[NOT SCHEDULED FOR ORAL ARGUMENT]

Case No. 16-5202

IN THE

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITED STATES HOUSE OF REPRESENTATIVES,

Plaintiff-Appellee,

v.

SYLVIA MATHEWS BURWELL,

IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
(NO. 1:14-CV-01967) (HON. ROSEMARY M. COLLYER)

AMICUS CURIAE BRIEF OF FAMILIES USA, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, COMMUNITY CATALYST, INC., NATIONAL HEALTH LAW PROGRAM, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, AND NATIONAL WOMEN'S LAW CENTER IN SUPPORT OF DEFENDANTS-APPELLANTS AND REVERSAL OF THE JUDGMENT BELOW

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INTEREST OF *AMICI CURIAE*[1]

Families USA is a national non-partisan, non-profit organization that has represented the interests of health care consumers and promoted health care reform in the United States for more than 30 years. Families USA has analyzed the serious medical and financial harms inflicted on the millions of Americans who lack health insurance. With regard to medical harms, for example, a Families USA study showed that many uninsured forgo needed medical care because of cost, resulting in 26,100 premature deaths in 2010 alone.[2] With regard to financial injuries, Families USA has studied the ruinous impact of medical debts the uninsured have incurred.

To remedy the harms from the widespread lack of health insurance, Families USA has backed reforms to achieve universal health insurance coverage. The organization fought for enactment of the Affordable Care Act ("ACA"), sponsored studies on which it was predicated, and promoted reform by convening structured dialogues among key stakeholders—including organizations representing a diverse array of consumers, as well as associations of hospitals, physicians, insurers, pharmaceutical companies, businesses, and labor. The law that emerged from

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[1] All parties were timely notified and have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person or entity other than amicus made a monetary contribution to its preparation or submission.

[2] Families USA, *Dying for Coverage: The Deadly Consequences of Being Uninsured*, at 2 (June 2012), http://www.familiesusa.org/sites/default/files/product documents/Dying-for-Coverage.pdf.

these efforts has added 20 million Americans to the rolls of the insured, marking significant progress toward universal, affordable health insurance coverage.

Families USA has a strong interest in the continued vitality of the ACA, and, therefore, in the premium and cost-sharing assistance central to it. Further, having long represented the interests of health care consumers, Families USA offers a valuable perspective on what this assistance has meant to real people already at or beyond the cusp of economic hardship.

Asian & Pacific Islander American Health Forum ("APIAHF") is a national health policy organization committed to ensuring that Asian Americans, Native Hawaiians, and Pacific Islanders in the United States have adequate and cost-effective health care. APIAHF's national policy work focuses on expanding access to health care, improving the quality of health care through cultural competency and language access, increasing research, and improving the collection, reporting, and analysis of data about Asian American, Native Hawaiian, and Pacific Islander communities. APIAHF has an interest in ensuring that this lawsuit does not access to health care by these communities.

Community Catalyst, Inc. is a national nonprofit, nonpartisan organization providing leadership and support since 1997 to state and local consumer organizations, policymakers and foundations that seek universal access to high quality, affordable health care. Sustaining a powerful consumer voice in state and national decisions that affect consumers' health is central to the organization's mission. As such, Community Catalyst has an interest in protecting consumers

against threats to the cost-sharing reductions that allow low-income individuals and families to gain access to coverage and care.

The National Health Law Program (NHeLP), founded in 1969, protects and advances the health rights of low-income and underserved individuals and families. The vitality of the ACA is critical to this population. NHeLP therefore has actively defended the ACA, shaped its implementation to meet the needs of low-income and diverse communities, and worked to extend the law's benefits. To that end, NHeLP has published issue briefs and guides, advised federal grantees that helping individuals and families navigate enrollment in the Exchanges, and provided guidance on eligibility for ACA subsidies such as the cost-sharing reductions jeopardized in this case.

The National Partnership for Women & Families is a nonprofit, nonpartisan organization that uses public education and advocacy to promote equal rights and quality health care for all. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership advocated for the critical reforms established by the Affordable Care Act, which address discriminatory practices in the insurance industry and make affordable, quality health care a reality for women and their families -- reforms that this case seeks to undermine, as this case does.

The National Women's Law Center is a nonprofit legal advocacy organization dedicated to the advancement and protection of women's legal rights since its founding in 1972. The Center focuses on issues of key importance to women and their families, including economic security, employment, education, health, and reproductive rights, with special attention to the needs of low-income women. The Center has advocated

specifically on issues affecting women's health care – from discrimination in health care to pregnancy and reproductive health care to Medicare and Medicaid – and has participated as *amicus* in the Supreme Court and in the courts of appeals in numerous cases that affect those issues.

The House's position in this litigation threatens the health and wellbeing of individuals and families represented by the Amici, yet those Americans have had no voice in these proceedings. By championing the interests of the people directly affected by this suit, Amici can assist this Court in resolving the issues before it.

SUMMARY OF ARGUMENT

This lawsuit embodies the latest chapter in a relentless, six-and-a-half-year battle against the ACA, a law that is benefiting millions of Americans. After fighting in Congress against enactment of the law, and failing, ACA opponents brought lawsuit after lawsuit to overturn majority rule and gut the legislation. They sought to strike the law down as unconstitutional, and failed. They asked the Court to kill it through statutory interpretation, and failed. They brought numerous other suits attacking various features of the law, and failed. Until this case, however, Congressional opponents of the ACA had merely encouraged the lawsuits and filed amicus briefs supporting them.[3] Now, frustrated after some 60 futile votes to repeal the ACA that failed to command the concurrence of the Senate, the House

[3] Most recently, after limiting the Executive Branch's ability to implement ACA provisions aimed at balancing the losses or gains insurers could incur in the fledgling health insurance marketplaces, Congressional opponents have sought leave to file an amicus curiae brief in an insurer's lawsuit in the Court of Claims to prevent reimbursement through the legal system.

itself has brought suit, asking the Court to do what Congress lacks the votes to do itself: nullify a duly-enacted, effectively functioning statute.

The dogma the House uses to justify this latest litigation assault is that the Act is a disastrous failure. But, despite the opponents' fiercest efforts to undermine the ACA, despite their fondest wishes for its demise, reality belies the disinformation. The ACA is working. No doubt, it would work better without the incessant efforts to subvert it, but the law nonetheless has extended insurance to 20 million people who did not have it previously. It has made the health insurance system more equitable. It has lowered health care costs and reduced the burden of medical debt. And despite claims of skyrocketing prices for insurance, the increases align with the initial projections for the ACA, and most consumers purchasing through the Exchanges can find a plan for $100 or less per month.[4] The attacks on the ACA cannot detract from these accomplishments. They cannot devalue the benefits that millions of Americans have received. And they cannot obscure the favorable contrast with the unsustainable conditions that prevailed before the ACA's enactment.

Rather than curtail its criticisms to fit the reality of the ACA, the House in this lawsuit seeks to curtail the ACA to fit its criticisms. By seeking to defund the cost-sharing subsidies that are critical to make insurance affordable for low-income Americans, the House threatens to undo the gains the ACA has made, to take away

[4] U.S. Department of Health and Human Services ("HHS"), *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*, 3 (Oct. 24, 2016), https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief25.pdf ("*2017 Marketplace Landscape Brief*").

benefits on which millions of people rely, to cause costs to rise, and to drive insurers from the market. The imbalances and uncertainties that would result if the House prevailed could leave millions of consumers as collateral damage in the unrelenting partisan war against this statute. As the Chief Justice made clear in *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015), this political contentiousness should stay in the legislative arena. Policy disputes are not for the Court, the Chief Justice ruled, and, so long as the text of the statute permits, courts should interpret the ACA in accordance with its self-evident purpose. Here, the Government's brief demonstrates that the text of the ACA is reasonably read to fund the mandated cost-sharing subsidies, and those subsidies are critical to the Act's evident purpose of making health care affordable for all Americans.

The contrast between the concrete, gut-wrenching harms that the House lawsuit threatens to impose on low-income people who are not parties to this lawsuit, and the abstract, amorphous "institutional" stake the House asserts here further highlights the infirmities of the House's claims. It would be an odd mutation of the law of standing to allow such an attenuated interest by legislators to trump the vital interests of the people they are supposed to represent.

Millions of Americans rely on the ACA. In this lawsuit, the House not only evades its responsibility to them, but actually threatens to cause them injury. This Court should reject that evasion and end that threat by reversing the judgment of the District Court.

I. THE HOUSE'S INTERPRETATION OF THE ACA WOULD DISABLE A STATUTE THAT IS FUNCTIONING EFFECTIVELY

A. The Court Must Adopt a Textually Permissible Interpretation that Preserves the ACA's Effectiveness over One that Undermines It

A fundamental principle of statutory construction is that courts must choose a textually permissible reading of a statute that furthers its evident purpose over one that obstructs that purpose. This well-worn canon of statutory construction "follows inevitably from the facts that (1) interpretation always depends on context, (2) context always includes evident purpose, and (3) evident purpose always includes effectiveness." Antonin Scalia & Bryan Garner, *Reading Law: The Interpretation of Legal Texts* 63 (2012). Thus, when faced with competing interpretations, one of which—like the House's interpretation here—would undermine the statute, and another that—like the Government's reading—would preserve the ability of the statute to achieve its purpose, a court must choose preservation if the text can sustain that reading.

Amidst the surfeit of myths and false premises swirling around the ACA, the purpose of the law has remained incontestably clear. The very name of the Act—the Patient *Protection* and *Affordable* Care Act—conveys its goals, and the headings throughout the statute reiterate them: "Quality, Affordable Care for All Americans;" "Immediate Improvements in Health Care Coverage for All Americans;"[5] "Quality Health Insurance Coverage for All Americans;"[6]

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[5] *Id.*, Subtitle A.

[6] *Id.* at 154; Subtitle C.

"Available Coverage Choices for All Americans;"[7] "Affordable Coverage Choices for All Americans;"[8] and "Strengthening Quality, Affordable Health Care for All Americans."[9] Moreover, Congress found—in language adopted by both Houses and approved by the President—that the Act "will increase the number and share of Americans who are insured," "achieve[] near-universal coverage," "reduc[e] the number of uninsured," "lower health insurance premiums," "significantly increas[e] health insurance coverage," and "improve financial security for families." ACA §§ 1501(a)(2)(C), (D), (E), (F), (G). Congress's evident purpose to make health care "affordable" and "available" to all Americans is a touchstone for interpreting the statute.

The ACA achieves its purpose through a combination of tax credits, which offset premiums for consumers earning between 100 percent and 400 percent of the federal poverty level, and cost-sharing reductions, which lower, and place an annual cap on, deductibles, co-pays and other out-of-pocket medical expenses for consumers earning between 100 percent and 250 percent of the poverty level. These two subsidies are inextricably linked. Both use the same measure of recipients' income, and Congress determined the amount of the tax credits based on the assumption that eligible recipients would also receive cost-saving reductions.[10] Further, the statute *requires* the Executive both to extend the credits

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[7] *Id.* at 162; Subtitle D.

[8] *Id.* at 213; Subtitle E.

[9] *Id.* at 883; Title X.

[10] Congressional Budget Office ("CBO"), *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (Nov. 2009), at

[Footnote continued on next page]

and to pay the subsidies on behalf of eligible individuals. The payment is not discretionary. Yet, while the tax credits are fully funded under the ACA amendment to 31 U.S.C. § 1324, requiring no annual appropriation, the House claims that the same section requires Congress to vote on appropriations for the subsidies every year. Congress had no reason in the appropriations provisions of the ACA to delink subsidies that are intertwined throughout the ACA. By contrast, Congress had compelling reasons—serious potential harm and disruption—not to delink them. It is implausible that Congress would incur these serious risks without saying so. *Whitman v. Am. Trucking Assoc., Inc.*, 531 U.S. 457, 468 (2001) (Congress does not "hide elephants in mouseholes") (citations omitted). The Government 's interpretation of the ACA and of the permanent appropriation under 31 U.S.C. § 1324, funding the subsidies that Congress mandated, plainly serve the purpose of the ACA. By contrast, it would be contrary to the statutory purpose—not to mention, odd—for Congress to require that insurers reduce co-pays, deductibles, and out-of-pocket medical expense, to promise reimbursement for those expenses, and then to deny funding to fulfill that promise.

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23-24, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf (projecting that the national average premium for the second-lowest-cost silver plan would be $5,200 for single coverage in 2016 under the version of the ACA debated by the Senate). After passage of the final version of the law, CBO testified that premium projections under the final version of the ACA would have been "quite similar" to those included in its November 2009 analysis. *See CBO's Analysis of the Major Health Care Legislation Enacted in March 2010* (Mar. 30, 2011), http://www.cbo.gov/sites/default/files/03-30-healthcarelegislation.pdf.

As the Government has demonstrated, it is at the very least textually permissible to recognize the unitary bond between the tax credit and cost-sharing provisions of the ACA and to treat both as "refunds due from" the IRS, within the meaning of § 1324. This brief does not reiterate those arguments, but rather demonstrates that the presumption against ineffectiveness strongly favors the Government's interpretation over the one offered by the House. As shown below, the House's cramped construction of the ACA would seriously undermine its ability to achieve its intended purposes. The obligation to avoid needlessly undermining the statute counsels against interpreting the Act to impose potentially serious harms on the people the Act was designed to help, and that it is in fact helping every day.

The Chief Justice, rejecting a similarly noxious interpretation of the ACA in *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015), found this point determinative. "Congress passed the Affordable Care Act," the Chief Justice stated, "to improve 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." *Id*.

B. Contrary to the Claims of the House, and Despite the Attempted Roadblocks, the ACA Is Functioning Effectively

Notwithstanding the potential harm to the millions of people who have relied on and benefited from the ACA, the House and its allied ACA opponents have sought to obstruct its implementation at every turn. Despite the constitutional challenges they advanced and the lawsuits seeking to interpret the ACA into

oblivion, the more than 60 failed attempts by the House to repeal the law,[11] and the innumerable other legal and extralegal attacks, the ACA is functioning effectively. Contrary to the cataclysmic claims of ACA opponents, the Act in fact has increased access to health insurance, improved services, and lowered costs for many millions of Americans.

Because of the ACA, many more Americans have health insurance. Since enactment of the law in 2010, the percentage of the population without health insurance has declined by 43 percent, reflecting an increase of more than 20 million people who have coverage.[12] Additionally, enrollment in the individual market continues apace: during the 2016 enrollment period, 12.7 million people signed up for non-group plans.[13] Since 2013, the share of parents with health insurance increased by 6 percent, which is crucial because children of insured parents are far more likely to have health insurance than those whose parents are uninsured.[14] Further, since enactment of the ACA, more parents and children have begun having routine check-ups, reflecting improved access to healthcare.[15]

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[11] Jennifer Steinhauer, *House Votes to Send Bill to Repeal Health Law to Obama's Desk*, New York Times (Jan. 6, 2016), http://www.nytimes.com/2016/01/07/us/politics/house-votes-to-send-bill-to-repeal-health-law-to-obamas-desk.html?_r=0.

[12] Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, Jama Network (Aug. 2, 2016), http://jamanetwork.com/journals/jama/fullarticle/2533698.

[13] Liz Hamel et al., *Survey of Non-Group Health Insurance Enrollees, Wave* 3 The Henry J. Kaiser Family Foundation (May 20, 2016), http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/.

[14] Michelle Karpman et al., *Health Care Coverage, Access, and Affordability for Children and Parents: New Estimates from March 2016* The Urban Institute (Sept. 14, 2016), http://hrms.urban.org/briefs/health-care-coverage-access-affordability-children-parents-march-2016.html (finding that children of uninsured parents have

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The ACA has made health insurance not only more accessible, but also more fair. The ACA bars insurers from denying coverage based on pre-existing medical conditions and charging higher premiums based on health status and gender. No longer will those who most need insurance be the least likely to get it. The ACA also provides tax credits for the purchase of insurance by low income families to make insurance more affordable. And it offers the cost-sharing reductions at issue in this case to offset the amount that low-income families pay in deductibles, co-pays, or other out-of-pocket medical expenses.[16] This is a significant benefit. A mid-level, or "silver," health plan, for example, typically covers 70 percent of an individual's health care costs. With cost-sharing reductions, a silver plan for a person earning 100-150 percent of the federal poverty level on average would cover 94 percent of her medical expenses; for a person at 150-200 percent of the poverty level, it would cover 87 percent of her medical costs; and for a person at 200-250 percent of the poverty level, it would cover an average of 83 percent of medical costs.[17] The cost-sharing provisions also limit the individual's out-of-

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a 22 percent uninsurance rate, while children with insured parents have a 1.6 percent uninsurance rate).

[15] *Id.*

[16] Sara R. Collins et al., *How Will the Affordable Care Act's Cost-Sharing reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, Exhibits 1, 4 (Mar. 2016) ("Collins") http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/mar/1865_collins_aca_cost_sharing_rb_final_v3.pdf.

[17] Matthew Rae et al., *Cost-Sharing Subsidies in Federal Marketplace Plans, 2016*, The Henry J. Kaiser Family Foundation (Nov. 13, 2016) ("Rae"), http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/.

pocket expenses for 2016 to $2250 for persons with income 100-200 percent of poverty, and $5450 for persons with income 200-250% of poverty, with insurance covering any costs above that amount. Without these reductions, the out-of-pocket maximum in a silver plan would be $6850 for self-only coverage in 2016.[18] In 2017, a similar out-of-pocket maximum will apply: without reductions, the maximum expense would be $7150; for a person with income 100-200% of poverty, cost-sharing reductions will lower the maximum out-of-pocket expense to $2350, and for a person with income 200-250% of poverty, cost sharing reductions will lower the maximum to $5700.[19] These reductions save consumers thousands of dollars. For many financially disadvantaged enrollees, the reductions are critical to make insurance affordable.[20]

Not only low-income consumers have reaped cost-savings from the ACA. In states that have expanded Medicaid under the ACA, premiums for all consumers who used the Exchanges—both those consumers who received tax credits or

[18] HHS, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10749 (Feb. 27, 2015) (codified at 45 C.F.R. Parts 144, 147, 153-56, 158), https://www.federalregister.gov/documents/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016.

[19] HHS, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*, 81 Fed. Reg. 12203 (Mar. 8, 2016) (codified at 45 C.F.R. Parts 144, 147, 153-56, 158), https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017.

[20] Rae, *supra*.

subsidies and those who did not—declined by about 7 percent.[21] Moreover, under the ACA, the previously escalating costs of healthcare have slowed, which benefits market participants across income levels.[22]

Although ACA opponents trumpet projected increases of insurance costs averaging 25 per cent in 2017, those critics downplay the historically modest rises in prior years—2 percent in the second year of the Exchanges and 7 percent in the third year. Further, they ignore the inconvenient fact that the increases have been lower than, and now are coming into line with, the Congressional Budget Office's initial ACA projections.[23] The ACA opponents similarly sweep under the rug the effective rates paid by consumers purchasing plans on the Exchanges. After tax credits, 77 percent of returning Exchange customers will be able to find an insurance plan for $100 or less per month, and 72 percent will be able to find one for $75 a month or less.[24] Moreover, despite the sensationalized reports regarding glitches with the Exchanges, most people who obtained plans through the Exchanges were satisfied with their coverage overall.[25]

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[21] HHS, *Medicaid Expansion Lowers Marketplace Premiums by 7 Percent* (Aug. 25, 2016), https://www.hhs.gov/about/news/2016/08/25/medicaid-expansion-lowers-marketplace-premiums-7-percent.html.

[22] Jason Furman et al., White House, *New Data Show that Premium Growth in Employer Coverage Remained Low in 2016* (Sept. 14, 2016), https://www.whitehouse.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016.

[23] *2017 Marketplace Landscape Brief*, at 5.

[24] *Id.*

[25] Liz Hamel et al., The Henry J. Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, Wave 3*, Figure 7 (May 20, 2016), http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/.

In sum, the ACA has been remarkably successful in improving access to health care and moving toward universal health insurance coverage.

C. The House's Interpretation of the Statute Would Seriously Impede the Functioning of the Statute and Potentially Harm Those the ACA Was Designed to Help

The House's position that funds for cost-sharing reductions must be appropriated annually—by which they mean "not appropriated"—undercuts the statutory objectives of increasing access to health insurance and lowering related costs. Further, it potentially harms the most vulnerable people that the ACA seeks to help.

Delinking tax credits and cost-sharing reductions and denying funding to reimburse insurers' cost-sharing reductions, as the House demands, would create uncertainty and disrupt the market, raising premiums and pushing people ineligible for subsidies out of the Exchanges. That development would undermine the Exchanges' continued viability. Moreover, adopting the House's position would induce many insurers to drop out of the Exchanges, narrowing—if not eliminating—viable choices for consumers in those markets. Perhaps the plaintiffs here find such disruption and deprivation acceptable or even advantageous, but the Congress that enacted the ACA and the President who signed it assuredly did not intend such a result.

The ACA requires insurers to provide cost-sharing reductions to eligible consumers. If the House's interpretation prevails and Congress then declines to appropriate funds for those subsidies, as House members have advocated, insurers would still be required to provide the cost-sharing reductions to eligible

consumers.[26] The difference is that the Government could not fulfill its obligation to reimburse insurers for those subsidies.

Faced with this unexpected, unreimbursed expense—estimated at $7 billion a year[27]—insurers could respond in several ways. Meekly absorbing the loss is not likely one of them. To cover their increased expenses, insurers would likely seek to raise premiums on all silver plans by an average of $1,040 per year, on top of already rising prices.[28] Because the ACA ties the amount of tax credits to silver plan premiums, those eligible for the credits—people earning less than 400 percent of the federal poverty level—would receive a corresponding increase in their tax credits. However, people who purchased on an Exchange but earned more than 400% of the federal poverty level and thus were ineligible for subsidies would likely withdraw from the Exchanges, either buying insurance elsewhere or going without. Economic models predict that one million consumers would leave the Exchanges.[29] Those staying behind probably would be the least healthy, who

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[26] Collins, *supra*.

[27] CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (Mar. 24, 2016), at 8, Table 2, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf.

[28] Linda J. Blumberg et al., *The Implications of a Finding for the Plaintiffs in House v. Burwell*, at 5, The Urban Institute (Jan. 2016), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf.

[29] *Id.*

could not readily obtain insurance elsewhere. A less healthy pool of insureds would further raise the cost for insurers that sell on the Exchanges, further increasing premiums and potentially yielding a "death spiral" of declining participation and rising costs.[30]

The prospect that insurers may be unable to recoup the costs of uncompensated cost-sharing reductions by raising premiums—or, perhaps, just the uncertainty and chaos engendered by a ruling in favor of the House—might well lead a substantial number to abandon the Exchanges.[31] Indeed, while *King v. Burwell* was pending, insurers in the 37 federally-run Exchanges asked HHS to allow them to withdraw from those Exchanges, and even cancel existing plans, in the event the decision in that case rendered premium tax credits and cost-sharing subsidies unavailable.[32] Here, such withdrawals would further destabilize the Exchanges, making insurance sold there more expensive and less available.[33] The

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[30] Timothy Jost, *Implementing Health Reform: House Can Sue Administration Over Aca Cost-Sharing Reduction Payments*, Health Affairs Blog (Sept. 10, 2015) ("Jost"), http://healthaffairs.org/blog/2015/09/10/implementing-health-reform-house-can-sue-president-over-aca-cost-sharing-reduction-payments/.

[31] Collins, *supra*, at 5.

[32] Chris Jacobs, *In the House's Health-Care Lawsuit, High Stakes Over Subsidies*. Wall Street Journal, Dec. 3, 2014, http://blogs.wsj.com/washwire/2014/12/03/in-the-houses-health-care-lawsuit-high-stakes-over-subsidies/.

[33] Collins, *supra*, at 9.

limited number of insurers is already an issue in some jurisdictions.[34] The exodus prompted by defunding cost-sharing reductions could leave many communities with no insurers participating on the Exchange, denying residents there many key benefits of the ACA. Other Exchanges may have only one remaining insurer, offering a narrow network of providers that greatly restricts consumers' health care options, requiring them, for example, to travel across the state to find a doctor who accepts their coverage. These effects plainly contravene the ACA's stated purpose.

Insurers also could, and likely would, sue the Federal Government in the U.S. Court of Claims, as they have done with regard to the Government's nonpayment of reimbursements to insurers under the "Risk Corridor" program.[35] It is unfair, if not unconstitutional, for Congress to impose a cost on them and then renege on the promised reimbursement. In such a lawsuit, the insurers could demand reimbursement for the cost-sharing reductions. But, in the alternative, they could seek to strike down the uncompensated imposition as a violation of due process.[36]

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[34] Cynthia Cox et al., *Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces*, The Henry J. Kaiser Family Foundation (Aug. 28, 2016), http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/.

[35] Sandra J. Durkin et al., *Emerging Disputes Over Risk Sharing Under The ACA*, Law360 (Apr. 18, 2016), http://www.law360.com/articles/785120/emerging-disputes-over-risk-sharing-under-the-aca.

[36] Jost, *supra*.

If the insurers succeeded on such a claim, it would be disastrous for low-income health care consumers. Cost-sharing reductions are essential to the ACA's goals of making health insurance affordable, driving down costs to families and individuals, and improving the health of the nation's population by ensuring access to essential health care services for low and moderate-income Americans. As of March 31, 2016, more than 6.3 million Americans, or 57.3 percent of all marketplace enrollees, were receiving cost-sharing reductions.[37] Without these reductions, many of the 6.3 million recipients could not afford to remain insured. Absent the mandated reductions in out-of-pocket expenses, an individual earning 150 percent of the federal poverty level ($17,820/year in 2016) who continued paying premiums for a silver plan would see deductibles increase on average from $246 per year to $3063 per year and would be less likely to receive primary care or prescription drugs before the deductible was met.[38] If this individual faced a serious illness in 2016, such as hospitalization, the average out-of-pocket expense, absent cost-sharing reductions, would surpass the $6,224 limit for the second lowest cost silver plan. That would eat up 35 percent of the individual's annual

[37] Centers for Medicare & Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (June 30, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

[38] Jon R. Gabel et al., *The ACA's Cost-Sharing Reduction Plans: A Key to Affordable Health Coverage for Millions of U.S. Workers*, The Commonwealth Fund (Oct. 13, 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/oct/aca-cost-sharing-reduction-plans.

income. With cost-sharing reductions, the average limit on out-of-pocket expenses would be $1,102 per year.

Amicus Families USA regularly hears from these newly insured Americans about the difference cost-sharing reductions have made in their lives. For example, Terri, a 61 year-old woman, lives in South Carolina with her husband who is disabled by Multiple Sclerosis. The couple takes care of their 11-year-old grandson, who has special needs. Their grandson receives Medicaid coverage, but caring for him prevents Terri from working outside the home. Terri's husband is on Medicare, but receives no health benefits from his employer because he works only part-time. The couple's estimated taxable income for 2016 is $34,390. They chose a high deductible plan on the Exchange for Terri. After tax credits, the monthly premium payment is $125. Cost-sharing reductions brought the deductible and maximum out-of-pocket expenses down from $6,500 to $400.

Terri has type 2 diabetes and sarcoidosis, which requires her to take injections every six weeks. Without cost-saving reductions, she would have to pay 18.9 percent of the family's income to cover the deductible and out-of-pocket maximum. The family could not afford to keep the insurance. Terri would likely scrimp on the medical care she needs. Her health could well deteriorate a result, impairing her ability to care for her grandson and

for her husband as his MS inevitably worsens. This is precisely the type of nightmare scenario the ACA was intended to avoid.

David, a self-employed graphic designer in North Carolina, has a projected income of approximately $20,000 this year. Before enactment of the ACA, David could afford only high deductible, catastrophic coverage. Because, absent a major illness or injury, David bore the costs of medical care, he often delayed or neglected needed treatment. In 2010, for example, he sliced off part of his thumb preparing kindling, and self-treated the wound with gauze and pain pills rather than going to the emergency room.

During the first open enrollment period, David and his now ex-wife enrolled in coverage through the Exchange. His premium, after tax credits, was $6. Once enrolled, David was able to schedule doctors' appointments and seek the care he needed. One of the first things he did was to schedule a colonoscopy, which revealed a digestive disorder. He also sought care during two medical emergencies, knowing that a trip to the emergency room did not threaten him with bankruptcy.

David's premiums have risen, and will be $130 a month after tax credits in 2017. In 2015 and 2016, his plan had a $500 deductible and, after cost-sharing reductions, a $700 out-of-pocket maximum. In 2016, the insurer added a co-pay of $50 for medications. David hit his out-of-pocket maximum in 2016, and expects to

do so again in 2017. Absent the cost-sharing reductions, David would be unable to afford his insurance. As he has gastrointestinal and heart conditions that require prescription medications, losing his insurance would undermine his quality of life and diminish his ability to work. Again, this is precisely the result the ACA sought to prevent.

These examples are typical. A Commonwealth Fund study of out-of-pocket expenses for consumers covered by employer-sponsored and private insurance plans, found that 13 percent of 19-to-64-year-olds spent 10 percent or more of their income on out-of-pocket costs, not including premiums.[39] The percentage of income consumed by out-of-pocket costs was highest for low-income adults.[40] Notwithstanding the premium tax credits the ACA provides to help make insurance affordable, absent additional financial assistance, millions of low-income Americans could not afford the deductibles and coinsurance required by these plans. Approximately 60 percent of privately-insured low-income adults and 50 percent of those with moderate incomes reported that their deductibles were difficult to afford.[41] When out-of-pocket health care costs become unaffordable,

[39] Sara R. Collins et al., *Too High a Price: Out-of-Pocket Health Care Costs in the United States*, Commonwealth Fund (Nov. 13, 2014), at 1-2, http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs.

[40] *Id.*, at 3.

[41] *Id.*, 4, Exh. 3.

many low income families will find that the monthly premiums no longer make sense for them, and will drop their insurance. If they keep the insurance, they may delay needed care.[42] Indeed, 40 percent of adults with private insurance who had high deductibles relative to their income said that the deductible had caused them to delay needed care.[43] To make this problem worse undermines the core goals of the ACA.

II. THE CONTRAST BETWEEN THE CONCRETE HARMS TO INDIVIDUALS NOT BEFORE THE COURT AND THE ETHEREAL HARMS ALLEGED BY THE HOUSE HIGHLIGHTS THE INFIRMITIES OF LEGISLATIVE STANDING

This case sets the abstract interest of the House of Representatives in maintaining its ostensible institutional prerogatives against the concrete and specific potential injuries to millions of people who stand to lose or suffer degraded access to affordable health care.

The basic requisites of standing to sue are well-established. A plaintiff must show injuries that are "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (internal quotations and citations omitted). A case and controversy defined by specific injuries is necessary to ensure that Courts address disputes "not in the rarefied atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action."

[42] *Id.*, 6-7, Exh. 6.
[43] *Id.*

Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc., 454 U.S. 464, 472 (1982).

To term the House's asserted injury "rarefied" would exaggerate its substance. The district court opinion describes the "injury in fact" suffered by the House as "a constitutional trespass," *House v. Burwell*, 130 F. Supp. 3d 53, 69-70 (D.D.C. 2015), "in [the] contravention" of the House's authority, *id.* at 71, and an assault on the House's "distinct role in the appropriations process." *Id.* at 72. The House has standing, the court theorizes, because the complaint alleges a violation of the Constitution's appropriations clause, which is intended to "keep the political branches of government in equipoise." *Id.* at 74. But, as the Supreme Court established long ago in rejecting a claim by Massachusetts that federal spending on social programs infringed on state sovereignty, federal courts do not rule on "abstract questions of political power, of sovereignty, of government." *Mass. v. Mellon,* 262 U.S. 477, 485 (1923).

The Government has ably shown why the case law on standing precludes the claims asserted by the House. These arguments are particularly persuasive given the anomaly that will arise if the Court grants standing to sue based on the nebulous interests the House asserts as sufficient.

If the Court rules against the House, none of its members will suffer financial harm. None will lose their health insurance. None will face the agonizing choice between buying medicine or food. The House—or, more aptly, the current majority party in the House—will simply find some other way to

advance its political agenda without making the courts an instrument of policy and politics.

By contrast, if the Court rules for the House, millions of people who are not even parties to this suit could suffer serious, concrete and particularized harms. Individuals and families who now can barely afford health insurance will likely pay more, receive less, or lose coverage altogether. As described above, the loss of cost-sharing reductions that could flow from the House's position would increase the out-of-pocket health care costs for millions of Americans, forcing many either to delay much needed care or to drop health insurance entirely. The departure of insurers from Exchanges, which also could result from adoption of the House's position, could deprive even more consumers of access to affordable care and potentially destabilize the health insurance Exchanges.

The individuals and families who face these risks are not combatants in the political wars over health care. They are not angling for some political advantage. They simply want to protect their families' health and financial security. To that end, they have come to rely on the ACA, and they do not deserve to be collateral damage from the continuing political efforts to eviscerate it.

For the Court to entertain that prospect offends the fundamental rationale behind the standing doctrine. To elevate the abstract interests of one party in one chamber of Congress over the concrete and elemental interests of millions of individuals not formally before the Court; to allow the House, in pursuit of its attenuated interests, to enlist the courts in undermining a law passed by both Houses of Congress and signed by the President, and in so doing, potentially

deprive millions of individuals of the benefits that statute is providing them, would entangle the Court in legislative disputes it has neither the wherewithal nor the jurisdiction to resolve. In the crusade of the current majority in the House to dismantle a statute that has extended insurance to 20 million people, the proper targets of persuasion are the Senate and the President, not the courts. To be sure, if the crusade succeeded, the 20 million people who receive insurance under the ACA probably would still be harmed. But at least they would be able to express their disapproval at the ballot box. There will be no such accountability if this Court does the House's job for it.

CONCLUSION

In *King v. Burwell*, 135 S. Ct. at 2496, the Chief Justice chided the opponents of the ACA for importing their legislative and policy disputes into the courts. The Chief Justice made clear that,

> "In a democracy, the power to make the law rests with those chosen by the people. [The Court's] role is more confined—"to say what the law is." *Marbury v. Madison*, 1 Cranch 137, 177 (1803). That is easier in some cases than in others. But in every case, we must respect the role of the Legislature, and take care not to undo what it has done."

Id.

Despite the ringing clarity of this message, the House apparently has not taken delivery. This Court therefore should send the message again. The Court should reverse the judgment of the District Court.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(A)

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 6,352 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

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CERTIFICATE OF SERVICE

I hereby certify that, on this 31st day of October, 2016, the foregoing Brief of Amici Curiae was filed and served upon all counsel of record electronically by filing a copy of the document with the Clerk through the court's ECF system.

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