No. 14-114

IN THE
Supreme Court of the United States

DAVID KING, *et al.*,

Petitioners,

v.

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

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT

AMICI CURIAE BRIEF OF PUBLIC HEALTH DEANS, CHAIRS, AND FACULTY AND THE AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI[1]

Amici curiae Public Health Deans, Chairs, and Faculty and The American Public Health Association ("APHA") submit this brief in support of Respondent Sylvia Mathews Burwell, in her official capacity as Secretary of the Department of Health and Human Services. *Amici curiae* urge this Court to affirm the District Court's order granting Summary Judgment to Respondent Burwell.

Amici curiae are deans, departmental chairs, and faculty members of public health and public health law. *Amici* include deans, chairs, and faculty from some of the leading schools of public health in the United States listed in Appendix A. *Amici curiae* are engaged in the policy and science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research to reduce disease and prevent injury. *Amici* believe that the public's health will be adversely affected if the decision of the United States Court of Appeals for the Fourth Circuit is not affirmed.

Amici curiae also include APHA, an organization that champions the health of all people and all communities and strengthens the profession of public health, shares the latest research and

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[1] It is hereby certified that counsel for the parties have consented to the filing of this brief. It is further certified that no counsel for a party authored any portion of this brief and that no person other than these *amici curiae* or their counsel made a monetary contribution to the preparation of this brief.

information, promotes best practices and advocates for public health issues and policies grounded in research. APHA is the only national health organization that combines a 140-plus year perspective, a broad-based member community working to improve the public's health, and the ability to influence federal policy to improve the public's health. It has been APHA's longstanding position that access to health care is a fundamental right and integral to the health and well-being of individuals and to the broader public health. Further, APHA supports the increased access to health care provided by the Patient Protection and Affordable Care Act of 2010 ("ACA"). APHA believes that the public's health and the health of individuals will be adversely affected if the decision of the Fourth Circuit is overturned.

INTRODUCTION AND SUMMARY OF ARGUMENT

Based upon the incontrovertible evidence that health insurance coverage improves access to health care and overall health, Congress structured the ACA to provide near-universal access to affordable insurance. To ensure that coverage is affordable, the ACA creates a federal Health Insurance Premium Tax Credit ("Premium Tax Credit") that is projected to benefit approximately 26.7 million Americans who otherwise lack public or private health insurance and have qualifying incomes.[2] Thirty-four states[3]—

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[2] *See* U.S. CENSUS BUREAU, 2013 American Community Survey,http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t.

some for political reasons, others out of practical considerations—have chosen to use the federally-funded exchange ("FFE"), an option provided under the ACA, to link lower-income residents with affordable health insurance coverage. An estimated 18 million children and adults—nearly 70% of this 26.7 million-person total—reside in these FFE states.[4]

By conditioning Premium Tax Credits on whether states can and will run a state-based exchange ("SBE"), Petitioners seek to eliminate payments of subsidies to millions of Americans who are not before this Court, even though doing so completely undermines the law's fundamental goal of near-universal coverage for Americans.

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[3] The 34 FFE states include the seven partnership Exchange states (Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia) and the 27 states whose Exchanges were run fully by the FFE in 2014: Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. Health Insurance Marketplace: January Enrollment Report for the Period: Oct. 1, 2013 – Feb. 1, 2014, 22–24 (Dep't Health & Human Serv. Feb. 12, 2014) [hereinafter HHS Report]. Fourteen states (plus the District of Columbia) have implemented their own SBEs: California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont and Washington. *Id.* Idaho and New Mexico were federally supported SBEs for 2014; that is, they were using the FFE website platform for 2014. *Id.*

[4] *Id.*

The FFE states—home to approximately two-thirds of the American population—were given no notice of the harsh consequences that might befall their residents as a result of their choice to use the FFE. Those receiving subsidies through the FFE are even poorer as a group than residents of states with SBEs. Many FFE states have also elected to opt out of the adult Medicaid expansion authorized under the ACA which impacts millions of individuals whose incomes fall between 100% and 138% of the federal poverty level and, therefore, would have qualified for Medicaid had their states not opted out. Compared to residents of SBE states, residents of states using the FFE will be disproportionately adversely affected by a loss of the Premium Tax Credit. They are not only poorer as a group but are also in worse health, using a broad range of population health indicators. Preventable mortality is higher in the FFE states, as measured by infant mortality and death rates for cardiovascular disease and cancer. Diabetes, high blood pressure, and depression rates—all associated with premature mortality—are higher in the group of states whose residents depend on the FFE. Eliminating subsidies in these states would deprive precisely those individuals of affordable health insurance.

If the Court reverses the Fourth Circuit's decision, one expert study reports that over 9.3 million residents of FFE states will lose subsidies by 2016, resulting in an 8.2 million-person increase in the number of uninsured people.[5] Other experts

[5] Linda J. Blumberg, Matthew Beuttgens, and John Holahan, *The Implications for a Supreme Court Finding for the Plaintiffs* (continued…)

have estimated that such a decision could result in the loss of subsidies by 68% of those individuals who currently receive them.[6]

Because of the interrelationship between insurance coverage, health care access, and population health, a decision striking down the IRS rule can be expected to lead to a loss of improvements in access to care, worsening health, and more preventable deaths. Applying the results of a prior study estimating mortality declines linked to the first four years of health reform in Massachusetts, a loss of health insurance by estimated 8.2 million persons can be expected to translate into over 9,800 additional deaths annually.

Nothing in the ACA requires these terrible health outcomes; indeed, the text of the law requires the opposite result. The Court should affirm the Fourth Circuit's Order preserving access to Premium Tax Credits for the 18 million eligible people living in FFE states.

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in King v Burwell: 8.2 Million More Uninsured and 35% Higher Premiums, Urban Institute (Jan. 2015), http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf.

[6] Christine Eibner and Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act*, Rand Corporation, at 19 (Table 2) (Oct. 2014), http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR708/RAND_RR708.pdf.

ARGUMENT

I. Eliminating Access to Premium Tax Credits for Residents of the 34 States That Have Not Established a SBE Will Defeat the Public Health Goals of the ACA and Harm Population Health.

A. *The ACA Rests on a Population-Wide Health Goal of Near-Universal Access to Insurance—a Goal of Special Importance in States that Have Not Established a SBE.*

Despite the clear evidence that Congress intended to provide Americans with near-universal access to insurance, Appellants would deny affordable insurance to an estimated 18 million subsidy-eligible people simply because they happen to live in one of 34 states that has elected not to establish a SBE and has instead chosen to rely on an FFE, either wholly or as state partners.

About two-thirds of the nation's population—roughly 200 million people—live in the 34 FFE states.[7] The states electing to use the FFE did so with no notice of the dire consequences that would befall their residents were they to make such an

[7] A total of 37 states use the FFE, but three of these states—Oregon, Nevada, and New Mexico—have established a SBE and use the FFE only for operational purposes in the individual market, as provided under 42 U.S.C. § 18041(c)(1)(B)(i) and (ii). These states, however, have SBEs and are not FFE states under the law.

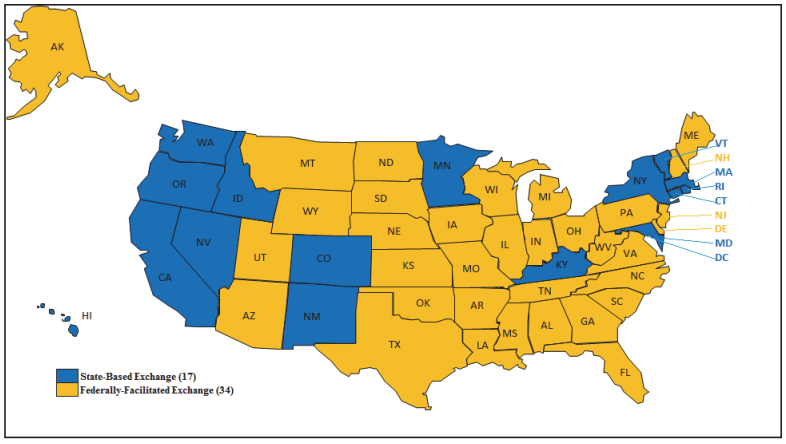
election; indeed, states reasonably relied on the Treasury rule when making their decisions.

For millions of people, access to affordable health insurance rests on the availability of Premium Tax Credits for qualified health plans purchased on the FFE or on a SBE (collectively referred to as "the Exchange" or "the Exchanges"). As this Court has previously explained, the ACA "attempts to achieve near-universal health insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers—while, at the same time, *offsetting significant portions of those costs with new benefits to each group*." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2670 (2012) (emphasis added). Unlike Medicaid, financial assistance based on federal tax policy does not contemplate state-to-state variation. Instead, as this Court has acknowledged, social welfare legislation that rests on tax policy contemplates a nationally uniform approach and cannot be subjected to individual objections. *Cf.*, *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2784 (2014) (quoting *United States v. Lee*, 455 U.S. 252, 260 (1982)) (in the context of religious objections to taxation, the Court noted that "'[t]he obligation to pay the social security tax initially is not fundamentally different from the obligation to pay income taxes' [and] . . . [b]ased on that premise, [the Court] explained that it was untenable to allow individuals to seek exemptions from taxes based on religious objections to particular Government expenditures . . . .").

To deprive residents of these 34 FFE states of Premium Tax Credits simply because their state elected to utilize the FFE—whether for philosophical or practical reasons—will leave millions without access to affordable coverage and thereby undermine the public's health. It will also further exacerbate the significant racial, ethnic, and income-based health disparities that already exist between the populations of FFE states and residents of states that have elected to establish a SBE.

The characteristics of the residents in the 34 FFE states—depicted in Figure 1 (below)—provide some insight into the catastrophic consequences of a ruling by this Court that invalidates their residents' access to Premium Tax Credits.

Figure 1: State-Based Exchanges and Federally-Facilitated Exchanges for Open Enrollment 2015



As shown in **Table 1** (App. B), these 34 states accounted for 171.6 million out of 264.8 million (64%)

nonelderly U.S. residents in 2013. The residents of the 34 FFE further accounted for an even greater share—66%, or 84.8 million out of 127.2 million U.S. residents whose 2013 incomes made them eligible for Premium Tax Credits, with family incomes between 100% and 400% of the poverty level.[8]

The FFE states are also home to the nation's most vulnerable populations. As of April 2014, FFE states accounted for nearly 4.7 million of all people receiving Premium Tax Credits in 2014, 87% of all recipients.[9] **Table 2** (App. B). Experts further project that by 2016, the number of tax credit recipients in the FFE states will exceed 9.3 million people.[10]

The FFE states benefit heavily from Premium Tax Credits, because the great majority of the uninsured U.S. population resides in these states. Census data show that prior to implementation of the ACA system of subsidized insurance available through the Exchanges, residents of the 34 FFE

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[8] In Medicaid expansion states, the income threshold for Premium Tax Credits begins at 139% of the Federal Poverty Level ("FPL") (the point at which Medicaid income eligibility ceases) and phases out at 400% of the FPL. In states that have not expanded Medicaid to cover all non-elderly adult residents with incomes up to 138% of the FPL, the threshold income eligibility for Premium Tax Credits begins at 100% and phases out at 400% of the FPL.

[9] Table 2 includes Idaho and New Mexico, which as of the time of the study, had elected to establish a SBE but relied on the federal IT platform. Together these states account for slightly less than 100,000 of the 4.7 million premium subsidy recipients in FFE states.

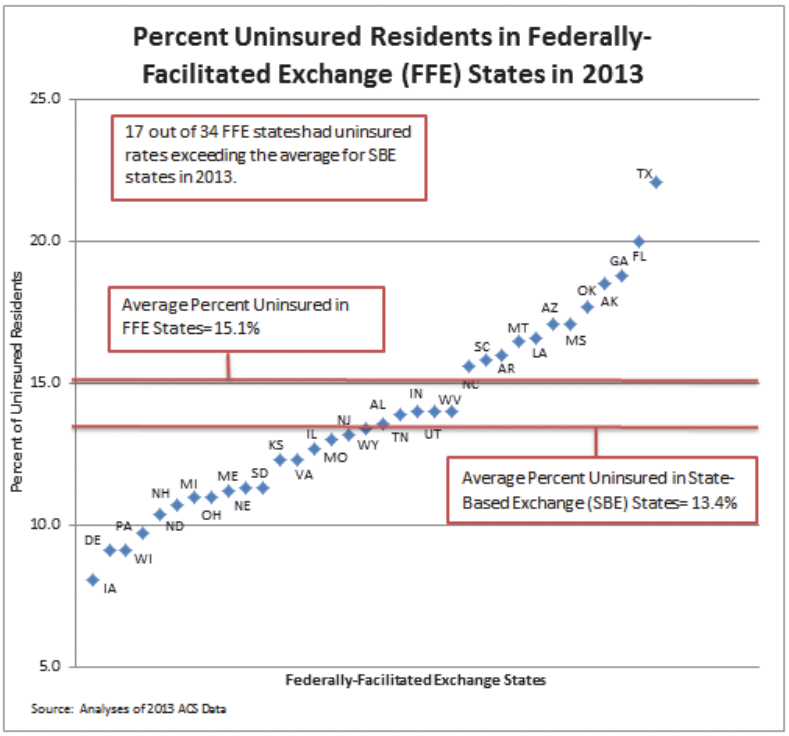
[10] *See supra* n.5 and Table 4 (App. B).

states accounted for 68% of all uninsured Americans—30.6 million out of 45.2 million uninsured U.S. residents. If residents of the 34 FFE states were deprived of Premium Tax Credits as a result of this Court's ruling. More than 4.6 million people who had received assistance as of April 2014 would lose nearly $15 billion in tax credits. **Table 2** (App. B). By 2016, the number of people receiving Premium Tax Credits in the FFE states is expected to rise to 9.346 million, representing a total of $28.8 billion in expected tax credits ($3,090 per person, on average). As a result, the number of uninsured people resulting from the loss of Premium Tax Credits is expected to rise by approximately 8.2 million.[11]

Moreover, uninsured Americans are disproportionately concentrated in FFE states to begin with (15.1% of all residents compared to the national average of 14.5%). **Table 3** (App. B). This disproportionate concentration of the uninsured is depicted in **Figure 2.**

[11] *Id.*

Figure 2: Percent Uninsured Residents in Federally-Facilitated Exchange States in 2013



Were Premium Tax Credits to be terminated in the FFE states, these coverage disparities would widen over time as the number of insured residents of FFE states falls ever further behind in the number of insured residents in the SBE states. The public health consequences of these widening disparities would be severe, exacerbating the already poor population health measures in the FFE states.

Just as the FFE states constitute approximately two-thirds of the United States' population, these states are home to the majority of low-to-moderate-

income uninsured African-Americans who would be affected by the loss of Premium Tax Credits (15 million out of 19 million African Americans with incomes between 100% and 400% of the federal poverty level). **Table 4** (App. B). Similarly, the vast majority of uninsured African-Americans live in FFE states (2.6 million out of 3.1 million), and moreover, that African American residents of FFE states are disproportionately likely to be uninsured (17.6% versus 12.7%). *Id.* Similarly, the majority of low-to-moderate-income uninsured Hispanic-Americans live in the 34 FFE states. *Id.* In sum, non-Hispanic African-Americans and Hispanic-Americans residing in one of the 34 FFE states are more likely to be both low-to-moderate income and uninsured. *Id.*

B. *Eliminating Access to the Premium Tax Credit for FFE State Residents Will Exacerbate Already-Existing Income-Based, Racial, and Ethnic Health Disparities that Affect the Populations of FFE States Compared to the Rest of the Nation.*

Poverty and poor health are more concentrated within the FFE states to begin with and eliminating Premium Tax Credits for residents of these states accordingly carries especially grave implications. Population health disparities between the FFE and SBE states were clearly evident even before implementation of the subsidized Exchange. **Table 5** (App. B) underscores that compared to residents of SBE states, residents of the 34 FFE states are more likely to report being unable to see a doctor due to cost (16.5% versus 14.9%). *Id.* They are more likely

to live in medically underserved areas that lack adequate access to primary health care (12.4% versus 10.1%). *Id.* Residents of FFE states are more likely to experience health risks amenable to health care: deaths from cardiovascular disease (258.6 deaths per 100,000 versus 236.8 deaths), infant mortality (6.5 deaths per 1000 live births versus 5.2 deaths); and deaths from cancer (194.2 deaths per 100,000 residents versus 181.0 deaths). *Id.*

Female residents of FFE states are less likely to have had a mammogram in the preceding year and adult residents are more likely to have been diagnosed with diabetes (a condition that can lead to the loss of limbs, kidney disease, and heart attacks). *Id.* FFE state residents are more likely to have been told that they have high blood pressure and depression and are more likely to be overweight and smoke. Regular and ongoing medical care—accessibility of which turns heavily on being insured—has been shown to be associated with reduced risks for all of these conditions.

The FFE states are two-thirds less likely than SBE states to be in a position to invest in public health services ($61 per resident to $103). *Id.* This figure underscores the weaker economies and higher poverty in FFE-reliant states, a reality that intensifies the implications of withdrawing premium tax subsidies from residents of those states.

The role that insurance plays in addressing these population health disparities has been extensively documented. Improved infant health, better management of obesity, and reduced health

risks from conditions such as diabetes are associated with access to timely, appropriate and quality health care, which in turn is significantly associated with health insurance. For example, evidence drawn from the 2011-2012 National Health and Nutrition Examination Survey shows that 32% of uninsured people with diabetes remain undiagnosed, compared with 15% of people with diabetes who have insurance.[12] This is because health insurance facilitates access to affordable medical care at an earlier point, when it is possible to avert often-fatal consequences by treating and managing serious health conditions.

C. *Because Most of the FFE States Also Have Opted Out of Expanding Their State Medicaid Programs, Additional Numbers of Near-Poor Residents in Those States Are Entirely Dependent on the Premium Tax Credit for Affordable Insurance Coverage.*

The loss of access to Premium Tax Credits in the FFE states would compound an already bad situation, because in addition to the millions of people with incomes between 139% and 400% of the federal poverty level, census data show that approximately 3.9 million residents of FFE states have incomes between 100% and 138% of the FPL

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[12] *See* National Health and Nutrition Examination Survey ("NHANES"), 2011-2012 (Dep't Health & Human Serv. Centers for Disease Control and Prevention Nat'l Center for Health Statistics 2012).

and also depend on FFE subsidies.[13] These people depend on the FFE because, as of January 2015, 22 out of 34 FFE states also had opted out of the ACA-authorized Medicaid expansion.[14] *See* **Figure 3** (below). This means that nonelderly adults with incomes up to 138% of the FPL and not otherwise eligible for traditional Medicaid coverage have no Medicaid eligibility pathway.[15] Instead, these people, falling into the insurance gap left by their state's decision not to expand Medicaid, are able to use Premium Tax Credits to purchase insurance on the Exchanges, since in the non-Medicaid expansion states, subsidy eligibility commences at 100 percent of the federal poverty level.

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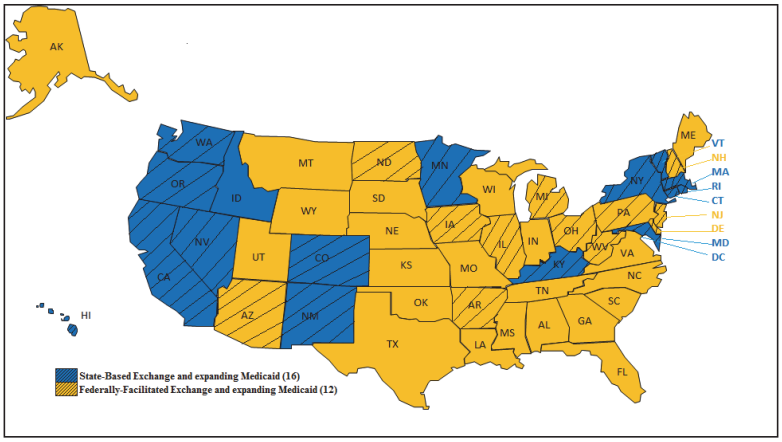
[13] As states elect to expand Medicaid, the number of persons with incomes between 100% and 138% of the FPL who obtain affordable coverage using Premium Tax Subsidies can be expected to decline. However, most of the states (including the largest states of Texas and Florida) that have placed residents in the "coverage gap" by failing to expand Medicaid have, as of January 2014, shown no inclination to change their decisions.

[14] These 22 states are: Indiana, Tennessee, Maine, Virginia, North Carolina, South Carolina, Florida, Georgia, Tennessee, Alabama, Mississippi, Louisiana, Texas, Missouri, Oklahoma, Kansas, Nebraska, South Dakota, Utah, Wyoming, Montana, and Alaska.

[15] By contrast, all SBE states (except Idaho) have expanded Medicaid to cover this population. Thus, in these states, residents with incomes between 138% and 400% of the FPL are eligible for the Premium Tax Credit.

Figure 3: Marketplace Status and Medicaid Expansion for Open Enrollment 2015



If this Court reverses the decision of the Fourth Circuit, these people will lose their premium subsidies—and will remain ineligible for Medicaid coverage, as well, due to their states' election not to expand Medicaid.

II. The Overriding Purpose of The ACA Was to Enact National Health Reform, Specifically By Ensuring the Availability of Affordable Health Insurance Coverage for All Americans.

A. *Congress Recognized that Universal Health Insurance Coverage Improves Access to Health Care and Health Outcomes.*

The ACA rests on the fundamental premise that universal coverage is vital to improving the health of

the American population. This premise was front and center in Congress, even at the earliest point in the debate over health reform.[16] In fact, irrefutable evidence shows that access to health insurance promotes individual and community health and that Congress was aware of this nexus in enacting the ACA. In the earliest stages of the ACA debate, Members of Congress focused on the nexus between health reform and population health.[17] The seminal body of research Congress relied on is a multi-year study undertaken by the Institute of Medicine ("IOM"),[18] whose 2002 exploration of the consequences of being uninsured led to a pivotal conclusion: more than 18,300 American adults died annually because they lacked health insurance.[19]

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[16] *See* S. Con. Res. 6, 111th Cong., 155 Cong. Rec. S2164–02 (2009) (Senate Concurrent Resolution 6 – Expressing the Sense of Congress that National Health Care Reform Should Ensure that the Health Care Needs of Women and All Individuals in the United States are Met).

[17] *See supra* n.16, at S2165 ("Whereas the Institute of Medicine estimates that the cost of achieving full health insurance coverage in the United States would be less than the loss in economic productivity from existing coverage gaps…."); *see also* Michelle Andrews, *Deaths Rising for Lack of Ins., Study Finds*, N.Y. TIMES, Feb. 26, 2010, http://prescriptions.blogs.nytimes.com/2010/02/26/deaths-rising-due-to-lack-of-insurance-study-finds/?_php=true&_type=blogs&_r=0 (summarizing the IOM research and reporting on a later update of its estimates).

[18] The IOM is the medical/public health component of the Congressionally-chartered National Academy of Sciences.

[19] Comm. on the Consequences of Uninsurance; Bd. on Health Care Servs. (HCS) & Inst. of Med. ("IOM"), CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 163 (The National

(continued…)

The IOM Committee found that: (1) health insurance is associated with better health outcomes among adults and with the receipt of appropriate care across a range of preventive, chronic, and acute care; (2) older adults with chronic conditions are the most likely to realize the health benefits of coverage because of their greater need for health care; (3) populations facing the highest health risks (those with low incomes and members of racial and ethnic minority groups) stand to benefit the most from coverage, thereby leading to a reduction in disparities in health and health care; (4) comprehensive coverage (of the type that ultimately would be made available through subsidized, qualified health plans offered on an Exchange) was most strongly associated with improved health; and (5) with stable insurance coverage, the health of uninsured adults improves over time.[20]

A range of studies have shown that uninsured adults, especially those without insurance for over a year, have more unmet health needs than those adults with stable coverage, because they encounter greater barriers to early detection and treatment of chronic illnesses, delay seeking medical care, and even forgo necessary care for potentially serious symptoms.[21] The IOM studies show that uninsured

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Academies Press ed. 2002) [hereinafter "CARE WITHOUT COVERAGE"].

[20] *Id.* at 91–103.

[21] *Id.*; CARE WITHOUT COVERAGE, *supra* note 19, at 47–90; J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, MILBANK Q, June 2009, at 443, 485.

patients with chronic diseases are less likely to receive appropriate care to manage their conditions and have worse clinical outcomes than insured patients.[22] They also show that uninsured patients who are hospitalized are more likely to die in the hospital, receive fewer services, and experience more adverse medical events due to negligence than insured patients.[23] Further, the IOM studies have found that uninsured patients are more likely to experience worse health outcomes than among those with private insurance coverage.[24]

Finally, the IOM research extended beyond the individual impact of being uninsured and considered community-wide effects of populations at elevated risk for being uninsured. The IOM concluded that communities with high rates of uninsured have worse access to health care and report higher proportions of low income families in fair to poor health, as opposed to communities with low uninsured rates.[25] Hospitalization rates for conditions amenable to early treatment with ambulatory care are higher in communities experiencing a greater proportion of lower income and uninsured residents, including both access problems and greater severity of illness.[26] Finally,

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[22] CARE WITHOUT COVERAGE, *supra* note 19, at 57–71.
[23] *Id.* at 73–76.
[24] *Id.* at 80–82.
[25] Comm. on the Consequences of Uninsurance; Bd. on Health Care Servs. (HCS); & Inst. of Med. (IOM), A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE 140 (The National Academies Press ed. 2003) [hereinafter "COMMUNITY EFFECTS OF UNINSURANCE"].
[26] *Id.* at 142.

the incidence of vaccine-preventable and communicable disease was shown to be higher in areas with high uninsured rates that experience chronic underfunding of local public health agencies.[27]

Subsequent studies echoed the IOM's findings.[28] One study, which updated the earlier IOM estimate regarding the impact of being uninsured on life and health, significantly increased the earlier estimate—from 18,314 excess deaths in 2001 among Americans ages 25-64 to 35,327 in 2005. This study concluded that the uninsured are 1.4 times more likely to die from preventable causes.[29] This disparity in deaths could be attributed in part to the fact that uninsured adults are less likely than adults with insurance to receive timely, appropriate, and quality health care.[30] Subsequent studies found that the absence of health insurance significantly affected the health outcomes of patients with the most serious

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[27] *Id.* at 147.

[28] One study issued in 2009 argued that it is not possible to draw causal inferences between insurance coverage and death. Richard Kronick, *Health Insurance Coverage and Mortality Revisited*, 44 HEALTH SERVS. RESEARCH, Aug. 2009, at 1211. However, the IOM has not altered its previous estimates, and no additional studies supporting this contrary finding have been published.

[29] Andrew P. Wilper, *et al.*, *Health Ins. and Mortality in US Adults*, AM. J. PUB. HEALTH, Dec. 2009, at 2289, 2292.

[30] CARE WITHOUT COVERAGE, *supra* note 19, at 47–90 (reviewing the empirical literature on the association between insurance and health care and health outcome).

conditions such as cancer, principally because of delayed diagnosis.[31]

B. *The ACA's Purpose Was to Enact Comprehensive Health Reform on a National Scale.*

Congress cited the link between coverage and health outcomes and set national public health improvement goals that hinge on achieving near-universal coverage. The ACA's text provides evidence of Congressional intent to raise the health of the entire American population—regardless of whether their state elects to operate its own Exchange or, as permitted under the law, to rely on the FFE. No state was ever told that relying on the FFE would sacrifice the profound health and health care advantages for its at-risk population that flow from being insured. Congressional findings make clear that being uninsured burdens the national economy and interstate commerce. ACA § 1501(a)(2), codified at 42 U.S.C. § 18091(2) (2011). By extending the coverage mandate to all Americans—facilitated by access to affordable health insurance through the use of Premium Tax Credits—Congress intended to improve the nation's health and to reduce the annual costs of $207 billion to the national economy that flow from the poorer health and shorter lifespan of the uninsured. ACA § 1502(a)(2)(E), codified at 42 U.S.C. § 18091(2)(E) (2011).

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[31] John Z. Ayanian, *et al.*, *Unmet Health Needs of Uninsured Adults in the United States*, JAMA, Oct. 25, 2000, at 2061.

Congress signaled its intent in the ACA to couple a nationwide system of affordable insurance with other national strategies to improve the public health. For instance, the ACA directed the Secretary of Health and Human Services ("Secretary") to identify national priorities to establish a strategy to improve the delivery of health care services, patient health outcomes, and population health. ACA § 3001, codified at 42 U.S.C. § 280j (2011). The ACA directed the President to establish the National Prevention, Health Promotion, and Public Health Council to coordinate and lead all federal departments and agencies on prevention, wellness and health promotion practices, the public health system, and integrative health care strategy nationwide. ACA § 4001(a), codified at 42 U.S.C. § 300u-10 (2011). Congress further directed the Secretary to undertake a "national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span." ACA § 4004(a), codified at 42 U.S.C. § 300u-12(a) (2011).

These national programs demonstrate that the ACA is a comprehensive health care reform effort on a national scale.[32] Read in its entirety, the ACA is a

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[32] Further demonstrating Congress never intended for Premium Tax Credits to be restricted to SBE states, a recent study analyzed 68 separate analyses related to the ACA and performed by the Congressional Budget Office ("CBO"). *See* Theda Skocpol, *Why Congressional Budget Office Reports Are The Best Evidence Of Congressional Intent About Health Subsidies*, Scholars Strategy Network, Harvard University (Jan. 2015),

(continued…)

law with a pathway to affordable insurance coverage that is national in scope, not one reserved for states that happen to run their own Exchanges.

C. *The ACA's Structure Underscores That Exchanges Exist as a National Public Health Intervention to Connect Americans to Affordable Coverage.*

The health insurance Exchanges—which were to be created for each and every state—are one element of the ACA's national health care reform strategy. The Petitioners' position that seeks to deny Premium Tax Credits to an otherwise eligible taxpayer based on her state of residence contravenes this national approach.

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http://www.scholarsstrategynetwork.org/content/why-congressional-budget-office-reports-are-best-evidence-congressional-intent-about-health-. Professor Skocpol noted that:

> [t]hroughout hard-fought debates about health reform, lawmakers in both parties looked for ways to save taxpayer money. Partial subsidies would have greatly reduced costs, so the total absence of this kind of analysis among the 68 [estimates, reports, and responses] prepared by CBO for the 111th Congress (and its continuing absence in reports done for the next Congress) is the best objective evidence we have that no one in Congress considered premium subsidies restricted to certain states to be either possible or desirable. If Congress intended to threaten states with withheld subsidies, nobody said so.

Id.

Rather, to bring about national health care reform under the ACA, Congress designed the FFE to serve as an *operational* fallback to accomplish what a state either could not or would not do—operate an Exchange for its citizens. Irrespective of the entity running the Exchange machinery, however, Congress intended the ACA to transform the national market for health insurance.

The ACA's market reforms, designed to ensure access to coverage regardless of health status (*e.g.*, guaranteed insurance coverage regardless of preexisting conditions), apply in *all* states, thereby restructuring the health insurance market on a national scale. Furthermore, Congress preserved (albeit in regulated form) the health insurance market outside the Exchange structure, thereby ensuring that any individual who wished to discharge the personal responsibility obligation by purchasing coverage on the open market could do so. ACA § 1312(d), codified at 42 U.S.C. § 18032(d) (2011) (expressly preserving the operation of the private insurance market outside the Exchanges). The Exchanges added a unique feature that is essential to maintaining a reformed insurance market in all states, by extending financial assistance to individuals who need subsidies in order to secure coverage.

Viewed in this light, the Exchanges exist as a national structure designed to ensure affordable coverage in all states—including the FFE fallback system for states that either could not or would not establish their own Exchanges. Petitioners' position would punish residents of states that refuse to

establish an Exchange for political reasons, as well as residents of states that ardently desire to operate their own Exchange yet must depend on the FFE because they lack the resources to operate their own system. This is an absurd result contrary to the ACA's text, structure, and purpose. Given the myriad technical issues that have arisen as the states have attempted to construct and operationalize the web-based platform necessary to implement the ACA-mandated Exchanges, to argue that Congress meant to place entire populations at heightened health risk simply because their states rely on the FFE is legally and factually untenable. Accepting Petitioners' reading of the ACA would thwart its overriding stated goal.

D. *Congress Recognized the Correlation Between Insurance Coverage and Population Health and the ACA Was Structured to Achieve a Nationwide, Positive Health Impact.*

Studies published subsequent to ACA enactment have borne out the wisdom of Congress' decision to improve access to health care and population health through insurance reform. In this regard, two seminal studies are instructive. The first examined the impact on adult mortality of Massachusetts' 2006 health reform law, which is widely regarded as the prototype for the ACA.[33] That study found that

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[33] Benjamin D. Sommers, MD, PhD; Sharon K. Long, PhD; and Katherine Baicker, PhD, *Changes in Mortality after Massachusetts Health Care Reform: A Quasi-experimental* (continued…)

adults in Massachusetts experienced a 2.9% drop in mortality in the wake of health reform compared to individuals in other states with similar socioeconomic characteristics. The most dramatic results were seen in Massachusetts counties with the lowest incomes and the highest rates of uninsured adults. The authors concluded that such results could be attributed to significant gains in health insurance coverage and access to health care for conditions such as diabetes or cardiovascular disease that threaten life and health but are amenable to treatment.

The second study was nationwide and directly examined the effects of the ACA's first open enrollment period on health insurance coverage and access to health care. This study found more than a five percentage point drop in the uninsured rate among U.S. adults between fall 2013 and April 2014.[34] The drop in the proportion of uninsured Americans coincided with the 2013-2014 open enrollment period, meaning that the first open enrollment period under the new law is associated with a 25% decline in the proportion of nonelderly Americans who are uninsured. The sub-populations at highest risk for being uninsured saw the most significant gains and people with incomes within the premium subsidy eligibility range saw significantly

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Study, ANN. INTERN. MED., May 2014, at 585, http://annals.org/article.aspx?articleid=1867050.

[34] Benjamin D. Sommers, M.D., Ph.D., et al., *Health Reform and Changes in Health Insurance Coverage in 2014*, NEW ENG. J. MED., Aug. 28, 2014, at 867, 871, http://www.nejm.org/doi/full/10.1056/NEJMsr1406753.

greater rates of coverage in all states. Expanded insurance coverage resulted in significant, measurable gains in access to care and a significant decline in the proportion of adults who reported being unable to afford medical care.[35]

E. *Eliminating the Premium Tax Credits and Thus Diminishing the Affordability and Likelihood of Insurance in the Very States Whose Residents Most Need Coverage Would Eviscerate the ACA's Public Health Goals.*

Congress envisioned that all Americans in need of assistance in order to make coverage affordable would receive it, thus benefiting the entire nation. The coverage mandate, applicable to all states—not just those with a SBE—is a central pillar of the legislative framework for ensuring near-universal access to affordable coverage. Since Congress saw creation of a robust yet affordable health insurance marketplace as the key to achieving this level of coverage, it logically provided for federal subsidies in both types of Exchange—state and federal—in order to ensure affordability for residents of all states.

As described above, the FFE states, as a group, are poorer and have markedly worse population health status than the SBE states. This is especially true for minority populations in these states. They are also, for the most part, the same states that have eschewed federally-funded expansion of their

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[35] *Id.* at 870.

Medicaid programs. They are the very states whose populations most need access to affordable health insurance, but who would be the *least* likely to achieve it in the absence of Premium Tax Credits.

The ACA's overriding statutory purpose is clear—to expand access to health insurance. Interpreting a provision of the law in a manner that would essentially *eliminate* access to affordable health insurance for low income residents of two-thirds of the states—that happen to be those very states where residents are poorer and have worse health—would be contrary to the ACA's most fundamental population health improvement aims.

F. *This Court Should Affirm the Fourth Circuit's Decision in Order to Avoid Conflicts with the Text of the ACA That Would Unnecessarily Lead to Devastating Population Health Impact, Including Increasing the Uninsured Population by 8.2 Million People and Costing Thousands of Lives Annually.*

As noted earlier in this brief, previous research has documented the public health implications of Massachusetts' health reform law, which expanded coverage using a health insurance marketplace and subsidies that closely resemble the scheme under the ACA.[36] Researchers found that, in the first four years of the law in Massachusetts, for every 830

[36] *See supra* n.33 and accompanying text.

adults gaining insurance coverage there was one fewer death per year.[37] Using the national estimate that 8.2 million people can be expected to lose health insurance in the absence of subsidies on the federal marketplace, this ratio equates to over 9,800 additional Americans dying each year. Although the specific policy context and population impacts of any policy cannot be directly extrapolated from one setting to another, the general magnitude and power of these findings from the Massachusetts study demonstrate that even when approached cautiously, these earlier findings carry enormous public health implications for withdrawing subsidies and coverage from millions of Americans.

Petitioners' interpret the Premium Tax Credit provision of the ACA in a manner that produces absurd results, such as the elimination of health insurance coverage for those that need it most. *Cf. Kloeckner v. Solis*, 133 S. Ct. 596, 606–07 (2012). A statute's nominal plain language must give way if it would conflict with Congress' manifest purposes or lead to absurd results. "This Court, in interpreting the words of a statute, has some scope for adopting a restricted rather than a literal or usual meaning of its words where acceptance of that meaning would lead to absurd results . . . or would thwart the obvious purpose of the statute . . . ." *In Re Trans Alaska Pipeline Rate Cases*, 436 U.S. 631, 643 (1978) (quoting *Comm'r v. Brown*, 380 U.S. 563, 571 (1965) (internal quotations omitted); *see also United States v. Kirby*, 74 U.S. 482, 486–87 (1868) ("All laws

[37] *Id.*

should receive a sensible construction . . . [and] [t]he reason of the law in such cases should prevail over its letter").

In this case, Premium Tax Credits represent a critical element of the ACA to ensure that lower income Americans across the nation can afford insurance coverage. If two-thirds of otherwise eligible Americans lose their Premium Tax Credit simply because of their state residence, the goals of the ACA—to improve the public health and bring about near-universal coverage—will be thwarted.

CONCLUSION

For the reasons set forth above and in the brief of the Respondent, *Amici Curiae* Public Health Deans, Chairs, and Faculty and the APHA urge the Court to affirm the decision of the Fourth Circuit.

Respectfully submitted,

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APPENDIX

APPENDIX A:

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APPENDIX B: DATA TABLES

Table 1: Number and Characteristics of Nonelderly[1] Residents of Federally-Facilitated Exchange vs. State-Based Exchange[2] States in 2013[3]

Population Criteria	"Federal" Includes Partnership States But Excludes Original State-Based States		Total United States
	State-Based Exchange States	Federally-Facilitated Exchange States	
Number of States, Including D.C.	17	34	51
Total nonelderly population (millions)	93.2	171.6	264.8
People with incomes below 100% of poverty (millions)	15.0	29.7	44.7
% of people below 100% of poverty	16.1%	17.3%	16.9%
People with incomes between 100%-400% of poverty (millions)	42.4	84.8	127.2

[1] Universe consists of the civilian non-institutionalized population for whom poverty status is determined.

[2] Includes states that have elected to establish a state Exchange, but are using the federal IT platform.

[3] Based on analyses of the U.S. CENSUS BUREAU, 2013 American Community Survey, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t.

Table 2: Estimated Number of People Receiving Federal Premium Tax Credits, Average Monthly Value of Tax Credits, and Annual Value of Tax Credits in Federally-Facilitated Exchange States as of April 2014[4,5,6]

Federally-Facilitated Exchange State	Estimated Number of People Receiving Tax Credits (1000s)	Percent of Exchange Enrollees Receiving Tax Credits	Average Monthly Tax Credit Value ($/person)	Estimated Annual Value of Tax Credits (million $)[7]
TOTAL, FFE States	**4,685.8**	**87%**	**$264**	**$14,821**
Alabama	83.2	85%	$258	$258
Alaska	11.3	88%	$413	$56
Arizona	92.5	76%	$159	$176
Arkansas	39.1	89%	$293	$137
Delaware	11.4	81%	$263	$36
Florida	895.2	91%	$278	$2,987
Georgia	275.4	87%	$287	$948
Idaho	70.0	91%	$207	$174
Illinois	167.5	76%	$202	$406
Indiana	117.9	89%	$336	$475

[4] Based on April 2014 data as reported in Amy Burke, Arpit Misra, and Steven Sheingold, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*, Office of the Assistant Secretary for Planning and Evaluation (ASPE), HHS, June 18, 2014, http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.Pdf.

[5] Universe consists of the civilian non-institutionalized population for whom poverty status is determined.

[6] Includes Idaho and New Mexico, which as of the date of the ASPE study, had elected to establish a SBE but used the federal IT platform.

[7] Estimated annual value is the product of the number of tax credit recipients times the average value times 12 months.

Federally-Facilitated Exchange State	Estimated Number of People Receiving Tax Credits (1000s)	Percent of Exchange Enrollees Receiving Tax Credits	Average Monthly Tax Credit Value ($/person)	Estimated Annual Value of Tax Credits (million $)[7]
Iowa	24.5	83%	$242	$71
Kansas	45.0	78%	$223	$121
Louisiana	89.6	88%	$314	$337
Maine	39.8	89%	$344	$164
Michigan	237.1	87%	$246	$700
Mississippi	57.8	94%	$415	$288
Missouri	129.5	85%	$286	$444
Montana	31.5	85%	$246	$93
Nebraska	37.4	87%	$214	$96
New Hampshire	31.0	76%	$290	$108
New Jersey	135.9	84%	$317	$517
New Mexico	25.3	78%	$214	$65
North Carolina	325.4	91%	$300	$1,171
North Dakota	9.0	84%	$218	$24
Ohio	131.5	84%	$250	$394
Oklahoma	54.7	79%	$202	$133
Pennsylvania	257.6	81%	$246	$761
South Carolina	104.1	87%	$283	$354
South Dakota	11.8	89%	$271	$38
Tennessee	121.1	78%	$195	$283
Texas	616.4	84%	$233	$1,723
Utah	73.6	86%	$159	$140
Virginia	177.4	82%	$254	$541
West Virginia	17.1	85%	$302	$62
Wisconsin	127.2	90%	$316	$482
Wyoming	11.1	93%	$422	$56

Table 3: Health Insurance Coverage by Age in 34 States Electing Not to Establish a State-Based Exchange[89]

	Residents of Federally-Facilitated Exchange States	Total United States
Total Uninsured Population (2013) (mil)	30.6	45.2
Millions of uninsured adults, 18-44 years (2013)	17.9	26.7
Millions of uninsured adults, 45-64 years (2013)	8.7	12.8
% of people uninsured, all ages (2013)	15.1%	14.5%

[8] Universe consists of the civilian non-institutionalized population for whom poverty status is determined.
[9] These items are based on analyses of the ACA. *See id.*

Table 4: Economic and Health Insurance Status of Minority Populations: States Electing State-Based Exchanges versus States Electing Not to Establish a State-Based Exchange

	Residents of State-Based Exchange States	Residents of Federally-Facilitated States	Total United States
Non-Hispanic African-Americans			
Millions of Non-Hispanic African-Americans between 100%-400% of poverty (2013) [10]	4.0	15.0	19.0
% of Non-Hispanic African- Americans who are between 100%-400% of poverty (2013)	46.4%	51.5%	50.3%
Millions of Uninsured Non-Hispanic African-Americans between 100%-400% of poverty (2013)	0.5	2.6	3.1
% of Non-Hispanic African- Americans between 100%-400% of poverty who are uninsured (2013)	12.7%	17.6%	16.6%

[10] *See* Census Bureau's March 2014 Current Population Survey ("CPS") (indicating income and health insurance status in 2013). The data was tabulated using the U.S. CENSUS BUREAU, Current Population Survey (2014), CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

	Residents of State-Based Exchange States	Residents of Federally-Facilitated States	Total United States
Hispanics			
Millions of Hispanics between 100%-400% of poverty (2013)	13.4	18.4	31.7
% of Hispanics who are between 100%-400% of poverty (2013)	59.1%	58.3%	58.6%
Millions of Uninsured Hispanics between 100%-400% of poverty (2013)	2.9	5.3	8.2
% of Hispanics between 100%-400% of poverty who are uninsured (2013)	21.5%	29.1%	25.9%

Table 5: Key Health Indicators for Residents in States with State-Based Exchanges (SBEs) and Federally-Facilitated Exchanges (FFEs, including Partnership States)

Health Indicator	Average Level for Residents of 17 SBE States	Average Level for Residents of 34 FFE States
Mortality Rates		
1. **Age-adjusted rate of cardiovascular deaths (e.g., heart attacks, strokes, etc.) per 100,000 residents, 2010-12 [1]**	**236.8**	**258.6**
2. **Age-adjusted rate of cancer deaths per 100,000 residents, 2010-12 [1]**	**181.0**	**194.2**
3. **Infant mortality rate per 1,000 live births, 2011-12 [2]**	**5.2**	**6.5**
Access to Health Services		
4. **Percent of adults who needed to see a doctor in the past year but could not, due to cost, 2013 [3]**	**14.9%**	**16.5%**
5. **Percent of residents living in medically underserved areas, 2010 [4]**	**10.1%**	**12.4%**
6. **Percent of women (40-64 years) who had a mammogram in the past year, 2012 [5]**	**58.6%**	**56.4%**
7. **Average annual federal and state public health expenditures per resident, 2011-2012 [6]**	**$103**	**$61**
Health Status , Conditions and Behaviors		
8. **Percent of adults who report they are in excellent or very good**	**52.3%**	**50.0%**

Health Indicator	Average Level for Residents of 17 SBE States	Average Level for Residents of 34 FFE States
health (*as opposed to good, fair or poor health*), 2013 [3]		
9. **Percent of adults who have been diagnosed with diabetes, 2013 [3]**	**9.7%**	**10.5%**
10. **Percent of adults who have been told they have high blood pressure, 2013 [3]**	**30.7%**	**33.4%**
11. **Percent of adults who have been told they have depression, 2013 [3]**	**17.1%**	**18.1%**
12. **Percent of adults who currently smoke, 2013 [3]**	**16.1%**	**19.3%**
13. **Percent of adults who are obese (body mass index of 30 or higher, a measure of weight relative to height), 2013 [3]**	**25.8%**	**29.7%**

Sources:

1. State-level multi-cause mortality data from the National Center for Health Statistics, Centers for Disease Control and Prevention, weighted to account for the number of state residents. America's Health Rankings, United Health Foundation (drawn from http://www.americashealthrankings.org/, accessed Dec. 11, 2014)
2. State-level infant mortality data from the National Center for Health Statistics, Center for Disease Control and Prevention, weighted to account for the number of live births in each state. America's Health Rankings, United Health Foundation (drawn from http://www.americashealthrankings.org/, accessed Dec. 11, 2014)

3. Data reported by the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance Survey, 2013, weighted to account for the number of adults (18 or older) in each state. Prevalence and Trends Data, Office of Surveillance, Epidemiology, and Laboratory Services, Behavioral Risk Factor Surveillance System, (drawn from https://apps.nccd.cdc.gov/brfss/, accessed Dec. 10, 2014)
4. Based on data reported by the National Women's Law Center, using criteria defined by the Health Resources and Services Administration. People in Medically Underserved Areas (%), National Women's Law Center, http://hrc.nwlc.org/status-indicators/people-medically-underserved-areas (last updated June 7, 2010), weighted to account for the number of state residents.
5. Based on data reported by the American Cancer Society, weighted to account for the number of 40-64 year old women in each state. *Cancer Prevention & Early Detection Facts & Figures, Tables and Figures 2014*, American Cancer Society, 2014, http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-042924.pdf, accessed Dec. 9, 2014.
6. Based on data reported by the Trust for America's Health, weighted to account for the number of residents in each state. *Investing in America's Health: A State by State Look at Public Health Funding and Key Health Facts*, Trust for America's Health, Apr. 2013, http://healthyamericans.org/assets/files/TFAH2013InvstgAmrcsHlth05%20FINAL.pdf, accessed Dec. 11, 2014.