No. 19-10011

In The United States Court of Appeals
For The Fifth Circuit

STATE OF TEXAS, ET AL,
Plaintiffs Appellees,

v.

UNITED STATES OF AMERICA, ET AL.,
Defendants-Appellants,

STATE OF CALIFORNIA; ET AL.,
Intervenor Defendants-Appellants.

On Appeal from the U.S. District Court for the
Northern District of Texas No. 4:18-cv-00167-O

Amici Curiae Brief of AARP, AARP Foundation, Center for Medicare Advocacy, and Justice In Aging Supporting Intervenor Defendants-Appellants Urging Reversal

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CERTIFICATE OF INTERESTED PARTIES

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The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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AMICI CURIAE ORGANIZATIONS ON THIS BRIEF:

AARP and AARP Foundation

The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) of the Internal Revenue Code and is exempt from income tax. The Internal Revenue Service has determined that AARP Foundation is organized and operated exclusively for charitable purposes pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. AARP and AARP Foundation are also organized and operated as nonprofit corporations under the District of Columbia Nonprofit Corporation Act.

Other legal entities related to AARP and AARP Foundation include AARP Services, Inc., and Legal Counsel for the Elderly. Neither AARP nor AARP Foundation has a parent corporation, nor has either issued shares or securities.

Center for Medicare Advocacy

The Internal Revenue Service has determined that the Center for Medicare Advocacy Inc. (the Center) is organized and operated exclusively for charitable purpose pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. The Center has no parent corporation, nor has it issued shares or securities.

Justice in Aging

The Internal Revenue Service has determined that Justice in Aging is organized and operated exclusively for charitable purpose pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. Justice in Aging is also organized and operated as a non-profit corporation pursuant to Title 29 of Chapter 6 of the District of Columbia Code (1951). It has no parent corporation, nor has it issued shares or securities.

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STATEMENT OF THE IDENTITIES AND INTERESTS OF AMICI CURIAE[1]

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness.

Among other things, AARP and AARP Foundation advocate for access to quality health care across the country and frequently appear as friends of the court on issues affecting older Americans, including challenges to the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

The Center for Medicare Advocacy (the Center) is a national, nonprofit law organization, founded in 1986, that provides education, analysis, advocacy, and

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[1] Amici Curiae certify that no party or party's counsel authored this brief in whole or in part, or contributed money intended to fund its preparation or submission. Amici curiae also certify that only Amici Curiae provided funds to prepare and submit this brief.

All parties have consented to the filing of this brief. FED. R. APP. P. 29(a)(2).

legal assistance to help older adults and people with disabilities access Medicare and necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care, and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage.

Justice in Aging is a national, nonprofit organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Justice in Aging focuses its advocacy on those who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency. Justice in Aging conducts training and advocacy regarding Medicare and Medicaid, and provides technical assistance to attorneys from across the country on how to address problems that arise under these programs. Justice in Aging frequently appears as friend of the court on cases involving health care access for older adults.

Amici are organizations that represent the interests of older adults. We file this brief because this Court's ruling will dramatically impact whether older adults have access to affordable health care and other protections.

SUMMARY OF ARGUMENT

What is at stake for older adults if the Affordable Care Act (ACA) is struck down? Simply put: everything.

The ACA is a lifeline for millions of Americans, including older adults, who rely on it for their health and financial stability. More than nine years after its enactment, the ACA has become an integral part of the nation's health care system. Among other things, it expands access to quality affordable care, guarantees coverage for people with preexisting conditions, and limits how much more insurers can charge older adults. It strengthens the financial viability of Medicare, lowers Medicare prescription drug costs, and expands Medicaid eligibility. It also helps protect nursing facility residents from fraud and abuse, and the ability of older adults to live independently.

If this Court finds that the ACA is invalid, millions of older adults will lose the health care coverage and consumer protections they have relied on for years. It will also throw the Medicare and Medicaid programs into fiscal and administrative chaos, which will disrupt the nation's health care system and economy. It will plunge the more than 100 million people with preexisting conditions into an abyss of uncertainty about whether they can obtain coverage. Finally, it will destroy hard-fought gains, including protections for nursing facility residents and the lowest income seniors who rely on Medicare.

When Congress reduced the tax penalty for not complying with the minimum coverage provision, it did not intend to dismantle the entire ACA. It also did not intend for that reduction to affect any other ACA provision, including those that protect people with preexisting conditions and limit age rating. Instead, Congress limited its actions in the Tax Cuts and Jobs Act of 2017 to reducing the tax penalty for not complying with the minimum coverage provision to $0.

The ACA transformed the lives of millions of Americans. Its provisions are vital to the health and well-being of older adults. The lower court's decision should be reversed and the ACA confirmed as the law of the land.

ARGUMENT

I. Invalidating The ACA Would Return Millions Of Older Adults To Their Pre-ACA Days When Health Care Was Inaccessible And Unaffordable.

The loss of the ACA would return older adults to their pre-ACA days when millions could not access or afford health care coverage. This lack of coverage took a heavy toll on their health and finances that rippled throughout the country.

A. Before The ACA, Millions Of Older Adults Could Not Access Or Afford Health Care Coverage.

Before the ACA, health care coverage was unaffordable or inaccessible for millions of older adults. Many uninsured adults ages 50 to 64 (pre-Medicare adults) lacked access to affordable employer-sponsored insurance. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population*, 2 (Sept. 2013).[2] They also could not afford private insurance on the individual market nor could they qualify for Medicaid. *Id.* These barriers led to devastating economic and health consequences for the adults, their families, and the nation.

In 2007, 61% of pre-Medicare adults who tried to purchase health insurance on the private market found it difficult or impossible to afford. *See* Sara Collins, et al., *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable*

[2] https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

Care Act of 2010, The Commonwealth Fund, 5, ex. 4 (Dec. 14, 2010). Among those who purchased insurance, 60% reported difficulty paying medical bills or accessing services due to costs, leaving them functionally uninsured. *Id.* at 6, ex. 5.

Even pre-Medicare adults who could get private insurance often paid high health insurance premiums and exorbitant out-of-pocket medical expenses. Insurers could deny coverage or offer sparse policies to people with preexisting conditions, charge higher premiums based on age alone, or offer policies with high cost-sharing. Elizabeth Abbott et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers*, 10 (Aug. 2012); Lynn Nonnemaker, *Beyond Age Rating: Spreading Risk in Health Insurance Markets*, AARP Pub. Policy Inst., 3, tbl. 1 (Oct. 2009).[3]

These practices disproportionately affected older adults because 48 to 86% of people ages 55 to 64 had preexisting conditions. U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, 4, fig. 1 (2011).[4] Insurers routinely denied them coverage because of health problems such as rheumatoid arthritis, chronic headaches, kidney stones, angina,

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[3] https://assets.aarp.org/rgcenter/ppi/health-care/i35-age-rating.pdf.

[4] https://aspe.hhs.gov/system/files/pdf/76376/index.pdf.

heart disease, or stroke. *See* Gary Claxton, et al., *Preexisting Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,* Kaiser Family Found. (Dec. 12, 2016).[5] Insurers who did not deny coverage would often limit benefits or charge excessive premiums. H.R. Rep. No. 111-443, pt. 2, at 981 (2010).

These coverage denials and higher charges due to preexisting conditions were only part of the problem. Insurers often charged pre-Medicare adults exorbitant rates – even as much as six times greater than younger adults – based solely on their age (a practice known as "age rating"). *See* Karen Pollitz, et al., *Georgetown Univ. Inst. For Health Care Research and Policy; and The Kaiser Family Foundation, How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* 9, 35 (June 2001).[6]

Even a healthy person age 50 to 64 with no preexisting conditions faced markedly higher rates than a younger person. *Id.* at 35. This put the cost of health insurance out of reach for many pre-Medicare adults. *See* Linda J. Blumberg et al.,

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[5] http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA.

[6] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf.

Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens, Urban Inst., 8 (Oct. 2009).[7]

B. Before The ACA, Older Adults Who Lacked Health Insurance Had Worse Health Outcomes And Financial Instability.

Unsurprisingly, the lack of health insurance harmed older adults. Uninsured pre-Medicare adults were about three times less likely to be up-to-date with clinical preventive services than those who were insured. *See* Megan Multack, *Midlife Not Getting Recommended Preventative Services*, AARP Pub. Policy Inst. (Sept. 11, 2013).[8] Uninsured adults had higher mortality rates because they were less likely to be aware of heart disease and its risk factors, and were more likely to have undiagnosed cancers treated at later stages. Inst. of Med. (IOM), *America's Uninsured Crisis: Consequences for Health and Health Care,* 72-83 (2009).[9]

Because they did not have health insurance before becoming eligible for Medicare at 65, many pre-Medicare adults were sicker and more expensive to care for when they enrolled in Medicare than if they had been able to access to adequate preventative care throughout adulthood. *Id.* at 72, 77; s*ee* U.S. Gov't

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[7] https://www.urban.org/sites/default/files/publication/30701/411970-Age-Rating-Under-Comprehensive-Health-Care-Reform-.PDF.

[8] http://blog.aarp.org/2013/09/11/midlife-adults-not-getting-recommended-preventive-services/.

[9] https://www.ncbi.nlm.nih.gov/books/NBK214966/.

Accountability Off., GAO-14-53, *Medicare: Continuous Insurance Before Enrollment Associated With Better Health and Lower Program Spending*, 9 (Dec. 2013)[GAO study][10] (finding that the previously uninsured had 35% more program spending in the first year of Medicare enrollment than those insured continuously for six years).

The lack of adequate, affordable health insurance profoundly affected the financial stability of pre-Medicare adults and, in turn, the national economy. Many pre-Medicare workers who relied on employer-sponsored health insurance could not leave their jobs, reduce their hours, or retire for fear that they would lose and be unable to regain health benefits. *See* Richard W. Johnson et al., *Older Workers on the Move: Recareering in Later Life,* AARP Pub. Policy Inst., 10, 18 (Apr. 2009);[11] *see also* Sara R. Collins et al., *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief*, The Commonwealth Fund, 3 (March 16, 2011) [*Help on the Horizon*] (57% of adults ages 18 to 64 who lost a job with health benefits in 2010 could not regain insurance).

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[10] https://www.gao.gov/assets/660/659753.pdf.

[11] https://assets.aarp.org/rgcenter/econ/2009_08_recareering.pdf.

People with inadequate or no health insurance had financially debilitating health care costs when they did get care. Their medical costs depleted retirement savings and contributed to debt and bankruptcy. One 2010 study estimated that 29 million people had used all their savings on medical expenses. *Help on the Horizon*, *supra*, at 12, ex. 12. Another 22 million were unable to pay for basic necessities such as rent, food, and utilities due to medical bills. *Id.* Before the ACA, the median pre-Medicare household with a newly ill and uninsured member lost between 30 and 50% of its assets. Keziah Cook et al., *Does Major Illness Cause Financial Catastrophe?*, 45 Health Servs. Res. 418, 430-32 (Apr. 2010).

Indeed, Medicare beneficiaries also felt the strain of health costs even though they had insurance. Before the ACA, Medicare Part D required enrollees to pay the full cost of their drugs in the benefit's coverage gap, commonly known as the "doughnut hole." Dena Bunis, *Medicare "Doughnut Hole" Will Close in 2019*, AARP (Feb. 2018).[12] After reaching an initial coverage limit, enrollees had to pay 100% of their prescription drug costs until they spent enough to qualify for catastrophic coverage. In 2010, a Medicare enrollee had to spend $4,550 out-of-pocket before reaching the catastrophic-coverage threshold. Leigh Purvis, *Health*

[12] https://www.aarp.org/health/medicare-insurance/info-2018/part-d-donut-hole-closes-fd.html.

Care Reform Legislation Closes the Medicare Part D Coverage Gap, AARP Pub. Policy Inst., 1 (Apr. 2010).[13]

Some beneficiaries who entered the coverage gap had to resort to strategies used before Medicare even had a prescription drug benefit, including skipping doses or not even filling prescriptions. Yuting Zhang *et al*., *The Effects of the Coverage Gap on Drug Spending: A Closer Look at Medicare Part D,* Health Affairs (Mar./Apr. 2009);[14] Patricia Barry, *Doing Away with the Doughnut Hole—the Gap in Part D Prescription Drug Coverage,* AARP (May 19, 2009). This all changed with the passage of the ACA.

II. Invalidating The ACA Would Cause Many Millions Of Older Adults To Lose The Health Insurance And Consumer Protections That They Have Relied On For Years.

Consistent with its primary purpose, the ACA improved the lives of older adults by making health insurance, and thus health care, more accessible and affordable. 42 U.S.C. §§ 18091(2)(D)-(H); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012). Since 2010, many millions of Americans have gained health insurance, including adults ages 50 to 64. *See e.g.*, Kaiser Family Found., *Key Facts About the Uninsured Population* (Dec. 7, 2018).

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[13] http://assets.aarp.org/rgcenter/ppi/health-care/fs182-doughnut-hole-reform.pdf.

[14] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.2.w317.

The ACA helps older adults access much-needed health care services without experiencing financial ruin. To begin with, the ACA expands access to coverage with strong consumer protections, including prohibiting discrimination against people with preexisting health conditions and establishing limits on age rating. It also provides income-based subsidies and tax credits for individual coverage offered in the Marketplaces, and financial incentives for states to expand Medicaid coverage.

The result is that millions of older adults now have access to health care, many for the first time. Invalidating the law will tear hard-earned gains away from older adults at a time when they need them most.

A. The ACA Protects Older Adults Against Insurance Discrimination Based on Age or Health Status.

The ACA addresses the barriers that many pre-Medicare adults once faced in accessing affordable health insurance in the individual market. Indeed, the Act's consumer protection provisions transformed the health care landscape for older adults. *See* 42 U.S.C. § 300gg to gg-4.

One of the Act's most important provisions requires insurers to "accept every employer and individual in the State that applies for such coverage," regardless of preexisting conditions. 42 U.S.C. § 300gg-1(a). This protection is vital to all Americans, but is crucial for older adults because they have a high incidence of preexisting conditions that increase as they age. Without this

protection, four out of ten adults ages 50 to 64 – or about 25 million people in this age group – could be denied health coverage because of a preexisting condition. *See* Claire Noel-Miller and Jane Sung, *In Health Reform, Stakes are High for Older Americans with Preexisting Health Conditions*, AARP Pub. Policy Inst. (March 2017).[15] Overall, this provision protects over 100 million Americans. ASPE, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Ac*t (Jan. 2017).[16]

The ACA also bans insurers' previous practice of cancelling the policies of people who became ill. 42 U.S.C. § 300gg–12. Thus, the ACA protects consumers by ensuring that they have access to insurance when they need it.

The Act also prohibits setting insurance premiums based on health status-related factors such as disability, claims experience, receipt of health care, and medical history. 42 U.S.C. § 300gg-4. It eliminates annual and lifetime coverage limits. 42 U.S.C. § 300gg-11.

Moreover, the Act increased affordability by establishing that, although insurers may still use a formula that considers age when determining premiums, they may not charge older adults premiums that are more than three times the

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[15] https://www.aarp.org/content/dam/aarp/ppi/2017-01/ACA-Protects-Millions-of-Older-Adults-with-Preexisting-Health-Conditions-PPI-AARP.pdf.

[16] https://aspe.hhs.gov/pdf-report/health-insurance-coverage-americans-pre-existing-conditions-impact-affordable-care-act.

premiums charged to younger adults (3:1 limit on age rating). 42 U.S.C. § 300gg(a)(1)(A)(iii). This limit ensures adults ages 50 to 64 have access to affordable health insurance coverage, while fairly considering predictions of increased health care consumption. *See* Jane Sung, *Protecting Affordable Health Insurance for Older Adults: The Affordable Care Act's Limit on Age Rating*, AARP Pub. Policy Inst. (Jan. 2017).[17]

The loss of the ACA would open the door to increasing the age rating formula. This could financially devastate older adults and again place health coverage out of their reach. For example, the median personal income among adults ages 60 to 64 with individual market insurance or no insurance is about $20,000, according to 2016 Current Population Survey data. *See* AARP Pub. Policy Inst., *Weakening Age Rating Protections Will Make Health Care Unaffordable For Older Adults* (Jan. 2017). Even increasing the age rating limit from 3:1 to 5:1 would increase premiums by 22% for an adult age 60 and over or $3,192 per year on average. *See* Jane Sung and Olivia Dean, *Impact of Changing the Age Rating Limit for Health Insurance Premiums*, AARP Pub. Policy Inst.

[17] https://www.aarp.org/ppi/info-2016/protecting-affordable-health-insurance-for-older-adults.html.

(Feb. 2017).[18] Without the ACA subsidies, adults ages 60 to 64 would have an annual premium of $18,000 if the age-rating ratio became 5:1. *Id.*

Paying this added cost damages older adults' health, financial security, and well-being. It also puts public insurance programs at risk of having higher expenditures for older adults who are sicker when they enroll because they could not previously afford insurance.

Amicus the Center for Medicare Advocacy has a website where it has collected stories about the ACA.[19] On January 9, 2017, Maryland resident Mary, age 64, explained how she finally got insurance on the ACA marketplace after being precluded from getting insurance because of a preexisting condition. Mary said:

> In June of 2011, I lost my job due to budget cuts. I had health insurance for 18 months. I tried to get health insurance on my own, but was declined because I had sleep apnea. So for over a year, I had no health insurance. During that year, I paid $3,000 to doctors. That's all well and good, but just have a car accident, cancer, or a heart attack and you will be bankrupt in a heartbeat.
>
> So when the Affordable Care Act kicked in in 2014, I signed up in March and was covered on April 1st. What's the first thing a woman would do? Get a pap smear and mammogram. I was diagnosed with breast cancer - early stages, but an aggressive strain. I had a lumpectomy, chemo, and radiation, and am now cancer free. But without the Affordable Care Act, I would probably be sitting here with stage 4 cancer.

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[18] https://www.aarp.org/ppi/info-2016/Impact-of-Changing-the-Age-Rating-Limit-for-Health-Insurance-Premiums.html.

[19] https://www.esurveyspro.com/s/390566/Share-Your-Healthcare-Story.

The barriers that Mary and others faced getting insurance could return if the ACA is invalidated.

B. The ACA Increases Older Adults' Access to Health Insurance on the Individual Market Through the ACA Marketplaces, Tax Credits, and Subsidies.

The ACA also improved pre-Medicare adults' access to health insurance in the individual market by establishing the ACA marketplaces and providing consumers with tax credits and subsidies to make the insurance more affordable. *See* 42 U.S.C. § 18031(b); 26 U.S.C. § 36B(b)(3)(A); 42 U.S.C. § 18071(c)(2). In 2019, 11.4 million people secured health coverage by enrolling in the federal and state health insurance exchanges. CMS, *Health Insurance Exchanges 2019 Open Enrollment Report* (Mar. 25, 2019).[20]

The tax credits reduce the cost of premiums for people with incomes between 100 and 400% of the federal poverty level, 26 U.S.C. § 36B(b)(3)(A). Subsidies reduce out-of-pocket expenses for people with incomes under 250% of the federal poverty level, 42 U.S.C. § 18071(c)(2). In 2017, over 3 million low and moderate-income adults ages 50 to 64 relied on ACA tax credits to purchase health insurance coverage in the individual health insurance market. *See* Jane Sung et al., *Adequate Premium Tax Credits are Vital to Maintain Access to Affordable Health*

[20] https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report.

Coverage for Older Adults, AARP Pub. Policy Inst. (March 2017);[21] Laura Skopec et al., *Fewer Americans Ages 50-64 Have Difficulty Paying Family Medical Bills after Early ACA Marketplace Implementation,* Urban Inst. & AARP Pub. Policy Inst. (Jan. 2016).[22] Without the subsidies and tax credits, many older adults could not afford insurance.

The legislative history of the American Health Care Act of 2017 includes this statement from Kentucky resident Kevin S., age 62, about how purchasing insurance on the ACA marketplace financially helped his family:

> I am 62 years old and I'm a lifelong resident of Louisville, Kentucky. I worked hard, took risks and built a successful small business that I sold at age 59. My wife and I were excited about our prospects as we headed into early retirement. As a retiree too young for Medicare, I purchased health insurance on the open market. Less than a year later, I was diagnosed with lymphoma. I have undergone multiple scans and 2 cycles of chemo. I am winning the battle so far, but since this disease is in my blood I will be fighting it for the rest of my life.
>
> A cancer diagnosis is a life-changing event that not only attacks the body, but the mental stress is just as tough to deal with. Thanks to ObamaCare, I've been able to rest easier knowing that my illness wouldn't bankrupt my family and that I'll be able to provide for my wife even after I'm gone.[23]

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[21] https://www.aarp.org/content/dam/aarp/ppi/2017-01/adequate-premium-tax-credits-are-vital-to-maintain-access-to-affordable-health-coverage-for-older-adult.pdf.

[22] https://www.aarp.org/content/dam/aarp/ppi/2015/fewer-americans-ages-50-64-have%20-difficulty-paying-family-medical-bills-after-early-aca-marketplace%20Implementation.PDF.

[23] 163 CONG. REC. H2406-7 (daily ed. March 24, 2017)(statement of Cong. Yarmuth).

C. The ACA Increases Low-Income Older Adults' Access to Health Coverage by Expanding Eligibility for Medicaid.

The Act increases access to health insurance for lower income older adults by encouraging states to expand their Medicaid programs. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Before the ACA, in most states, low-income adults under age 65 without dependent children could not qualify for Medicaid, unless they had a disability. The ACA makes it possible for adults with incomes at or below 138% of the federal poverty level to qualify for Medicaid if their state elects to expand the program. 42 U.S.C. § 1396d(y); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. at 2607 (making Medicaid expansion optional for the states).

Currently, 36 states and the District of Columbia have expanded Medicaid. Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision* (Feb. 13, 2019).[24] As a result, over 13 million Americans in expansion states have gained Medicaid coverage. Medicaid & CHIP Payment & Access Commission, *Medicaid enrollment changes following the ACA*.[25] Many new enrollees have received diagnoses and consistent treatment for serious conditions such as cancer.

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

[25] www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#ftn1.

Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Mar. 28, 2018).[26]

Kaiser Family Foundation published a journal profiling people who obtained Medicaid coverage through the expansion. Kaiser Family Found., *Faces of The Medicaid Expansion* (Jan. 2013).[27] A Minnesota resident, John L., age 50, explained how obtaining Medicaid coverage gave him access to a comprehensive team of health care professionals to help him recover from heart surgery and manage diabetes:

"If I didn't have [Medicaid], I wouldn't be able to go to the cardiac rehab program. I wouldn't be able to have my diabetes under control… Having medical insurance is absolutely key to my physical recovery and my eventual return to my desired career."

Id. at 20.

III. Invalidating The ACA Will Harm The Financial Health And Efficiency Of The Medicare Program And End Many Cost Savings For Medicare Beneficiaries.

Invalidating the ACA, including its Medicare provisions, would directly harm older adults and people with disabilities, and throw the Medicare program

[26] http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review.

[27] https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8404.pdf.

into fiscal and administrative chaos. Because the program is so large, this sort of chaos would upend the financial markets and the entire health care system.

Medicare is a bedrock of security for millions and represents a significant portion of the national economy. It currently provides health care coverage for 60 million people who are either at least 65 years old or disabled. Kaiser Family Found., *An Overview of Medicare* (Feb. 13, 2019).[28] In 2017, Medicare spending accounted for 15% of total federal spending and 20% of the total national health spending. *Id*.

The ACA significantly altered, and is now woven into, the Medicare program. The statute contains about 165 provisions that impact Medicare. Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds, *2018 Annual Report,* 3 (June 2018).[29] Among other things, these provisions focus on "reducing costs, increasing revenues, improving benefits, combating fraud and abuse,…[and identifying] alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs." *Id.*

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[28] https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/.

[29] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf.

In short, the ACA vastly improved the financial health, efficiency, and quality of Medicare, goals that Congress has long sought to attain. Even attempts to directly repeal and replace the ACA maintained virtually all of the ACA's Medicare fiscal savings. *See, e.g.*, Juliette Cubanski & Tricia Neuman, *What Are the Implications for Medicare of the American Health Care Act and the Better Care Reconciliation Act?*, Kaiser Family Found. (Jul. 6, 2017).[30] When Congress zeroed out the ACA's penalty for lacking minimum coverage, it could not have intended to strike down provisions that would result in a dramatic undermining of the Medicare program.

A. The ACA Strengthens the Financial Health and Efficiency of the Medicare program.

The ACA benefits Medicare's budget. It slowed the growth of payments to providers and reduced payments to Medicare Advantage plans. Kaiser Family Found., *An Overview of Medicare* (Feb. 13, 2019).[31] It also enacted certain tax increases and delivery system reforms aimed at improving health care quality and reducing federal costs. *See generally*, Kaiser Family Found., *Potential Impact of*

[30] https://www.kff.org/medicare/issue-brief/what-are-the-implications-for-medicare-of-the-american-health-care-act-and-the-better-care-reconciliation-act/.

[31] About one-third of beneficiaries (over 20 million) receive their Medicare coverage through privately sponsored plans, such as HMOs. https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/; http://www.medpac.gov/docs/default-source/reports/mar09_ch03.pdf.

Texas v. U.S. Decision on Key Provisions of the Affordable Care Act (Dec. 20, 2018) [32] (KFF Report). As a result, the Medicare Hospital Insurance Trust Fund will be solvent for eight years longer. Center on Budget and Policy Priorities, *Medicare Is Not "Bankrupt"* (July 2018).[33]

Invalidating the ACA would cause massive confusion and disruption to Medicare reimbursement. It would wipe out statutory payment provisions, and would reverse cost savings. The Congressional Budget Office (CBO) estimated that eliminating the changes to Medicare Advantage payments *alone* would increase Medicare spending by approximately $350 billion over ten years, accelerating the insolvency of the Medicare Trust Fund. CBO, *Budgetary and Economic Effects of Repealing the Affordable Care Act*, 10 (June 2015).[34]

Reversing the ACA's payment reductions to providers would also increase Medicare spending by another $350 billion over ten years. *Id.*; *see also* KFF Report. This result is precisely the opposite of Congress's longstanding aim to *improve* Medicare's sustainability. *Id.*

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[32] https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/.

[33] https://www.cbpp.org/research/health/medicare-is-not-bankrupt.

[34] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf.

1. The ACA provides greater continuity of coverage, resulting in a healthier population entering Medicare and reduced program costs.

The ACA also brings a healthier population into the Medicare program, thereby reducing program costs. People who were uninsured before enrolling in Medicare cost the program far more than people who consistently had insurance before age 65. *See* GAO Study.

The same is true for people under age 65 who qualify for Medicare based on disability. Most of these individuals, who have often lost their health, jobs, income, and health insurance, must wait 24 months after entitlement to Social Security disability benefits before they can receive Medicare coverage. 42 U.S.C. § 1395c. Before the ACA, many people in this two-year waiting period faced enormous problems obtaining or affording health insurance coverage, which could lead to severe financial and medical hardships. Juliette Cubanski, *et al*., *Medicare's Role for People Under Age 65 with Disabilities*, Kaiser Family Found. (Aug. 12, 2016).[35]

The ACA helps these people get insurance by other means before Medicare eligibility begins. If the ACA were struck down, this particularly vulnerable

[35] https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/.

population would lose a vital lifeline to coverage. They would enter Medicare far sicker, thus requiring more costly care.

2. The ACA improves value, quality, and efficiency in Medicare.

Largely due to the ACA, the Medicare program "has taken a lead in testing a variety of new models that include financial incentives for providers, such as doctors and hospitals, to work together to lower spending and improve care for patients in traditional Medicare." Kaiser Family Found., *An Overview of Medicare* (Feb. 2019).[36] For example, the ACA established the Center for Medicare and Medicaid Innovation (CMMI) to design, implement, and test new approaches for payment and delivery systems to reduce spending and improve quality of care. 42 U.S.C. § 1315a.

As of early 2018, CMMI had started over 40 new payment models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Kaiser Family Found., *"What is CMMI?" and 11 other FAQs about the CMS Innovation Center* (Feb. 27, 2018).[37] These models affect 18 million individuals and 200,000 health care providers in all 50 states and the District of Columbia. *Id.* CBO estimates CMMI "will save the federal government an estimated $34 billion, on

[36] https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/.

[37] https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/.

net, from 2017-2026." *Id*. All of these investments and savings risk being forfeited without the ACA.

The ACA authorizes other Medicare innovations, including accountable care organizations (ACOs), bundled payments, and medical homes. *Id.* These innovations focus on aligning financial incentives with improved quality of care – in other words – linking payment with value. *Id*. As of 2018, ACOs alone affected over 10 million Medicare beneficiaries due to numerous providers participating in the program. CMS, *Medicare Shared Savings Program Fast Facts* (Jan. 2018).

Invalidating the ACA would also end other reforms aimed at enhancing health, quality, and efficiency. For example, without the ACA, changes to the payment system for Medicare Advantage plans that reward higher quality plans would be eliminated. KFF Report.

The ACA requires Medicare Advantage and Medicare prescription drug plans to maintain a "medical loss ratio" of at least 85% (meaning the plan must spend at least 85% of premium dollars on providing care, rather than on profits or overhead). *Id*. Without the ACA, Medicare would lose these value- and quality-enhancing reforms.

Finally, the ACA also established many measures to combat waste, fraud, and abuse across government health care programs. These include enhanced funding, screening, oversight, data sharing, and investigation to prevent and

identify fraud and abuse, and imposing harsher fines and penalties for offenses. These powerful tools have already enabled CMS to better protect and also recover billions in taxpayer dollars. CMS Fact Sheet, *The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud* (Feb. 26, 2016).[38]

3. The ACA has critical coverage improvements for Medicare beneficiaries, enhancing access to care and affordability.

The ACA includes important improvements to Medicare coverage by enhancing access to specific medical services and products. First, the ACA decreases the amount that beneficiaries enrolled in Medicare Part D pay for prescription drugs. The ACA helped reduce Part D enrollees' out-of-pocket expenses by effectively closing the doughnut hole through a series of escalating contributions from drug manufacturers and Part D plans. 42 U.S.C. § 1395w-102. As a result, more than 11.8 million Medicare beneficiaries have saved over $26.8 billion on prescription drugs under the ACA. CMS, *Nearly 12 million people with Medicare have saved over $26 billion on prescription drugs since 2010* (Jan. 13, 2017)[39] (CMS Jan. 2017 Press Release).

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[38] https://www.cms.gov/newsroom/fact-sheets/health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers-combating-health-care.

[39] https://www.cms.gov/newsroom/press-releases/nearly-12-million-people-medicare-have-saved-over-26-billion-prescription-drugs-2010.

Second, the ACA eliminated beneficiary cost-sharing (*e.g.*, copayments or coinsurance amounts) for many screening services. 42 U.S.C. §1395l(a)(1)(T); *see also* Nat'l Council on Aging, *Nat'l Ctr. for Benefits Outreach & Enrollment, Quick Reference Chart: Medicare's Preventive Benefits*, 1-7 (Aug. 2015).[40] Examples of these services are mammograms, pap smears, bone mass measurement for those with osteoporosis, depression screening, diabetes screening, HIV screening, obesity screening and counseling, and free annual wellness visits.

The elimination of out-of-pocket costs for preventive services removed a barrier to care for many. *See, e.g.*, Sukyung Chung *et al.*, *Medicare Annual Preventive Care Visits: Use Increased Among Fee-For-Service Patients, But Many Do Not Participate*, Health Affairs (Jan. 2015)[41] (finding significant increases in use of preventive exams among Medicare patients after ACA took effect). In 2016, an estimated 40.1 million Medicare beneficiaries used at least one preventive service and 10.3 million had an annual wellness visit with no copay or deductible. CMS Jan. 2017 Press Release.

Third, the ACA created an important consumer protection for the over 20 million individuals enrolled in Medicare Advantage (MA) plans. Specifically, cost-

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[40] http://www.ct.gov/agingservices/lib/agingservices/choices/medicare-preventive-benefits-chartncoa.pdf.

[41] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0483.

sharing under MA plans cannot exceed cost-sharing in traditional Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services at the discretion of the Secretary of HHS. 42 U.S.C. § 1395w-22(a)(1)(B)(iv).

Finally, the ACA created the Federal Health Care Coordination Office (also known as the Medicare-Medicaid Coordination Office or MMCO) to focus on the 12 million older Americans and people with disabilities who are enrolled in both Medicare and Medicaid. 42 U.S.C. § 1315b(a); CMS Medicare-Medicaid Coordination Office, *People Dually Eligible for Medicare and Medicaid*, (Mar. 2019). These people, referred to as "duals," typically have high health and long-term care needs, multiple chronic conditions, and social risk factors, and account for a third of Medicare and Medicaid spending. *Id.*

For nearly a decade, the MMCO has been improving the health and long-term care quality, care continuity, and the integration of Medicare and Medicaid benefits. The MMCO administers demonstration projects that have improved coordination of care for duals. CMS, *Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results through the 2017 CAHPS Surveys* (Dec. 2017).

The MMCO has also implemented mechanisms to ensure that providers do not illegally bill the lowest-income duals for Medicare cost-sharing. Losing this

oversight would harm older adults and people with disabilities who have the highest health care needs and the least resources.

IV. Invalidating The ACA Will Harm Nursing Facility Residents By Ending Quality And Safety Improvements, And Harm Older Adults Who Want To Age In The Community.

The ACA provides accountability and access to long-term services and supports, which are critical to older adults and people with disabilities.

The ACA's Nursing Home Transparency and Improvement Act expands access to nursing facility information to improve accountability and ensure resident safety. It requires nursing facilities to: (1) disclose their ownership and management so they are accountable to residents; (2) establish compliance and ethics programs, and quality assurance and performance improvement programs; and (3) report on nursing facility staffing through payroll-based information. 42 U.S.C. §§ 1320a-7j(c), (g).

The Act requires that nursing facilities electronically submit direct care staffing information based on payroll and other verifiable, auditable data. 42 U.S.C. §§ 1320a-7j(g). CMS has recognized that daily staffing levels in a facility affects quality of care and outcomes. CMS, *"Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and*

the Five Star Quality Rating System," QSO-18-17-NH, at 1 (Apr. 6, 2018).[42] Accurate and reliable data also provides valuable information to consumers. *Id.*

The ACA also codifies the Elder Justice Act, the first comprehensive federal law fighting elder abuse, neglect, and exploitation. 42 U.S.C. §§ 1305, *et seq*. Its sweeping provisions:

- Fund adult protective services;
- Establish forensic centers focused on elder abuse, neglect, and exploitation;
- Provide grants for Long-Term Care Ombudsman Programs;
- Provide grants to enhance long-term care;
- Require reporting of crimes committed in federally funded long-term care facilities and state demonstration grants to monitor elder abuse detection and prevention methods.

Along with tools to fight abuse and neglect in nursing facilities, the ACA also provides incentives to states to shift Medicaid long-term care spending from institutions to the community. Nearly 90% of adults aged 65 and older say they want to stay in their homes and communities as they age, rather than moving to a

[42] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO18-17-NH.html.

nursing facility. AARP, *2018 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus* (August 2018).[43]

By providing these financial incentives, Congress sought to improve the quality of life for older adults receiving Medicaid-funded long-term care services and help states comply with their obligations under the Americans with Disabilities Act. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999) (holding that unjustified segregation of people with disabilities in an institutional setting is discrimination).

For example, the ACA created the Community First Choice Option that provides states increased federal funds to provide personal care services that keep older adults and persons with disabilities in their homes and communities. 42 U.S.C. § 1396n(k). That program also allows Medicaid coverage for the costs of transitioning from an institution to the community, including first month's rent and utilities, bedding, basic kitchen supplies, and other necessities.

The ACA also abolished some of the original restrictions of Section 1915(i) of the Medicaid Act, so now states can provide home and community-based services to people who do not meet an institutional level of care. 42 U.S.C. § 1396n. States can tailor services to specific populations, including individuals with

[43] https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html.

up to 300% of the Federal Supplemental Security Income benefit rate, and incorporate additional services.

The ACA has additional provisions that protect older adults, such as Section 1557. 42 U.S.C. § 18116. That section prohibits discrimination on the basis of age, disability, race, color, national origin, or sex in certain health programs or activities. *Id.* If invalidated, older adults would lose an avenue to enforce their rights. All in all, these provisions are critical to the most vulnerable older adults.

V. The ACA Continues to be a Valid Exercise of Congress's Taxing Authority.

The ACA is constitutional and should remain in force. Congress did not repeal the ACA or the minimum coverage provision when it passed the Tax Cuts and Jobs Act of 2017 (TCJA). *See* Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). Instead, the text of the TCJA shows that Congress limited its action to reducing the tax penalty to $0. *Id.*

When a statute's text is plain and unambiguous, it must be enforced according to its terms. *See generally King v. Burwell,* 135 S.Ct. 2480, 2489 (U.S. 2015). Here, a plain language reading of the TCJA shows that Congress intended to reduce the tax penalty to zero dollars, but leave the rest of the ACA intact. *See* 26 U.S.C. § 5000A.

By reducing the penalty to $0 while not eliminating the statutory scheme for imposing tax penalties, Congress explicitly maintained its authority to raise the

penalty in the future. Congress's taxing authority is not dependent on how much money the Internal Revenue Service collects for the penalty. Even before the passage of the TCJA, if every taxpayer had bought ACA-compliant insurance or met an exception, no one would have been required to pay a penalty. Yet the ACA would still have been a constitutional exercise of Congress' taxing authority. For that reason, reducing the tax penalty did not change the validity or constitutionality of the ACA.

The ACA is deeply rooted into the nation's health care system and economy. Millions of Americans depend on the Act for their health, protection, and well-being.

Their lives now hang in the balance.

This Court should restore the people's will as executed by their Congressional representatives and reverse the lower court's decision. The ACA is the law of the land.

CONCLUSION

For the reasons described above, Amici respectfully urge the Court to reverse the lower court's decision.

Dated: April 1, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. The foregoing Brief of Amici Curiae supporting Appellants complies with FED. R. APP. P. 32(A)(7)(B)'s type-volume limitation because the brief contains 6,447 words, excluding the parts of the brief that Fed. R. App. P. 32(a)(7)(B)(iii) exempts.

2. The foregoing Brief of Amici Curiae supporting Appellants complies with FED. R. APP. P. 32(A)(5)'s type-face requirements and Fed. R. App. P. 32(a)(6)'s type style requirements because the brief has been prepared in a proportionally spaced type-face using Microsoft Word 2016 in Times New Roman14-point font.

Dated: April 1, 2019

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the U.S. Court of Appeals for the Fifth Circuit by using the Appellate CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

/s/ Maame Gyamfi
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