ORAL ARGUMENT SCHEDULED FOR MARCH 25, 2014

Case No. 14-5018

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Jacqueline Halbig, *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 District of Columbia

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AMICUS CURIAE BRIEF OF PUBLIC HEALTH DEANS, CHAIRS, AND FACULTY IN SUPPORT OF APPELLEE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a) and Circuit Rules 26.1 and 29(b), deans and professors of public health and public health law ("Public Health Deans, Chairs, and Faculty") hereby state that:

1. Public Health Deans, Chairs, and Faculty are deans, chairs, and professors at leading public health and public health law schools in the United States.

2. No party to this filing has a parent corporation, and no publicly held corporation owns 10% or more of the stock of any party to this filing.

CERTIFICATE AS TO PARTIES, RULING, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), *Amici* Public Health Deans, Chairs, and Faculty submit this certificate as to parties, rulings, and related cases.

Parties

To *amici*'s knowledge, other than *Amici* Public Health Deans, Chairs, and Faculty, the briefs of Appellants have listed all parties and participants in the proceedings below.

Ruling Under Review

To *amici*'s knowledge, references to the Ruling Under Review appear in the Briefs for Appellants.

Related Cases

To *amici*'s knowledge, this case has not previously been before this Court and there are no pending related cases.

Statement Regarding Appendix

Amici Public Health Deans, Chairs, and Faculty adopt the Joint Appendix filed by Appellants.

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

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

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 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 and U.S. Court of Appeals for the D.C. Circuit Rule 29.

STATEMENT OF AUTHORSHIP AND FINANCIAL CONTRIBUTION

Pursuant to Rule 29(c)(5), Fed. R. App. P., Public Health Deans, Chairs, and Faculty state that no party or person other than *amici* and their counsel participated in or contributed money for the drafting of this brief.

INTRODUCTION AND 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 linking lower-income residents with affordable health insurance coverage.

The argument advanced by Plaintiffs-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 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 Plaintiff-Appellants and overturns the lower court decision, millions of children and adults will continue to go without insurance. Indeed, Plaintiff-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 Plaintiffs-Appellants will irretrievably compromise the ACA's public health improvement goals by eliminating access to affordable

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[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, 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 – 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 are federally supported SBEs for 2014; they are using the FFE website platform for 2014. *Id.*

insurance in the FFE states for those with lower incomes. Thus, this Court must 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.

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. That this premise was front and center in Congress, even at the earliest point in the debate over health reform, is without question.[2] Yet Plaintiffs-Appellants would deny affordable insurance to

[2] *See* S. Con. Res. 6, 111th Cong., 155 Cong. Rec. S2164–65 (2009) (Senate Concurrent Resolution 6 – 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). The Resolution, which came well before the Congressional Committees had even begun consideration of bills, explicitly 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.

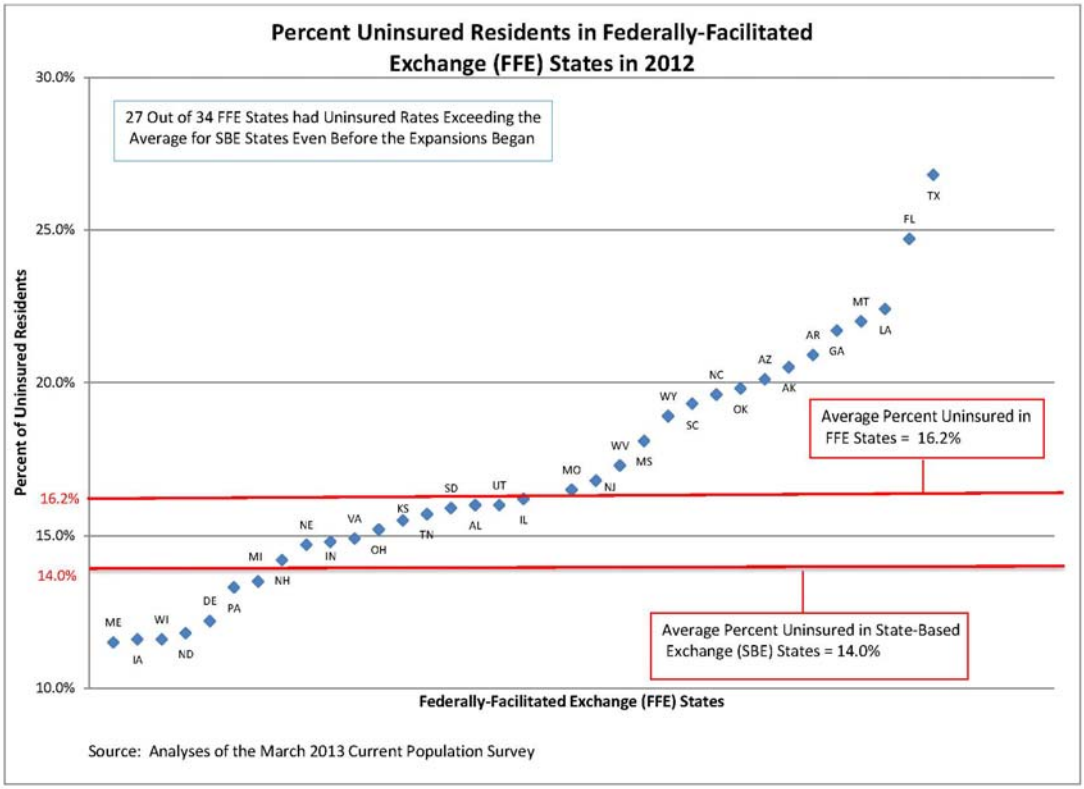
millions simply because they happen to live in one of the 34 states that, for political or practical reasons, has elected to use the FFE. Premium Tax Credits bear no resemblance to a state grant-in-aid program such as Medicaid, in which states have considerable discretion over the reach of the intervention. To deny access to the Premium Tax Credit simply because of the taxpayer's place of residence will not only leave millions without access to affordable coverage but will further exacerbate the 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, would produce 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

[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% of the FPL. In states that have not expanded Medicaid to cover all non-elderly adult residents with incomes below 138% of the FPL, the threshold income eligibility for Premium Tax Credits begins at 100% and phases out at 400% of the FPL.

Plaintiffs-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, being uninsured affected a larger proportion of the population of the FFE states (16.2% compared to 14.0% in the SBE states). (Table 3.) As evidenced by the scatterplot graph below, the FFE states already exhibit a higher rate of un-insurance. If Premium Tax Credits are terminated in these states, coverage disparities will widen over time as residents of FFE 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, and 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 1 million people in FFE states who already have relied on this subsidy to purchase coverage. According to an evaluation released by the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation, as of February 1, 2014, nearly 3.3 million people had enrolled in health insurance coverage through an exchange.[5] Most of those enrolling --1.9 million -- lived in FFE states.[6] Among these new enrollees, nearly 1.6 million (83%) received Premium Tax Credits.[7] If this Court

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[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 3. Note that these calculations include the 45,000 enrollees from Idaho and New Mexico.

[6] *Id.*

[7] *Id.* at 8–9.

reverses the District Court's Order and finds in favor of the Plaintiffs-Appellants, such a ruling would strip away the tax credit on which these enrollees relied to make coverage affordable – in short, this newly insured population would lose its coverage.

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.

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 clearly 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%). (Table 5.) They are more likely to have infants born at low-birth weight (8.5% versus 7.5%), a known risk factor for infant death and disability. (*Id.*) FFE state residents are more likely to 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. (*Id.*) FFE residents also are more likely to be overweight (64.8% versus 60.9%), a major risk factor for a host of health conditions. (*Id.*) FFE state residents are more likely to live in

communities identified as medically underserved by the federal government as a result of elevated poverty and health risks and a shortage of primary care access (12.4% versus 10.1%). (*Id.*).

The role that insurance plays in addressing these population health disparities is 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 coverage can facilitate the medical care to diagnose diabetes and take actions to treat it to avoid more serious health consequences.

The loss of Premium Tax Credits would fall especially hard on minority residents of FFE states. The vast majority of low and moderate income African Americans and the substantial majority of low and moderate income Hispanic

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[8] *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). Analyses of the NHANES were conducted by Leighton Ku, Ph.D., George Washington University School of Public Health and Health Services, January 2014.

Americans reside in FFE states. (Table 4.) Of 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 living in the U.S. 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 low and moderate 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 low and moderate income Hispanic residents in the U.S. (5.7 million out of 9.5 million). Compared to SBE states, low and moderate income minority residents of FFE states are more likely to be uninsured (20% of all low and moderate income African Americans in FFE states compared to 14.1% in SBE states and 34.0% of all low and moderate income Hispanics in FFE states compared to 27.5% in SBE states). (*Id.*) Loss of the Premium Tax Credit will widen the already serious 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% of the FPL (Table 1) 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, leaving nonelderly adults with incomes up to 138% FPL and not otherwise eligible for traditional coverage without any pathway to Medicaid,[9] which was amended to reach virtually all nonelderly low income adults with incomes up to 138% FPL. In the states that do not expand Medicaid, the one avenue to affordable health insurance coverage for adults with incomes between 100% and 138% of the FPL is with Premium Tax Credits, which in the non-expansion states become available once the 100% of FPL threshold is reached. But if this Court rules in the Plaintiffs-Appellants' favor, state residents in FFE states with incomes between 100% and 138% FPL will lose access to this critical federal assistance to obtaining coverage as well.

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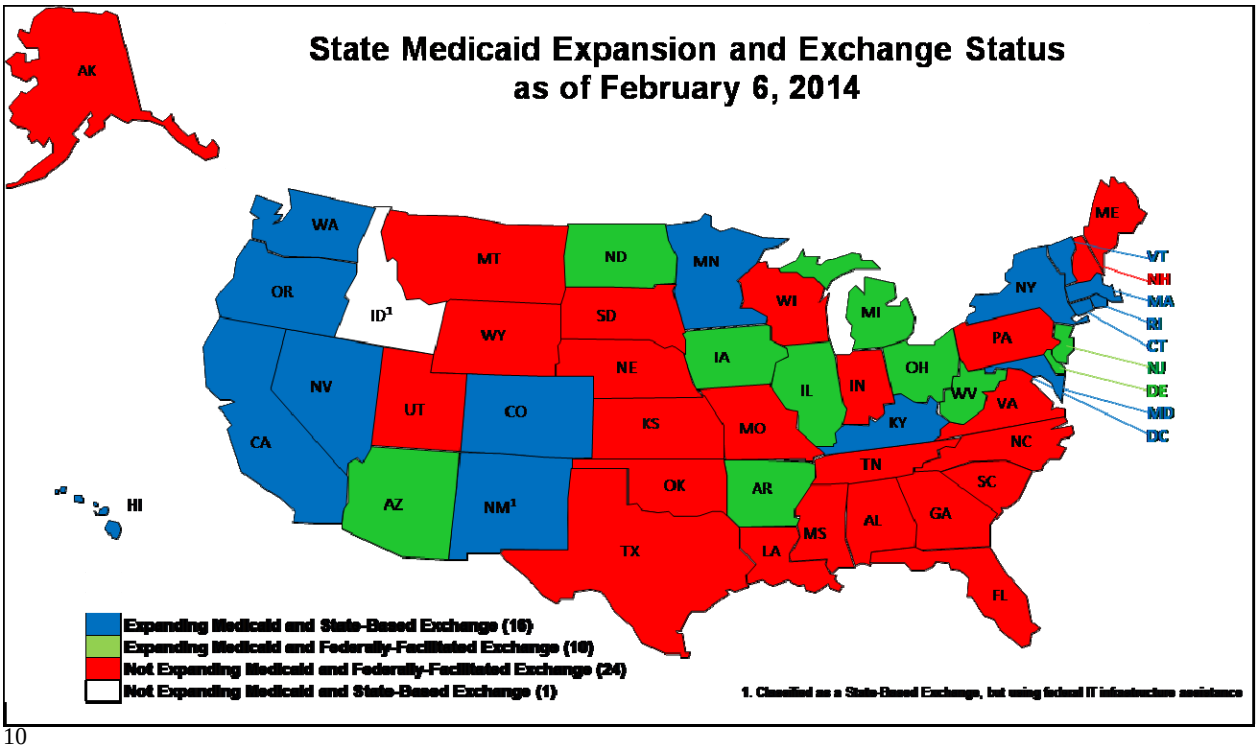
[9] By contrast all SBE states (except Idaho) have expanded Medicaid to cover this population. Thus, in these states, residents with incomes between 138% and 400% of the FPL are eligible for the Premium Tax Credit.



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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 and increased access to health care, improved health outcomes, and mortality reduction.

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[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).

In the earliest stages of the ACA debate, Members of Congress focused on the nexus between health reform and population health.[11] In this regard, a veritable wealth of research documents the significant and positive effect of health insurance, not only on access to care, but on health itself.

The seminal body of research can be found in a multi-year study undertaken by the Institute of Medicine ("IOM"),[12] whose 2002 exploration of the consequences of being uninsured led to a pivotal conclusion: more than 18,300 adults died in America annually because they lacked health insurance.[13] The IOM Committee, whose members included leading figures in scientific research into public health, found, *first*, that health insurance is associated with better health outcomes among adults and with the receipt of appropriate care across a range of

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[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] Committee on the Consequences of Uninsurance; Bd. on Health Care Services (HCS) & Inst. of Med. ("IOM"), CARE WITHOUT COVERAGE: Too Little, Too Late, 163 (The National Academies Press ed.) (2002) [hereinafter "CARE WITHOUT COVERAGE"].

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 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 notion that based on these findings, Congress would leave access to Premium Tax Credits to the happenstance of state policy and politics is absurd.

The IOM's research was echoed in subsequent studies. One, 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

[14] *Id.* at 91–103.

the uninsured are 1.4 times more likely to die from preventable causes.[15] This disparity in deaths could be attributed in part to the fact that uninsured adults are less likely than 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 heart attacks.[16] As with the earlier IOM research, subsequent studies found that the absence of health insurance significantly affected 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

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

[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*, J. AM. MED. ASS'N 2061 (2000).

necessary care for potentially serious symptoms.[18] The IOM studies show that 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] The IOM studies also show that uninsured patients who are hospitalized are more likely to die in the hospital, receive fewer services, and experience adverse medical events due to negligence than insured patients.[20] Further, the IOM studies have found that uninsured patients are more likely to experience worse health outcomes; longitudinal population-based mortality studies find a higher risk of dying for the uninsured than among 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, as opposed to communities with

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[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.

[20] *Id.* at 73–76.

[21] *Id.* at 80–82.

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, including both access problems and greater severity of illness.[23] Finally, 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.[24]

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.

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[22] Committee on the Consequences of Uninsurance; Bd. on Health Care Services (HCS); & Inst. of Medicine (IOM), A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE 140 (The National Academies Press ed.) (2003) [hereinafter "COMMUNITY EFFECTS OF UNINSURANCE"].

[23] *Id.* at 142.

[24] *Id.* at 147.

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

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 evinces 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 assistance. For instance, 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, 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 the uninsured. ACA § 1502(a)(2)(E), codified at 42 U.S.C. § 18091(2)(E). Making affordable coverage available nationwide would enable Congress to achieve national health reform over time.

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 national 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 truly national scale.

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 Plaintiffs-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 due solely to the alleged carrot/stick of subsidies, the ACA would not include an FFE fallback.[26] 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.[27] Irrespective of the entity running the exchange machinery, however, Congress intended the ACA to transform the national market for health insurance.

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

[27] 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 structure. Two states, Idaho and New Mexico, elected to establish SBEs; however, for 2014, they are using the FFE website platform. Oregon and Maryland elected to establish SBEs, but their respective state website platforms, Cover Oregon and Maryland Health Connection, have undergone a number of technical problems that may require them to also rely on federal support for their exchanges in 2014.

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 buying 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 exchange). What is evident from the fact that the ACA preserved a non-exchange health insurance market is that while exchanges ostensibly offer a marketplace for any individual or small business desiring to purchase coverage, their true mission is to ensure a means of connecting people who need financial assistance with health plans that have been certified for sale on both a subsidized and unsubsidized basis.

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 Plaintiff-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 a federal platform for technical reasons. Given everything that can transpire when government attempts to interface with a new type of technology, to argue that

Congress meant to place entire populations at heightened health risk simply because their states rely on a federal technology platform amounts to a legally and factually untenable position. Accepting Plaintiffs-Appellants' myopic reading of the ACA would clearly and simply thwart the overriding stated goal of the legislation.

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. Given that creating a robust health insurance marketplace at an affordable cost was seen as the key to near-universal coverage, Congress recognized that federal subsidies, in turn, would be a key component 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 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 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 lead to an absurd result.

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

An interpretation of an individual clause that produces absurdity in another part of the statute is not a permissible interpretation. *Kloeckner v. Solis*, 133 S. Ct. 596, 606–07 (2012). A statute's nominal plain language must give way if the plain language would conflict with Congress's 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 . . . ." *Trans Alaska Pipeline Rate Cases*, 436 U.S. 631, 643 (1978) (quoting *Commissioner 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 should receive a sensible construction…. The reason of the law in such cases should prevail over its letter").

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 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 Appellee, *Amici Curiae* Public Health Deans, Chairs, and Faculty urge the Court to affirm the District Court's order.

Dated: February 14, 2014

Respectfully submitted,

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APPENDIX B: DATA TABLES

Table 1: Economic Status of People in States with SBEs and FFEs

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Total population (2012)[28] (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

[28] 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 States with SBEs and FFEs

Population Criteria	Level for Residents of SBE States	Level for Residents of FFE States	Level for Total United States
Millions of uninsured people (2012)[29]	15.3	**32.7**	48.0
Millions of uninsured people between 100%–400% of poverty (income-eligible for Premium Tax Credits) (2012)[30]	6.8	**16.2**	22.9
Millions of uninsured people between 100%–137% of poverty (income eligible for the Premium Tax Credit) (2012)[31]	0.03	**2.8**	2.8

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

[30] 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.

[31] *Id.*

Table 3: Health Insurance by Age in States with SBEs and FFEs

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)[32]	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%

[32] All the data in Table 3 are based on analyses of the CPS. *See supra* note 28.

Table 4: Economic and Health Insurance of Minorities in States with SBEs and FFEs

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)[33]	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	0.6	**3.1**	3.7

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

between 100%-400% of poverty (2012)			
% of African-Americans between 100%-400% of poverty who are uninsured	14.1%	**20.1%**	18.7%
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 States with SBEs and FFEs

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)[34]	15.4%	**17.2%**	16.5%
Infant mortality rate (deaths per 1,000 births) (2009)[35]	5.6	**7.1**	6.6
% of infants born with low birth weight, under	7.5%	**8.5%**	8.1%

[34] 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.

[35] 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).

2500 grams (2010)[36]			
% of adults who have ever been told by a doctor that they have diabetes (2012)[37]	9.4%	**10.5%**	10.2%
% of adults who are overweight or obese (2012)[38]	60.9%	**64.8%**	63.4%
% of people living in Medically	10.1%	**12.4%**	11.6%

[36] 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-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 36.

[37] 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.

[38] 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.

Underserved Areas[39]

[39] 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 WITH D.C. CIRCUIT RULE 29(D) REGARDING SEPARATE BRIEFING

Pursuant to D.C. Circuit Rule 29(d), undersigned counsel for *amici curiae* certify that a separate brief is necessary because the substantive argument contained herein is different from that presented by the parties and other *amici*. *Amici curiae* are deans, chairs, and faculty members of some of the leading public health schools in the United States. *Amici curiae* are engaged in the policy as well as the science of protecting and improving the health of communities. Thus, *amici curiae* are particularly well-suited to discuss the resulting public health implications, as well as to provide the Court with background on the literature that establishes the direct link between health insurance and health status.

Dated: February 14, 2014

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,876 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 2003 in Times New Roman, 14-point type.

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CERTIFICATE OF SERVICE

I hereby certify that on this 14th day of February 2014, I caused the foregoing *Amicus Curiae* Brief of Public Health Deans, Chairs, and Faculty in Support of Appellee to be electronically filed using the Court's CM/ECF system, which served a copy of the document on all counsel of record in the case.

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