ORAL ARGUMENT SCHEDULED FOR DECEMBER 17, 2014

No. 14-5018

IN THE

United States Court of Appeals for the District of Columbia Circuit

JACQUELINE HALBIG, *et al.*,
Plaintiffs-Appellants,

v.

SYLVIA MATHEWS BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Columbia
No. 1:13-cv-00623-PLF (Friedman, J.)

BRIEF AMICI CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND AMERICA'S ESSENTIAL HOSPITALS IN SUPPORT OF APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), the *amici* certify the following:

Parties and Amici. a. All parties, intervenors, and *amici* appearing before the District Court and in this Court are listed in the Appellants' brief.

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

AHA has no parent company, and no publicly held company holds more than a ten percent interest in AHA. AHA is a "trade association" for purposes of D.C. Circuit Rule 26.1(b).

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The Federation has no parent company, and no publicly held company holds more than a ten percent interest in the Federation. The Federation is a "trade association" for purposes of D.C. Circuit Rule 26.1(b).

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

CHA has no parent company, and no publicly held company holds more than a ten percent interest in CHA. CHA is a "trade association" for purposes of D.C. Circuit Rule 26.1(b).

The Association of American Medical Colleges is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

AAMC has no parent company, and no publicly held company holds more than a ten percent interest in AAMC. AAMC is a "trade association" for purposes of D.C. Circuit Rule 26.1(b).

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems, is a champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care.

America's Essential Hospitals has no parent company, and no publicly held company holds more than a ten percent interest in it. America's Essential Hospitals is a "trade association" for purposes of D.C. Circuit Rule 26.1(b).

Rulings Under Review. The ruling under review is listed in the Appellants' brief.

Related Cases. Counsel are not aware of any related cases within the meaning of Circuit Rule 28(a)(1)(C).

/s/ Dominic F. Perella
Dominic F. Perella

CERTIFICATE IN SUPPORT OF SEPARATE BRIEF

Pursuant to Circuit Rule 29(d), *amici* state that a separate brief is necessary for its presentation to this Court because they alone among the *amici* intending to file in support of Appellees represent the distinct interests of American hospitals. In addition, a joint brief is not feasible because other *amici* in support of Appellees have interests divergent from those of *amici* and their members.

/s/ Dominic F. Perella
Dominic F. Perella

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES:

STATUTES:

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* Authorities on which we chiefly rely are marked with an asterisk.

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

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STATEMENT OF INTEREST OF AMICI CURIAE

The American Hospital Association, Federation of American Hospitals, Catholic Health Association of the United States, Association of American

Medical Colleges, and America's Essential Hospitals respectfully submit this brief as *amici curiae*.[1]

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

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than

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

600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Association of American Medical Colleges is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems, is a champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care.

Amici's members are deeply affected by the nation's health care laws, particularly the Affordable Care Act (ACA). That is why *amici* have filed briefs supporting the law in the Supreme Court and courts across the nation. Subsidies are critical to the law's success, and access to those subsidies for the uninsured in

all states, not just some, will have a profound positive impact on both patients and hospitals. *Amici* write to offer guidance, from hospitals' perspective, on the disastrous impact plaintiffs' position would have on American health care if they prevail.

SUMMARY OF ARGUMENT

It is impossible to overstate the centrality of subsidies to the ACA. Congress knew that many Americans could not afford to buy insurance. And Congress knew that it wanted to—indeed, *had* to—bring insurance within everyone's reach if the ACA were to work. Congress thus built subsidies into the statute. The subsidies make it possible for millions who otherwise could not afford insurance to buy it. That, in turn, increases the ranks of the insured, lowers average costs, and averts the "death spiral" that would result if only the sickest customers paid the required premiums. As one Senator put it, subsidies are one leg of the ACA's "three-legged stool. If you take any leg out, the stool collapses." 157 Cong. Rec. S737 (daily ed. Feb. 15, 2011).

In short, the ACA will not work without subsidies, and Congress knew it. Yet plaintiffs insist that Congress designed the ACA so that tens of millions of Americans, in more than half the states, would be walled off from subsidies altogether. That interpretation should be rejected for many reasons. It would be devastating to the ACA and to that statute's key goal of health care for all. It

would be equally devastating to millions of Americans who would no longer be able to afford coverage. And, critically, it bears no resemblance to what Congress intended. That last factor is dispositive. After all, "[w]hen possible, statutes should be interpreted to avoid 'untenable distinctions,' 'unreasonable results,' or 'unjust or absurd consequences.' " *Kaseman* v. *District of Columbia*, 444 F.3d 637, 642 (D.C. Cir. 2006) (quoting *American Tobacco Co.* v. *Patterson*, 456 U.S. 63, 71 (1982)). This case presents the triple whammy: Plaintiffs' statutory interpretation creates untenable distinctions, unreasonable results, *and* unjust and absurd consequences. The District Court's judgment should be affirmed.

ARGUMENT

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

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

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

1. One of the ACA's chief reforms was to create health insurance Exchanges to serve the individual and small-group health insurance markets. 42 U.S.C. §§ 18031-18044. Through the Exchanges, qualified individuals can select among and purchase health insurance plans that provide a comprehensive essential

health benefits package. *Id.* § 18021(a)(1)(B). Although rates on the Exchanges are lower than many initially expected, *see* L. Skopec & R. Kronick, Department of Health & Human Servs., *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected*,[2] they are still high enough that—just as before the ACA—many lower- and even middle-income Americans cannot easily afford to buy comprehensive coverage, *see* J. Cohn, *Five Things We Know About Obamacare—And One We Don't*, The New Republic, Sept. 6, 2013.[3]

Congress understood the affordability issue. It therefore built into the Exchanges a system of tax credits that act as subsidies, reducing the cost of Exchange-offered plans for those with household incomes from 100%-400% of the federal poverty level. *See* 26 U.S.C. § 36B. Though the amounts depend on the plan level and a patient's household income, the subsidies are often quite substantial. The Congressional Budget Office (CBO) has estimated that subsidies will cover nearly two-thirds of the premiums for policies purchased through the Exchanges, CBO, *An Analysis of Health Insurance Premiums Under the Patient*

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

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

Protection and Affordable Care Act, at 6 (Nov. 30, 2009),[4] and the average subsidy will total $4,410 per subsidized enrollee, CBO, *Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline* tbl.2 (Apr. 2014) (*2014 Baseline*).[5]

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

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

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

The bottom line: The ACA's subsidies are often the difference between health coverage that is affordable for lower-income Americans and health coverage that is not. Plaintiffs do not disagree. Indeed, their very claim to standing is predicated on their allegation that the Exchange-offered subsidies are what makes health coverage "affordable" for them under the ACA. *See* Panel Opinion 10-11.

3. Plaintiffs' bid to eliminate subsidies for individuals who purchase policies through federally facilitated Exchanges, if accepted, therefore would cost millions of Americans comprehensive coverage. According to the CBO, 6 million people are expected to purchase insurance through the Exchanges in 2014, but only 1 million of them will pay full sticker price. *2014 Baseline*, *supra*, at tbl.3. In other words, 5 million Americans will rely on the ACA's subsidies to obtain coverage just this year. *See id.*

Indeed, that process is already well under way, and the numbers exceed CBO's estimates: Some 7.3 million Americans had signed up through the Exchanges through October 2014, A. Gorman & J. Appleby, *Obamacare Round 2: States Gear Up for Start of Next Enrollment Period in November*, Wash. Post, Oct.

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

5, 2014,[7] and while exact figures are not available, the CBO projections suggest that most relied on subsidies.

And these numbers will only grow with time. In 2024, the CBO estimates that *19 million* Americans will use subsidies to purchase insurance from the Exchanges. *2014 Baseline*, *supra*, at tbl.3. And most of them—around 72%, according to one study—live in states where the Exchange is federally facilitated. Kaiser Family Foundation, *State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act* 3 tbl.1 (Nov. 2013).[8] Extrapolating from that percentage, that means some 13.68 million people who would use subsidies to purchase insurance in 2024 will not be able to do so if plaintiffs prevail. *See id.*

Because many of these millions simply cannot afford insurance on their own, they will remain uninsured. According to one study, unsubsidized Exchanges would lead to "essentially no increase" in the number of Americans enrolled in individual coverage. J. Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* 5 (Aug. 2010). That

[7] *Available at* http://www.washingtonpost.com/national/health-science/obamacare-round-2-states-gear-up-for-start-of-next-enrollment-period-in-november/2014/10/05/031f0522-4b44-11e4-a046-120a8a855cca_story.html.

would imperil the uncovered individuals' health and finances, *see* Kaiser Comm'n on Medicaid & the Uninsured, *The Uninsured & the Difference Health Care Makes* 2 (Sept. 2010) (*Difference Health Care Makes*),[9] and increase the load on this country's already-stressed health care system.

The impact on these uninsured patients would be grave. Because hospitals treat all emergency cases without regard to ability to pay, many uninsured rely on hospital emergency rooms to serve as their *de facto* primary care providers and to treat acute conditions. *See, e.g.*, M. William Salganik, *ER Use by Uninsured Disproportionately High*, The Baltimore Sun, Jan. 31, 2001 (noting that "the uninsured use hospital emergency departments for routine care").[10] But that is no substitute for regular treatment; "[d]elaying or forgoing needed care can lead to serious health problems, making the uninsured more likely to be hospitalized for avoidable conditions." *Difference Health Care Makes*, *supra*, at 2. Exchange-offered plans give the uninsured the ability to purchase comprehensive insurance that will allow them to receive care in more appropriate and less expensive

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

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

[10] *Available at* http://articles.baltimoresun.com/2001-01-31/business/0101310215_1_uninsured-emergency-room-visits-emergency-departments.

settings, benefiting both patients and hospitals alike and reducing health care costs across the board. *See* S.M. Miller, Robert Wood Johnson Foundation, *The ACA Helps Correct Incentives for Patients to Use the Health Care System Inefficiently* (Aug. 30, 2013).[11]

For plaintiffs, making health coverage unaffordable apparently is a boon, freeing them from purchasing insurance they would rather not currently have. But people like plaintiffs are the rare exception. Most Americans would prefer to have comprehensive coverage, but cite high cost or lack of employer-sponsored health plans as the primary reason they do not have it. Kaiser Family Foundation, *Key Facts About the Uninsured Population* 2 (Sept. 2013).[12] By contrast, only 1.5% of uninsured Americans say they lack insurance because they do not think they need it. *Id.* This Court should not withdraw needed coverage for millions based on the policy preferences of an idiosyncratic few.

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

The loss of subsidies in states with federally facilitated Exchanges would be particularly painful in light of many states' refusal to expand Medicaid coverage.

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[11] *Available at* http://www.rwjf.org/en/blogs/human-capital-blog/2013/08/the_aca_helps_correc.html.

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

The ACA was expected to cover Americans with incomes too low to purchase private insurance through the Exchanges but not eligible to receive Medicaid under current criteria by expanding Medicaid to all non-disabled adults with income at or below 138% of the poverty level. Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 2 (Oct. 2013) (*The Coverage Gap*).[13] However, in light of the Supreme Court's ruling that the Medicaid expansion is optional, *see Nat'l Fed. of Indep. Business* v. *Sebelius*, 132 S. Ct. 2566, 2609 (2012), half the states have refused to do so, *The Coverage Gap*, *supra*, at fig.1.

Experts to this point have assumed that the Exchanges could help some of those left behind by states' refusal to expand Medicaid. The CBO, for example, has estimated that 2 million of the 6 million people denied expanded Medicaid coverage will enroll through Exchanges using subsidies, mitigating—at least somewhat—the impact in those states. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* 12 & tbl.1 (July 2012).[14]

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

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

If plaintiffs prevail, however, these 2 million people are unlikely to be able to obtain policies through the Exchanges. That is because, of the 25 states opting out of the Medicaid expansion, all but two have federally facilitated exchanges. *Compare The Coverage Gap*, *supra*, at 1 fig.1 (listing states opting out of the Medicaid expansion), *with* The Commonwealth Fund, *State Action to Establish Health Insurance Marketplaces* (July 2013) (listing the states with federally facilitated exchanges).[15] In those states, individuals making 100% to 138% of the poverty level—about $11,500 to $15,900 per year[16]—would have to seek coverage on the market with no subsidies at all, and would face premiums they could not possibly pay. *See supra* at 5-9. Plaintiffs' position thus would not only deny millions of Americans access to coverage. It would deny access to those who need it most: low-income Americans who are not eligible for Medicaid in their states.

C. The Loss Of Subsidies Would Undercut The ACA.

The loss of subsidies would be devastating to millions of Americans who otherwise could obtain health coverage. Lack of health coverage has a demonstrable negative impact on health outcomes and raises the risk of personal bankruptcy, among other ill effects. *See Difference Health Care Makes*, *supra*, at

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

2. But the removal of subsidies from the ACA's "three-legged stool" in most states also would imperil the law itself.

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

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

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

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

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

Medicare and Medicaid have long pegged reimbursement rates at a level too low to cover the costs hospitals incur treating patients. *See* American Hosp. Ass'n, *Trendwatch Chartbook 2014* tbl.4.5 (2014).[17] Thus in 2012, hospitals spent $56 *billion* providing care to Medicare and Medicaid patients. *Id.* That staggering figure represents only one year out of a decade-long history of expenses. Hospital spending on government-insured-patient care over that time has ranged from a low of $3.8 billion in 2000 to a high of $56 billion in 2012. *Id.* In none of those years

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

did hospitals' reimbursements from the government cover their aggregate expenses—adding up to a total expenditure by hospitals of $318.4 billion between 2000 and 2011. *See id.*

Hospitals therefore directly underwrite Medicare and Medicaid by covering costs for government-insured patients that the government does not. Moreover, hospitals provide substantial uncompensated care to patients for which they are not reimbursed by anyone. That care added up to an additional $45.9 billion in 2012. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 3 (Jan. 2014).[18] Indeed, since 2000, hospitals provided more than *$412 billion* in uncompensated care to the uninsured and under-insured. *Id.*

Plaintiffs' position would cause hospitals an even greater strain in meeting increasing demands, requiring them to furnish similar or greater amounts of uncompensated care while at the same time losing billions in government support. *See* American Hosp. Ass'n, *Summary of 2010 Health Care Reform Legislation* 34-35 (Apr. 19, 2010) (ACA cuts support for hospitals providing uncompensated care by $40.2 billion over the next decade)[19]; B. Semro, The Bell Policy Center, *Potential Impacts of New Federal Policies on Provider Reimbursement Rates*

5.pdf.

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

(Nov. 1, 2011) (ACA cuts overall provider payments by $156 billion to $233 billion in the next decade).[20] That is a far cry from what Congress had in mind.

Moreover, if plaintiffs were to prevail, individuals in states with federally facilitated exchanges will find their healthcare options significantly limited as compared to those with state-run exchanges. And the impact would be more severe in many areas of the country—for example, southern Maryland, the District of Columbia, and northern Virginia—where patients often seek medical care across state lines. Patients from the District of Columbia and Maryland, which have state-run exchanges, will benefit from the ACA. On the flip side, patients from Virginia, whose exchange is federally facilitated, will not. And as a result, hospitals in states with state-run exchanges will "operat[e] at a distinct advantage to hospitals in those states" with federally facilitated exchanges. Fitch Ratings, *HIX Subsidy Decisions Mean Risks for U.S. Hospitals* (July 23, 2014).[21] There is no legal justification for these arbitrary distinctions among similarly situated patients and hospitals. *See infra* at 18-21.

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

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

[21] *Available at* https://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/HIX-Subsidy-Decisions?pr_id=841117.

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

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

This Court typically divines Congress' intent by applying the " 'plain and unambiguous meaning' " of statutory text. *United States* v. *Barnes*, 295 F.3d 1354, 1359 (D.C. Cir. 2002) (citation omitted). Contrary to plaintiffs' simplistic approach, however, plain-meaning interpretation does not involve looking at the words of particular statutory phrases in isolation. Instead, the meaning of text depends on "the specific context in which that language is used, and the broader context of the statute as a whole." *Id.* (citation omitted); *accord King* v. *St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (the "cardinal rule is that the statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context.") (citation omitted). Moreover, this Court's inquiry ends with

supposedly plain language only if the "resulting 'statutory scheme is coherent and consistent.' " *Barnes*, 295 F.3d at 1359 (citation omitted).

Plaintiffs' interpretation violates both caveats. As the Government has pointed out, plaintiffs' myopic focus on the words "established by the State" creates incongruities throughout the ACA. *See* Govt. Panel Br. 25-34. But one stands out above all others: Under Section 1312 of the Act, a "qualified individual" may "enroll in any qualified health plan available to such individual, and for which such individual is eligible." 42 U.S.C. § 18032(a)(1). And the Act goes on to define a "qualified individual" as one "who—(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange." *Id.* § 18032(f)(1)(A). If plaintiffs' reading of the words "State," "established" and "Exchange" were correct, not only would *subsidies* not be available in states with federally facilitated Exchanges; *insurance* would not be available in those states. After all, only "qualified individuals" can purchase insurance from the Exchanges. But under plaintiffs' reading there would be no "qualified individuals" in states with federally facilitated Exchanges because there would be no "State that established the Exchange." *See* J.A. 355 (pointing out this consequence of plaintiffs' interpretation).

Even plaintiffs cannot accept this conclusion; they appeal to increasingly strained distinctions to escape the logical endpoint of their supposed plain-language construction. *See* Plaintiffs' Br. 37-40. The fact that plaintiffs must resort to such contortions only underscores the perils of resting an argument on a single phrase in a massive piece of legislation. Here, the text, purpose, and history of the ACA demonstrate that Congress intended to make credits broadly available, as a means to make health insurance affordable for all Americans. *Supra* at 5-17. Plaintiffs' statutory snippets and inconclusive canons cannot overcome that overarching statutory purpose, enacted throughout the ACA's many interlocking provisions.

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

"[w]hen possible, statutes should be interpreted to avoid 'untenable distinctions,' 'unreasonable results,' or 'unjust or absurd consequences.' " *Kaseman*, 444 F.3d at 642 (quoting *American Tobacco*, 456 U.S. at 71).

In *Kaseman*, the Court applied that principle to hold that Congress had not made statutory eligibility for an entitlement turn on a factual distinction that anyone with common sense would have viewed as irrelevant to the entitlement at issue. *See id.* ("We see no evidence in the IDEA or the appropriations act that Congress intended to vary parents' entitlement to fees depending on whether the parents' rights are vindicated administratively or judicially."). So too here. Statutory text, context, and history all make abundantly clear that Congress designed the ACA to provide subsidies to those who need them, regardless of where they live.

CONCLUSION

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

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed R. App. P. 32(a)(7)(C) and Circuit Rule 32(a), I hereby certify that the foregoing brief was produced using the Times New Roman 14-point typeface and contains 4,120 words.

/s/ Dominic F. Perella
Dominic F. Perella

CERTIFICATE OF SERVICE

I certify that on November 3, 2014, the foregoing was electronically filed through this Court's CM/ECF system, which will send a notice of filing to all registered users.

/s/ Dominic F. Perella
Dominic F. Perella