No. 19-10011

IN THE

# United States Court of Appeals

FOR THE FIFTH CIRCUIT

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STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

*Plaintiffs-Appellees*,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

*Defendants-Appellants*,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

*Intervenor Defendants-Appellants*.

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**On Appeal from the United States District Court**
**for the Northern District of Texas, No. 4:18-cv-167-O**
Hon. Reed Charles O'Connor, U.S. District Judge

## AMICI CURIAE BRIEF OF 24 STATE HOSPITAL ASSOCIATIONS SUPPORTING INTERVENOR DEFENDANTS-APPELLANTS AND REVERSAL OF THE DISTRICT COURT

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## CORPORATE DISCLOSURE STATEMENT

Amici curiae are non-profit organizations. They have no parent corporations and do not issue stock.

## INTEREST OF AMICI CURIAE[1]

This brief is filed on behalf of 24 state hospital associations,[2] which together represent over 4,000 hospitals and health systems that treat tens of millions of patients every year. 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 time and resources complying with the law and meeting its objectives of delivering higher-quality, more coordinated care at a reasonable cost. Amici are submitting this brief because they are committed to ensuring that the ACA's meaningful reforms remain in effect and because reverting back to old delivery models would significantly disrupt amici's operations and the care provided to patients.

Although this brief focuses on health care delivery, a subject that received little attention in the district court and the principal briefs in this Court, amici agree with and endorse the constitutional and severability arguments presented by intervenor-defendant states and intervenor-defendant the U.S. House of

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[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), amici certify that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting the brief; and no person–other than the amici, their members, or their counsel–contributed money that was intended to fund preparing or submitting the brief.

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

Representatives.[3] Amici agree that the ACA's minimum coverage provision, as amended, is constitutional. But if this Court decides otherwise, amici concur that the rest of the ACA should remain intact—including the expansion of Medicaid and the delivery reforms described in this brief.

[3] *See* Opening Br. of State Defs., ECF No. 00514887395, at 27-47 (State Defs. Br.); Opening Br. of Intervenor U.S. House of Representatives, ECF No. 00514887408, at 35-57 (House of Representatives Br.).

## 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 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, creating 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 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 district court did not mention in its opinion,[5] transformed the way hospitals and health systems deliver and are paid for health care. These provisions have promoted innovative new models of care, provided substantial investments in the health care workforce, addressed wellness and prevention, and launched health care quality initiatives. They make fundamental improvements in the quality and coordination of care and have

[4] Pub. L. 111-148, 124 Stat. 119-1045 (2010). All citations to the law are styled as ACA § ___.

[5] *See* Mem. Op. & Order, Dist. Ct. ECF No. 211 (Op.).

become integral to the delivery of health care services in the United States during the nine years since the ACA was enacted.

## ARGUMENT

In invalidating the entirety of the ACA, the district court cast these health care delivery reforms into a dustbin of "minor" provisions. The court then invalidated these important provisions along with the rest of the law because the court considered them "adjuncts of" the requirement that most Americans obtain health care coverage or pay a penalty (the "minimum coverage provision"). As amici demonstrate below, 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 those innovations are independent of the ACA's insurance-related provisions, they are severable and should be left intact regardless of how the Court rules on the constitutionality of the minimum coverage provision.

### I. THE DISTRICT COURT IGNORED THE ACA'S SIGNIFICANT REFORMS THAT MODERNIZED THE DELIVERY OF, AND PAYMENT FOR, HEALTH CARE IN THE UNITED STATES.

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, provides subsidies to help individuals buy insurance on the

Marketplaces, requires that insurance policies permit young adults up to age 26 to remain on their parents' health insurance plans, and prohibits 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 successfully incentivized states to expand Medicaid coverage to millions of Americans.

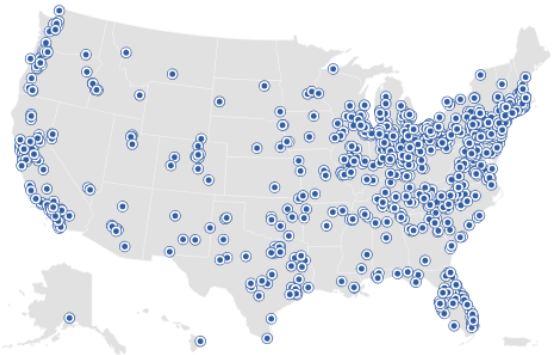
Importantly, the ACA also contained landmark provisions that have made a sea change in health care delivery, coordination, and payment. These reforms have modernized the way hospitals and health systems deliver services. The law also invested in the health care workforce, prioritized wellness and prevention, and launched new initiatives to study and compare health care quality. All of these important innovations were swept under the rug in the district court's opinion and would be eliminated if this Court affirmed that decision.

### A. The ACA Fundamentally Transformed the Way Hospitals and Health Systems Deliver and Are Paid for Health Services.

The ACA's reforms include pioneering new models of care to foster better coordination between health professionals, and payments to health systems based on the quality of care provided to Medicare beneficiaries rather than 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 mirror the federal government's policies with respect to payment.[6]

As part of that effort, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) and gave it authority to test 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.[7] CMMI has launched over 40 new payment and health care service delivery models, involving more than 18 million patients and 200,000 health care providers across the country.[8] The below map from the Centers for Medicare & Medicaid Services (CMS) shows where in the country health providers are working with CMMI to test methods for improving the delivery and coordination of care at a lower cost.



Source: Centers for Medicare & Medicaid Services

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

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

[8] CMS, *CMS Innovation Center: Report to Congress* 1-2 (Dec. 2016).

According to a September 2016 report issued by the Congressional Budget Office, CMMI's programs are expected to reduce federal spending by roughly $34 billion from 2017 through 2026.[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 such as hospitals, primary care physicians, and nursing homes to join together in ACOs.[10] The ACO members agree to coordinate and take collective responsibility for the quality and total 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 the ACOs reduced Medicare spending compared to their

[9] *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).

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

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 Medicare beneficiaries receive during an episode of care across different settings (including hospitals, physician's offices, and skilled nursing facilities). 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 BPCI model bundles payments for all inpatient hospital services, physician services, post-acute services, and hospital readmission care that a patient receives during and after a hip 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 bundling there is essentially one payment to reward trying to deliver care in an integrated fashion."[14]

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[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), *available at* 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.

[14] 155 CONG. REC. S11910 (daily ed. Nov. 21, 2009) (statement of Sen. Wyden).

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 tethered Medicare reimbursement 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 on the quantity of procedures performed.[17] Under the VBP program, CMS makes payments to hospitals based on how closely clinical best practices are followed and how well hospitals enhance patients' experience of care during hospital stays over a relevant time period.

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[15] The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models: Year 5 Evaluation & Monitoring Annual Report* (Oct. 2018), *available at* 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), *available at* 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.

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, as 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, based on recent statistics.

Together, these reforms represent the most significant attempts at reforming the health care delivery and payment systems in decades. 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 evaluated and improved, they have all spurred a significant amount of investment and innovation among hospitals.

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[18] ACA § 3025; *see* CMS, *Hospital Readmissions Reductions Program*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html.

[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.

### B. The ACA Further Reformed Health Care Delivery by Investing in the Health Care 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 made substantial investments in the health care workforce and in graduate medical education, refocused health systems on wellness and prevention, and launched a number of measures intended to study and improve health care quality.

#### 1. *Workforce and Graduate Medical Education*

Important to hospitals and health systems, the ACA strengthened the health care workforce. Among these significant measures, the law established flexible loan repayment programs and public health workforce loan repayment programs 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

[21] ACA §§ 5201-10.

[22] ACA § 5301.

[23] ACA § 5503.

geographic location when a nearby teaching hospital closed.[24] Data show that these workforce initiatives are increasing the number of health providers in underserved and high-need areas.[25]

2. *Wellness and Prevention*

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 coordinate and lead federal strategy with respect to wellness, prevention, and health promotion practices in the United States.[26] Since passage of the law, the Council has created a comprehensive National Prevention Strategy and an Action Plan to achieve the Strategy's goals. The ACA 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 zero cost-sharing, as well as incentives to state

[24] ACA § 5506.

[25] *See* Shannon Mace & Megan Dormond, Univ. of Mich. School of Behavioral Health, *The Impact of the Patient Protection and Affordable Care Act on Behavioral Health Workforce Capacity: Results from Secondary Data Analysis*, at 13 (Mar. 2018), http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/ACA-Full-Paper_4.16.18-1-1.pdf.

[26] ACA § 4401.

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) headed by a Deputy Assistant Secretary for Women's Health.[28] Many of these reforms have made substantial progress in promoting prevention and public health.[29]

3. *Quality Initiatives*

The ACA launched ongoing initiatives designed to improve health care quality. To name a few, the law directed the HHS Secretary to establish a national quality improvement strategy to elevate priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency.[30] First published in 2011 and updated annually by participating agencies, the National Quality Strategy aims to "improve the delivery of health care services, patient health outcomes, and population health."[31]

The ACA created public web resources where doctors and patients can evaluate and compare health systems and professionals. The *Physician Compare*

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[27] ACA §§ 4103 & 4106.

[28] ACA § 3509.

[29] *See* Nadia Chait & Sherry Glied, *Promoting Prevention Under the Affordable Care Act*, ANN. REV. PUBLIC HEALTH, at 508-12 (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] *See generally* Agency for Health Care Research & Quality, *About the National Quality Strategy*, https://www.ahrq.gov/workingforquality/about/index.html.

website provides feedback reports to physicians that compare their resource use with that of their peers, and displays to the public a star-rating system reflecting physician performance against quality measures such as care coordination, health outcomes, and safety and effectiveness.[32] Similarly, the *Nursing Home Compare* website provides the public with information on nursing home staffing data, civil monetary penalties levied, and the number, type, and severity of substantiated patient complaints.[33]

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.[34] And the Patient-Centered Outcomes Research Institute is an independent, tax-exempt organization that conducts comparative clinical effectiveness research to evaluate the effectiveness, risks, and benefits of two or more medical treatments or services.[35]

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[32] ACA § 10331; *see* CMS, *Physician Compare*, https://www.medicare.gov/physiciancompare/.

[33] ACA § 6103; *see* CMS, *Nursing Home Compare*, https://www.medicare.gov/nursinghomecompare/.

[34] 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.

[35] ACA §§ 6301-6302, as amended by § 10602; *see* Patient-Centered Outcomes Research Institute, *Patient-Centered Outcomes Research Institute*, https://www.pcori.org/.

### C. The District Court Failed to Consider the ACA's Transformative Health Care Delivery Reforms.

Rather than reckoning with the substantial reforms that Congress adopted in the ACA, including those described above, the district court chose a judicial shortcut which minimized their significance so that they were not even considered in the Court's severability analysis. Thus the court below divided the provisions of the ACA other than the minimum coverage provision into three tranches: (1) the community-rating and guaranteed issue provisions respecting private health insurance, (2) the ACA's remaining "major provisions," and (3) the ACA's "minor provisions.[36] The court limited the remaining "major provisions" to the "insurance regulations and taxes," "hospital-reimbursement reductions and other reductions in Medicare expenditures,"[37] the "health-insurance exchanges and their federal subsidies," "the employer responsibility assessment," and "Medicaid expansion."[38]

By using this oversimplified taxonomy, the district court effectively avoided consideration of the significance of any provision that it classified as "minor," including every one of the provisions discussed above and many others. Rather

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[36] Op. at 10.

[37] 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.

[38] Op. at 10, 48-49.

than determining whether these important provisions are severable from the minimum coverage requirement, which it 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."[39] For their part, Plaintiffs-Appellees devoted only three paragraphs in their district-court briefs to provisions they deemed "minor" within 974 pages of the statute.[40] They, too, failed to mention any of the delivery reform provisions discussed above.

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 reimagine the way they deliver care. Reverting back to outdated delivery models would be harmful to patients and exceptionally disruptive.

## II. THE ACA'S DELIVERY REFORMS ARE WHOLLY INDEPENDENT OF THE MINIMUM COVERAGE PROVISION, AND THUS ARE SEVERABLE.

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,

[39] Op. at 49-50.

[40] *See* Br. of Pls. in Supp. of Appl. For Prelim. Inj., Dist. Ct. ECF No. 40, at 39-40 (offering four illustrative examples of "minor provisions": a tax on medical devices, 26 U.S.C. § 4191(a); a mechanism for the HHS Secretary to issue compliance waivers to States, 42 U.S.C. § 1315; regulations on the display of nutritional content at restaurants, 21 U.S.C. § 343(q)(5)(H); and "a number of provisions that provide benefits to the State of a particular legislator"—which were "[o]ften . . . the price paid for [the legislator's] support of a major provision").

independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (emphasis added); *see also EEOC v. Hernando Bank, Inc.*, 724 F.2d 1188, 1190 (5th Cir. 1984) (noting severability requires "the court [to] inquire into whether Congress would have enacted the remainder of the statute in the absence of the invalid provision"). Here, there is no basis for concluding that Congress would not have enacted the rest of the ACA absent the minimum coverage provision.

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.[41] In that Act, Congress zeroed out the financial penalty for violating the minimum coverage requirement, but did not repeal the ACA's other reforms, or even debate changing the provisions of law that put them in place. To the contrary, the legislative history of this targeted change underscores that Congress meant to leave the ACA's other provisions undisturbed.[42] As intervenor-defendant states and intervenor-defendant the U.S. House of Representatives demonstrated, the fact that Congress left the rest of the ACA in place when it eliminated the minimum coverage payment "answers the severability question."[43] The remainder of the law

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

[42] *See* State Defs. Br., at 40 (collecting statements of Senators); House of Representatives Br., at 44 (same).

[43] House of Representatives Br., at 43; *see also* State Defs. Br., at 34-35 ("In these unique circumstances, there is no need to hypothesize about whether Congress would have preferred to

must remain.

To the extent Congress's intent when it passed the ACA is relevant to determining the impact of the 2017 law, debates from that era demonstrate that in addition to expanding and improving insurance and Medicaid coverage, Congress independently sought to improve the quality of care, reform delivery systems, invest in the health workforce, and focus on prevention and wellness. Hence, these other provisions are severable and should survive even if this Court strikes down some or all of the ACA's private health-insurance provisions.

These debates show that the ACA was the culmination of congressional efforts to modernize health care delivery and reimbursement. In November 2008, Senator Max Baucus, 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. 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."[44] 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***

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preserve the rest of the ACA if it had known that the minimum coverage provision could not be enforced." (internal citation omitted)).

[44] 155 CONG. REC. S12859 (daily ed. Dec. 10, 2009) (statement of Sen. Baucus); *see also* 155 CONG. REC. S13717 (daily ed. Dec. 22, 2009) (statement of Sen. Baucus) ("[B]asically that is the foundation from which almost all ideas in health care reform emanated.").

> ***pursue***. 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).[45] The white paper further stated that "Congress must dedicate the time and attention to graduate medical education that it deserves."[46] Finally, the Baucus plan called to "immediately refocus our health care system toward prevention and wellness, rather than on illness and treatment."[47]

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 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 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.[48]

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

[46] *Id.* at 59.

[47] *Id.* at *v*.

[48] 155 CONG. REC. S12477 (daily ed. Dec. 5, 2009).

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."[49]

- 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."[50]

- 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."[51]

- 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."[52]

- Senator Kohl: "This bill will also train and expand the health care workforce so they are prepared to care for the growing elderly

[49] 156 CONG. REC. H1896 (daily ed. Mar. 21, 2010).

[50] 155 CONG. REC. S12048 (daily ed. Dec. 1, 2009).

[51] 155 CONG. REC. S11922 (daily ed. Nov. 21, 2009).

[52] 155 CONG. REC. S11995 (daily ed. Nov. 21, 2009).

> population. By implementing recommendations from the Institutes of Medicine, we will begin to address the severe shortage we face of direct care workers."[53]

- 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. In my part of the country . . . we have actually been in the forefront of trying to move away from a system that rewards inefficiency, rewards volume. What we have shown is that changing these incentives pays off. People can be healthier and America can do it for less money. [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. Probably folks on Main Street are not familiar with what is called 'bundling.'"[54]

Congress's intent to enact delivery reforms independent of the insurance provisions is crystalized in the text and structure of the ACA.[55] 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 "transform[] the

[53] 155 CONG. REC. S12361 (daily ed. Dec. 4, 2009).

[54] 155 CONG. REC. S11910 (daily ed. Nov. 21, 2009).

[55] The district court erred in concluding that "Congress codified its intent plainly in 42 U.S.C. § 18091, 'Requirement to maintain minimum essential coverage; findings.'" Op. at 38. 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 "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.

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.[56]

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 the district court suggested.[57] The way in which hospitals and health systems deliver and are paid for treating Medicare beneficiaries hardly depends on 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. In fact, as the Eleventh Circuit concluded, "the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance." *Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1322 (11th Cir. 2011). Since there is not a shred of evidence that Congress would not have enacted these reforms absent the minimum coverage provision, they must remain in force.

[56] 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.

[57] Op. at 49-50 (quoting *Williams v. Standard Oil Co. of Louisiana*, 278 U.S. 235, 243 (1929)).

## CONCLUSION

This Court should reverse the district court's order striking down the ACA. If the Court holds the minimum coverage provision unconstitutional, it should sever that one provision and leave the rest of the law intact. Any other ruling would disrupt nine years of innovations that have become enmeshed in the health care landscape, wreak havoc in health care delivery in this country, and subvert the will of Congress.

Dated: April 1, 2019

Respectfully Submitted,

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## CERTIFICATE OF SERVICE

I certify that on April 1, 2019, a true and correct copy of the foregoing document was filed electronically via the CM/ECF system, which gave notice to all counsel of record.

*/s/ Nicholas M. DiCarlo*
Nicholas M. DiCarlo

## CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a)(7)(B) because, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f), it contains 4,033 words. I further certify that this brief complies with the typeface and style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared in Microsoft Word using 14-point Times New Roman font.

Dated: April 1, 2019

*/s/ Nicholas M. DiCarlo*
Nicholas M. DiCarlo

# APPENDIX

## DESCRIPTION AND INTERESTS OF INDIVIDUAL AMICI

**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. In partnership with members and stakeholders, the association also builds alliances and develops resources and services to further that mission in the state's hospitals and its communities. Because caring for patients, protecting them, and protecting hospitals' ability to serve them is at the heart of ArHA's mission, access to affordable health insurance coverage is priority number one. 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's members include all types of hospitals and health systems: nonprofit; children's hospitals; those owned by various public entities, including cities/counties, local health care districts, the University of California, and the Department of Veterans Affairs; as well as investor-owned. The vision of CHA is an "optimally healthy society," and its goal is for every Californian to have equitable access to affordable, safe, high-quality, medically necessary health care. To help achieve this goal, 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. CHA promotes its objectives, in part, by participating as amicus curiae in important cases like this one.

**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 170 hospitals 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 Association represents its members in legislative matters, as well as in filing amicus curiae briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens.

**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. As the representative of virtually every hospital in the state, the IHA has a profound interest in this case. The IHA respectfully offers this amicus curiae brief in hopes of providing information not addressed by the litigants that will help the Court evaluate the litigants' arguments more thoroughly.

**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 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. Its acute-care hospitals are non-profit, community-governed organizations with more than 800 volunteer community leaders serving on the boards of Maine's hospitals. Maine is one of only a handful of states in which all of its acute-care hospitals are non-profit.

**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 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; promote universal health care coverage, access, and value; and coordinate the development of innovative health care delivery systems. MHA serves it members and the State of Minnesota as a trusted leader in health care policy and as a valued source for health care information and knowledge.

**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. MHA's membership serves patients across one of the nation's largest frontier states.

**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. In furtherance of this mission, NJHA undertakes research and health care policy development initiatives, fosters public understanding of health care issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems.

**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' members range from rural Critical Access Hospitals to large, urban Academic Medical Centers and other Medicaid and safety net providers. 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. NCHA is an advocate before the legislative bodies, the courts, and administrative agencies on issues of interest to hospitals and health systems and the patients they serve.

**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 OHA's mission is to collaborate with member hospitals and health systems to ensure a healthy Ohio.

**The Oklahoma Hospital Association** 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 OHA also believes hospitals play a vital role in helping to advance the overall state of health for their patients and the public at large. The OHA is a statewide trade association that provides a variety of membership services, including representation at the state and federal government, educational programs, data analysis, patient quality and safety resources, and industry communication.

**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.

**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 Virginia Hospital & Healthcare Association (VHHA)** is a nonprofit trade association formed in 1926. VHHA's mission is to transform Virginia's health care system to achieve top-tier performance in safety, quality, value, service, and population health. VHHA currently has 27 member health systems and hospitals, representing 110 community, psychiatric, rehabilitation, and specialty

hospitals throughout Virginia. VHHA's member hospitals and health systems provide services across the care continuum, including, but not limited to, inpatient, outpatient, rehabilitation, psychiatric, long-term care, home care, and hospice services. VHHA acts as a representative of hospitals and health systems before executive, legislative, and judicial branches of government and as an advocate for policy issues affecting the delivery, quality, accessibility, and cost effectiveness of health care in Virginia.

**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