No. 14-1158

IN THE

United States Court of Appeals for the Fourth Circuit

DAVID KING, *et al.*,
Plaintiffs-Appellants,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Virginia
No. 3:13-cv-00630-JRS (Spencer, J.)

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF APPELLEES AND AFFIRMANCE

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Dated: March 21, 2014

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

AHA represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

AHA has no parent company and no publicly held company holds more than a ten percent interest in AHA. In addition, no other publicly held corporation or other publicly held entity has a direct financial interest in the outcome of the litigation within the meaning of Local Rule 26.1(b).

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STATEMENT OF INTEREST OF AMICUS CURIAE

The American Hospital Association (AHA) respectfully submits this brief as *amicus curiae*.[1]

AHA represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. AHA's members are

[1] Pursuant to Federal Rule of Appellate Procedure 29, AHA certifies that all parties have consented to the filing of this brief. AHA likewise certifies that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than AHA and its members and counsel contributed money intended to fund the brief's preparation or submission.

committed to improving the health of communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

AHA's members are deeply affected by the nation's health care laws, particularly the Affordable Care Act (ACA). That is why AHA has filed *amicus* briefs in support of the law in the Supreme Court and in courts across the nation. AHA participated in this case in the District Court and is participating in this Court for the same reason: Subsidies are critical to the success of the law, and access to those subsidies for the uninsured in *all* states, not just some, will have a profound positive impact on both patients and hospitals. AHA writes to offer guidance, from hospitals' perspective, on the disastrous impact plaintiffs' position would have on American health care if they prevail.

SUMMARY OF ARGUMENT

It is impossible to overstate the centrality of subsidies to the ACA. Congress knew that many Americans could not afford to buy insurance. And it knew that it wanted to—indeed, *had* to—bring insurance within everyone's reach if the ACA were to work. Congress thus built subsidies into the statute. The subsidies make it possible for millions who otherwise could not afford insurance to buy it. That, in turn, increases the ranks of the insured, lowers average costs, and averts the "death

spiral" that would result if only the elderly and sick paid the required premiums. As one Senator put it, subsidies are one leg of the ACA's "three-legged stool. If you take any leg out, the stool collapses." 157 Cong. Rec. S737 (daily ed. Feb. 15, 2011).

In short, the ACA will not work without subsidies, and Congress knew it. Yet plaintiffs insist that Congress designed the ACA so that tens of millions of Americans, in more than half the states, would be walled off from subsidies altogether. That interpretation should be rejected for many reasons. It would be devastating to the ACA and to that statute's key goals. It would be equally devastating to America's hospitals—especially in their efforts to care for the poorest among us. And, critically, it bears no resemblance to what Congress intended. That last factor is dispositive. After all, " '[s]tatutes should be interpreted to avoid untenable distinctions and unreasonable results' " that would "defeat the plain intent of Congress in enacting th[e] the statute." *United States* v. *Bice-Bey*, 701 F.2d 1086, 1092 & n.7 (4th Cir. 1983) (quoting *American Tobacco Co.* v. *Patterson*, 456 U.S. 63, 71 (1982)). This case presents a double whammy: Plaintiffs' interpretation creates untenable distinctions *and* unreasonable results. The District Court's judgment should be affirmed.

ARGUMENT

I. ELIMINATING SUBSIDIES IN STATES WITH FEDERALLY-FACILITATED EXCHANGES WOULD HARM MILLIONS OF AMERICANS AND BADLY UNDERCUT THE ACA.

The plaintiffs' case is based on a technicality, but there is nothing technical about the consequences of their position. It would leave insurance coverage out of the reach of millions of people and would gut the ACA's design.

A. Subsidies Are Critical To Make Insurance Affordable Under The ACA.

One of the ACA's chief reforms was to create health insurance Exchanges to serve the individual and small-group health insurance markets. 42 U.S.C. §§ 18031-18044. Through the Exchanges, qualified individuals can select among and purchase health insurance plans that provide a comprehensive essential health benefits package. *Id.* § 18021(a)(1)(B). And although rates on the Exchanges are lower than many initially expected, *see* L. Skopec & R. Kronick, Department of Health & Human Servs., *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected*,[2] they are still high enough that—just as before the ACA—many lower- and even middle-income Americans cannot easily afford to buy comprehensive

[2] *Available at* http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.pdf.

coverage. *See* J. Cohn, *Five Things We Know About Obamacare—And One We Don't*, The New Republic, Sept. 6, 2013.[3]

Congress understood the affordability issue. It therefore built into the Exchanges a system of tax credits that act as subsidies, reducing the cost of Exchange-offered plans for those with household incomes from 100-400% of the federal poverty level. *See* 26 U.S.C. § 36B. Though the amounts depend on the state and a patient's household income, the subsidies are often quite substantial. The Congressional Budget Office (CBO) has estimated that subsidies will cover nearly two-thirds of the premiums for policies purchased through the Exchanges, CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009),[4] and the average subsidy will total $4,700 per subsidized enrollee, CBO, *Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline* tbl.2 (Feb. 2014) (*2014 Baseline*).[5]

A few examples illustrate the effect subsidies have on affordability. According to a recent calculation, a 60-year-old couple in Los Angeles with a

[3] *Available at* http://www.newrepublic.com/article/114622/obamacare-premiums-and-rate-shock-new-studies-and-consensus.

[4] *Available at* http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf.

[5] *Available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf.

$30,000 income would have to spend $1,082 per month—or about $13,000 per year, a huge chunk of their after-tax income—to buy an unsubsidized "silver" plan. With the ACA's subsidies, that plan would cost $150 per month. C. Cox, *et al.*, Kaiser Family Foundation, *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014*, at 9 (Sept. 2013).[6] Likewise, a single 60-year-old in Hartford, Connecticut making $28,725 per year would have to spend $697 per month before the subsidy but will pay only $193 per month with it. *Id.* at 6 fig.5. And a single 25-year-old in Burlington, Vermont making $28,725 per year would have to pay $413 per month without the subsidy but will pay only $193 per month with it. *Id.* at 5 fig.4.

The bottom line: The ACA's subsidies are often the difference between health coverage that is affordable for lower-income Americans and health coverage that is not. Plaintiffs do not disagree. Indeed, their very claim to standing is predicated on their allegation that the Exchange-offered subsidies are what makes health coverage "affordable" for them under the ACA. *See* D. Ct. Dkt. No. 21 at 3-4.

Plaintiffs' bid to eliminate subsidies for people who purchase policies through federally-facilitated Exchanges, if accepted, therefore would cost millions

[6] *Available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf.

of Americans comprehensive coverage. According to the CBO, 6 million people are expected to purchase insurance through the Exchanges in 2014, but only 1 million of them will pay full sticker price. *2014 Baseline*, *supra*, at tbl.2. In other words, 5 million Americans will rely on the ACA's subsidies to obtain coverage just this year. *See id.*

That number will only grow with time. In 2022, the CBO estimates that *19 million* Americans will need subsidies to purchase insurance from the Exchanges. *See id.* And most of them—around 72%, according to one study—live in states where the Exchange is federally facilitated. Kaiser Family Foundation, *State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act* 3 tbl.1 (Nov. 2013).[7]

Put differently, well over 10 million people would be stripped of eligibility for subsidies if plaintiffs were to prevail. *See id.* Because many of them simply cannot afford insurance on their own, they will remain uninsured. According to one study, unsubsidized Exchanges would lead to "essentially no increase" in the number of Americans enrolled in individual coverage. J. Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* 5 (Aug. 2010). That would imperil the uncovered individuals'

[7] *Available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8509-state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits.pdf.

health and finances, *see* Kaiser Comm'n on Medicaid & the Uninsured, *The Uninsured & the Difference Health Care Makes* 2 (Sept. 2010) (*Difference Health Care Makes*),[8] and increase the load on this country's already-overburdened health care system.

For plaintiffs, making health coverage unaffordable apparently is a boon, freeing them from purchasing insurance they would rather not currently have. But people like plaintiffs are the rare exception. Most Americans would prefer to have comprehensive coverage, but cite high cost or lack of employer-sponsored health plans as the primary reason they do not have it. Kaiser Family Foundation, *Key Facts About the Uninsured Population* 2 (Sept. 2013).[9] By contrast, only 1.5% of uninsured Americans say they lack insurance because they do not need it. *Id.* This Court should not withdraw needed coverage for millions based on the policy preferences of an idiosyncratic few.

B. The Loss Of Subsidies Would Be Particularly Harmful Given The Refusal Of Many States To Expand Medicaid.

The loss of subsidies in states with federally facilitated Exchanges would be particularly painful in light of many states' refusal to expand Medicaid coverage. The ACA was expected to cover Americans too poor to purchase private insurance

[8] *Available at* http://www.kff.org/uninsured/upload/1420-12.pdf.

[9] *Available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

through the Exchanges but not eligible to receive Medicaid by expanding Medicaid to all non-disabled adults with income at 138% of the poverty level or lower. Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 2 (Oct. 2013) (*The Coverage Gap*).[10] However, in light of the Supreme Court's ruling that the Medicaid expansion is optional, *see Nat'l Fed. of Indep. Business* v. *Sebelius*, 132 S. Ct. 2566, 2609 (2012), half the states have refused to do so, *The Coverage Gap*, *supra*, at fig.1.

Experts to this point have assumed that the Exchanges could help some of those left behind by states' refusal to expand Medicaid. The CBO, for example, has estimated that 2 million of the 6 million people denied expanded Medicaid coverage will enroll in private plans through Exchanges using subsidies, mitigating—at least somewhat—the impact in those states. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* 12 & tbl.1 (July 2012).[11]

If plaintiffs prevail, however, these 2 million people are unlikely to be able to obtain policies through the Exchanges. That is because, of the 25 states opting out of the Medicaid expansion, all but two have federally-facilitated exchanges.

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[10] *Available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8505-the-coverage-gap-uninsured-poor-adults7.pdf.

[11] *Available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

Compare The Coverage Gap, *supra*, at 1 fig.1 (listing states opting out of the Medicaid expansion), *with* The Commonwealth Fund, *State Action to Establish Health Insurance Marketplaces* (July 2013) (listing the states with federally-facilitated exchanges).[12] In those states, individuals making 100% to 138% of the poverty level—about $11,500 to $15,900 per year[13]—would have to seek coverage on the market with no subsidies at all, and would face premiums they could not possibly pay. *See supra* at 4-6. Plaintiffs' position thus would not only deny millions of Americans access to coverage. It would deny access to those who need it most: the poor who are not eligible for Medicaid in their states.

C. The Loss Of Subsidies Would Undercut The ACA.

The loss of subsidies would be devastating to millions of Americans who otherwise could obtain health coverage. Lack of health coverage has a demonstrable negative impact on health outcomes and raises the risk of personal bankruptcy, among other ill effects. *See Difference Health Care Makes*, *supra*, at 2. But the removal of subsidies from the ACA's "three-legged stool" in most states also would imperil the law itself.

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[12] *Available at* http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx.

[13] U.S. Dep't of Health & Human Servs., *2013 Poverty Guidelines*, *available at* http://aspe.hhs.gov/poverty/13poverty.cfm.

The ACA prohibits insurers from charging disparate premiums based on health status (known as "community rating") and requires them to offer coverage to all people wishing to purchase it (known as "guaranteed issue"). *See* 42 U.S.C. § 300gg(a); *id.* §§ 300gg1-4. And Congress explicitly recognized that health coverage providers could make the economics of guaranteed issue and community rating work only if they received an influx of new, relatively low-cost customers. *See* 42 U.S.C. § 18091(2)(I). That is one reason why Congress also included the individual mandate and subsidies in the law. Those provisions are designed to give Americans young and old, healthy and less so, the buying power and incentives to enter the market. Without those incentives, only highly motivated people—who expect to consume health care, so that coverage is worthwhile even at a high price—tend to sign up, raising insurers' average costs. *See id.* Premiums therefore go up, further impeding entry into the market by healthier customers and risking a "marketwide adverse-selection death spiral," A. Monheit *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, *Health Affairs*, July/Aug. 2004, at 167, 169.

That is exactly what Congress tried to avoid by including subsidies in the ACA. As legislators recognized, subsidies are one of the three key "legs" of the statutory design. And "[i]f you take any leg out, the stool collapses." 157 Cong. Rec. S737 (daily ed. Feb. 15, 2011).

D. The Loss Of Subsidies Would Harm Hospitals And Further Fray The Already Fragile Safety Net.

Denying subsidies to those in states with federally facilitated exchanges would lead to an inevitable result: far more uninsured patients than anyone anticipated. Those patients would be forced to rely on hospitals and other safety-net providers for care. And that additional strain—a strain the subsidies were specifically designed to eliminate—would come at a time when hospitals are particularly ill-equipped to handle it.

Medicare and Medicaid have long pegged reimbursement rates at a level too low to cover the costs hospitals incur treating patients. *See* American Hosp. Ass'n, *Trendwatch Chartbook 2013* tbl.4.5 (2013).[14] Thus in 2011, hospitals lost a total of $29.8 *billion* providing care to Medicare and Medicaid patients. *Id.* That staggering figure represents only one year out of a decade-long history of losses. Losses on government-insured-patient care over that time have ranged from a low of $3.8 billion in 2000 to a high of $36.5 billion in 2009. *Id.* In none of those years did hospitals' reimbursements from the government cover their aggregate expenses—adding up to a total loss of $262.4 billion between 2000 and 2011. *See id*.

[14] *Available at* http://www.aha.org/research/reports/tw/chartbook/2013/table4-5.pdf.

Hospitals therefore directly underwrite Medicare and Medicaid by covering costs for government-insured patients that the government does not. Moreover, hospitals provide substantial uncompensated care to patients for which they are not reimbursed by anyone. That care added up to an additional $41.1 billion in 2011. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 3 (Jan. 2013).[15] Indeed, since 2000, hospitals provided more than *$367 billion* in uncompensated care to the uninsured and under-insured. *Id.*

Plaintiffs' position would cause hospitals to shoulder an even greater burden, requiring them to furnish similar amounts of uncompensated care while at the same time losing billions in government support. *See* American Hosp. Ass'n, *Summary of 2010 Health Care Reform Legislation* 34-35 (Apr. 19, 2010) (ACA cuts support for hospitals providing uncompensated care by $40.2 billion over the next decade)[16]; B. Semro, The Bell Policy Center, *Potential Impacts of New Federal Policies on Provider Reimbursement Rates* (Nov. 1, 2011) (ACA cuts overall provider payments by $156 billion to $233 billion in the next decade).[17] That is a far cry from what Congress had in mind.

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[15] *Available at* http://w ww.aha.org/content/13/1-2013-uncompensated-care-fs.pdf.

[16] *Available at* http://www.aha.org/advocacy-issues/tools-resources/advisory/2010/100419-legislative-adv.pdf.

[17] *Available at* http://bellpolicy.org/content/potential-impacts-new-federal-policies-provider-reimbursement-rates.

II. PLAINTIFFS' POSITION IS INCOMPATIBLE WITH THE TEXT AND STRUCTURE OF THE ACA.

In short, plaintiffs propose an interpretation of the ACA's subsidy provision that flies in the face of everything Congress intended when it enacted the statute. Congress's goal in the ACA was "[t]o ensure that health coverage is affordable," S. Rep. No. 111-89, at 4 (2009). It recognized that the subsidies provided under Section 36B "are key to ensuring people affordable health coverage;" H.R. Rep. No. 111-443, vol. I, at 250 (2009) —and yet plaintiffs would read Section 36B to deny subsidies to more than half the nation. That is, to put it mildly, implausible. Moreover, the statute's text and structure prove that that result is not what Congress had in mind.

This Court typically divines Congress' intent by applying the " 'plain and unambiguous meaning' " of statutory text. *Green* v. *Young*, 454 F.3d 405, 408 (4th Cir. 2006) (citation omitted). Contrary to plaintiffs' simplistic approach, however, plain-meaning interpretation does not involve looking at the words of particular statutory phrases in isolation. Instead, the meaning of text depends on "the specific context in which that language is used, and the broader context of the statute as a whole." *Id.* (citation omitted); *accord King* v. *St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (the "cardinal rule is that the statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context") (citation omitted). Moreover, this Court's inquiry ends with supposedly plain language only

if the resulting " 'statutory scheme is coherent and consistent.' " *United States* v. *Burgess*, 478 F.3d 658, 661 (4th Cir. 2007) (citation omitted).

Plaintiffs' interpretation violates both caveats. As the Government points out, plaintiffs' myopic focus on the words "established by the State" creates incongruities throughout the ACA. *See* Govt. Br. 25-30. But one stands out above all others: Under Section 1312 of the Act, a "qualified individual" may "enroll in any qualified health plan available to such individual, and for which such individual is eligible." 42 U.S.C. § 18032(a)(1). And the Act goes on to define a "qualified individual" as one "who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1)(A). If plaintiffs' reading of the words "State," "established" and "Exchange" were correct, not only would *subsidies* not be available in states with federally-facilitated Exchanges; *insurance* would not be available in those states. After all, only "qualified individuals" can purchase insurance from the Exchanges. But under plaintiffs' reading there would be no "qualified individuals" in states with federally-facilitated Exchanges because there would be no "State that established the Exchange." *See* J.A. 307-308 (pointing out this consequence of plaintiffs' interpretation).

Even plaintiffs cannot accept this conclusion; they appeal to increasingly strained distinctions to escape the logical endpoint of their supposed plain-language construction. *See* Plaintiffs' Br. 31-35. The fact that plaintiffs must resort to such contortions only underscores the perils of resting an argument on a single phrase in a massive piece of legislation. Here, the text, purpose, and history of the ACA demonstrate that Congress intended to make credits broadly available, as a means to make health insurance affordable for all Americans. *Supra* at 4-13. Plaintiffs' statutory snippets and inconclusive canons cannot overcome that overarching statutory purpose, enacted throughout the ACA's many interlocking provisions.

This Court need not, and should not, accept a statutory interpretation that (1) contradicts congressional intent and statutory purpose and (2) introduces absurdities into the statutory structure. With respect to the first point, the Supreme Court has long held that "[t]he canon in favor of strict construction is not an inexorable command to override common sense and evident statutory purpose. It does not require magnified emphasis upon a single ambiguous word in order to give it a meaning contradictory to the fair import of the whole remaining language." *United States* v. *Brown*, 333 U.S. 18, 25-26 (1948); *accord United States* v. *Campos-Serrano*, 404 U.S. 293, 298 (1971); *Lynch* v. *Overholser*, 369 U.S. 705, 710 (1962). And with respect to the second, this Court has held that

" '[s]tatutes should be interpreted to avoid untenable distinctions and unreasonable results.' " *Bice-Bey*, 701 F.2d at 1092 n.7 (citation omitted).

Applying these principles, courts have held that Congress does not make statutory eligibility for an entitlement turn on a factual distinction that anyone with common sense would have viewed as irrelevant to the entitlement at issue. *See Kaseman* v. *District of Columbia*, 444 F.3d 637, 642 (D.C. Cir. 2006) ("We see no evidence in the IDEA or the appropriations act that Congress intended to vary parents' entitlement to fees depending on whether the parents' rights are vindicated administratively or judicially."). So too here. Statutory text, context, and history all make abundantly clear that Congress designed the ACA to provide subsidies to those who need them, regardless of where they live.

CONCLUSION

For the foregoing reasons, the District Court's judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed R. App. P. 32(a)(7)(C) and Circuit Rule 32(a), I hereby certify that the foregoing brief was produced using the Times New Roman 14-point typeface and contains 3,467 words.

/s/ Sean Marotta
Sean Marotta

CERTIFICATE OF SERVICE

I certify that on March 21, 2014, the foregoing was electronically filed through this Court's CM/ECF system, which will send a notice of filing to all registered users.

/s/ Sean Marotta
Sean Marotta