No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

TEXAS, *et al.*,
Plaintiffs-Appellees,

v.

UNITED STATES, *et al.*,
Defendants-Appellants.

THE STATE OF CALIFORNIA, *et al.*,
Intervenors-Defendants-Appellants.

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

BRIEF OF AMICI CURIAE

AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF ALLERGY, ASTHMA AND IMMUNOLOGY, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN ASSOCIATION OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN COLLEGE OF RADIATION ONCOLOGY, AMERICAN GERIATRICS SOCIETY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN OSTEOPATHIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN SOCIETY OF HEMATOLOGY, AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY, GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, AND RENAL PHYSICIANS ASSOCIATION

IN SUPPORT OF INTERVENORS-APPELLANTS

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SUPPLEMENTAL STATEMENT OF INTERESTED PERSONS

In accordance with Fifth Circuit Rule 29.2, amici hereby disclose that no one has an interest in this amicus brief beyond the named amici.

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INTEREST OF AMICI CURIAE

The district court held that the Affordable Care Act's individual mandate provision, 42 U.S.C. § 18091, became unconstitutional when, in the 2017 Tax Cuts and Jobs Act (TCJA), Congress changed the tax/penalty rate for noncompliance to zero. Holding the mandate "inseverable from the entire ACA," the court struck all of the Act's other provisions—without properly considering the intent of Congress in 2017 or undertaking meaningful analysis of the remaining ACA provisions.

The American Medical Association (AMA) is the country's largest association of physicians. The remaining amici, listed on the cover of this brief, are associations of physicians and other health care professionals with areas of specialized medical knowledge and expertise. They are all represented in the AMA House of Delegates.

Amici and their member physicians are committed to seeing that all Americans have access to affordable, quality medical care. The decision below, if affirmed, would have devastating effects on the quality, cost, and availability of such care. We therefore offer this brief to describe some of these effects and to explain why, under proper analysis, the individual mandate is severable from the remaining provisions of the ACA.[1]

[1] *Amici* file this brief with the parties' consent, given on March 25, 2019. No one other than *Amici* and their counsel authored any part of this brief or monetarily funded its preparation

SUMMARY OF ARGUMENT

We adopt the Intervenors' positions that: (1) the Plaintiffs lack standing to challenge the individual mandate and (2) the individual mandate remains constitutional as a tax. We offer this brief to describe the havoc that striking the entire ACA would cause to the entire U.S. healthcare system and to demonstrate that, under proper analysis, the individual mandate is severable from the remaining provisions of the ACA.

As enacted in 2010, the ACA was a multifaceted statute, with 10 Titles, 57 Subtitles divided into Parts and Subparts, and 452 Sections (not counting subsections). Its Table of Contents alone is 16 single-spaced pages.[2] As one commentator has noted, "the vast majority [of its provisions are] unrelated to the minimum coverage requirement, or indeed to insurance reform."[3] The Plaintiffs lack standing to challenge any of these other provisions. Substantively, striking down the entire ACA based on a holding that the individual mandate is unconstitutional is contrary to Supreme Court precedent governing the severance of an invalid provision from the rest of an otherwise valid statute.

In Part I, we explain why the Plaintiffs lack standing to challenge provisions of

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[2] https://www.hhs.gov/sites/default/files/patient-protection.pdf (TOC attached as an Appendix to this brief). Its provisions were codified in diverse parts of the U.S. Code. *See* http://uscode.house.gov/table3/111_148.htm (table, ACA (Pub. L. 111-148) to U.S. Code).

[3] Timothy Jost, "The Arguments over Severability of the Minimum Coverage Requirement" (March 29, 2012) (https://www.healthaffairs.org/do/10.1377/hblog20120329.018283/full/).

the ACA beyond the individual mandate.

In Part II, we articulate the standard for severability: When one provision of a statute is held unconstitutional, the remaining provisions are presumed to survive—unless it is evident that (a) Congress intended them to be inseparable and (b) they cannot function independently. Here, the district court improperly discounted congressional intent when, in 2017, Congress zeroed-out the tax on non-compliance with the individual mandate. Likewise, it failed to conduct a comprehensive analysis of whether other ACA provisions remain functional after that change.

In Part III, we demonstrate that in eliminating the payment for non-compliance with the individual mandate, Congress intended all other ACA health care provisions to continue in force, including:

1. Subsidies to low-income Americans who purchase health insurance on exchanges established under the ACA;
2. Payments to states for voluntary expansion of their Medicaid programs;
3. Required coverage of "essential health benefits" and preventive services; and
4. Required coverage of people with preexisting conditions.

Nothing indicates that the 2017 Congress intended these provisions to be struck down because the tax on non-compliance with the individual mandate was reduced to zero. Rather, these provisions are fundamental to the delivery of high-quality, affordable care in this country. As leading supporters of the legislation recognized, their invalidation would throw our health care system into chaos and would deprive

patients of critical benefits that Congress intended them to have.

In Part IV, we identify numerous other ACA provisions not remotely related to the individual mandate—including, for example, changes to the process for approval of biosimilars. Further, we identify laws that were part of the ACA but whose provisions have been subsequently repealed or amended. The striking down of these entirely unrelated provisions underscores the fundamental impropriety of the decision below.

ARGUMENT

I. The Plaintiffs Lack Standing to Challenge the Entire ACA.

The only specific ACA provision whose constitutionality plaintiffs challenged was the individual mandate. DE 1, §§ 41, 52, 57. Yet plaintiffs claimed that their attack on the mandate gave them standing to invalidate the entire ACA—despite their lack of any constitutional complaint about or proven injury arising from the other provisions.

This sweeping view of standing contravenes established Supreme Court and Fifth Circuit precedent. "[S]tanding is not dispensed in gross." *Lewis v. Casey*, 518 U.S. 343, 358 n.6 (1996). And for good reason: "[t]he actual-injury requirement would hardly . . . prevent[] courts from undertaking tasks assigned to the political branches . . . if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy all inadequacies in that administration." *Id.* at 357.

Plaintiffs, then, must establish standing for every challenged statutory provision, and cannot claim standing to challenge every provision because they believe they are inseverable. Thus, *National Federation of the Blind of Texas v. Abbott*, 647 F.3d 202 (5th Cir. 2011), rejected the contention that plaintiffs had standing to challenge certain provisions of a statute as inseverable from others, finding that "the seemingly intertwined fates of the two provisions" could not "eviscerate Article III's requirements." *Id.* at 209.

Plaintiffs cannot rest standing on abstract injuries from the ACA as a whole. The Plaintiffs have argued that the ACA generally keeps them from applying their own laws and policies, without identifying how the allegedly unconstitutional mandate does so. Their "forced-change-of-law" argument is based at most on speculation—not established facts. Furthermore, that argument rests on a case "limited to its facts" by a later opinion. *See Texas v. United States*, 809 F.3d 134, 154–55 (5th Cir. 2015) (emphasizing that "pressure to change state law may not be enough" to establish standing when states have not "surrendered some of their control over immigration to the federal government"), *aff'd by equally divided court*, 136 S. Ct. 2271 (2016).

Plaintiffs also cite *Alaska Airlines v. Brock,* 480 U.S. 678 (1987), as supporting their claim that standing may arise from injuries caused by inseverable provisions. While addressing the severability of various provisions of the Airline

Deregulation Act (*id.* at 684-97), that case did not address standing at all, much less undo decades of precedent. Controlling precedent precludes the Plaintiffs' expansive vision of standing.

II. When One Provision of a Statute Is Unconstitutional, the Other Provisions Survive Unless It Is Evident That Congress Would Not Otherwise Have Enacted Them and They Are Incapable of Functioning Independently.

Ever since *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803) (holding one provision of the Judiciary Act of 1789 unconstitutional, without invalidating the entire Act), the Supreme Court has been reluctant to strike down entire statutes when one provision was held unconstitutional. As the Supreme Court has stated:

> "[W]hen confronting a constitutional flaw in a statute, we try to limit the solution to the problem," severing any "problematic portions while leaving the remainder intact." . . . Because "[t]he unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions," . . . the "normal rule" is "that partial, rather than facial, invalidation is the required course."

Free Ent. Fund v. Pub. Co. Accounting Oversight Bd., 561 U.S. 477, 508 (2010) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328–29 (2006); *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932); and *Brockett v. Spokane Arcades, Inc.,* 472 U.S. 491, 504 (1985)).

Thus, in deciding whether the remaining portions of a statute survive when one part is invalid, courts must consider two questions:

- Is it evident that Congress would not have enacted those portions without the invalid part?
- Is it evident that the remaining portions cannot function independently?

Unless the answer to both questions is clearly "no," the court "must sustain" the remaining portions. *Free Ent. Fund*, 561 U.S. at 509. And "the presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984).

The first question asks "[w]ould the legislature have preferred what is left of its statute to no statute at all?" *Ayotte*, 546 U.S. at 330. The legislature's preference, however, may be presumed rather than expressed. The Supreme Court has emphasized that "[t]he absence of a severability clause" is just "silence" and "does not raise a presumption against severability." *Alaska Airlines,* 480 U.S. at 686. *See also, e.g., New York v. United States,* 505 U.S. 144, 186-87 (1992) (explicit severability clause is unnecessary); *United States v. Jackson*, 390 U.S. 570, 585 n.27 (1968) ("the ultimate determination of severability will rarely turn on the presence or absence of [a severability] clause"). Notably, both the Senate and House legislative drafting manuals instruct that such clauses are unnecessary.[4]

In sum, a court "must refrain from invalidating more of the statute than is necessary." *United States v. Booker*, 543 U.S. 220, 258 (2005) (internal quotation marks and citation omitted) (severing and excising invalid mandatory sentencing provision from remainder of sentencing act, when "[m]ost of the statute is perfectly

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[4] *See* U.S. Senate Office of Legislative Counsel, Legislative Drafting Manual, § 131 (Feb. 1997) (https://law.yale.edu/system/files/documents/pdf/Faculty/SenateOfficeoftheLegislativeCounsel_LegislativeDraftingManual%281997%29.pdf); U.S. House of Representatives Office of Legislative Counsel, House Legislative Counsel's Manual on Drafting Style, § 328 (Nov. 1995) (https://legcounsel.house.gov/HOLC/Drafting_Legislation/draftstyle.pdf).

valid”).

Indeed, in previously reviewing the ACA, the Supreme Court stressed that “we have a duty to construe a statute to save it, if fairly possible.” *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012) (*NFIB*). While striking down the ACA’s essentially mandatory Medicaid expansion, it noted:

> The question here is whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion. Unless it is “evident” that the answer is no, we must leave the rest of the Act intact. . . . We are confident that Congress would have wanted to preserve the rest of the Act. . . . [W]e do not believe Congress would have wanted the whole Act to fall, simply because some may choose not to participate. The other reforms Congress enacted, after all, will remain “fully operative as a law,” and will still function in a way “consistent with Congress’ basic objectives in enacting the statute.” . . . Confident that Congress would not have intended anything different, we conclude that the rest of the Act need not fall in light of our constitutional holding.

Id. at 587 (quoting *Champlin,* 286 U.S. at 234, and *Booker*, 543 U.S. at 259). The same is true here.

At the very least, the district court’s deficient severability analysis requires a remand for a proper analysis.

III. The Key ACA Health Care Provisions Do Not Depend on the Individual Mandate.

A. Congress Did Not Intend Its Action Regarding the Individual Mandate to Invalidate Any Other Provision of the ACA.

Whether the individual mandate was severable from the rest of the ACA, as the Act stood in 2010, was squarely addressed by the Eleventh Circuit in *Florida v.*

U.S. Dep't of HHS, 648 F.3d 1235, 1320–22 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom. NFIB v. Sebelius*, 567 U.S. 519 (2012). There, the Court ruled:

> Excising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.' As our exhaustive review of the Act's myriad provisions ... demonstrates, the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance.

648 F.3d at 1321–22.

This reasoning is even stronger today. The question before this Court is not whether, as the district court believed, the Congress that enacted the ACA in 2010 regarded the mandate as essential to the functioning of the Act as a whole. Rather, the question is what the Congress that eliminated the payment for violation of the individual mandate in 2017 thought about severability. *See Pierce v. Underwood,* 487 U.S. 552, 566–67 (1988) (the views of one session of Congress do not control legislation passed by another Congress); *United States v. Sw. Cable Co.,* 392 U.S. 157, 170 (1968) (same); *FDIC v. RBS Sec. Inc.,* 798 F.3d 244, 256 (5th Cir. 2015) (current Congress's intent not controlled by past Congress).

Notably, when Congress removed the tax/penalty on noncompliance with the individual mandate, it gave no indication that it intended to invalidate any other provision of the ACA. Indeed, proponents of the bill to change the tax/penalty stressed that the change would leave other provisions intact. Brief of Intervenor U.S. House of Representatives at 44, quoting Senators Hatch, Toomey, and Scott.

It is hardly surprising that the 2017 Congress did not intend the remainder of the ACA to be invalidated if the individual mandate were subsequently found unconstitutional. Wholesale invalidation of the ACA would have a devastating impact on patients and the American health care system. It would undo "[h]istoric gains in health insurance coverage . . . achieved since the implementation of the [ACA]."[5] But for the ACA, 27% of adults age 18–64 (52 million people)—and 47% of those age 60–64—would have been denied insurance in the individual market due to a preexisting condition.[6]

A March 2019 Urban Institute analysis ("State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA")[7] concluded that, "if the entire law were eliminated and pre-ACA Medicaid expansion waivers were reinstated,"

> the number of uninsured people in the US would increase to 50.3 million, an increase of 65.4 percent or 19.9 million people. Medicaid and CHIP enrollment would fall by 15.4 million people through the elimination of the ACA's Medicaid expansion. Reduced Medicaid

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[5] Dep't of HHS, ASPE Issue Brief, "Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage" (Sept. 29, 2016) (https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf).

[6] KFF, "Mapping Pre-Existing Conditions Across the U.S." (Aug. 28, 2018) (https://www.kff.org/health-reform/issue-brief/mapping-pre-existing-conditions-across-the-u-s/).

[7] https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state.pdf. *See also* the Urban Institute's June 2018 analysis, "The ACA Remains Critical for Insurance Coverage and Health Funding, Even without the Individual Mandate" (https://www.urban.org/sites/default/files/publication/98634/aca-remains-critical_2001873_0.pdf).

> eligibility would increase uninsurance among the low-income population.
>
> The total number of people with private nongroup insurance (ACA compliant and noncompliant) would drop 35.4 percent (6.9 million people), compared with having the ACA in place.

And, if states were unable to reinstate their pre-ACA Medicaid expansion waivers, "up to 1.3 million *more* people could become uninsured . . . , increasing national uninsurance under repeal by 21.2 million people." *Id.* (emphasis added). Judicial invalidation of the entire ACA would cause these devastating results—without deliberation by the politically-accountable branches of government.

One authority has summarized the "sweeping potential effects" if the district court's decision stands:

> [I]t would invalidate the protections of the current law against discrimination by insurers based on preexisting conditions—something the Trump administration, Republican candidates for the 2018 midterm elections, and members of Congress who voted for the tax bill said they did not want to do. But it would also invalidate many other protections that apply to Americans, including the majority who have employer coverage, such as required coverage of preventive services without cost sharing, prohibitions on annual or lifetime dollar limits, coverage of children up to age 26, and limits on out-of-pocket cost sharing.
>
> It would invalidate the Medicaid expansions, throwing millions of Americans off Medicaid, but would also invalidate Medicaid coverage for children aging out of foster care, expansion of Medicaid community care options for long-term services, and simplification of Medicaid eligibility. The ruling would also eliminate what [the district court] characterized as "minor provisions" of the ACA: expansion of Medicare preventive services requirements and possibly expansion of Medicare drug coverage in the "donut hole." Invalidation of the ACA would cause numerous changes in payment for Medicare providers,

> possibly pitching the Medicare program into chaos. The ruling would also invalidate taxes that finance the Medicare program.
>
> [It] would end Food and Drug Administration authority to approve generic biologics. It would impede fraud and abuse enforcement, including the enforcement authority of the Department of Labor against association health plans, which have a history of fraud and insolvency. It would end privacy protections for nursing mothers and disclosure requirements for fast food. The ruling would also invalidate extensive changes the ACA made to the Indian Health Service.
>
> In sum, [it] would adversely affect virtually all Americans, regardless of the type of health care coverage they have.[8]

As the Supreme Court stated in *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015), "Congress passed the [ACA] to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."

B. The Key Health Care Provisions of the ACA Function Independently of the Individual Mandate.

Review of the key health care provisions of the ACA confirms that Congress correctly determined that these provisions can function independently of the individual mandate.

[8] Timothy S. Jost, "Court Decision to Invalidate the Affordable Care Act Would Affect Every American," *To the Point* (Dec. 17, 2018) (https://www.commonwealthfund.org/blog/2018/court-decision-invalidate-affordable-care-act-would-affect-every-american). Another commentator noted that promising HIV research may be stalled. Jerome Groopman, "The London Patient and a Plan to End the H.I.V. Epidemic in the United States," *The New Yorker* (March 9, 2019) (https://www.newyorker.com/news/daily-comment/the-london-patient-and-a-plan-to-end-the-hiv-epidemic-in-the-united-states).

1. Premium Subsidies and Cost-Sharing Reduction Provisions.

For those with incomes between 100% and 400% of the Federal Poverty Level (FPL), the ACA provides for premium credits to purchase insurance through health insurance exchanges established pursuant to the Act.[9] 26 U.S.C. § 36B; *King v. Burwell*, 135 S. Ct. at 2487. For those with incomes between 100% and 250% of FPL,[10] the ACA provides for cost-sharing subsidies to reduce their cost-sharing amounts and annual cost-sharing limits. 42 U.S.C. § 18071. The mandate is severable from these provisions.

These provisions offer the ability to purchase health insurance to persons who otherwise could not afford it. They are not dependent on the legislative change to the individual mandate. In fact, with the tax/penalty eliminated, it is even more important to retain the incentives for persons with low incomes to purchase insurance. Had Congress intended to eliminate these subsidies, it could have done so when it passed the TCJA. Significantly, it did not.

Indeed, TCJA proponents confirmed that the bill left these provisions intact. Senator Hatch explained:

> Let us be clear, repealing the tax does not take anyone's health insurance away. No one would lose access to coverage or subsidies that

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[9] In Medicaid-expansion states, the threshold is 138% of FPL, because Medicaid eligibility supplants the credit/subsidy. *See* https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/.

[10] In Medicaid-expansion states, 138–250%. *Id.*

> help them pay for coverage unless they chose not to enroll in health coverage once the penalty for doing so is no longer in effect.

Senate Finance Committee, Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" (Nov. 15, 2017) at 106.[11] Similarly, Senator Scott said that "our bill take[s] nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage." 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017).

2. Preventive Services, Essential Heath Benefits, and Related Provisions.

The ACA requires non-grandfathered group and non-group plans to cover certain preventive health services on a first-dollar basis (with no cost sharing). 42 U.S.C. § 300gg-13. It creates incentives for use of Medicare preventive services; eliminates co-insurance; and provides for Medicare coverage of annual risk assessments, wellness visits, and personalized prevention plan, with incentives for healthy lifestyles. Notably, this provision became effective in 2011, while the mandate did not become effective until 2014. This fact alone demonstrates that the two provisions are not dependent on one another. In any event, specifying coverage for preventive services is not so related to the mandate that the mandate cannot be severed. If anything, this provision encourages the purchase of insurance even in the

[11] https://www.finance.senate.gov/imo/media/doc/11-15-17%20--%20The%20Tax%20Cuts%20and%20Jobs%20Act%20--%20Day%203.pdf)

absence of a tax/penalty.

Similarly, the ACA requires compliant plans in the small-group and individual markets to include coverage of ten categories of essential health benefits, including hospitalization, outpatient medical care, maternity care, mental health and substance use disorder treatment, prescription drugs, habilitative and rehabilitative services, and pediatric services, including dental and vision services. 42 U.S.C. § 18022. According to the Kaiser Family Foundation (KFF), in 2013, before the ACA essential-health-benefits requirements took effect, 75% of non-group health plans did not cover maternity care, 45% did not cover substance use disorder treatment, and 38% did not cover mental health services.[12] Thus, these requirements are critical to our health care delivery system, and they can easily exist in the absence of the individual mandate.

Other ACA provisions are linked to the essential-health-benefits provisions, including 42 U.S.C. § 300gg-11 (which prohibits plans from placing annual and lifetime limits on the dollar value of benefits) and 42 U.S.C. § 18022 (requiring non-grandfathered plans to limit cost sharing for essential health benefits covered in-network). According to the KFF, in 2009, before the ACA, 59% of covered workers' employer-sponsored health plans had a lifetime limit, and 19% of covered workers

[12] http://files.kff.org/attachment/Issue-Brief-Potential-Impact-of-Texas-v-US-Decision-on-Key-Provisions-of-the-Affordable-Care-Act.

had no limit on out-of-pocket expenses. Among those with out-of-pocket maximums, not all expenses counted toward the limit. For example, in 2009, among workers in PPOs with out-of-pocket maximums, 85% were in plans that did not count prescription drug spending toward the out-of-pocket limit.

All of these provisions are independent of the individual mandate. They came into effect in 2010, 2011, and 2013, respectively —before the mandate became effective. Substantively, specifying what compliant plans must cover does not depend on the enforcement provisions of the individual mandate.

3. Voluntary Medicaid Expansion Provisions.

The ACA provides for federal funding of states' expansion of Medicaid to include adults with incomes up to 138% of the FPL—states are receiving 93% federal funding for the expansion this year, and will receive 90% federal funding beginning in 2020. 42 U.S.C. §§ 1396a, 1396d(y). The 2012 *NFIB* decision declared it unconstitutional to compel states to expand Medicaid, but permitted states to voluntarily expand Medicaid and receive federal funding support under the ACA.[13] The Medicaid eligibility expansion has been critical for expanding services for mental health and substance use disorders to people who previously had limited

[13] *See NFIB,* 567 U.S. at 585–86 ("In light of the Court's holding [on Medicaid expansion], the Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion. That fully remedies the constitutional violation we have identified.").

access to such services. It is especially critical for addressing the opioid epidemic.

After the *NFIB* decision, each State could decide whether to expand its Medicaid program as provided for in the ACA—and thereby receive the funding offered by Congress to encourage the Medicaid expansion. Thirty-six states and DC have chosen to expand their Medicaid programs in accordance with the ACA.[14] It would be disastrous for them if this provision of federal funding were judicially eliminated.

Significantly, there is no reason to believe that modification of the individual mandate rules is inseverable from federal funding to support state Medicaid expansion. Had Congress intended to discontinue this funding, it could have done so when it passed the TCJA. But it did not. In fact, elimination of the funding would be directly contrary to the congressional objective of maintaining the mandate, only without financial coercion of individuals.

4. Pre-Existing Conditions Provisions.

Under Title I of the ACA, non-grandfathered plans are prohibited from discriminating against individuals based on their health status. 42 U.S.C. § 300gg-4. In the non-group, small-group, and large-group market, insurers must guarantee coverage. 42 U.S.C. § 300gg-1. Further, health plans are prohibited from applying

[14] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

preexisting-condition exclusions (42 U.S.C. § 300gg-3), and rescission of coverage is prohibited (42 U.S.C. § 300gg-12). Insurers in the non-group and small-group market must use modified community rating (i.e., they may not vary premiums based on health status, gender, or any other factor, except age, geography, and family size). 42 U.S.C. § 300gg. These are vital health care protections.

The district court wrongly concluded that these provisions are inextricably intertwined with the removal of the tax on non-compliance with the mandate. First, it is not "evident" that the 2017 Congress intended these provisions to fall when it enacted the TCJA. On the contrary, many congressional leaders voiced support for the law's preexisting condition protections even as they voted for the TCJA. For example, Senator Hatch said "nothing [in the bill] impacts Obamacare policies like coverage for preexisting conditions" and "[t]he bill does nothing to alter Title I of Obamacare, which includes all of the insurance mandates and requirements related to preexisting conditions." Senate Finance Committee Open Executive Session (n.12 above) at 106, 286. Most telling of all, when Congress changed the tax/penalty rate to zero, it did not repeal the preexisting-conditions, guaranteed-issue, and community-ratings provisions, and other key consumer protections in Titles I and II of the ACA.

Second, the preexisting-conditions, guaranteed-issue, and community-ratings provisions are capable of functioning even with the tax/penalty rate changed to zero.

The CBO did not forecast a "death spiral," but rather that non-group markets would remain stable.[15] The tax credit structure helps promote this market stability, as premiums for the benchmark second-lowest-cost silver plan are tied to a percentage of income.[16] Whatever the view in 2010, by 2017 the mandate was not viewed as the lynchpin it was originally thought to be. In fact, the Urban Institute analyzed Marketplace data to test the claim that "the ACA's private nongroup insurance markets could not function effectively with guaranteed issue and modified community rating but without an individual mandate," and concluded the following, "despite elimination of the mandate penalties beginning in the 2019 plan year":

- [2019] enrollment (measured as plan selections) as of the end of the open enrollment period is 97 percent of 2018 enrollment at the same point in the year;
- more insurers are participating in the Marketplaces in 2019 than in 2018; and
- typical benchmark (second-lowest-cost silver) premium increases in 2019 were well below those in 2018, and many more rating regions experienced benchmark premium decreases in 2019 than in 2018.[17]

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[15] In November 2017, before enactment of the December 2017 TCJA, the CBO reported that "[i]f the individual mandate penalty was eliminated but the mandate itself was not repealed"—which is what the 2017 Congress did—"[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." CBO, "Repealing the Individual Health Insurance Mandate: An Updated Estimate" (Nov. 2017) at 1 (https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf).

[16] "The amount of the tax credit ... is equal to the difference between the individual or family's premium cap and the cost of the benchmark silver plan." https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/.

[17] https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state.pdf.

IV. Innumerable ACA Provisions Are Independent of the Individual Mandate.

As the Eleventh Circuit's "exhaustive review" showed, "the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance," and "[e]xcising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.'" *Florida v. HHS*, 648 F.3d at 1321–22 (and Appendix A, *id.* at 1365-71).

A. Provisions Not Conceivably Related to the Mandate.

Many ACA provisions have no possible relationship to the individual mandate, including these examples:

- **Biosimilar pathway** (42 U.S.C. §§ 262, 284m, 35 U.S.C. § 271, 28 U.S.C. § 2201, 21 U.S.C. §§ 355, 355a, 355c, 379g). Gives FDA immediate authority to establish an abbreviated pathway to approve biosimilars for market, introducing more competition in the pharmaceutical marketplace. Effective in 2010, preceding and unrelated to the mandate.
- **Electronic funds transfers** (EFT) (42 U.S.C. § 1320d-2). Required adoption of EFT operating rules for health care payment and remittance advice by July 1, 2012, effective by January 1, 2014. Health care providers, including physicians, also required to comply with EFT standard for Medicare payments by January 1, 2014.
- **Graduate Medical Education** (GME) (42 U.S.C. § 294g). Authorizes redistribution of 65% of unused GME residency slots to qualifying hospitals to

address physician shortages, especially in rural/underserved areas (eff. July 1, 2011). More flexibility to count training in outpatient settings and didactic/scholarly activities toward GME payments (eff. July 1, 2010, applicable to previous cost reporting periods). Preserves GME positions from closed hospitals and directs HHS to establish a process to redistribute medical residency slots from qualifying closed hospitals (eff. 2010 for 2010–11).

- **Health disparities** (42 U.S.C. § 1396w-5). Requires qualified health plans to reduce health disparities by using language services, community outreach, and cultural competency trainings.

- **Health outcomes** (42 U.S.C. § 300gg-17). Requires HHS to develop guidelines for health insurers to report on initiatives to improve health outcomes by care coordination and chronic disease management, prevent hospital readmissions, improve patient safety, and promote wellness and health.

- **Health plan identifier** (42 U.S.C. § 1320d-2). Requires adoption of unique health plan identifier system.

- **HHS national health care quality strategy and plan** (42 U.S.C. § 280j). Provides resources to develop national strategy for performance improvement, quality measures and best practices, data aggregation, and public reporting of performance information.

- **Loan forgiveness** (42 U.S.C. § 292s). Requires medical students who receive

federal loan funds to practice in primary care until the earlier of 10 years or loan repayment.

- **Long-term care** (42 U.S.C. §§ 293k-1, 1396a, 1396d, 1396p). Many provisions to improve the nation's long-term care system, including new options for states to offer home and community-based services, to increase non-institutional long-term care services.

- **Medicaid drug rebate percentage** (42 U.S.C. § 1396r-8). Increased Medicaid drug rebate for most brand-name drugs to 23.1% and increased Medicaid rebate for non-innovator multiple-source drugs to 13%. Extended drug rebate program to Medicaid MCOs.

- **National Health Service Corps** (NHSC) (42 U.S.C. § 254g). Authorizes increased funding for NHSC scholarship and loan repayment program; allows part-time service and teaching time to qualify toward NHSC service requirements; increases annual NHSC loan repayment amount from $35,000 to $50,000 in 2010.

- **National prevention and health promotion strategy and other prevention provisions** (42 U.S.C. §§ 280*l* et seq., 300gg et seq., 300u-10, 300u-11, 1396a, 1396d, 1396r-8, 1396o, 1396o-1). Develops a national prevention and health promotion strategy that sets specific goals for improving health. Creates a prevention and public health investment fund, providing $7 billion in funding from 2010 through 2015, and $2 billion for each fiscal year after 2015, to expand and sustain

funding for prevention and public health programs. Permits insurers to create incentives for health promotion and disease prevention practices through significant premium discounts, and encourages employers to provide wellness programs and premium discounts for participating employees. Covers only proven preventive services and provides incentives to Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women. Includes food labeling requirements.

B. Sample Provisions Effective Before the Individual Mandate.

Even those ACA sections relating to private insurance are not tied to the mandate. Indeed, many private-insurance-related and other provisions took effect before the mandate's 2014 effective date. Examples include the following.

- **Dependent coverage up to age 26** (42 U.S.C. § 300gg-14). About 2.3 million young adults gained coverage under this provision, effective 2010.

- **Medical loss ratio** (42 U.S.C. § 300gg-18). Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs, and provide consumer rebates if medical loss ratio is less than 85% for large-group-market plans and 80% for individual and small-group markets. Became effective in 2010, with rebates beginning in 2011.

- **Premium rate reviews** (42 U.S.C. § 300gg–94). Process for review/justification of health plan premium increases. States must report to HHS on premium-increase

trends and recommend whether to exclude plans from the exchange for unjustified premium increases. Gives states grants to support premium-increase review and approval. Effective plan year 2010, with HHS monitoring premium increases (in and outside exchanges) beginning plan year 2014.

- **Center for Medicare and Medicaid Innovation** (CMMI) (42 U.S.C. § 1315a). Establishes the CMMI to test care models that improve quality and slow Medicare cost growth rate, including programs promoting greater efficiencies and timely access to outpatient services by not requiring physician/professional referrals or involvement in creating care plan. Effective in 2011.

C. Other Coverage-Related and Consumer Protection Provisions.

- **Special patient protections** (42 U.S.C. §§ 300gg-9–300gg-28). Includes the right to select a primary care provider (or pediatrician) from available participating providers; no prior authorization or increased cost-sharing for emergency services (whether in-network or out-of-network); direct access to ob/gyn care; the right not to be dropped from coverage for participating in approved clinical trials for life-threatening diseases; no denial of coverage for routine patient costs; right to internal appeals of coverage determinations and claims.

- **Mental health parity** (42 U.S.C. § 1396u-7). Requires Medicaid coverage of mental-health and substance-use-disorder services at parity with other Medicaid medical benefits, for adults in Medicaid expansion programs and other adults under

Medicaid Alternative Benefit Packages.

- **Consumer information and transparency** (42 U.S.C. § 300gg-15). Requires non-grandfathered health plans to summarize coverage in plain language, and to report transparency data (e.g., number of claims submitted and denied).

- **Health insurance exchanges** (42 U.S.C. §§ 18031-18044). Created marketplaces for qualified health plans (QHPs) meeting specific criteria; exchanges must certify that QHPs meet ACA requirements, provide subsidies to eligible individuals, operate a website for application and comparison of health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators. Marketplace operation does not depend on a mandate, but ACA-compliant plans sold on the marketplaces may be more expensive without a mandate.

- **Waiting periods** (42 U.S.C. § 300gg-7). Requires no-more-than-90-day waiting periods on eligibility for employer health benefits (e.g., for new hires).

- **Risk adjustment** (42 U.S.C. §§ 18061–18063). Program to redistribute funds from plans with lower-risk enrollees to plans with higher-risk enrollees.

- **Simplification of enrollment processes** (42 U.S.C. §§ 1395cc, 1396a, 1397gg). Requires states to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges.

- **Non-discrimination** (42 U.S.C. § 18116). Building on federal civil rights laws, prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs or activities.

D. Other Medicare-Related Provisions.

- **Accountable Care Organization provisions** (42 U.S.C. § 1395jjj). Requires HHS to establish a program allowing ACOs to share in cost savings if they meet criteria for managing/coordinating care for Medicare beneficiaries. Promotes accountability for patient populations, coordination of services, investment in infrastructure, redesigned care processes for high-quality, efficient service delivery.

- **Medical home pilot program** (42 U.S.C. § 1396w-4). Establishes independence-at-home demonstration program to bring primary-care services into the home for highest-cost Medicare beneficiaries with multiple chronic conditions. Shared savings available to health teams for achieving quality outcomes, patient satisfaction, and cost savings. Allows NPs and PAs to lead home-based primary care teams.

- **Medicare Advantage (MA)** (42 U.S.C. §§ 1395eee, 1395w-21, 1395w-23, 1395w-24, 1395w-27a). Requires HHS to transition to fiscal neutrality between regular Medicare fee-for-service and MA plans. Benchmarks vary from 95% of regular Medicare spending in high-cost areas to 115% in low-cost areas.

- **Medicare data release provision/qualified entity program** (42 U.S.C.

§ 1395kk). HHS will provide Medicare claims data to qualified entities, for public provider performance reports, subject to safeguards ensuring validity and reliability of the data. Physicians/providers can review data before public reports, with right to appeal and correct errors. Data is non-discoverable and inadmissible without consent of provider/supplier.

- **Medicare "donut hole"** (42 U.S.C. § 1395w-102(b)). Reduces the coverage gap for Medicare prescription drug benefits over time, 2010–2020.

E. Provisions Amended After the Enactment of Pub. L. 111-148.

Finally, the district court totally ignored changes in the ACA between its enactment in 2010 and the zeroing of the tax/penalty in 2017. After declaring the individual mandate unconstitutional, the court "declare[d] the remaining provisions of the ACA, Pub. L. 111-148" invalid. DE 211 at 55. The ACA as enacted in P.L. 111-148 on March 23, 2010 did not remain static. A court should not invalidate every provision of a statute without considering changes in those provisions after its enactment.

The ACA-to-U.S.C. conversion table[18] shows many ACA sections that have been repealed (marked "Rep"). Examples:

- Title VII of the ACA (the so-called CLASS Act) (42 U.S.C. §§ 300*ll* et seq.) was to create a voluntary and public long-term care insurance option for employees.

[18] http://uscode.house.gov/table3/111_148.htm (table, ACA (P.L. 111-148) to U.S. Code).

Congress repealed this Act on January 2, 2013 (P.L. 112–240, title VI, § 642(a)).

- The Independent Payment Advisory Board (ACA §§ 3403, 10320, 42 U.S.C. § 1395kkk) was to be created to achieve Medicare program savings. Before the Board was established, the statute was repealed under the Bipartisan Budget Act of 2018 (P.L. 115–123, § 52001).

Other ACA provisions have been modified. Examples:

- The Health Care and Education Reconciliation Act (P.L. 111-152, March 30, 2010) amended many ACA provisions.[19]

- Numerous additional ACA amendments followed. *See* Congressional Research Service, "Legislative Actions to Modify the [ACA] in the 111th–115th Congresses" (June 27, 2018).[20]

Such examples illustrate the need to consider the ACA's provisions individually before deciding their constitutionality. They also show that if Congress intends to change or repeal provisions of the ACA, it does so through legislative action. This Court should not countenance displacement of legislative authority by judicial fiat.

[19] *See* https://www.govinfo.gov/app/details/PLAW-111publ152.

[20] https://fas.org/sgp/crs/misc/R45244.pdf. These included, as just some examples, changing the small-employer definition (42 U.S.C. § 18024(b)(2)-(3)); delaying the "Cadillac tax" (26 U.S.C. §4980*I*); amending tort-litigation-alternative evaluation requirements (42 U.S.C. § 280g-15); reducing the itemized-deduction threshold for medical/dental expenses (26 U.S.C. § 213(a)).

CONCLUSION

The district court found that holding the individual mandate unconstitutional made every provision of the ACA as enacted on March 23, 2010, including those it called "minor provisions" (DE 211 at 49), also unconstitutional. None of these provisions are "minor," but are important congressional enactments providing tremendous benefits for the American people. They are independent of the individual mandate. The district court's striking them down without discussing whether each one depends on enforcement provisions for the mandate underscores the fundamental flaw in its severability analysis.

The district court's decision to invalidate the entire ACA should be reversed, or at least remanded for proper analysis.

April 1, 2019

Respectfully submitted,

/s/ *Jack R. Bierig*

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CERTIFICATE OF SERVICE

I certify that on April 1, 2019, we electronically filed the foregoing Brief of Amici Curiae American Medical Association et al. with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system, causing it to be served on all counsel of record.

Dated: April 1, 2019 /s/ Jack R. Bierig

CERTIFICATE OF COMPLIANCE

This brief complies with the word limits of Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), it contains 6447 words.

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and Fifth Circuit Rule 32.1, and the type-style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Baskerville Old Face font (with footnotes in 12-point Baskerville Old Face font).

Dated: April 1, 2019 /s/ *Jack R. Bierig*

APPENDIX (ACA Table of Contents)

Attached is the Table of Contents of the "official certified full panel-body" of the Affordable Care Act (per https://www.hhs.gov/healthcare/about-the-aca/index.html), as published at https://www.hhs.gov/sites/default/files/patient-protection.pdf.

CH2\21809338

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

December 24, 2009

Ordered to be printed as passed

In the Senate of the United States,

December 24, 2009.

Resolved, That the bill from the House of Representatives (H.R. 3590) entitled "An Act to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.", do pass with the following

AMENDMENTS:

Strike out all after the enacting clause and insert:

1 ***SECTION 1. SHORT TITLE; TABLE OF CONTENTS.***

2 *(a) SHORT TITLE.—This Act may be cited as the "Pa-*

3 *tient Protection and Affordable Care Act".*

4 *(b) TABLE OF CONTENTS.—The table of contents of this*

5 *Act is as follows:*

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS

"SUBPART II—IMPROVING COVERAGE

"Sec. 2711. No lifetime or annual limits.
"Sec. 2712. Prohibition on rescissions.
"Sec. 2713. Coverage of preventive health services.
"Sec. 2714. Extension of dependent coverage.
"Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
"Sec. 2716. Prohibition of discrimination based on salary.
"Sec. 2717. Ensuring the quality of care.
"Sec. 2718. Bringing down the cost of health care coverage.
"Sec. 2719. Appeals process.
Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.
Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

Sec. 1201. Amendment to the Public Health Service Act.

Case: 19-10011 Document: 00514896475 Page: 45 Date Filed: 04/01/2019

"SUBPART I—GENERAL REFORM

"Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
"Sec. 2701. Fair health insurance premiums.
"Sec. 2702. Guaranteed availability of coverage.
"Sec. 2703. Guaranteed renewability of coverage.
"Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.
"Sec. 2706. Non-discrimination in health care.
"Sec. 2707. Comprehensive health insurance coverage.
"Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.
Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.
Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Sec. 1301. Qualified health plan defined.
Sec. 1302. Essential health benefits requirements.
Sec. 1303. Special rules.
Sec. 1304. Related definitions.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311. Affordable choices of health benefit plans.
Sec. 1312. Consumer choice.
Sec. 1313. Financial integrity.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.
Sec. 1323. Community health insurance option.
Sec. 1324. Level playing field.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.
Sec. 1332. Waiver for State innovation.
Sec. 1333. Provisions relating to offering of plans in more than one State.

PART V—REINSURANCE AND RISK ADJUSTMENT

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.
Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.

Sec. 1343. Risk adjustment.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

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Sec. 10902. Inflation adjustment of limitation on health flexible spending arrangements under cafeteria plans.
Sec. 10903. Modification of limitation on charges by charitable hospitals.
Sec. 10904. Modification of annual fee on medical device manufacturers and importers.
Sec. 10905. Modification of annual fee on health insurance providers.
Sec. 10906. Modifications to additional hospital insurance tax on high-income taxpayers.
Sec. 10907. Excise tax on indoor tanning services in lieu of elective cosmetic medical procedures.
Sec. 10908. Exclusion for assistance provided to participants in State student loan repayment programs for certain health professionals.
Sec. 10909. Expansion of adoption credit and adoption assistance programs.