UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*,

Plaintiffs,

v.

KATHLEEN SEBELIUS,
U.S. Secretary of Health and Human Services,
et al.

Defendants.

Civil Action No. 13-0623 (PLF)

MOTION OF THE AMERICAN HOSPITAL ASSOCIATION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS

The American Hospital Association (AHA) respectfully requests leave to file the attached brief as *amicus curiae* in support of defendants' cross-motion for summary judgment. Counsel for defendants has advised that defendants consent to this motion. Though counsel for plaintiffs initially consented as well, counsel has since advised that plaintiffs now oppose this motion, as described below.

1. The 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. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

2. AHA's members are deeply affected by the nation's health care laws, particularly the Affordable Care Act. That is why AHA has filed *amicus* briefs in support of the Act in the Supreme Court and in courts across the nation. AHA is seeking to participate in this case for the same reason: Whether the uninsured and underinsured in states with federally-facilitated

exchanges can obtain subsidies that make health insurance affordable has a profound impact on both patients and hospitals. AHA's proposed amicus brief describes, from hospitals' perspective, the disastrous impact Plaintiffs' position will have on American health care if they prevail.

3. As judges in this District have recognized, district courts "have inherent authority" to allow *amicus* briefs, even though there is no rule governing *amicus* participation at the District Court level. *Jin* v. *Ministry of State Security*, 557 F. Supp. 2d 131, 136 (D.D.C. 2008) (citation omitted); *see also Nat'l Ass'n of Home Builders* v. *U.S. Army Corps of Engineers*, 519 F. Supp. 2d 89, 93 (D.D.C. 2007) ("[T]he court has broad discretion to permit * * * participation in this suit as an *amicus curiae*."). In general, courts permit *amici* to participate where their brief provides new and useful information for the Court's consideration and the *amici*'s participation does not prejudice the existing parties. *See Ellsworth Assocs., Inc.* v. *United States*, 917 F. Supp. 841, 846 (D.D.C. 1996).

4. As the attached brief demonstrates, AHA has an important perspective to offer on the harms that will befall individuals and hospitals if plaintiffs prevail.

5. Plaintiffs initially consented to AHA's brief last Friday without qualification; they did not condition that consent on a particular filing date. Plaintiffs withdrew that consent today, as AHA was preparing to file this brief, on the ground that AHA did not file its *amicus* brief yesterday, when defendants filed their summary judgment papers.

5. Plaintiffs' objection carries little weight. There is no requirement that an *amicus* in the district court file at the same time as the brief the *amicus* is supporting. (Indeed, in the courts of appeals, the default rule is that *amici* are permitted to file 7 days after the party they support. *See* Fed. R. App. P. 29(e)). Moreover, plaintiffs suffer no prejudice from receiving

AHA's brief four business hours after plaintiffs apparently (and unilaterally) expected AHA to file. Finally, allowing AHA to file shortly after defendants benefits the Court, as it reduces the potential for repetition between AHA's and defendants' briefs.

6. No party or counsel for a party authored this motion or AHA's brief in whole or in part. No party, counsel for a party, or person other than AHA, its members, or counsel made any monetary contribution intended to fund the preparation or submission of this motion or AHA's brief.

For the foregoing reasons, AHA's motion should be granted.

Respectfully submitted,

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Dated: November 13, 2013

CERTIFICATE OF SERVICE

I hereby certify that on November 13, 2013, I caused the foregoing document to be served on the parties' counsels of record electronically by means of the Court's CM/ECF system.

/s/ Dominic F. Perella
Dominic F. Perella

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BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF DEFENDANTS

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STATEMENT OF INTEREST

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.

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

SUMMARY OF ARGUMENT

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

In short, the ACA will not work without subsidies, and Congress knew it. Yet plaintiffs insist that Congress designed the ACA so that tens of millions of Americans, in more than half the states, would be walled off from subsidies altogether. That interpretation should be rejected for many reasons: It would be devastating to the ACA and to that statute's key goals. It would be equally devastating to America's hospitals—especially to "safety-net" hospitals, which care for large numbers of the poorest among us. 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' interpretation creates untenable distinctions, unreasonable results, *and* unjust and absurd consequences. Because the provisions at issue can fairly be read as the government would read them, they must be so read. The government's cross-motion for summary judgment should be granted.

ARGUMENT

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

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

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

One of the ACA's chief reforms was to create health insurance Exchanges to serve the individual and small-group health insurance markets. 42 U.S.C. §§ 18031-18044. Through the

Exchanges, qualified individuals can select among and purchase health insurance plans that provide a comprehensive essential health benefits package. *Id.* § 18021(a)(1)(B). And although rates on the Exchanges are lower than many initially expected, *see* L. Skopec & R. Kronick, Department of Health & Human Servs., *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected*,[1] 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.[2]

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. 26 U.S.C. § 36B. Though the amounts depend on the state and a patient's household income, the subsidies are often quite substantial. The Congressional Budget Office (CBO) has estimated that subsidies will cover nearly two-thirds of the premiums for policies purchased through the Exchanges, CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009),[3] and the average subsidy will total $5,320 per subsidized enrollee, CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* tbl.3 (July 2012) (*Insurance Coverage Estimates*).[4]

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

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

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

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

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

The bottom line: The ACA's subsidies are often the difference between health coverage that is affordable for lower-income Americans and health coverage that is not. Plaintiffs do not disagree: Indeed, their very claim to standing is predicated on their allegation that the Exchange-offered subsidies are what makes health coverage "affordable" for them under the ACA. *See* Pls.' Reply in Support of Their Motion for a Preliminary Injunction, Dkt. No. 39, at 3.

Plaintiffs' bid to eliminate subsidies for people who purchase policies through federally-facilitated Exchanges, if accepted, therefore would cost millions of Americans comprehensive coverage. According to the CBO, 9 million people are expected to purchase insurance through the Exchanges in 2014, but only 1 million of them will pay full sticker price. *Insurance Coverage Estimates*, *supra*, at tbl.3. In other words, 8 million Americans will rely on the ACA's subsidies to obtain coverage just next year. *See id.* That number will only grow with time. In 2022, the CBO estimates that *20 million* Americans will need subsidies to purchase insurance

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

from the Exchanges. *See id.* And most of them—around 72%, according to one study—live in states where the Exchange is federally facilitated. Kaiser Family Foundation, *State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act* 3 tbl.1 (Nov. 2013).[6] Put differently, well over 10 million people would be stripped of eligibility for subsidies if plaintiffs were to prevail. *See id.* Because many of them simply cannot afford insurance on their own, they will remain uninsured; indeed, the government cites a study showing that unsubsidized Exchanges would lead to "essentially no increase" in the number of persons enrolled in individual coverage. Docket No. 38 at 25. That 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*),[7] and increase the load on this country's already-overburdened health care system.

For plaintiffs, making health coverage unaffordable apparently is a boon, freeing them from purchasing insurance they would rather not currently have. But people like plaintiffs are the rare exception. Most Americans would prefer to have comprehensive coverage, but cite high cost or lack of employer-sponsored health plans as the primary reason they do not have it. Kaiser Family Foundation, *Key Facts About the Uninsured Population* 2 (Sept. 2013).[8] By contrast, only 1.5% say that they lack insurance because they do not need it. *Id.* This Court should not withdraw needed coverage for millions based on the policy preferences of an idiosyncratic few.

[6] *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.

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

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

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

The loss of subsidies in states with federally facilitated Exchanges would be particularly painful in light of many states' refusal to expand Medicaid coverage. The ACA was expected to cover Americans too poor to purchase private insurance through the Exchanges but not eligible to receive Medicaid by expanding Medicaid to all non-disabled adults with income at 138% of the poverty level or lower. Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 2 (Oct. 2013) (*The Coverage Gap*).[9] 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. *Insurance Coverage Estimates*, *supra*, at 12 & tbl.1.

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

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

federally-facilitated exchanges).[10] In those states, individuals making 100% to 138% of the poverty level—about $11,500 to $15,900 per year[11]—would have to seek coverage on the market with no subsidies at all, and would face premiums they could not possibly pay. *See supra* at 4. Plaintiffs' position thus would not only deny millions of Americans access to coverage. It would deny access to those who need it most: the poor who are not eligible for Medicaid in their states.

C. The Loss Of Subsidies Would Undercut The ACA.

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

The ACA prohibits insurers from charging disparate premiums based on health status (known as "community rating") and requires them to offer coverage to all people wishing to purchase it (known as "guaranteed issue"). *See* 42 U.S.C. § 300gg(a); *id.* §§ 300gg1-4. And Congress explicitly recognized that health coverage providers could make the economics of guaranteed-issue and community-rating work only if they received an influx of relatively low-cost, newly-insured customers. *See* 42 U.S.C. § 18091(2)(I). That is one reason why Congress also included the individual mandate and subsidies in the law. Those provisions are designed to give Americans young and old, healthy and less so, the buying power and incentives to enter the market. Without those incentives, only highly motivated people—who expect to consume health care so that coverage is worthwhile even at a high price—tend to sign up, raising insurers'

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

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

average costs. *See id.* Premiums therefore go up, further impeding entry into the market by healthier customers and risking a "marketwide adverse-selection death spiral," A. Monheit *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey, Health Affairs*, July/Aug. 2004, at 167, 169.

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

II. ELIMINATING SUBSIDIES IN STATES WITH FEDERALLY-FACILITATED EXCHANGES WILL HARM HOSPITALS AND FURTHER FRAY THE ALREADY FRAGILE SAFETY NET.

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

A. Subsidies Were Designed To Help Offset Hospitals' Losses Under The ACA.

The ACA imposed three major cuts to government reimbursement for hospital services. Those cuts, standing alone, would be devastating to hospitals' fiscal health. But the ACA was designed so that those deep reductions would fund subsidies—subsidies that in turn would bring in newly insured patients and replace the revenue lost from those steep cuts.

1. First, the ACA contains deep cuts in Disproportionate Share Hospital, or "DSH," payments, which compensate safety-net hospitals that serve a large number of low-income patients, including the uninsured and those enrolled in Medicaid. National Health Policy Forum, *Medicaid Disproportionate Share Hospital Payments and Health Care Reform* 2 (June 19,

2009).[12] DSH payments are in addition to the regular payments all hospitals receive for treating Medicare and Medicaid patients. They compensate hospitals for the cost of caring for the uninsured and underinsured and help hospitals maintain the resources to care for those patients, many of whom have nowhere else to turn for medical assistance. L. Fishman & J.D. Bentley, *The Evolution of Support for Safety-Net Hospitals* 34-35, Health Affairs (July 1997). The ACA slashes both Medicare and Medicaid DSH payments. It reduces hospitals' Medicare DSH payments by an estimated $22.1 billion over 10 years. *See* American Hospital Ass'n, *Summary of 2010 Health Care Reform Legislation* 34 (Apr. 19, 2010) (*AHA 2010 Summary*);[13] 42 U.S.C. § 1395ww(r). It similarly reduces federal Medicaid DSH spending by $18.1 billion over 11 years. *AHA 2010 Summary* 35; 42 U.S.C. § 1396r-4(f)(7).

Without anything to offset them, these cuts are devastating to hospitals. One study found that the ACA's cuts to Medicare DSH will drive the operating margins of the average California safety-net hospital from a barely positive 1.1 percent to *negative* 2.8 percent. Private Essential Access Community Hospitals, *The Impact of Medicare Disproportionate Share Reductions on Private Safety-Net Hospitals in California* 5 (Jan. 2011).[14] Another found that the 75 percent cut in Medicare DSH would by itself cause close to 10 percent of urban safety-net hospitals to go from positive to negative operating margins. National Ass'n of Urban Hosp., *Financial Challenges To Urban Hospitals* (Jan. 2011).[15] Without replacement revenue, some safety-net hospitals cannot not keep operating.

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[12] *Available at* http://www.nhpf.org/library/forum-sessions/FS_06-19-09_MedicaidDSH.pdf.

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

[14] *Available at* http://www.peachinc.org/wp-content/uploads/2011/03/January-2011-Impact-of-Medicare-DSH-cuts-to-Californias-private-safety-net-hospitals.pdf.

[15] *Available at* http://www.nauh.org/component/option,com_rubberdoc/format,raw/id,1/view,doc/.

The subsidies, working together with the individual mandate, were designed to solve that problem by bringing in newly insured patients to offset the hospitals' lost revenue. *See* S. Tavernise, *Cuts in Hospital Subsidies Threaten Safety-Net Care*, N.Y Times, Nov. 8, 2013 (DSH subsidies were cut "substantially on the assumption that the hospitals would replace much of the lost income with payments for patients newly covered by Medicaid or private insurance").[16] As one member of Congress said in describing a similar change in Massachusetts: "[T]hey said we are giving all of this money to hospitals for disproportionate share payments, what if we just took that money and helped people buy insurance? Everybody is insured, and then you don't need to provide the disproportionate share payments any longer." 156 Cong. Rec. H2204 (daily ed. Mar. 22, 2010) (statement of Rep. Burgess).

But if the uninsured and underinsured cannot obtain subsidies in states with federally-facilitated Exchanges, that solution will be thwarted. Safety-net hospitals will be forced to curtail services or even close. *See Cuts in Hospital Subsidies*, *supra* (noting that three rural hospitals in Georgia have closed this year). And just as with individuals, the impact of the DSH cuts on hospitals is magnified by states' refusal to expand their Medicaid programs. *See* J. Mullin, The Advisory Board Company, *For States Not Expanding Medicaid, DSH Cuts Will Deal a Tough Blow* (Sept. 23, 2013).[17]

2. The same is true of two other major cuts directly affecting hospitals in the ACA: the "productivity adjustment" and market-basket cuts. Congress provides payments to hospitals and other providers to compensate them for services they furnish to Medicare recipients. The ACA changes the formula to calculate those payments in two significant ways. First, it reduces

[16] *Available at* http://www.nytimes.com/2013/11/09/health/cuts-in-hospital-subsidies-threaten-safety-net-care.html?_r=0.

[17] *Available at* http://www.advisory.com/Daily-Briefing/Blog/2013/09/For-states-not-expanding-Medicaid-DSH-cuts-will-deal-a-tough-blow.

the update for inflation. 42 U.S.C. § 1395ww(b)(3)(B)(xi). Second, it reduces the "market basket" rates used to annually adjust Medicare payments. *Id.* § 1395ww(b)(3)(B)(xii). Although seemingly technical, these changes amount to a major reduction in Medicare reimbursements. The CBO estimated that the two changes will cut payments to providers by $156 billion over ten years, while the Center for Medicare and Medicaid Services' actuary pegged the reduction at $233 billion. B. Semro, The Bell Policy Center, *Potential Impacts of New Federal Policies on Provider Reimbursement Rates* (Nov. 1, 2011).[18]

The Obama administration and Congress included these massive funding cuts in the ACA on the express understanding that the cuts would go to fund Exchange subsidies that would bring hospitals newly insured patients. In July 2009, Vice President Biden described these cuts "as part of a health overhaul *that assumes coverage of 95 percent of the American people*." J. Reichard, *Biden Announces Deal With Hospitals to Cut Medicare, Medicaid Payments by $155 Billion*, CQ Healthbeat, July 8, 2009 (emphasis added).[19] In other words, hospitals reasonably expected to receive "offsetting revenues * * * from significant numbers of newly insured individuals receiving care under the ACA." L. Blumberg & J. Holahan, The Urban Institute, *Delaying the Individual Mandate Would Disrupt Overall Implementation of the Affordable Care Act* 4 (Sept. 2013).[20] Denying subsidies to those in states with federally facilitated Exchanges would unravel the understanding that formed the basis for these reductions in the first place.

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

[19] *Available at* http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2009/Jul/July-13-2009/Biden-Announces-Deal-with-Hospitals-to-Cut-Medicare-Medicaid-Payments-by-155-Billion.aspx.

[20] *Available at* http://www.urban.org/UploadedPDF/412902-Delaying-the-Individual-Mandate-Would-Disrupt-Overall-Implementation-of-the-Affordable-Care-Act.pdf.

B. The Absence Of Subsidies Would Force Hospitals To Shoulder Even More Of The Burden To Pay For The Nation's Health Care.

The broken bargain discussed above would only exacerbate a problem that pre-existed the ACA. Medicare and Medicaid have long pegged reimbursement rates at a level too low to cover the costs hospitals incur treating patients. *See* American Hosp. Ass'n, *Trendwatch Chartbook 2013* tbl.4.5 (2013).[21] Thus in 2011, hospitals lost a total of $29.8 *billion* providing care to Medicare and Medicaid patients. *Id.* That staggering figure represents only one year out of a decade-long history of losses. Losses on government-insured-patient care over that time have ranged from a low of $3.8 billion in 2000 to a high of $36.5 billion in 2009. *Id.* In none of those years did hospitals' reimbursements from the government cover their aggregate expenses—adding up to a total loss of $262.4 billion between 2000 and 2011. *See id.*

Hospitals therefore directly underwrite Medicare and Medicaid by covering costs for government-insured patients that the government does not. Moreover, hospitals provide substantial uncompensated care to patients for which they are not reimbursed by anyone. That care added up to an additional $41.1 billion in 2011. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 3 (Jan. 2013).[22] Indeed, since 2000, hospitals provided more than *$367 billion* in uncompensated care to the uninsured and under-insured. *Id.*

Plaintiffs' position would cause hospitals to shoulder an even greater burden, requiring them to furnish similar amounts of uncompensated care while at the same time losing billions in government support. That is a far cry from what Congress had in mind.

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

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

III. THIS COURT SHOULD REJECT PLAINTIFFS' INTERPRETATION AS CONTRARY TO CONGRESSIONAL INTENT AND INCOMPATIBLE WITH THE ACA'S STRUCTURE.

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). Congress 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 those subsidies to more than half the nation. That is, to put it mildly, implausible. And the statutory structure proves that reading is not what Congress had in mind: As the government has explained, reading the words "established by the State" from Section 36B in isolation produces illogical distortions throughout the ACA. *See* Docket No. 38 at 10-18. Among many others problems, importing plaintiffs' reading across the ACA leads to the absurd result that *no one in the entire nation* could meet the statutory definition for eligibility to buy insurance offered on a federally-facilitated Exchange. *See id.* at 13-14.

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, the D.C. Circuit 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 D.C. Circuit 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, defendants' cross-motion for summary judgment should be granted, and plaintiffs' motion for summary judgment should be denied.

Respectfully submitted,

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Dated: November 13, 2013

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JACQUELINE HALBIG, *et al.*,

Plaintiffs,

v.

KATHLEEN SEBELIUS,
U.S. Secretary of Health and Human Services,
et al.

Defendants.

Civil Action No. 13-0623 (PLF)

LOCAL CIVIL RULE 7.1 CERTIFICATE

We, the undersigned counsel of record for the American Hospital Association certify that to the best of our knowledge and belief, there are no parent companies, subsidiaries, or affiliates of the American Hospital Association which have any outstanding securities in the hands of the public.

These representations are made in order that judges of this Court may determine the need for recusal.

Respectfully submitted,

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