No. 14-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

David King, *et al.*,

Plaintiffs-Appellants,

v.

Kathleen Sebelius, in her official capacity as Secretary of Health and Human Services, *et al.*,

Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of Virginia

BRIEF OF PUBLIC HEALTH DEANS, CHAIRS, AND FACULTY AS *AMICI CURIAE* IN SUPPORT OF APPELLEE AND AFFIRMANCE

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
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Disclosures must be filed on behalf of all parties to a civil, agency, bankruptcy or mandamus case, except that a disclosure statement is **not** required from the United States, from an indigent party, or from a state or local government in a pro se case. In mandamus cases arising from a civil or bankruptcy action, all parties to the action in the district court are considered parties to the mandamus case.

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No. 14-1158 Caption: David King, et al., v. Kathleen Sebelius, et al.,

Pursuant to FRAP 26.1 and Local Rule 26.1,

Public Health Deans, Chairs, and Faculty
(name of party/amicus)

who is amici, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including grandparent and great-grandparent corporations:
N/A

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:
N/A

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(b))? ☐YES ☑NO
If yes, identify entity and nature of interest:

N/A

5. Is party a trade association? (amici curiae do not complete this question) ☐YES ☐NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐YES ☑NO
If yes, identify any trustee and the members of any creditors' committee:

N/A

Signature: s/ Clint A. Carpenter Date: March 21, 2014

Counsel for: Amici Curiae

CERTIFICATE OF SERVICE

****

I certify that on March 21, 2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

s/ Clint A. Carpenter
(signature)

March 21, 2014
(date)

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Amici curiae Public Health Deans, Chairs, and Faculty submit this brief in support of Appellee Kathleen Sebelius, in her official capacity as Secretary of the Department of Health and Human Services ("Secretary"). *Amici* urge this Court to affirm the District Court's order granting Summary Judgment to the Secretary.

STATEMENT OF THE *AMICI CURIAE*'S IDENTITY, INTEREST, AND SOURCE OF AUTHORITY TO FILE

As shown in Appendix A, *amici curiae* are deans, departmental chairs, and professors of public health and public health law from some of the leading schools of public health in the United States. *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 District Court's order is not affirmed. This brief is filed with the consent of all parties and pursuant to Federal Rule of Appellate Procedure 29.

STATEMENT OF AUTHORSHIP AND FINANCIAL CONTRIBUTION

Pursuant to Federal Rule of Appellate Procedure 29(c)(5), Public Health Deans, Chairs, and Faculty state that no party, party's counsel, or person other than *amici* and their counsel authored this brief in whole or in part or contributed money that was intended to fund preparing or submitting this brief.

SUMMARY OF ARGUMENT

Based upon the incontrovertible evidence that health insurance coverage improves access to health care and health, Congress structured the Patient Protection and Affordable Care Act of 2010 ("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 22.9 million Americans who otherwise lack public or private health insurance and have qualifying incomes. An estimated 16.2 million children and adults – over 70% of this 22.9 million-person total – reside in states that for either political or practical reasons have chosen to use the federally-facilitated exchange ("FFE") for connecting lower-income residents with affordable health insurance coverage.

The argument advanced by Appellants completely undermines the law's fundamental goal of near-universal coverage for all Americans by conditioning Premium Tax Credits on whether states can and will run a state-based exchange ("SBE"). Thirty-four states – some for political reasons, others out of practical considerations – have chosen to use the FFE.[1] The FFE states are home to

[1] 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 are run fully by the FFE in 2014: Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi,

approximately two-thirds of the American population. Residents of states using the FFE are poorer – and in worse health – than those who live in states that have established a SBE. If this Court rules for the Appellants and overturns the lower court decision, millions of children and adults will continue to go without insurance. Indeed, Appellants' position suggests that in designing the ACA, Congress decided to roll the dice on the American people, when in fact the entire legislative fabric of the ACA points in the opposite direction. Because of the intimate nexus between insurance coverage, health care access, and health, a decision in favor of the Appellants would irretrievably compromise the ACA's public health improvement goals by eliminating access to affordable insurance in the FFE states for those with lower-incomes. Accordingly, this Court should affirm the District Court's Order to preserve access to Premium Tax Credits for millions of otherwise eligible taxpayers living in the 34 FFE states – a total of 16.2 million people.

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: October 1, 2013 – Mar. 1, 2014, 21–23 (Dep't Health & Human Serv. Mar. 11, 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 are federally supported SBEs for 2014; they are using the FFE website platform for 2014. *Id.*

ARGUMENT

I. ELIMINATING ACCESS TO THE PREMIUM TAX CREDIT FOR RESIDENTS OF THE 34 FFE STATES WILL HARM POPULATION HEALTH AND DEFEAT THE PUBLIC HEALTH GOALS OF THE ACA.

A. The ACA Rests On a Population-Wide Health Goal of Near-Universal Access to Insurance – A Goal of Special Importance in the FFE States, Whose Populations Experience the Greatest Health Risks.

The ACA rests on a fundamental premise: universal coverage is vital to improving the health of the American population. This premise was unquestionably a Congressional focus, even during the early debate over health reform.[2] Yet Appellants would deny affordable insurance to millions solely because they happen to live in one of the 34 states that, for political or practical reasons, have elected to use the FFE. Premium Tax Credits bear no resemblance to a state grant-in-aid program such as Medicaid, in which states have considerable discretion over the reach of the intervention. To deny access to the Premium Tax Credit simply because of a taxpayer's place of residence will not only leave millions without access to affordable coverage but will further exacerbate the

[2] *See* Expressing the Sense of Congress that National Health Care Reform Should ensure that the Health Care Needs of Woman and All Individuals in the United States are Met, S. Con. Res. 6, 111th Cong., 155 Cong. Rec. S2164–65 (2009). The Concurrent Resolution, which came well before the Congressional Committees had even begun consideration of bills, reviewed the body of evidence linking the absence of health insurance coverage to elevated health risks across the American population, including excess and preventable death and disability.

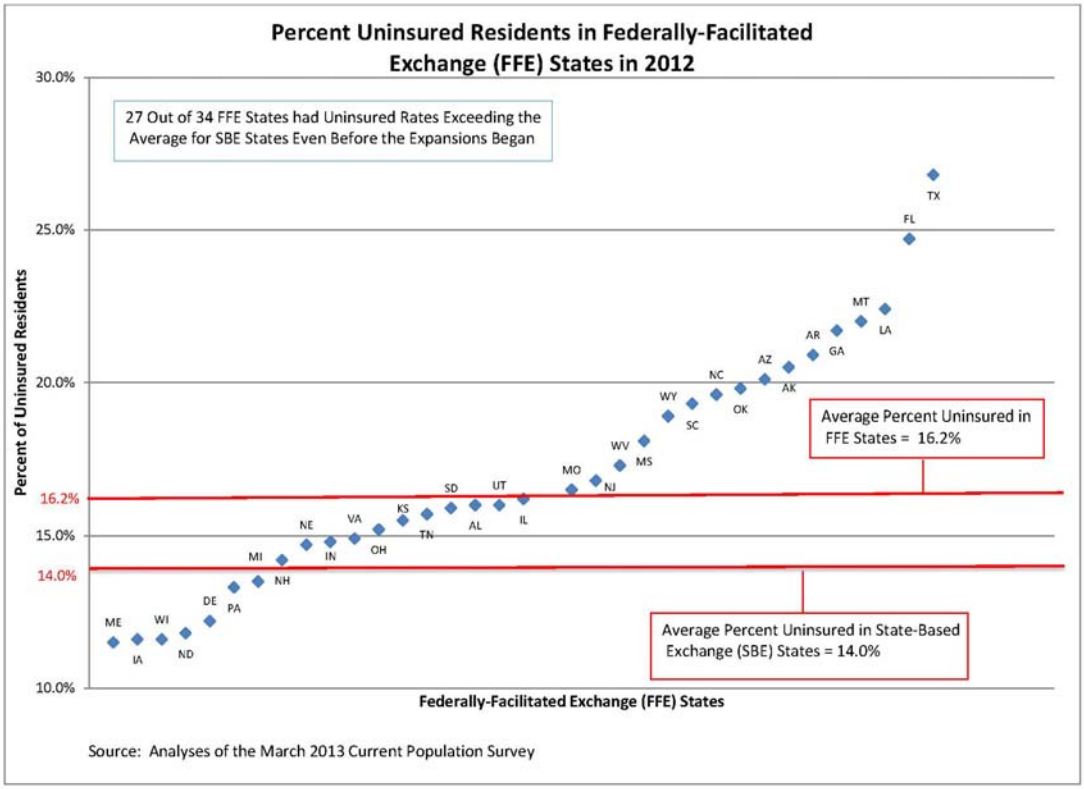
racial, ethnic, and income-based health disparities that already exist between the populations of the FFE and SBE states. Depriving people of federal assistance, simply because their state happens to use the FFE, produces cruel and absurd results that are contrary to the law.

About two-thirds of the nation's population – more than 200 million people – lives in the 34 FFE states. Of the 153.1 million U.S. residents with incomes falling within the eligibility range for Premium Tax Credits (between 100% and 400% of the poverty level[3]), 102.3 million (over two-thirds) live in an FFE state. (Table 1.) Were this Court to overturn the District Court ruling and find for the Appellants, its decision would affect the majority of the U.S. population that stands to benefit from Premium Tax Credits. (*Id.*)

The FFE states are home to the nation's most vulnerable residents. In 2012 – before the ACA's Premium Tax Credits took effect – the FFE states accounted for 32.7 million out of 48.0 million uninsured U.S. residents – 68% of the uninsured. (Table 2.) Moreover, as shown by the scatterplot graph below, the uninsured comprised a larger proportion of the population of the FFE states (16.2% compared

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

to 14.0% in the SBE states). (Table 3.) Terminating Premium Tax Credits in FFE states will widen coverage disparities over time as residents of those states fail to match the coverage gains in SBE states – precisely the opposite effect from what Congress intended.



Included among the 32.7 million uninsured people living in FFE states are especially vulnerable sub-populations. For example, the uninsured in these states include 9.1 million older adults, ages 45 to 64. (*Id.*) Indeed, in 2012, over two-thirds of the nation's 13.1 million uninsured older adults – who tend to have more serious health conditions and need more assistance with medical bills – resided in

FFE states. (*Id.*) Their age and more vulnerable health status mean that these older adults face extraordinary difficulty finding affordable coverage without subsidies, yet they are too young to qualify for Medicare.

Were Premium Tax Credits unavailable in FFE states, we estimate (using 2012 Census data) that approximately 16.2 million uninsured people whose incomes fall within Premium Tax Credit range and who otherwise are ineligible for public[4] or private insurance coverage would immediately be rendered ineligible for subsidies. (Table 2.)

Moreover, a ruling rendering residents of FFE states ineligible for Premium Tax Credits would be catastrophic for nearly 2.2 million people in FFE states who already have relied on this subsidy to purchase coverage. According to an analysis released by the U.S. Department of Health and Human Services, as of March 1, 2014, over 4.2 million people had enrolled in health insurance coverage through an exchange.[5] Most of those enrolling – 2.6 million – lived in FFE states.[6] Among

[4] In most states, children in families with incomes below 200% of the FPL are eligible for Medicaid or Children's Health Insurance Program ("CHIP") coverage and are therefore not eligible for coverage through the health insurance exchanges. Similarly, adults eligible for full Medicaid coverage are ineligible for Premium Tax Credits.

[5] HHS Report, *supra* note 1, at 7. Note that these calculations include the 58,873 enrollees from Idaho and New Mexico.

[6] *Id.*

these new enrollees, over 2.2 million (85%) received federal assistance.[7] If this Court reverses the District Court's Order and finds in favor of the Appellants, such a ruling would strip away the tax credit on which these enrollees relied to make coverage affordable causing these newly insured people to lose their coverage.

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

Because poverty and poor health are more concentrated among the FFE states, eliminating Premium Tax Credits for residents of these states carries especially grave implications. Population health disparities between the FFE and SBE states were evident even before implementation of the ACA. Compared to residents of SBE states, residents of FFE states are more likely to

- report being unable to see a doctor due to cost (17.2% versus 15.4%);
- have infants born at low-birth weight (8.5% versus 7.5%), a known risk factor for infant death and disability;
- have been told by a physician that they have diabetes (10.5% versus 9.4%), a condition that leads to health problems such as kidney disease, blindness, heart attacks, loss of limbs, and ultimately, death;

[7] *Id.* at 16.

- be overweight (64.8% versus 60.9%), a major risk factor for a host of health conditions; and
- live in medically underserved communities as a result of elevated poverty and health risks and a shortage of primary-care access (12.4% versus 10.1%).

(Table 5.)

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 timely and appropriate health care, and 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.[8] Health insurance coverage facilitates the medical care to diagnose and treat diabetes, thereby avoiding more serious health consequences.

[8] *See* Dep't Health & Human Serv. Centers for Disease Control and Prevention Nat'l Center for Health Statistics, *National Health and Nutrition Examination Survey ("NHANES")*, 2011-2012 (2012). Analyses of the NHANES were conducted by Leighton Ku, Ph.D., George Washington University School of Public Health and Health Services, January 2014.

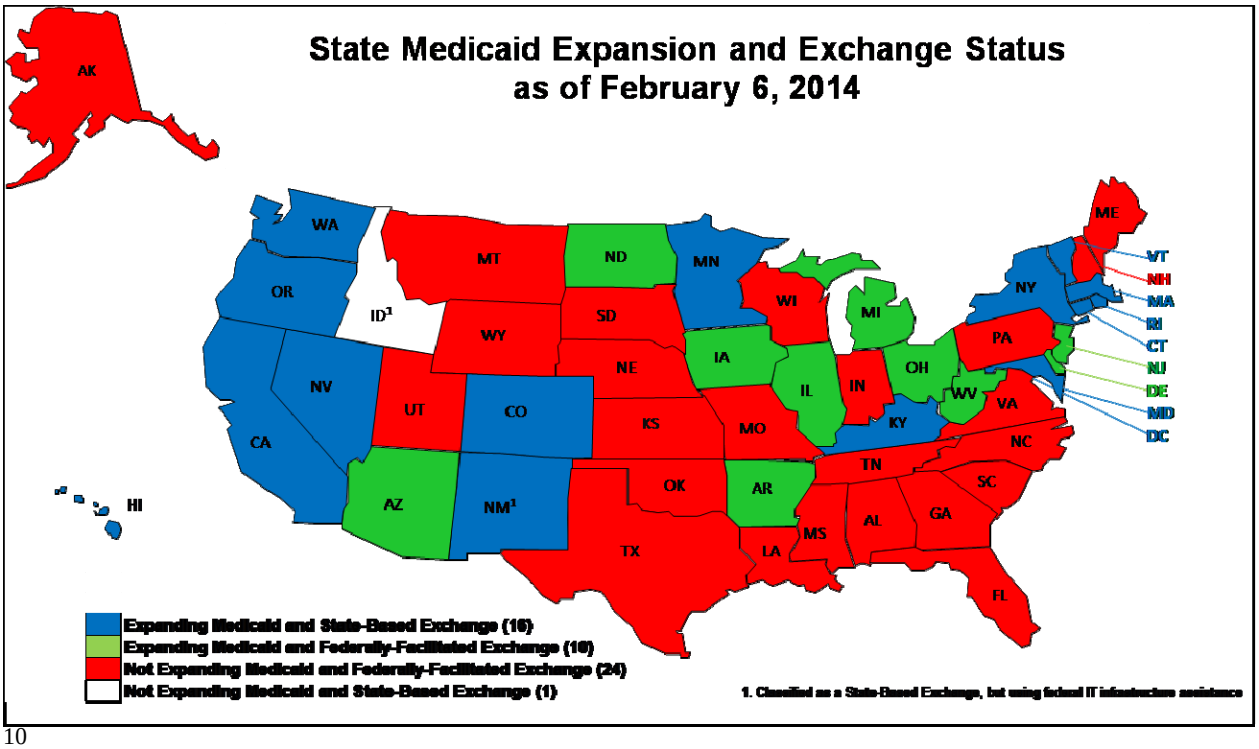
The loss of Premium Tax Credits would fall especially hard on minority residents of FFE states. The vast majority of lower-income African Americans and the substantial majority of lower-income Hispanic Americans reside in FFE states. (Table 4.) Of the 19.7 million African Americans with incomes between 100% and 400% of the FPL, 15.2 million (over three-quarters) live in FFE states. (*Id.*) Among the 30.6 million Hispanic Americans with incomes between 100% and 400% of the FPL, 16.7 million (55%) live in FFE states. (*Id.*)

Similarly, minority populations without health insurance are disproportionately concentrated in FFE states. The FFE states account for 84% of all uninsured lower-income African Americans – with incomes between 100% and 400% of the poverty level – (3.1 million out of 3.7 million in the U.S.) and 60% of all uninsured lower-income Hispanic residents in the U.S. (5.7 million out of 9.5 million). Compared to SBE states, lower-income minority residents of FFE states are more likely to be uninsured: 20% of all lower-income African Americans are uninsured in FFE states compared to 14.1% in SBE states, while 34.0% of all lower-income Hispanic Americans are uninsured in FFE states compared to 27.5% in SBE states. (*Id.*) Loss of the Premium Tax Credit will widen this insurance gap that confronts minority Americans.

C. Because Most of the FFE States Also Have Opted Out of Expanding their State Medicaid Programs, the Near-Poor in those States are Entirely Dependent on the Premium Tax Credit to Afford Health Insurance Coverage.

The loss of access to Premium Tax Credits in the FFE states would compound an already bad situation – especially for 2.8 million near-poor adults with incomes between 100% and 138% FPL (Table 2) who live in FFE states. Among the 34 FFE states, as of the end of January 2014, 24 also have opted out of the ACA Medicaid expansion that extends coverage to all nonelderly adult citizens and long-term legal residents with incomes up to 138% FPL. These states' refusal to expand Medicaid leaves this group of adults without any pathway to Medicaid unless they satisfy traditional eligibility standards.[9] In the non-expansion states, the one avenue to affordable health insurance coverage for adults with incomes between 100% and 138% FPL is through the Premium Tax Credit, which in those states becomes available starting at 100% FPL. But if this Court rules in the Appellants' favor, these residents in the 24 states that have not expanded Medicaid and that depend on the FFE will lose access to this one remaining source of federal assistance as well.

[9] 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% FPL are eligible for the Premium Tax Credit.



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II. 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.

Underlying the fundamental population health goals of the ACA is a substantial body of evidence demonstrating the relationship between health insurance, increased access to health care, improved health outcomes, and mortality reduction. In the earliest stages of the ACA debate, members of

[10] KAISER FAMILY FOUNDATION, *State Decisions For Creating Health Ins. Marketplaces, 2014*, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (last updated May 28, 2013); KAISER FAMILY FOUNDATION, *Status of State Action on the Medicaid Expansion Decision, 2014*, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last updated Oct. 2, 2013).

Congress focused on this veritable wealth of research documenting the significant and positive effect of health insurance, not only on access to care, but on health itself.[11]

The seminal body of research is captured in a multi-year study undertaken by the Institute of Medicine ("IOM"),[12] whose investigation of the causes and consequences of uninsurance led to the pivotal conclusion that more than 18,300 adults died in America annually because they lacked health insurance.[13] The IOM Committee, whose members included leading figures in public health research, found, *first,* that 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; *second*, that older adults with chronic conditions are the most likely to realize the health benefits of coverage because of their greater need for health care; *third*, that populations facing the highest health risks (those with low incomes

[11] *See supra* note 2, 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 Health Ins.*, N.Y. Times, Feb. 26, 2010, *available at* 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).

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

[13] Comm. on the Consequences of Uninsurance; Bd. on Health Care Services & Inst. of Med., CARE WITHOUT COVERAGE: Too Little, Too Late, 163 (Nat'l Acad. Press ed.) (2002) [hereinafter "CARE WITHOUT COVERAGE"].

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; *fourth*, that 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 *finally*, that were uninsured adults given stable coverage, their health would improve over time.[14] The assertion that in the face of these findings, Congress would leave access to federal subsidies to the happenstance of state policy and politics is absurd.

The IOM's research was echoed in subsequent studies. One study updated and significantly increased the IOM estimate of uninsurance-linked mortality among Americans ages 25-64, from 18,314 excess deaths in 2001 to 35,327 in 2005. This study concluded that the uninsured are 1.4 times more likely than their insured counterparts to die from preventable causes.[15] This disparity in deaths is partially attributable to the fact that uninsured adults are less likely than insured adults to receive timely, appropriate, and quality health care – with differences found across a wide array of treatments ranging from preventive screening and early detection to the management of chronic illness and acute conditions such as

[14] *Id.* at 91–103.

[15] Andrew P. Wilper, *et al.*, *Health Ins. and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2292 (2009).

heart attacks.[16] Other studies confirmed the IOM finding that the absence of health insurance significantly affects the health outcomes of patients with the most serious conditions, such as cancer, principally because of delayed diagnosis.[17]

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.[18] The IOM studies further show the impact of being without health insurance on specific populations. For example, uninsured patients with chronic diseases are less likely to receive appropriate care to manage their conditions and have worse clinical outcomes than insured patients.[19] Moreover, uninsured patients who are hospitalized are more likely to die in the hospital, receive fewer services, and experience adverse medical events

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[16] CARE WITHOUT COVERAGE, *supra* note 13, at 47–90 (reviewing the empirical literature on the association between insurance and health care and health outcome).

[17] John Z. Ayanian, *et al.*, *Unmet Health Needs of Uninsured Adults in the United States*, 284 J. AM. MED. ASS'N 2061 (2000).

[18] *Id.*; CARE WITHOUT COVERAGE, *supra* note 13, at 47–90; J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q 443, 485 (2009).

[19] CARE WITHOUT COVERAGE, *supra* note 13, at 57–71.

due to negligence than insured patients.[20] Further, uninsured patients are more likely to experience worse health outcomes and face a higher risk of dying than those with private insurance coverage.[21]

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 who report fair to poor health, compared to communities with low uninsured rates.[22] 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.[23] Finally, the incidence of vaccine-preventable and communicable disease was higher in areas with high uninsured rates that experience chronic underfunding of local public health agencies.[24]

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[20] *Id.* at 73–76.

[21] *Id.* at 80–82.

[22] Comm. on the Consequences of Uninsurance; Bd. on Health Care Services; & Inst. of Med., A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE 140 (Nat'l Acad. Press ed.) (2003).

[23] *Id.* at 142.

[24] *Id.* at 147.

Cognizant of this strong, well-documented correlation between insurance coverage and health,[25] Congress enacted the ACA to improve the public health by providing near-universal coverage, nationwide.

III. BECAUSE OF THE PROVEN NEXUS BETWEEN INSURANCE COVERAGE AND HEALTH STATUS, THE ACA WAS INTENDED TO ACHIEVE NEAR-UNIVERSAL HEALTH INSURANCE COVERAGE IN ALL STATES.

A. 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.

1. The Purpose of the ACA Was to Enact Comprehensive Health Reform on a National Scale.

Aware of the link between coverage and health outcomes, Congress set national public health improvement goals that hinged on achieving near-universal coverage. The ACA's text underscores Congressional intent to raise the health of the entire American population – not just those people who happened to live in states that operated their own exchanges without federal support. For instance, Congressional findings report that being uninsured burdens the national economy and interstate commerce.[26] By extending the coverage mandate to all Americans, Congress intended to improve the national health and reduce the annual costs of $207 billion to the national economy from the poorer health and shorter lifespan of

[25] *See supra* notes 2 and 11 and accompanying text.

[26] ACA § 1501(a)(2), codified at 42 U.S.C. § 18091(2) (2011).

the uninsured.[27] Making affordable coverage available nationwide would enable Congress to achieve national health reform over time.

Congress signaled its intent to couple a nationwide system of affordable insurance with other national strategies to improve the public health. Similarly, the ACA directed the Secretary to identify national priorities to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.[28] The ACA authorized 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.[29] Congress further instructed 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."[30] These national programs demonstrate that Congress intended the ACA to implement a comprehensive health care reform strategy on a national scale.

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[27] ACA § 1502(a)(2)(E), codified at 42 U.S.C. § 18091(2)(E).

[28] ACA § 3001, codified at 42 U.S.C. § 280j (2011).

[29] ACA § 4001(a), codified at 42 U.S.C. § 300u-10 (2011).

[30] ACA § 4004(a), codified at 42 U.S.C. § 300u-12(a) (2011).

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

The health insurance exchanges are one element of the ACA's national health care reform strategy. Under the ACA, Congress used the concept of an exchange to connect the uninsured to affordable coverage throughout the nation. The Appellants' position that seeks to deny Premium Tax Credits to an otherwise eligible taxpayer based on her state of residence contravenes Congressional intent, defies logic, and leads to absurd results.

Were Congress naïve enough to assume that states would operationalize an exchange based upon the purported threat of losing subsidies, the ACA would not include the FFE fallback.[31] 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 alone – operate an exchange for its qualified residents. Indeed, the very concept of separating the FFE states from the SBE states is impractical. For instance, seven states have partnered with the FFE to create a hybrid State Partnership Marketplace because of the practical and operational difficulties with building their own exchange

[31] Medicaid and CHIP, for example, give states the option to participate in the program without any federal default system.

structure.[32] Two states elected to establish SBEs, but are using the FFE website platform for 2014.[33] Moreover, the potential for some states to switch from SBE to the FFE due to technological difficulties[34] demonstrates the futility of drawing such distinctions. Irrespective of the entity running the exchange machinery, however, Congress intended the ACA to transform the *national* market for health insurance.

Further, the exchange's nationwide scope is underscored by Congress' preservation (albeit more regulated) of the health insurance market outside the exchange structure. Congress' decision to leave states' traditional individual and small business health insurance markets intact,[35] demonstrates that the exchange's

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[32] These seven states have been classified as FFE states throughout this brief. *See supra* note 1.

[33] *See id*.

[34] Oregon and Maryland elected to establish SBEs, but their respective state website platforms, Cover Oregon and Maryland Health Connection, have encountered a number of technical problems that may require them to rely on federal operational support. *See* Elizabeth Hayes, *Should Cover Oregon Stay the Course or Cut Bait and Seek IT Elsewhere?*, Portland Business Journal, Mar. 17, 2014, *available at* http://www.bizjournals.com/portland/blog/health-care-inc/2014/03/should-cover-oregon-stay-the-course-or-cut-bait.html; Jennifer Haberkorn, *Oregon Exchange Suffered 'Fundamental Breakdown'*, POLITICO.com, Mar. 20, 2014, *available at* https://www.politicopro.com/go/?id=31988; Brian White, *Congressman: Inspector General of US Health Department to Review Maryland Health Exchange*, The Republic, Mar. 10, 2014, *available at* http://www.therepublic.com/w/MD--Health-Overhaul-Maryland.

[35] ACA § 1312(d), codified at 42 U.S.C. § 18032(d) (2011).

most fundamental purpose is to connect consumers needing financial assistance with *tax subsidized* insurance products nationwide.

Viewed in this light, the existence of a national structure to undergird the ACA's exchange provisions – including the FFE fallback system for states that either could not or would not establish their own exchanges – makes perfect sense. Indeed, the position taken by Appellants would bring about absurd results contrary to the ACA's purpose – not only by punishing residents of states that refuse to establish an exchange for political reasons, but also residents of states that ardently desire to operate their own exchange yet must depend on the federal platform for technical reasons. To argue that Congress meant to place entire populations at heightened health risk simply because their states rely on a federal technology platform is legally and factually untenable. Recognizing the unfairness of denying Premium Tax Credits to taxpayers who are unable to obtain coverage due to technical difficulties, CMS has provided guidance allowing those taxpayers to receive Premium Tax Credits retroactively for purchasing Qualified Health Plans outside the exchanges.[36] Accepting Appellants' myopic reading of the ACA would thwart the overriding stated goal of the legislation.

[36] CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances (Feb. 27, 2014).

B. 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 Public Health Goals of the ACA.

Congress envisioned that all Americans in need of assistance to obtain affordable coverage would receive it, thus benefiting the entire nation. The coverage mandate, applicable to all states – not just those that are willing and able to set up a SBE – is a central pillar of how Congress sought to ensure near-universal coverage. Moreover, Congress recognized that federal subsidies, in turn, would be critical to ensure affordability for residents of all states. Without subsidies, people are less likely to purchase insurance until they need health care, producing a substantial increase in average premiums, and risking collapse of the market – both inside and outside the exchanges.[37] Perceived unaffordability remains the greatest barrier to enrollment.[38]

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

[37] Brief *Amici Curiae* for Economic Scholars in Support of Appellees at 12, Halbig v. Sebelius, No. 14-5018 (D.C. Cir. Feb. 17, 2014).

[38] In February 2014, 82% of those who shopped for coverage, but did not enroll and cited affordability as the reason, were eligible for subsidies. McKinsey & Company, Individual Market Enrollment: Updated View Mar. 6, 2014. Most (66%) of the subsidy-eligible respondents were not aware of their subsidy eligibility. *Id.*

same states that have eschewed federally-funded expansion of their Medicaid programs. They the very states whose populations most need access to affordable health insurance are the *least* likely to achieve it without Premium Tax Credits.

The overriding statutory purpose of the ACA is clear. 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 markedly poorer health – would eviscerate its public health goals.

C. This Court Should Affirm the District Court's Order to Avoid Conflicting with the Express Purpose of the ACA and Causing Absurd Results.

An interpretation of a statutory provision that produces absurdity in another part of the statute is an impermissible interpretation. *Kloeckner v. Solis*, 133 S. Ct. 596, 606–07 (2012). Likewise, if a statute's plain language would conflict with Congress's purposes or lead to absurd results, it should give way. *See FBI v. Abramson*, 456 U.S. 615, 625, 634 (1982) (selecting statutory construction that "more accurately reflects the intention of Congress, is more consistent with the structure of the Act, and more fully serves the purposes of the statute," despite dissent's claim that this interpretation ignored the statute's plain meaning); *see also Rector, Etc of Holy Trinity Church v. United States*, 143 U.S. 457, 460 (1892)

("The object designed to be reached by the act must limit and control the literal import of the terms and phrases employed").

In this case, the Premium Tax Credit is a critical element of the ACA to ensure that lower-income Americans across the nation can afford coverage. If two-thirds of otherwise-eligible Americans lose their Premium Tax Credits simply because they live in FFE states, 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 Appellee, *Amici Curiae* Public Health Deans, Chairs, and Faculty urge the Court to affirm the District Court's order.

Dated: March 21, 2014

Respectfully submitted,

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APPENDIX B: DATA TABLES

Table 1: Economic Status of People in SBE and FFE States

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Total population (2012)[39] (mil.)	108.9	**202.1**	311.1
Millions of people with incomes below 100% of poverty (2012)	15.9	**30.6**	46.5
% of people below poverty (2012)	14.6%	**15.2%**	15.0%
Millions of people with incomes between 100%-400% of poverty (2012)	50.8	**102.3**	153.6

[39] All the data in Table 1 are based on analyses of the Census Bureau's March 2013 Current Population Survey ("CPS"), which indicates income and health insurance status in 2012. The data was tabulated using the U.S. CENSUS BUREAU, Current Population Survey (2013), CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

Table 2: Premium Tax Credit Status of Uninsured People in SBE and FFE States

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Millions of uninsured people (2012)[40]	15.3	**32.7**	48.0
Millions of uninsured people between 100%–400% of poverty (income-eligible for Premium Tax Credits) (2012)[41]	6.8	**16.2**	22.9
Millions of uninsured people between 100%–137% of poverty (income eligible for the Premium Tax Credit) (2012)[42]	0.03	**2.8**	2.8

[40] These items are based on analyses of the CPS. *See id.*

[41] These items are based on analyses of the U.S. CENSUS BUREAU, 2012 American Community Survey, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_B27016&prodType=table. These estimates exclude the uninsured adults and children who are income-eligible for Medicaid or the Children's Health Insurance Program, based on whether the state has expanded Medicaid or not.

[42] *Id.*

Table 3: Health Insurance by Age in SBE and FFE States

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Millions of uninsured people, all ages (2012)[43]	15.3	**32.7**	48.0
Millions of uninsured adults, 18–44 years (2012)	8.6	**18.5**	27.2
Millions of uninsured adults, 45–64 years (2012)	4.0	**9.1**	13.1
% of people uninsured, all ages (2012)	14.0%	**16.2%**	15.4%

[43] All the data in Table 3 are based on analyses of the CPS. *See supra* note 39.

Table 4: Economic and Health Insurance of Minorities in SBE and FFE States

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Millions of African-Americans (non-Hispanic) between 100%-400% of poverty (2012)[44]	4.4	**15.2**	19.7
% of African-Americans who are between 100%-400% of poverty (2012)	44.1%	**50.4%**	48.8%
Millions of Hispanics between 100%-400% of poverty (2012)	13.9	**16.7**	30.6
% of Hispanics between 100%-400% of poverty (2012)	56.8%	**58.0%**	57.5%
Millions of uninsured Non-Hispanic African-Americans between 100%-400% of poverty (2012)	0.6	**3.1**	3.7
% of African-Americans	14.1%	**20.1%**	18.7%

[44] All the data in Table 4 are based on analyses of the CPS. *See id.*

between 100%-400% of poverty who are uninsured			
Millions of uninsured Hispanics between 100%-400% of poverty (2012)	3.8	**5.7**	9.5
% of Hispanics between 100%-400% of poverty who are uninsured	27.5%	**34.0%**	31.0%

Table 5: Key Health Indicators of Residents in SBE and FFE States

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
% of adults reporting they were unable to see a doctor in the past twelve months because of cost (2012)[45]	15.4%	**17.2%**	16.5%
Infant mortality rate (deaths per 1,000 births) (2009)[46]	5.6	**7.1**	6.6
% of infants born with low birth weight, under 2500 grams (2010)[47]	7.5%	**8.5%**	8.1%

[45] Based on analyses of the Center for Disease Control and Prevention's 2012 Behavioral Risk Factor Surveillance Survey. *See* KAISER FAMILY FOUNDATION, *Percentage Reporting Not Seeing a Doctor in the Past 12 Months Because of Cost*, http://kff.org/other/state-indicator/could-not-see-doctor-because-of-cost/ (last visited Feb. 11, 2014). To compute aggregate percentages, we weighted each state's percentage by the number of adults in the state.

[46] Based on vital statistics data from the National Center for Health Statistics' Linked 2009 Birth/infant Death data set. *See* KAISER FAMILY FOUNDATION, *Infant Mortality Rate (Deaths per 1,000 Live Births), Linked Files, 2007-2009*, http://kff.org/other/state-indicator/infant-death-rate/ (last visited Feb. 11, 2014). To compute aggregate infant mortality rates, we weighted each state's number of live births in 2010. *See* KAISER FAMILY FOUNDATION, *Number of Births*, http://kff.org/other/state-indicator/number-of-births/ (last visited Feb. 11, 2014).

[47] Based on vital statistics data from the Centers for Disease Control and Prevention. *See* KAISER FAMILY FOUNDATION, *Births of Low Birthweight as a Percent of All Births by Race/Ethnicity*, http://kff.org/other/state-indicator/low-

% of adults who have ever been told by a doctor that they have diabetes (2012)[48]	9.4%	**10.5%**	10.2%
% of adults who are overweight or obese (2012)[49]	60.9%	**64.8%**	63.4%
% of people living in Medically Underserved Areas[50]	10.1%	**12.4%**	11.6%

birthweight-by-raceethnicity/ (last visited Feb. 11, 2014). To compute aggregate low weight birth rates, we weighted each state's number of live births in 2010. *See* KAISER FAMILY FOUNDATION, *Number of Births*, supra note 4647.

[48] Based on analyses of the Center for Disease Control and Prevention's 2012 Behavioral Risk Factor Surveillance Survey of adults with body mass indices greater than 25.0 kg/meter squared. *See* KAISER FAMILY FOUNDATION, *Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes*, http://kff.org/other/state-indicator/adults-with-diabetes/# (last visited Feb. 11, 2014). To compute total percentages, we weighted each state's percentage by the number of adults in the state.

[49] Based on reported weights and heights and computed body mass indices greater than 25 kg/meter squared as reported in the CDC's 2012 Behavioral Risk Factor Surveillance Survey. *See* KAISER FAMILY FOUNDATION, *Percent of Adults Who are Overweight or Obese*, http://kff.org/other/state-indicator/adult-overweightobesity-rate/# (last visited Feb. 11, 2014). To compute total percentages, we weighted each state's percentage by the number of adults in the state.

[50] These items are based on the state percentage living in medically underserved areas in 2010. *See* NATIONAL WOMEN'S LAW CENTER, *People in Medically Underserved Areas (%)*, http://hrc.nwlc.org/status-indicators/people-medically-underserved-areas (last updated Jun. 7, 2010). To aggregate total percentages, we weighted each state's percentage by the number of people in the state.

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(d) and 32(a)(7)(B) because this brief contains 6,858 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman, 14-point type.

Dated: March 21, 2014

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CERTIFICATE OF SERVICE

I hereby certify that on this 21st day of March 2014, I caused the foregoing *Amici Curiae* Brief of Public Health Deans, Chairs, and Faculty in Support of Appellee to be electronically filed using the Court's CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system. Pursuant to this Court's Rules, I will also file eight paper copies of the foregoing document, by UPS overnight delivery, with the clerk of this Court.

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