is a statewide trade association which serves the public by assisting its Members in the promotion of

excellence in health through education, public information, advocacy, and service.

The Montana Hospital Association (MHA) is the principal advocate for the state's health care providers and the communities they serve. MHA's diverse membership includes organizations that provide hospital, nursing home, physician, home health, hospice and other health services. The MHA Board serves voluntarily as Trustees of the not-for-profit organization and determines the association's public policy agenda based on input from member representatives through MHA councils, committees and task forces.

The Nebraska Hospital Association is a statewide trade association representing Nebraska's hospitals and health systems since 1927. The hospital and health system field is the only sector of Nebraska's economy that touches every citizen and business of Nebraska. Not only do hospitals support a healthy Nebraska and provide essential health care services, they are also among the largest employers and economic drivers in most regions of the state. Hospitals and health care are the foundation upon which communities in Nebraska are built.

The Nevada Hospital Association (NHA) is a not-for-profit, statewide trade association representing Nevada's acute care hospitals along with psychiatric, rehabilitation and other specialty hospitals, as well as health-related agencies and organizations throughout the state. Formally established in 1960 and incorporated in 1971, the NHA was created by hospital administrators to provide a

unified forum for various types of hospitals to address issues including reimbursement, worker's compensation, professional liability, and continuing education, among others.

The New Hampshire Hospital Association (NHHA) is the leading and respected voice for hospitals and health care delivery systems in New Hampshire, working together to deliver compassionate, accessible, high-quality, and financially sustainable health care to the patients and communities served by its member hospitals. NHHA represents 31 member hospitals, including a large academic medical center, 13 critical access hospitals, two specialty rehabilitation hospitals, one state psychiatric hospital, one private behavioral health hospital, and one VA Medical Center.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier health care association since its inception in 1918. NJHA currently has members across the health care continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible and affordable health care in New Jersey.

The New Mexico Hospital Association (NMHA) is a membership organization representing 46 New Mexico hospitals, health networks, ambulatory facilities, home health agencies and a variety of affiliate groups throughout the state on legislative, regulatory and public policy issues. For over seven decades, the NMHA has advocated for the common

good and collective interests of its members in an ever-changing health care environment.

The Healthcare Association of New York State (HANYS) is New York's statewide hospital and health system association representing over 500 not-for-profit and public hospitals and hospital based skilled nursing facilities, home health agencies, and hospices. HANYS seeks to advance the health of individuals and communities by providing leadership, representation, and service to health providers and systems across the entire continuum of care.

The Greater New York Hospital Association (GNYHA) is a Section 501(c)(6) organization that represents the interests of nearly 150 hospitals located throughout New York State, New Jersey, Connecticut, and Rhode Island, all of which are not-for-profit, charitable organizations or publicly-sponsored institutions. GNYHA engages in advocacy, education, research, and extensive analysis of health care finance and reimbursement policy.

The North Carolina Healthcare Association (NCHA) is a statewide trade association representing 136 hospitals and health systems in North Carolina, with the mission of uniting hospitals, health systems, and care providers for healthier communities.

The North Dakota Hospital Association (NDHA), comprised of 47 hospital members, is a non-profit, voluntary trade association established in 1934 which represents hospitals, health systems, health-related organizations, and other members with a

common interest in promoting the health of the people of North Dakota. The NDHA is the advocate for North Dakota's hospitals, health systems, communities, and patients before legislative and regulatory bodies.

The Ohio Hospital Association (OHA) is a private non-profit trade association established in 1915 as the first state-level hospital association in the United States. For decades the OHA has provided a forum for hospitals to come together to pursue health care policy and quality improvement opportunities in the best interest of hospitals and their communities. The OHA is comprised of 220 hospitals and 13 health systems, all located in Ohio, and works with its member hospitals across the state to improve the quality, safety, and affordability of health care for all Ohioans.

The Oklahoma Hospital Association (OHA) was established in 1919 to represent the interests and views of more than 130 member hospitals and health systems across the state of Oklahoma. OHA's primary objective is to promote the health and welfare of all Oklahomans by leading and assisting member organizations in providing high quality, safe, and valued health care services to their communities.

The Oregon Association of Hospitals and Health Systems (OAHHS), founded in 1934, is a statewide, non-profit trade association that works closely with local and national government leaders, business and citizen coalitions, and other professional health care organizations to enhance and promote community health and to continue improving Oregon's innovative health care community. Representing all 62

hospitals in Oregon, OAHHS provides leadership in health policy, advocacy, and comprehensive member services that strengthen the quality, viability, and capacity of Oregon hospitals to best serve their communities.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is a statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

The South Carolina Hospital Association is a private, not-for-profit organization founded in 1921 to serve as the collective voice of the state's hospital community. Today, it comprises approximately 100 member hospitals and health systems and 900 personal members. It advocates for sound healthcare policies and legislation, facilitates collaboration to tackle problems that no member could solve alone, finds and shares innovations and best practices, and provides data, education and business solutions to help its members better serve their patients and communities.

The Tennessee Hospital Association (THA) was established in 1938 as a not-for-profit membership association to serve as an advocate for hospitals, health systems, and other health care organizations and the patients they serve. The Association also provides education and information for its members, and informs the public about hospitals and health care issues at the state and national levels.

The Vermont Association of Hospitals and Health Systems (VAHHS) is a statewide non-profit member organization comprised of Vermont's network of not-for-profit hospitals. Working with partners and stakeholders locally and nationally, VAHHS supports and contributes to policies that meet the association's core principles of making health care more affordable, maintaining high quality care, providing universal access, and preserving the individual's ability to choose their doctor and hospital.

The Washington State Hospital Association (WSHA) is a non-profit membership organization that represents 107 member hospitals. WSHA works to improve the health of the people of the State by advocating on matters affecting the delivery, quality, accessibility, affordability, and continuity of health care.

The West Virginia Hospital Association (WVHA) is a not-for-profit statewide organization representing 63 hospitals and health systems across the continuum of care. The WVHA supports its members in achieving a strong, healthy West Virginia by providing leadership in health care advocacy, education, information, and technical assistance, and by being a catalyst for effective change through collaboration, consensus building, and a focus on desired outcome.