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

BRIEF FOR THE STATES OF MARYLAND, MAINE, NEW HAMPSHIRE, NEW MEXICO, PENNSYLVANIA, AND WISCONSIN AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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INTERESTS OF AMICI CURIAE

Like Texas and the other respondent States, and like California and its fellow petitioner States, amici curiae are States whose healthcare systems and residents have benefitted from and continue to depend on provisions of the challenged legislation, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("Affordable Care Act" or "ACA"). Amici include States with Republican governors (Maryland, New Hampshire) and Democratic governors (Maine, New Mexico, Pennsylvania, Wisconsin). As the Act not only permits, but encourages, amici States have chosen different paths and pursued their own innovations in implementing the ACA. Yet all agree that if this case were to result in the ACA's invalidation, the consequences would be devastating.

SUMMARY OF ARGUMENT

The amici States urge this Court to reverse the Fifth Circuit's decision and reject the plaintiffs' challenge to the constitutionality of the minimum insurance coverage provision in § 5000A of the Affordable Care Act, part of the Act this Court previously upheld. *National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) ("*NFIB*"). If, however, the Court were to deem the challenged provision unconstitutional due to a 2017 amendment to § 5000A(c), which reduced to zero the amount of alternative tax to be paid by persons who choose not to maintain the minimum insurance

coverage, then the Court should hold that § 5000A is severable from the ACA's hundreds of other provisions. Separating § 5000A and preserving the remainder of the ACA is the preference that Congress indicated when it enacted the 2017 Tax Cuts and Jobs Act, which carefully targeted the alternative tax amount in ACA § 5000A(c), while manifestly opting to leave the rest of the ACA intact.

This Court can be confident that Congress did not intend for an alteration of one subsection to spell the demise of the entire ACA, because Congress understood that the ACA's many other provisions were indispensable to the maintenance of public health in this country. This brief seeks to illustrate for the Court's benefit just how integral the ACA has become to the States' efforts to maintain and improve healthcare systems for the protection of public health. Even before the arrival of the Nation's worst health crisis in over a century, preservation of the ACA's various invaluable forms of support, incentives, and safeguards had become crucial, not only for the amici States, but for every State in the Union. Now as the States and our residents face the COVID-19 threat, losing the ACA has become unthinkable.

Especially now, States depend on two categories of ACA provisions that operate without reference to the subject addressed by the challenged § 5000A, which is an individual's minimum coverage under private insurance policies. The first of these categories on which States rely includes the multitude of ACA provisions that do not pertain to insurance, either private or

public, but instead seek to ameliorate various other deficiencies in healthcare delivery that Congress identified when it enacted the ACA. These encompass provisions that fund and otherwise support a wide range of public health initiatives that include, but are not limited to, improving and expanding healthcare services generally; creating and maintaining laboratory capacity for analyzing threats from infectious diseases and other sources; sustaining immunization programs and adapting them to address new threats; and establishing and continuing to fund health centers to serve communities that otherwise would not have access to healthcare. These provisions have been and continue to be critical for every State, including litigants on both sides of the present controversy.

The second category that has reshaped healthcare opportunities for state governments includes the ACA's provisions offering alternative ways and means to explore, expand, and improve healthcare delivery through Medicaid, Medicare, and private insurance marketplaces, while containing or reducing the costs. In this respect, the ACA embodies cooperative federalism, by authorizing States to be excused from certain federal requirements as a way of freeing the States to innovate and adapt programs to their respective needs and those of their residents. Through the ACA's flexible options and waiver provisions, amici States, like fellow States among both petitioners and respondents, have successfully adopted innovative customized arrangements tailored to their individual needs and concerns. These improvements have better positioned States to

address the needs of residents threatened by the COVID-19 pandemic, as well as the myriad other healthcare concerns that are ever-present. A precipitous unraveling of these authorities would directly impair the effectiveness of healthcare delivery in the States.

In the ten years since the ACA's enactment, States have invested heavily in statutory, regulatory, and infrastructure changes to carry out the ACA's provisions, and those investments have yielded significant advances for healthcare and its affordability. Under the ACA, States have seen steep declines in the number of people who lack health insurance, increased quality of the health insurance being sold, and generally improved health outcomes. The ACA has achieved this progress through means that include expanding and improving Medicaid, instituting robust consumer protections to prohibit insurers from mistreating the sick and vulnerable, and offering families and childless adults financial assistance to buy insurance that would otherwise be unaffordable. The access to healthcare that these reforms ensure is vital to the States in this time of global pandemic. Given the challenges we face, the complexity of the healthcare markets, and the fragility of our state fiscal conditions, invalidating these provisions would be catastrophic for the States and our citizens.

ARGUMENT

I. When it Amended the ACA in 2017, Congress Intended the Minimum Coverage Provision to Be Severable from the Remainder of the Act's Substantive Provisions.

When Congress rendered the ACA's minimum coverage provision in § 5000A unenforceable by enacting the Tax Cuts and Jobs Act ("TCJA"), it left intact the balance of the ACA's hundreds of provisions. § 11081, Pub. L. No. 115-97, 131 Stat. 2054, 2092 (2017). As petitioners have argued, the ACA's multipart statutory scheme, which Congress chose to leave in place when it enacted the TCJA, constitutes definitive evidence that Congress intended the balance of the ACA to stand, and remain in effect, because that is exactly what the TCJA's targeted terms accomplish.

The ACA "remains 'fully operative' without" an enforceable minimum coverage provision. *See Murphy v. National Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018) (quoting *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010)). In fact, the ACA has been operating in all of the States since passage of the TCJA, providing health insurance to tens of millions of people and continuing to reduce the rapid growth in healthcare costs that would have occurred in its absence. Although amici States agree with the petitioners that § 5000A is constitutional, if it were ultimately found to be "unconstitutional," it "must be severed unless the statute created in its absence is legislation that Congress would not have enacted." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685

(1987). Here, the ACA, without an enforceable minimum coverage provision, is the legislation that Congress *did* enact. The provisions of the ACA, along with the amendments worked by the TCJA, have now been integrated into all aspects of the States' provision of healthcare, and there is no evidence that Congress, with nary a word, meant to destroy the very backbone of state health programs.

II. In the Decade Since the Passage of the ACA, States Have Relied on its Provisions to Support Their Healthcare Systems.

In the "over 900 pages" and "hundreds of provisions" that comprise the Affordable Care Act, Congress set forth a sweeping plan "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 539, 538. Congress undertook this project with full understanding that "[e]veryone will eventually need health care at a time and to an extent they cannot predict." *Id.* at 547. To tackle this problem, "Congress could have taken over the health-insurance market by establishing a tax-and-spend federal program like Social Security," which "would have left little, if any, room for private enterprise or the States"; however, "[i]nstead of going this route, Congress" chose "a solution that retains a robust role for private insurers and state governments." *Id.* at 595-96 (Ginsburg, J., concurring in part and dissenting in part).

In choosing to enact such a sweeping program, Congress's exercise of its spending power was not limited to its attempted expansion of Medicaid to cover childless adults. Although *NFIB* held that particular aspect of the ACA to exceed Congress's spending clause power, *id.* at 575-86 (plurality opinion), the decision left intact many other ACA provisions through which Congress "offer[ed] funds to the States," and in doing so "induce[d] the States to adopt policies. . . ." *Id.* at 537. The offer of such funds was beneficial to the States; "[t]he alternative to conditional federal spending . . . is not state autonomy but state marginalization." *Id.* at 630 (Ginsburg, J., concurring in part and dissenting in part). Expanding "the state-level policy discretion and experimentation that is Medicaid's hallmark" to this new health insurance scheme has better served "the interests of federalism," because the "States retain a meaningful role in the implementation. . . ." *Id.*

Thus, over the past decade States around the country, regardless of their prevailing political affiliation, have taken advantage of funding offered by the federal government to create unique programs that increase the number of Americans covered by insurance while also decreasing the cost of healthcare. Ideas brought to the federal government by the States have yielded state-led programs that conserve federal funds and apply those funds more efficiently to meet local conditions. These flexible federal-state partnerships have become even more important in the rapidly evolving public health challenge we are now facing with the COVID-19 pandemic.

Whether in the provision of needed public health interventions or in fine-tuning the local markets for insurance, States have led the way in accomplishing Congress's vision for a comprehensive system that increases insurance coverage while lowering the cost of healthcare. Even States that have declined to implement parts of the ACA have relied on its other provisions to improve public health infrastructure and expand the provision of health services to vulnerable populations. Dismantling these programs would be difficult, costly, inefficient, and otherwise harmful to the States, their economies, and the health and well-being of their residents.

A. All States Rely on the ACA's Other Provisions to Support Their Public Health Infrastructure in Ways That Have Never Been More Necessary and Important Than They Are Now.

Aside from the ACA's more familiar provisions addressing Medicaid, Medicare, and private health insurance, the Act contains multiple other parts through which Congress sought to transform healthcare delivery for the better, improve prevention mechanisms, and enhance our healthcare systems' ability to anticipate and withstand new threats to the Nation's health as they arise. All States have benefitted from and continue to rely on these fruits of the ACA, including both the petitioner States who are defending the Act in this Court and the respondent States whose ill-considered

arguments, if accepted, would destroy the ACA entirely.

For example, among the ACA's innovations was the creation of the federal government's first permanent mandatory funding initiative to improve the Nation's public health system, the Prevention and Public Health Fund ("PPHF"). The PPHF's purpose is "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." ACA § 4002(a), 42 U.S.C. § 300u-11(a). According to the Centers for Disease Control and Prevention ("CDC"), the PPHF has "become integral to CDC program operations," by supplying more than 12 percent of the CDC's program funding.[1] The CDC has said that "[l]osing this funding would cripple CDC's ability to detect, prevent, and respond to vaccine-preventable respiratory and related infectious disease threats including pandemic influenza."[2]

But the CDC also recognizes that the PPHF's financial support has become just as essential to the States' ability to protect the health of their residents. One initiative "entirely funded by the PPHF" is the Preventive Health & Health Services ("PHHS") Block

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[1] CDC, *Accomplishing CDC's Mission with Investments from the Prevention & Public Health Fund, FY 2010-FY 2016* at 1, https://www.cdc.gov/funding/documents/CDC-PPHF-Funding-Impact.pdf (last visited Apr. 23, 2020) ("*CDC's Mission and the PPHF*").

[2] *Id*.

Grant, which "provides all 50 states, Washington D.C., two American Indian tribes, and eight U.S. territories with funding to address their unique public health needs in innovative and locally defined ways."[3] During one fiscal year alone, for example, every State received at least one PHHS Block Grant, and most States received two grant awards.[4]

The PPHF also supports the CDC's Epidemiology and Laboratory Capacity ("ELC") Grant Program, which the ACA directed the CDC to establish. ACA § 4304(a), 42 U.S.C. § 300hh-31(a). The Program awards "grants to State health departments as well as local health departments and tribal jurisdictions" to "assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases . . . ; (2) enhancing laboratory practice [and] systems to report test orders and results electronically; (3) improving information systems including developing and maintaining an information exchange using national guidelines . . . ; and (4) developing and implementing prevention and control strategies." *Id.*

The CDC considers the States' capability developed through the ELC Grant Program to have been

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[3] *Id*. at 2.

[4] U.S. Dep't of Health & Human Servs., *Prevention Awards* (searchable database: select "Preventive Health & Health Services Block Grant" and "FY 2017"), https://hhs.gov//open/prevention/awards/index.html (last visited Apr. 23, 2020).

"critical in recent outbreaks" that preceded the present pandemic.[5] When the first U.S. COVID-19 cases were reported, CDC needed to act quickly, and to do so it turned to the ELC Program. Thus, on March 5, 2020, the CDC awarded funding to 14 jurisdictions via its ELC Cooperative Agreement[6] "to begin implementation of coronavirus surveillance across the U.S., building on existing influenza activities and other surveillance systems."[7] Since then, the federal government has announced the award of an additional $631 million to 64 jurisdictions through the existing ELC cooperative agreement to support the COVID-19 response.[8]

All States have participated in and continue to benefit from the ELC Grant Program. During fiscal

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[5] *CDC's Mission and the PPHF* at 2.

[6] The CDC bases its statutory authority for the ELC Cooperative Agreements, in part, on ACA §§ 4002 (PPHF) and 4304 (ELC Grant Program). *See* Part II.A.1.b, "Statutory Authorities," CDC, Nat'l Ctr. for Emerging & Zoonotic Infectious Diseases, *2019 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) CDC-RFA-CK19-1904*, Application Due Date: 05/17/2019, https://apply07.grants.gov/apply/opportunities/instructions/PKG00248701-instructions.pdf.

[7] U.S. Dep't of Health & Human Servs., *HHS Announces Initial Funding to Jurisdictions Supporting COVID-19 Response* (Mar. 4, 2020), https://bit.ly/3b8d000.

[8] U.S. Dep't of Health & Human Servs., *HHS Announces CARES Act Funding Distribution to States and Localities in Support of COVID-19 Response* (Apr. 23, 2020), https://www.hhs.gov/about/news/2020/04/23/hhs-announces-cares-act-funding-distribution-to-states-and-localities-in-support-of-covid-19-response.html (last visited May 7, 2020).

years 2016 through 2019, the Program disbursed more than $1 billion in grants ($1,010,819,204), of which the 18 respondent States received just over 30 percent ($306,783,392) and the 22 petitioner States received approximately 41 percent ($413,966,712).[9] The three States that received the largest shares were respondent Florida, which received the most total grant money of any jurisdiction ($62,364,539), followed by petitioner California ($51,220,641) and respondent Texas ($43,027,799).[10]

When an effective COVID-19 vaccine becomes available, much of the responsibility for distributing and administering the vaccine will fall to state and local public-health-immunization infrastructure, which has received critical support from CDC immunization programs partially funded by the PPHF.[11] Since 2012, CDC has provided nearly $132 million to various jurisdictions, including both respondent States and petitioner States, as "Capacity Building Assistance to Strengthen Public Health Immunization

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[9] *See* CDC, *FY2016 ELC Award by Grantee*, https://www.cdc.gov/ncezid/dpei/pdf/cdc-elc-2016-funding-fact-sheet.pdf; CDC, *FY2017 ELC Awards by Grantee*, https://www.cdc.gov/ncezid/dpei/elc/elc-awards-by-grantee-2017.html; CDC, *FY2018 ELC Awards by Jurisdiction*, https://www.cdc.gov/ncezid/dpei/pdf/elc-2018-funding-fact-sheet-final-H.pdf (last visited May 12, 2020); CDC, *FY2019 ELC Awards by Jurisdiction*, https://www.cdc.gov/ncezid/dpei/pdf/elc-2019-funding-fact-sheet-final-H.pdf (last visited May 12, 2020).

[10] *Id*.

[11] U.S. Dep't of Health & Human Servs., *Prevention and Public Health Fund*, https://www.hhs.gov/open/prevention/index.html (last visited April 28, 2020).

Infrastructure and Performance."[12] The ACA will also prevent cost from being an obstacle to receiving the much-anticipated COVID-19 vaccine, because § 2713(a)(2) of the Act requires insurers to cover immunizations recommended by the CDC's Advisory Committee on Immunization Practices. *See* 42 U.S.C. § 300gg-13(a)(2).

Hawai'i and Maine offer examples of how the PPHF, PHHS Block Grants, ELC Grant Program, and CDC support for immunization programs have been instrumental to States' efforts to address epidemics and other health threats. In Fiscal Year 2018 alone, Hawai'i received a $1,405,406 PHHS Block Grant, fully funded by the PPHF; plus $500,567 from the ELC Program, thanks to money from the PPHF; and a $1,367,316 CDC Immunization Program grant, also from the PPHF.[13] In Fiscal Year 2019, Maine received a $1,609,040 PHHS Block Grant plus $544,071 from the ELC Program, both funded by the PPHF. The funding supported the Maine CDC epidemiology program

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[12] U.S. Dept of Health & Human Servs., *CFDA Information: Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance*, http://bit.ly/3aVP1kq.

[13] CDC, *Fiscal Year 2018 Grants Summary Profile Report for Hawai'i*, https://wwwn.cdc.gov/FundingProfilesApp/Report_Docs/PDFDocs/Rpt2018/Hawaii-2018-CDC-Grants-Profile-Report.pdf (last visited May 7, 2020); *see id*. at 1, 3 (showing PHHS Block Grant of $1,405,406); *id*. at 2 (category "Emerging and Zoonotic Infectious Disease," subcategory "Epi and Lab Capacity Program—PPHF $500,567"); *id*. (category "Immunization and Respiratory Diseases," subcategory "Immunization Program—PPHF $1,367,316").

and Health and Environmental Testing Laboratory, which have been essential to COVID-19 response.[14] Although much of the funding information available on the CDC and HHS websites pertains to prior periods, Congress has continued to fund both the ELC Grant Program and the PHHS Block Grant Program in the most recent budget. *See* Further Consolidated Appropriations Act of 2020, § 222, Pub. L. No. 116-94 (Dec. 20, 2019) (H.R. 1865); Explanatory Statement Regarding H.R. 1865, 165 Cong. Record H11061 (Dec. 17, 2019); *see id.* at H11065 (ELC Grant Program funding); *id.* at H11068 (PHHS Block Grant Program funding).

Still another emphasis of the ACA is expected to "play a critical role"[15] in state and local efforts to contain the spread of COVID-19 and treat its victims: the country's nearly 1,400 community health centers, which operate approximately 12,000 service delivery sites spread across every State in the country.[16] Community health centers are "community-based and patient-directed organizations that serve populations

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[14] CDC, *Fiscal Year 2019 Grants Summary Profile Report for Maine*, https://wwwn.cdc.gov/FundingProfilesApp/Report_Docs/PDFDocs/Rpt2019/Maine-2019-CDC-Grants-Profile-Report.pdf (last visited May 10, 2020).

[15] U.S. Health Res. & Servs. Admin. ("HRSA"), *Emergency Preparedness and Recovery Resources for Health Centers: COVID-19 Resources* (Apr. 24, 2020), https://bphc.hrsa.gov/emergency-response.

[16] HRSA Health Ctr. Program, *Health Center Program: Impact and Growth*, https://bphc.hrsa.gov/about/healthcenterprogram/index.html (last visited Apr. 28, 2020).

with limited access to health care."[17] The ACA created the Community Health Center ("CHC") Fund, and authorized it to invest "$11 billion over a 5-year period for the operation, expansion, and construction of health centers throughout the Nation."[18] In the years since that initial authorization expired, Congress has continued to extend the life of the CHC Fund, most recently as part of the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, § 3831(a), Pub. L. No. 116-136 (Mar. 27, 2020) (amending ACA § 10503(b)(1)(F), 42 U.S.C. § 254b-2(b)(1)(F), to authorize "$4,000,000,000 for fiscal year 2020, and $668,493,151 for the period beginning on October 1, 2020, and ending on November 30, 2020"). The CHC Fund provides as much as 70 percent of all grant funding for community health centers, which on average rely on federal grants for 19 percent of their operating revenue, but that percentage rises to as high as 44 percent for health centers in States that have elected not to adopt Medicaid expansion.[19]

Community health centers first appeared as a federal pilot program in 1965,[20] but the ACA is credited with transforming their role from a relatively "small dot" on the "healthcare landscape" into a component "essential to the functioning of the U.S. health system in medically underserved urban and rural

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[17] CDC, *Community Health Center Strengthening*, https://bit.ly/2V06baZ (last visited Apr. 28, 2020).

[18] *Id.*; *see* ACA § 10503, 42 U.S.C § 254b–2.

[19] Sara Rosenbaum, *The Community Health Center Fund: What's at Risk?*, 95 Milbank Quarterly 706, 707 (2017).

[20] *Id*. at 706.

communities."[21] According to the federal Health Resources and Services Administration ("HRSA"), the number of patients served by community health centers increased by more than 45 percent from 2010 to 2018 to reach more than 28 million people, including one in five rural residents and one in three persons living in poverty.[22]

Today, community health centers are on the "front lines" of the COVID-19 response.[23] In an HRSA analysis of survey responses from 70 percent of community health centers, nearly 88 percent of them reported having the capacity to perform COVID-19 testing, and during that reporting period they had tested 101,401 people.[24] Since passage of the CARES Act, the Department of Health and Human Services has recognized the essential role of community health centers during the pandemic by awarding $100,000,000 to 1,381

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[21] Health Affairs, *Keeping Community Health Centers Strong During the Coronavirus Pandemic is Essential to Public Health* (Apr. 10, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200409.175784/full/.

[22] HRSA Health Ctr. Program, *Health Center Program: Impact and Growth*, *see* bar graph, https://bphc.hrsa.gov/about/healthcenterprogram/index.html (last visited Apr. 28, 2020).

[23] Phil McCausland, *They're treating uninsured Americans. But as coronavirus ramps up, money is running out*, NBC News (Mar. 14, 2020), https://nbcnews.to/2xbNsAt.

[24] HRSA Health Ctr. Program, *Health Center COVID-19 Survey, National Summary Report: Latest Data from May 1, 2020*, https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data.

health centers on March 24, 2020,[25] followed by an additional $1.3 billion in funding for the centers, over and above the CARES Act's appropriation to extend the CHC Fund.[26]

The ACA's advancement of state public health interests through these and other programs serves to complement the Act's encouragement of innovation through provisions that are related to Medicare and Medicaid, but have yielded benefits for healthcare infrastructure that go beyond those two programs. For example, ACA § 3021 created a new Center for Medicare and Medicaid Innovation ("Innovation Center"). 42 U.S.C. § 1315a(b)(1), (2)(B)(xxv). A major Innovation Center program was the State Innovation Model ("SIM") Initiative, which awarded States nearly $78,000,000 for developing plans to modernize the healthcare delivery system, including projects aimed at extending the reach of States' health-information-exchange infrastructure.[27]

The SIM program enabled Maryland to expand the State's health information exchange, Chesapeake Regional Information System for our Patients

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[25] U.S. Dep't of Health & Human Servs., *HHS Awards $100 Million to Health Centers for COVID-19 Response* (Mar. 24, 2020), https://bit.ly/2xk3pEz.

[26] U.S. Dep't of Health & Human Servs., *HHS Awards $1.3 Billion to Health Centers in Historic U.S. Response to COVID-19* (Apr. 8, 2020), https://bit.ly/2xk9QHK; *see also* CARES Act § 3211(a).

[27] RTI International, *State Innovation Models (SIM) Round 2: Model Design Final Report*, ES-1 (Aug. 2017), https://innovation.cms.gov/files/reports/sim-designrd2-final.pdf.

("CRISP").[28] This investment has paid off; today CRISP serves a vital role in coordinating COVID-19 drive-through testing sites throughout the State, connecting provider prescriptions, and facilitating patient-scheduled appointments.[29] CRISP is also helping the State improve its response to the pandemic by analyzing its data to provide demographic information to epidemiologists, "so they can start to understand who is being infected, and which cases are more severe."[30]

B. Regardless of Political Orientation, States Have Used the ACA's Authorities to Craft Innovative and Transformative Change to Their Healthcare Systems.

The ACA also gave more flexibility to States by expanding the existing waiver authorities in the Social Security Act to provide additional mechanisms for States to innovate in the Medicaid, Medicare, and the new individual insurance marketplaces. Waiver authorities allow the federal government to suspend or alter the application of specified federal requirements

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[28] State of Maryland, Dep't of Health, *Maryland State Health System Innovation Plan*, 10, 69-79 (Jan. 13, 2017), available at https://mmcp.health.maryland.gov/sim/Documents/Maryland%20SHSIP%201.13.2017.pdf.

[29] CRISP, *COVID-19 Guidance: Navigating through the COVID-19 Testing Process*, https://www.crisphealth.org/guidance/ (last visited Apr. 23, 2020).

[30] Pamela Wood, *et al.*, *Maryland will start reporting info about race of coronavirus patients, Governor says*, Balt. Sun, Apr. 7, 2020, http://www.baltimoresun.com/coronavirus/bs-md-hogan-tuesday-20200407-jmvtijbmmrb5fmctde4poqta4i-story.html.

to enable each State to adapt programs to their local conditions. These programs will yield custom solutions "'through the workings of normal democratic processes in the laboratories of the States.'" *District Atty's Office for Third Judicial Dist. v. Osborne*, 557 U.S. 52, 79 (2009) (Alito, J., concurring) (quoting *Atkins v. Virginia*, 536 U.S. 304, 326 (2002) (Rehnquist, C.J., dissenting)). The ACA's embrace of cooperative federalism has created a unique web of programs tailored to specific state conditions, in respondent States no less than in other States. If this case were to result in those programs' abrupt disappearance, it would cause significant unraveling of the healthcare markets in those States.

One of the ACA's new waiver authorities provides an avenue for States to adjust for local conditions in their private health insurance markets. Section 1332 gives the Secretary of Health and Human Services the ability to waive portions of the ACA governing the establishment of qualified health plans, the requirement to maintain a single risk pool, the requirements surrounding cost sharing reductions, the available refundable tax credits, and shared responsibility payments for large employers and individuals. *See* 42 U.S.C. § 18052(a)(2). The § 1332 authority allows States to fund their own unique, approved programs through savings from forgone tax-credits that would otherwise revert to the federal government. 42 U.S.C. § 18052(a)(3). As described below, States on both sides of this appeal, amici States, and States who have taken no position have all taken advantage of this waiver opportunity.

States have used the § 1332 waiver authority most commonly to set up state-directed reinsurance programs. Originally, the ACA established a transitional reinsurance program that collected contributions from market participants and distributed them to insurers who experienced a higher than normal amount and volume of claims, but the program expired in 2017. 42 U.S.C. § 18061. Twelve States have received approval for § 1332 waivers to create their own reinsurance programs that extend years beyond the original transitional program.[31] Each State can also customize the program to its own needs. For example, Maryland reimburses participating insurers for 80 percent of enrollees' claims from $20,000 up to a $250,000 cap,[32] while North Dakota reimburses insurers for 75 percent of claims between $100,000 and $1,000,000.[33] Wisconsin reimburses insurers for 50 percent of the portion of

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[31] *See* Ctr. for Consumer Info. & Ins. Oversight, *Section 1332: State Innovation Waivers*, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (last visited Apr. 29, 2020). The 12 States are Alaska, Colorado, Delaware, Maine, Maryland, Minnesota, Montana, New Jersey, North Dakota, Oregon, Rhode Island, and Wisconsin.

[32] Maryland Health Benefit Exchange, *State Reinsurance Program 2019 – 2021 Program Update & Guidance Document*, 1 (Oct. 10, 2019), https://www.marylandhbe.com/wp-content/uploads/2019/10/2019-2021-State-Reinsurance-Program-a-Supplement-to-the-2020-Letter-to-Issuers.pdf.

[33] Ctr. for Consumer Info. & Ins. Oversight, *North Dakota: State Innovation Waiver Under Section 1332 of the PPACA* (July 31, 2019), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/ND-Fact-Sheet.pdf.

enrollees' claims between $40,000 and $175,000.[34] Alaska took an innovative approach, using a condition-based method, rather than the more common attachment point method, to provide reinsurance.[35] The program reimburses insurance providers for high-cost enrollees with conditions such as HIV/AIDS, cancer, and multiple sclerosis.[36] Alaska was able to react quickly to the COVID-19 pandemic by adding "cardio-respiratory failure and shock, including respiratory distress syndromes" to the list of high-risk conditions in late March 2020.[37] On February 11, 2020, Pennsylvania submitted a § 1332 waiver application seeking to implement a reinsurance program. The application is pending final approval. By reimbursing 60 percent of claims between an estimated $60,000 attachment point and an estimated $100,000 cap, Pennsylvania expects the program to reduce gross premiums by 4.6 percent in 2021.[38] In order to implement its program,

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[34] Wisconsin Office of the Comm'r of Ins., *Wis. Section 1332 Reinsurance Waiver Annual Report* (Mar. 30, 2020), https://oci.wi.gov/Documents/AboutOCI/WIHSP_Annual%20Report_2019.pdf.

[35] Ctr. for Consumer Info. & Ins. Oversight, *Alaska: State Innovation Waiver Under Section 1332 of the PPACA* (July 11, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf.

[36] Alaska Admin. Code, tit. 3 § 31.540 (Mar. 25, 2020).

[37] *Id*.

[38] *Pennsylvania's 1332 Waiver Application*, Pennsylvania Ins. Dep't (Feb. 11, 2020), https://www.insurance.pa.gov/Coverage/Documents/Pennsylvania%201332%20reinsurance%20waiver%20final%20application.pdf.

Pennsylvania will seek $95,100,000 in federal pass-through funds in 2021.[39]

States' efforts to contain premium growth have proved successful; by crafting appropriate and local interventions in their health insurance markets to spread risk among insurers, States have achieved lower premiums for consumers. For example, North Dakota anticipates premiums to be 20 percent lower than they would be without the reinsurance program;[40] it is able to achieve this significant reduction by using $21,487,029 in pass-through federal funding to support the program.[41] And, in 2019, Wisconsin rates decreased from the rates projected without the program by an estimated 10 percent[42] and saw a marked increase in counties with three or more insurers.[43] Maryland has also seen success; two years of double-digit premium decreases have resulted in 2020 premiums

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[39] *Id*.

[40] *North Dakota: State Innovation Waiver Under Section 1332 of the PPACA*.

[41] Letter from Randolph W. Pate, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Jon Godfread, Comm'r, N.D. Ins. Comm'n (Apr. 3, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-ND-2020.pdf.

[42] Press Release, Wisconsin Office of the Ins. Comm'r, *2019 Open Enrollment Begins November 1* (Oct. 29, 2018), https://oci.wi.gov/Pages/PressReleases/20181029OpenEnrollment.aspx.

[43] Press Release, Wisconsin Office of the Ins. Comm'r, *Gov. Evers Announces More Health Insurance Options for Wisconsinites in 2020 Ahead of Open Enrollment* (Oct. 10, 2019), https://oci.wi.gov/Pages/PressReleases/201910102020OpenEnrollment.aspx.

that are 22 percent lower than 2018 premiums and enrollment that exceeds projections by 24 percent.[44]

Waivers also have enabled States to continue local programs that are working. Petitioner Hawai'i was the first State to adopt a § 1332 waiver.[45] Hawai'i's waiver is unique: It is the only one in the country that addresses the Small Business Health Options Program ("SHOP"), a requirement under the ACA for businesses with less than 50 employees to offer health insurance coverage to full time employees.[46] Hawai'i already had nearly universal coverage under the Hawai'i Prepaid HealthCare Act of 1974,[47] which required virtually every employer to provide insurance. Hawai'i used the § 1332 waiver authority to leverage the unique state infrastructure already in place to forgo the SHOP requirement and to use federal pass-through small business tax credit savings to cover other costs.[48]

Other waiver authorities have enabled States to expand programs to support residents who have significant health needs, but are living in the community, thereby reducing the need for institutionalized care.

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[44] *State Reinsurance Program 2019 – 2021 Program Update & Guidance Document* at 1.

[45] David Y. Ige, Gov. Hawai'i, *Hawai'i's Proposal to Waive Certain Provisions of the Patient Protection & Affordable Care Act: Revised* 3-5 (Aug. 10, 2016), https://governor.hawaii.gov/wp-content/uploads/2014/12/REVISED-Hawaii-1332-Waiver-Proposal_-August-10-2016.pdf.

[46] *Id*.

[47] *Id*.

[48] *Id*. at 1-5.

The Community First Choice Option was added by § 2401 of the ACA and is known as a § 1915(k) waiver, after its authorizing provision in the Social Security Act. *See* 42 U.S.C. § 1396n(k). This option allows any qualified Medicaid recipient in participating States to receive assistance with activities of daily living, health-related tasks, voluntary management training, emergency response services, and related support services. *See* 42 U.S.C. § 1396n(k)(1)(B). Prior to the passage of the ACA, available federal authorizations for these types of personal care services often operated under enrollment caps, causing unmet demand for at-home services.[49]

States opting to provide community-based services receive an increase in federal matching funding to offset increased costs of providing these services. *See* 42 U.S.C. § 1396n(k)(2). Texas, California, Maryland, Montana, and Oregon have taken advantage of this increased match and established Community First Choice programs to expand their offerings to a wider number of residents who require personal care services

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[49] *Home & Community-Based Services 1915(c)*, Medicaid.gov, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html ("States choose the maximum number of people that will be served under a HCBS Waiver program.") (last visited May 10, 2020); *see also Community First Choice*, Tex. Health & Human Servs., https://hhs.texas.gov/services/health/medicaid-chip/programs/community-first-choice (last visited Apr. 29, 2020) (explaining how Community First Choice allows Texans to avoid waiting lists for other programs).

to maintain their residence in their community.[50] Community First Choice is another example of a program that even respondent States, such as Texas, have used to leverage federal funds as a way of improving healthcare for vulnerable populations. Programs that enable older and other vulnerable adults to remain in the community are increasingly important in current conditions, where "[p]eople who live in a nursing home or long-term care facility" are at high risk of severe illness from the COVID-19 pandemic.[51]

The ACA also gave the Department of Health and Human Services authority to waive certain fraud-and-abuse provisions normally required by Medicare; these waivers allow States, hospital systems, insurers, and providers to test innovative payment systems that incentivize enhanced quality of care at costs lower than the strict fee-for-service reimbursement scheme used by Medicare.[52] These programs include the Comprehensive End Stage Renal Disease Care Model, the Oncology Care Model, Next Generation Accountable Care Organization Model, and the Part D Enhanced

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[50] *Community First Choice, 1915(k)*, Medicaid.gov, https://www.medicaid.gov/25edicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k/index.html (last visited Apr. 29, 2020).

[51] CDC, *People Who Are at Higher Risk for Severe Illness* (Apr. 15, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

[52] CMS, *Fraud and Abuse Waivers*, https://www.cms.gov/medicare/physician-self-referral/fraud-and-abuse-waivers (Jan. 3, 2020).

Medication Therapy Management Model.[53] Every respondent State except Kansas has providers that participate in at least one of these programs, which are designed to allow for novel payment systems that incentivize enhanced quality of care.[54] Moreover, the Innovation Center, using these authorities in conjunction with grant programs, has enabled investment in telehealth;[55] this has contributed to the nation's readiness to continue delivering necessary healthcare services during the COVID-19 pandemic. One example is the Next Generation Accountable Care Organization Model, which contains a waiver of original Medicare requirements that limit the availability of telehealth services to rural areas.[56] Disruption of these federal waiver programs would be destabilizing to the provider and insurer networks in States with participants, including the respondent States and many of the amici and petitioner States.

The same fraud-and-abuse waiver authorities have yielded two comprehensive state-specific

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[53] *Id*.

[54] CMS, *Where Innovation is Happening*, https://innovation.cms.gov/innovation-models/map#model= (check listed waivers in "Health care facilities where Innovation Models are being tested" in sidebar; then follow "Display selected" hyperlink).

[55] Victoria L. Elliot, Cong. Research Serv., *Telehealth and Telemedicine: Description and Issues* 11 (Mar. 29, 2016), https://www.senate.gov/CRSpubs/757e3b90-ff10-497c-8e8c-ac1bdbdb3aaf.pdf (discussing role of Innovation Center in promoting telemedicine).

[56] CMS, *Next Generation ACO Model Telehealth Expansion Waiver: Frequently Asked Questions* (Sept. 2019), https://innovation.cms.gov/files/x/nextgenaco-telehealthwaiver.pdf.

programs that will serve as examples for potential reform across the Medicare system. Vermont's statewide waiver, the Vermont All-Payer Accountable Care Organization Model, allows extra incentives for care coordination, and Vermont "commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant health care payers."[57] Vermont Medicaid and other providers and insurers (on a voluntary basis) join together under the All-Payer ACO model to meet these goals.[58]

Maryland has also established a comprehensive payment reform program. From 1977 through 2014, Maryland operated an all-payer hospital reimbursement demonstration project authorized by Section 1814(b)(3) of the Social Security Act.[59] In 2014, given the availability of new waiver authority specifically permitting all-payer models under Social Security Act § 1115A(b)(2)(B)(xi), as amended by the ACA, Maryland entered into a new agreement with the federal government to allow Medicare reimbursement through its all-payer system consistent with the requirements of the ACA (the "Maryland All-Payer Model").[60] The Maryland All-Payer Model yielded $975

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[57] CMS, *Vermont All-Payer ACO Model*, https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model (last visited April 29, 2020).

[58] *Id*.

[59] In an all-payer system, insurers, consumers, and governments pay the same rate for services.

[60] CMS, *Maryland All-Payer Model*, https://innovation.cms.gov/innovation-models/maryland-all-payer-model (last visited May 12, 2020).

million in total savings between hospital and non-hospital settings and reduced all-cause and potentially avoidable hospital admissions.[61] Since that successful demonstration, Maryland and the federal government have partnered on a new demonstration, the Total Cost of Care Model, the first model where a State is fully at risk for the cost of care for Medicare beneficiaries.[62] The Total Cost of Care Model sets Maryland on course to achieve fixed amounts of savings to Medicare per capita total cost of care during each model year between 2019 and 2023. It is structured to generate more than $1 billion in Medicare savings.[63]

The ACA's opportunities for state experimentation extended to all the States, and many States have taken advantage of these opportunities to revolutionize payment mechanisms, prepare for the dramatic challenges of pandemic response, and test new ideas for innovative health services delivery. These programs operate independently of what was originally viewed as Congress's "three-part solution," *NFIB*, 567 U.S. at 597 (Ginsburg, J., concurring in part), and their continued relevance after the enactment of the TCJA evidences the importance of the ACA to all States today.

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[61] CMS, *Maryland All-Payer Model Final Evaluation Report (2014-2018) Findings at a Glance,* https://innovation.cms.gov/files/reports/md-allpayer-finalevalrpt-fg.pdf (last visited May 12, 2020)

[62] CMS, *Maryland Total Cost of Care Model*, https://innovation.cms.gov/innovation-models/md-tccm (last visited May 10, 2020).

[63] *Id*.

III. Healthcare Access and Outcomes Have Improved in All States Due to the ACA While Healthcare Costs Have Been Reduced.

If the ACA were invalidated, the resulting chaos would harm the healthcare markets, state government budgets, and the health of residents in every State, all amidst a global pandemic. In the ten years since the passage of the ACA, the promises of the ACA have been fulfilled and the States have experienced dramatic improvements in healthcare coverage and outcomes. The ACA brought about those improvements by, among other things, strengthening consumer protections in private insurance, making the individual insurance market accessible and affordable, and expanding and improving Medicaid. All these successes have endured despite the non-enforcement of the minimum coverage provision and, since 2017, the setting of the minimum coverage payment amount at zero. That evidence of enduring success further demonstrates congressional intent to maintain the balance of the ACA as "fully operative," *Murphy*, 138 S. Ct. at 1482, with or without the minimum coverage provision.

Before the ACA, almost 50 million Americans—over 17 percent of the population—lacked health insurance. *NFIB*, 567 U.S. 592 (Ginsburg, J., concurring in part and dissenting in part). Since the ACA's passage, the nationwide uninsured rate has fallen to 10

percent.[64] While some of those gains have slipped away under the current Administration, the uninsured rate remains far lower than it was pre-ACA,[65] and the coverage increases have been broadly shared across racial and ethnic groups.[66]

In the amici States, the ACA has delivered health insurance to millions who lacked coverage or had access only to low quality or unaffordable insurance plans. In Maine, from 2010 to 2018, the rate of uninsured people dropped from 11 to 8 percent.[67] In Maryland, more than 100,000 residents have obtained private health coverage, more than 1,000,000 are now covered by Medicaid, and this year the State's uninsured rate fell to six percent, the lowest ever.[68] In New Hampshire, the rate of uninsured fell from 11 to 5

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[64] Jennifer Tolbert, *et al.*, *Key Facts About the Uninsured Population*, Kaiser Family Found. (Dec. 13, 2019), https://tinyurl.com/uyjvvo6.

[65] The uninsured rate rose from a historic low of 10 percent 2016 to 10.4 percent in 2018. *Id.*

[66] From 2010-2018, the uninsured rates for non-elderly adults fell by 13.6 percent among people of Hispanic origin, 9.9 percent among Asians, 8.4 percent among African-Americans, and 5.6 percent among whites. Samantha Artiga, *et al.*, *Changes in Health Coverage by Race and Ethnicity since the ACA*, Kaiser Family Found. (Mar. 5, 2020), https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

[67] *Health Insurance Coverage of the Total Population*, Kaiser Family Found., https://tinyurl.com/y8q9m8q4 (last visited May 7, 2020).

[68] Maryland Health Benefit Exchange, *2019 Annual Report* 4, 19, https://tinyurl.com/tdrfkeo.

percent from 2010 to 2018.[69] In New Mexico, the uninsured rate has been cut in half.[70] Prior to the ACA, 10 percent of Pennsylvanians were uninsured. As of 2017, that number had been halved to 5.5 percent overall—6.4 percent for adults and 4.1 percent for children.[71] Currently, more than 1,000,000 Pennsylvanians are insured because of the ACA, including 331,825 through ACA exchange plans and 722,000 through Medicaid expansion.[72] If the ACA were invalidated, tens of millions of Americans would lose their health insurance; those retaining insurance would have policies with fewer benefits and more out-of-pocket spending, and policies would be much less accessible to those with health problems.[73]

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[69] *See supra*, note 62.

[70] *See* New Mexico Human Servs. Dep't, *Coverage and Affordability Initiatives Presentation to Legislative Health and Human Services Committee* 4 (Nov. 12, 2019), https://tinyurl.com/t2jmxpd.

[71] Pennsylvania Dep't of Human Servs., *Medicaid Expansion Report 2019 Update* (Revised Feb. 2019), https://www.dhs.pa.gov/Services/Assistance/Documents/Medicaid%20Expansion%20Report%20Updates.pdf.

[72] CMS, 2020 Federal Health Insurance Exchange Enrollment Period Final Weekly Enrollment Snapshot (updated Jan. 8, 2020), https://www.cms.gov/newsroom/fact-sheets/2020-federal-health-insurance-exchange-enrollment-period-final-weekly-enrollment-snapshot; Pennsylvania Department of Human Services, Health Choices (revised May 8, 2020), http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_281477.pdf.

[73] Linda J. Blumberg, *et al*., *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*, Urban Inst. (Mar. 26, 2019), https://tinyurl.com/vvkxqx2.

A. The ACA's Consumer Protections Have Broadened Access and Coverage.

The consumer protection provisions of the ACA safeguard our citizens from the everyday cruelties of the pre-ACA health insurance landscape. Prior to the ACA, insurance companies could charge unaffordable premiums or deny coverage outright to those with pre-existing conditions such as asthma, cancer, diabetes, or high blood pressure. Policies often had narrow coverage, paired with annual and lifetime limits on benefits that were quickly exhausted by treatments for serious medical conditions. Aggressive rescission practices meant that people submitting claims might find their policies retroactively canceled for frivolous, pretextual reasons.

The ACA guarantees access to health insurance for the estimated 133 million Americans who suffer from a pre-existing health condition.[74] Before the ACA, those millions of Americans could be denied coverage, charged exorbitantly, or offered restrictive policies that did not cover the health services they needed. Under the ACA, coverage in the individual market for those with pre-existing conditions rose by 64 percent between 2010 and 2014.[75]

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[74] Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act, *Issue Brief* (Jan. 2017), https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[75] *Id*.

The COVID-19 crisis underscores the paramount importance of protections for people with pre-existing conditions. More than 1,000,000 Americans are currently infected with the novel coronavirus as of this writing. ACA protections mean that plans cannot terminate coverage due to a change in health status, including diagnosis or treatment of COVID-19.[76] Preliminary research suggests that recovered patients can be left with kidney damage requiring chronic dialysis, permanently reduced lung function, or neurological damage, conditions that would have rendered them uninsurable in a pre-ACA environment.[77] The novelty of the virus and the corresponding lack of long-term survivorship data would likely induce medical underwriters to treat prior COVID-19 infection as a disqualifying condition, were they permitted to do so.

Prior to the ACA, coverage in plans sold on the individual market was often significantly weaker than

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[76] *See 3 things to know about coronavirus disease and your Marketplace coverage,* HealthCare.gov: Blog (Mar. 6, 2020), https://bit.ly/2RFL1gy.

[77] *See* Lenny Bernstein, *et al.*, *Coronavirus destroys lungs. But doctors are finding its damage in kidneys, hearts and elsewhere*, Wash. Post, Apr. 15, 2020, https://www.washingtonpost.com/health/coronavirus-destroys-lungs-but-doctors-are-finding-its-damage-in-kidneys-hearts-and-elsewhere/2020/04/14/7ff71ee0-7db1-11ea-a3ee-13e1ae0a3571_story.html; Gary Claxton, *et al.*, *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, Kaiser Family Found. (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/ (listing examples of declinable conditions in the medically underwritten individual market before the ACA).

employer-sponsored plans; individual policies routinely left people underinsured and exposed to enormous out-of-pocket costs. In response, the ACA mandated that qualified insurance plans cover ten categories of essential health benefits, including prescription drugs, emergency services, pregnancy care, and preventive services. ACA § 1302(b)(1), 42 U.S.C. § 18022(b)(1). The ACA's focus on comprehensive insurance coverage has, among other accomplishments, assisted the States in fighting the opioid epidemic by requiring insurers to cover addiction screening and to handle substance use disorder treatments in a manner no more restrictive than other medical and surgical services.[78] It has ameliorated the health risks and eased the financial burdens associated with pregnancy and childbirth, by increasing access to prenatal and maternity care. The essential health benefit requirement is also aiding the battle against COVID-19; under guidance from the Centers for Medicare and Medicaid Services ("CMS"), diagnosis and treatment of COVID-19 are covered services.[79] And once a COVID-19 vaccine is approved, it will be covered as an

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[78] Amanda Abraham, *et al*., *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, Am. J. Pub. Health (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/.

[79] *See* Ctr. for Consumer Info. & Ins. Oversight, U.S. Dep't of Health & Human Servs., *FAQs on Essential Health Benefit Coverage and the Coronavirus* (Mar. 12, 2020), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf.

essential health benefit without cost-sharing, thanks to the ACA's preventive services coverage requirement.[80]

The ACA prohibits all private health plans from imposing annual and lifetime limits on benefits. Prior to the ACA, people who suffered from serious illness or catastrophic injury could find themselves exceeding their lifetime limit within the span of a single hospital stay. Before the ACA, over 10.5 million people in the amici States with employer or individual market coverage had a lifetime limit on their insurance policy.[81] If the respondents were to prevail here, annual and lifetime limits could again become subject to those limits. In the absence of the ACA's consumer protections, millions of our citizens would live shorter, sicker, less productive lives that would in turn threaten the economic health of the amici States.[82]

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[80] *See* Karen Pollitz, *Private Health Coverage of COVID-19: Key Facts and Issues*, Kaiser Family Found. (Mar. 18, 2020), https://www.kff.org/private-insurance/issue-brief/private-health-coverage-of-covid-19-key-facts-and-issues/.

[81] Office of the Assistant Secretary of Planning & Evaluation, *Compilation of State Data on the Affordable Care Act* (Dec. 2016), https://aspe.hhs.gov/compilation-state-data-affordable-care-act.

[82] Pennsylvania Ins. Dep't: Comm'r Jessica Altman's Statement for the Record: *Hearing on "The Trump Administration's Attached on the ACA (Affordable Care Act): Reversal in Court Case Threatens Health Care for Millions of Americans"* (July 10, 2019) at 1 (citing Brief for Economic Scholars as Amici Curiae Supporting Intervenor-Defendants California, *et al*., *Texas v. United States*, No. 4:18-CV-00167-O (N.D. Tex. Dec. 14, 2018), at 4).

The ACA's suite of protections has resulted in a corresponding decrease in the need to provide uncompensated care to the uninsured. Uncompensated care costs, services not paid for by an insurer or patient, were a staggering $48 billion in 2008. 42 U.S.C. § 18091(2)(F). According to the Medicaid and CHIP Payment and Access Commission, hospitals' uncompensated care costs decreased by $21.6 billion nationwide in 2016 alone.[83] In the amici States that expanded Medicaid, from fiscal years 2013 to 2016, hospitals' uncompensated care costs collectively declined by approximately $1.5 billion.[84] Because some uncompensated care costs must be borne by the amici States, our state budgets have benefited from the reduction of uncompensated care driven by ACA coverage expansion.

B. The ACA Has Supported Access to Quality Private Insurance.

The ACA made insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line; those tax credits can be used to pay insurance premiums in advance through a

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[83] Medicaid & CHIP Payment & Access Comm'n, *March 2019 Report to Congress on Medicaid and CHIP* (Mar. 2019), https://www.macpac.gov/wp-content/uploads/2019/03/March-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[84] Matt Broaddus, *ACA Medicaid Expansion Drove Large Drop in Uncompensated Care*, Ctr. on Budget & Policy Priorities (Nov. 6, 2019), https://www.cbpp.org/blog/aca-medicaid-expansion-drove-large-drop-in-uncompensated-care.

health insurance exchange. *See* 42 U.S.C. § 18082. Of the 10.2 million people nationally who purchased health insurance through exchanges in 2019, roughly 87 percent received ACA tax credits, with an average annualized amount of $6,167.[85] The availability of these Advanced Premium Tax Credits has been crucial to lowering uninsured rates in our States. If the respondent States succeed in enjoining the ACA, that financial support would vanish, and the individuals and families who have benefitted from those provisions would either need to pay more for healthcare or forgo it altogether.

Of critical importance during the COVID-19 crisis is the ACA's requirement that marketplaces established under the Act must offer special enrollment periods after certain qualifying events, such as the loss of coverage that was provided by a job or a family member, decrease in income, and new eligibility for subsidies. *See* 45 C.F.R. § 155.420(d). This provision means that the estimated 25 to 43 million Americans who could lose their job-based health insurance,[86] and their dependents, qualify for a special enrollment period and can sign up for a plan through an exchange rather than having to wait months for the next open enrollment

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[85] CMS, *First Half of 2019 Average Effectuated Enrollment Data*, https://www.cms.gov/files/document/effectuated-enrollment-first-half-2019.

[86] Bowen Garrett & Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage*, Urban Inst. (May 2020), https://www.rwjf.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html.

period, as might be the case in the absence of the ACA. Maryland also used its authorities as a state-based exchange to open a special enrollment period in response to the coronavirus in March, as have ten other States and the District of Columbia.[87] By April 17, 2020, over 21,500 Marylanders had obtained health coverage during the special enrollment period.[88]

C. The ACA's Medicaid Expansion and Improvements Increased Accessibility to Healthcare in All States.

The ACA also expanded access to Medicaid for millions of individuals by allowing States to increase the income eligibility level to a standard 138 percent of the federal poverty level, with the federal government covering at least 90 percent of the costs of expansion. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i), 42 U.S.C. § 1396d(y)(1). After this Court held Medicaid expansion to be unenforceable as a mandate, *NFIB*, 567 U.S. 575-86 (plurality opinion), 36 States and the District of Columbia have chosen to opt-in to Medicaid expansion. According to estimates, in 2018 over

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[87] By one analyst's estimates, enrollment could total 923,200 in just the 12 jurisdictions that have opened special enrollment periods. Charles Gaba, *Follow-up: How many would likely #GetCovered in YOUR HC.gov state via a #COVID19-specific SEP*, ACASignups.net (Apr. 16, 2020), https://tinyurl.com/y9kpo2jt.

[88] Press Release, Md. Health Connection, *More Than 21,500 Marylanders Obtain HealthCoverage Through State Special Enrollment Periods* (Apr. 16, 2020), https://www.marylandhbe.com/wp-content/uploads/2020/04/EnrollmentMetricsPressRelease041620.pdf.

13,000,000 newly qualified low-income adults were receiving health coverage in the States that expanded their Medicaid program.[89] In the four amici States that expanded Medicaid, the ACA's Medicaid expansion permitted over 1.3 million new enrollees.[90]

Those numbers will predictably swell if, as expected, the COVID-19 pandemic continues to devastate the economy and increases the number of eligible enrollees.[91] In Maine, for example, enrollment under the expansion increased by over 10 percent (from 47,486 to 53,036) between April 1 and May 1, 2020.[92] Importantly for expansion States, the 90 percent ACA-enhanced match will mitigate harm to the state budget in a time of rising fiscal demands and plummeting state revenues. COVID-19 has proven particularly deadly to low-income populations; pre-existing

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[89] Medicaid & CHIP Payment & Access Comm'n, *Medicaid Enrollment Changes Following the ACA*, https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (last visited May 6, 2020).

[90] *Medicaid Expansion Enrollment*, Kaiser Family Found., https://tinyurl.com/yxtpxpbn (last visited May 10, 2020).

[91] For example, one economic study demonstrated that the new ACA eligibility rules enhanced Medicaid's role as a counter-cyclical program, offering a safety-net for the unemployed. Paul D. Jacobs, Steven C. Hill, & Salam Abdus, *Adults Are More Likely To Become Eligible For Medicaid During Future Recessions If Their State Expanded Medicaid*, 36:1 Health Affairs 37 (Jan. 2017) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1076.

[92] Maine Dep't of Health & Human Servs., *MaineCare Expansion*, https://www.maine.gov/dhhs/expansion.shtml (last visited May 10, 2020).

conditions are associated with higher mortality rates, and those with lower incomes have higher rates of chronic health conditions.[93] Low-income access to healthcare is therefore particularly crucial to effectively combating the virus. Expanding Medicaid has put expansion States in a better position to fight COVID-19.[94] Although saving lives should never be viewed as a partisan issue, it is notable that even conservative economists have called the expansion of Medicaid in non-expansion States "critically important during the current crisis" to protect the over two million uninsured adults who would gain Medicaid eligibility.[95]

In addition to the expansion of eligibility, the ACA improved Medicaid in other ways. It simplified eligibility guidelines and streamlined the enrollment process, expanded minimum coverage standards for children, and increased anti-fraud efforts. *See* 42 C.F.R. §§ 435.911, 435.907, 435.118, 1007.19. The ACA also

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[93] Wyatt Koma, *et al*., *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*, Kaiser Family Found. (May 7, 2020), https://www.kff.org/disparities-policy/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/.

[94] According to one study, of those who lose employer-sponsored health insurance during the COVID-19 crisis, 53.4 percent will be eligible for Medicaid in expansion States as opposed to only 33.4 percent in non-expansion States. Garrett, *supra* note 86 at 4.

[95] Joseph Antos & James C. Capretta, *Covering the Uninsured During the COVID-19 Pandemic*, Real Clear Health (Mar. 19, 2020), https://www.realclearhealth.com/articles/2020/03/19/covering_the_uninsured_during_the_covid-19_pandemic_110997.html.

has improved access to healthcare, in ways that have led to earlier stage cancer diagnoses, decreased smoking rates, and increased treatment for opioid-use disorder.[96] Medicaid expansion has improved the financial security of its participants, by reducing the probability of bankruptcy filings and raising credit scores.[97] Low income residents of Medicaid expansion States report having less stress about their financial situation.[98] Medicaid expansion has resulted in budgetary savings for expansion States by offsetting costs that would otherwise have been incurred due to the countless harms associated with the absence of healthcare coverage.[99]

Most importantly, Medicaid expansion has saved lives: It has significantly decreased mortality rates among vulnerable populations.[100] A recent study estimates that approximately 4,800 fewer deaths occurred

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[96] *See* Madeline Guth, *et al*., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, Kaiser Family Found. 8-9 (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

[97] *See id*. at 13-14.

[98] Stacey McMorrow, *et al*., *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, Health Affairs 36 no. 5, 808-18 (May 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1650.

[99] *See* Guth, *supra* note 96, at 15-16.

[100] Sarah Miller, *et al.*, *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data* (Nat'l Bureau of Economic Research, working paper no. 26081, July 2019), https://www.nber.org/papers/w25488.pdf.

each year within the population of adults aged 55 to 64 in expansion States due to increased Medicaid coverage.[101] Eliminating Medicaid expansion could undo those gains.

CONCLUSION

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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[101] *Id*. at 16.

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