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IN THE
Supreme Court of the United States

FLORIDA, *et al.*,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF NEITHER PARTY ON SEVERABILITY

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BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF NEITHER PARTY ON SEVERABILITY

STATEMENT OF INTEREST[1]

The American Hospital Association, Association of American Medical Colleges, Federation of American Hospitals, and National Association of Public Hospitals and Health Systems respectfully submit this brief as *amici curiae.*

The American Hospital Association represents nearly 5,000 hospitals, health care systems, and networks, plus 37,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund brief's preparation or submission. No person other than *amici* or their members or counsel made a monetary contribution to the brief. All parties filed blanket *amicus* consent letters.

and advocates to ensure that their perspectives are considered in formulating health care policy.

The Association of American Medical Colleges represents about 300 major non-federal teaching hospitals, all 136 accredited medical schools, and the clinical faculty and medical residents who provide care to patients there.

The Federation of American Hospitals is the representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and Washington D.C. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

The National Association of Public Hospitals and Health Systems is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. NAPH represents members' interests in matters before Congress, the Executive Branch, and the courts.

The four Hospital Associations represent the vast majority of the nation's hospitals and health systems. Their members are deeply affected by the nation's health care laws, which is why they have filed *amicus* briefs in many of the Patient Protection and Affordable Care Act ("ACA") cases. They are participating again here for the same reason: This Court's severability decision—to the extent it needs to make one at all—would affect hospitals as directly as will its decision whether to uphold the individual mandate in the first place. The ACA is a sprawling statute with myriad provisions, some tied tightly to the individual mandate and others less so. *Amici*

write to offer the Court guidance, from the hospitals' perspective, on ACA provisions that are intimately related to the mandate but that thus far have received scant attention from the parties.

SUMMARY OF ARGUMENT

1. This Court need not reach the severability question at all, because it should affirm the constitutionality of the individual mandate.

2. To the extent the Court reaches severability, it should decide the issue in this proceeding, rather than remand for fact-finding. That is the Court's usual practice, and the Court should adhere to it here. A remand would mean months or years of continued uncertainty for hospitals and others in the health care field as the severability issue makes its slow way back down to, and back up from, the district court. That uncertainty would be deeply damaging. ACA implementation requires extensive effort from health care providers and regulators across the country. Health care providers, and the patients they serve, cannot afford to wait in limbo for several more years before they learn which ACA provisions will stand and which—if any—will fall.

3. While *amici* are concerned about the guaranteed-issue and community-rating questions—both are important reforms—that is an issue on which this Court is receiving ample briefing. *Amici* wish to focus instead on a segment of the ACA that to date has received scant attention: its hospital-related Medicare and Medicaid spending cuts and penalties. The ACA contains several provisions that either slash the reimbursements hospitals receive for treating Medicare and Medicaid patients or require hospitals to engage in extensive additional spending

to meet new ACA mandates. Three of these provisions are intimately bound up with the individual mandate and would not have been enacted without it. If the Court strikes down the mandate, these provisions should fall as well. To leave them in place absent the mandate would impose massive additional burdens on hospitals, depriving them of resources to meet the needs of their patients. Congress did not intend that result.

ARGUMENT

I. THE COURT SHOULD UPHOLD THE INDIVIDUAL MANDATE AND DECLINE TO REACH SEVERABILITY.

The hospital associations urge the Court to uphold the individual mandate, rendering severability moot. As will be discussed in our brief in the individual mandate proceeding, some 50 million Americans lack health insurance, the vast majority seek and receive health care, and the cost of that care amounted to $86 billion in 2008 alone. That comes at a steep cost to everyone, including the uninsured, taxpayers, and hospitals and health care systems. These facts are relevant here both because they demonstrate the mandate's importance—it is absolutely necessary to alleviate the crisis of uninsurance and uncompensated care—and because they doom the petitioners' Commerce Clause arguments. It is perfectly obvious that the uninsured "substantially affect" the interstate markets in health care and health insurance. And even if petitioners' activity/inactivity distinction were coherent, it would fail because the uninsured are "active" in both the health *care* market—because they obtain care—and in the health *insurance* market—because even those who do not seek access to that market in a given year obtain the present

benefit of an insurance-funded infrastructure that will care for them when they need it.

II. THE COURT SHOULD DECIDE SEVERABILITY ITSELF RATHER THAN REMAND.

If the Court reaches severability, one thing is certain: It should resolve that issue in this proceeding. To remand for further severability analysis would be ruinous. It would take months or more likely years. And it would leave the field saddled with crippling uncertainty about which ACA provisions—and which of the thousands of regulations spawned from those provisions—will remain good law.

1. If this Court were to remand to the District Court for severability findings, the inevitable result would be extended delay. And it is unlikely either side would be satisfied with the district court's decision. The result: further appeals, with the issue eventually landing back at this Court's doorstep.

For several reasons, that sort of delay would be harmful to American health care.

First, it would be disastrous for hospitals, health care systems, physicians, and the patients they serve. Hospitals face an enormously complex regulatory system; they must be able to determine what their regulatory responsibilities will be and what expenses and programmatic changes those regulations will require. A severability remand would make that impossible. The hospitals would be left with an uncertain regulatory landscape as severability winds its way through the courts. They would face the possibility that dozens of statutory and regulatory requirements they have spent years implementing will disappear. And they would be

reluctant to participate in innovative ACA programs designed to improve health care delivery.

For example, the ACA authorizes the Centers for Medicare and Medicaid Services ("CMS") to work with hospitals to implement "demonstration projects"—i.e., experimental care-delivery and payment models—that are exempt from many CMS regulations. *See*, *e.g.*, 42 U.S.C. § 1315a. The idea is to try innovative solutions to improve quality of care and reduce spending. But demonstration projects require substantial commitments of time and money to launch. Many hospitals have been reluctant to commit to them while the ACA's future remains uncertain; they cannot justify shouldering high start-up costs when the ACA could be struck down, and the demonstration terminated, before any improvements are realized. That is just one of many impediments this Court could remove by making the severability determination without a remand.

Second, protracted remand proceedings would encourage states uncertain about the wisdom of the ACA to procrastinate. Some states have taken a "wait-and-see approach" to implementing the ACA while their legal challenges wind through the courts. M. LaPointe, *Health Care Reform in Limbo*, Business NH Magazine (Oct. 5, 2011).[2] Thus, for example, while some have begun to design insurance exchanges, others are "waiting for * * * the judicial challenges to PPACA to be resolved." K. Koster, *In the Eye of the Storm*, Employee Benefit Adviser (Mar. 1, 2011).[3]

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[2] *Available at* http://millyardcommunications.com/index.php?src=news&srctype=detail&category=News&refno=2616.

[3] *Available at* http://eba.benefitnews.com/news/eye-storm-2685251-1.html.

Indeed, at least two states' governors "have already said no to an exchange in their state until the Supreme Court has its say[.]" *See* K. Nocera, *SCOTUS Causes States to Hit Pause*, Politico, Nov. 28, 2011.[4]

If the Court were to remand for further severability proceedings, and if past is prologue, the procrastination would continue and some states likely would miss the deadline to get their exchanges up and running by January 1, 2014. *See id.* (states are on a "tight timeline" to implement the ACA on schedule). The important project of health care reform should move forward.

2. At least one *amicus* suggested below that any severability determination should be made by the district court on remand. *See* Br. of the Chamber of Commerce in Support of Neither Party 26-28, Nos. 11-11021-HH & 11-11067-HH (11th Cir.). Such a remand would be counterproductive for the reasons just discussed. But it also is contrary to this Court's usual practice. The Court typically decides for itself the severability of federal statutes—even complex ones—where the question is squarely presented.

In *Alaska Airlines* v. *Brock*, for example, the Court found an invalid legislative veto severable from the intricate Airline Deregulation Act. 480 U.S. 678, 697 (1987). In *INS* v. *Chada*, the Court severed another invalid legislative veto from the even more complex Immigration and Nationalization Act. 462 U.S. 919, 923-925, 934-935 (1983). In *Free Enterprise Fund* v. *Public Company Accounting Oversight Board*, the Court severed an invalid tenure-protection provision from the remainder of Sarbanes-Oxley. 130 S. Ct.

[4] *Available at* http://www.politico.com/politicopulse/1111/politicopulse631.html.

3138, 3161-3162 (2010). And in *United States* v. *Booker*, the Court carefully parsed the Sentencing Reform Act and found parts severable and other parts non-severable from an invalid enhanced-sentencing scheme. 543 U.S. 220, 259-265 (2005). Neither a law's length and complexity (*e.g.*, Sarbanes-Oxley) nor the interconnectedness of its provisions (*e.g.*, the Sentencing Reform Act) has deterred this Court from making the severability decision for itself.

To be sure, the Court occasionally has remanded for severability determinations. *See*, *e.g.*, *Exxon Corp*. v. *Eagerton*, 462 U.S. 176, 197 (1983) (remand to Alabama court); *Elfbrandt* v. *Russell*, 384 U.S. 11, 23 (1966) (remand to Arizona court). But in those cases, the law at issue was a *state* law. And the Court has made clear that the severability of a state law is itself "a question of state law to be addressed on remand," either by the state court or by the Court of Appeals, with its superior knowledge of state laws in its circuit. *United States Dep't of Treasury* v. *Fabe*, 508 U.S. 491, 509-510 (1993); *accord Metromedia Inc.* v. *City of San Diego*, 453 U.S. 490, 521 n.26 (1981). The lower courts' judgment as to the severability of a *federal* law is entitled to no similar deference. This Court should decide the question itself and avoid the uncertainty a remand would cause.

III. IF THE MANDATE FALLS, CERTAIN OF THE ACA'S MEDICARE AND MEDICAID FUNDING REDUCTIONS AND PENALTIES SHOULD FALL TOO.

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota* v. *Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). And while courts will presume

that constitutional portions of a statute should be "left intact," *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 329 (2006) (quotation marks omitted), they nevertheless must excise provisions that will no longer "function in a manner consistent with the intent of Congress" absent the invalid portion of the law. *Alaska Airlines*, 480 U.S. at 685.

Plaintiffs argue that the entire ACA meets this description and that the whole law must fall if this Court strikes down the individual mandate. The Hospital Associations strongly disagree. The ACA contains hundreds of provisions that would function just as Congress intended, and would improve health care delivery and extend coverage to millions of Americans, in the mandate's absence. Those provisions should be retained if the mandate falls.

There are, however, three Medicare- and Medicaid-related provisions—the Disproportionate Share Hospital reductions, readmissions program, and productivity and market-basket adjustments—that *should* be excised if the mandate is invalidated. Those provisions cut deeply into federal support for hospitals, reducing payments for the services hospitals provide by *more than $200 billion* over ten years.[5] And they are inextricably intertwined with the individual mandate. As we demonstrate below, the administration and Congress included them in the ACA on the explicit understanding that the mandate would "add millions of new consumers to the health insurance market," 42 U.S.C. § 18091(a)(2)(C), offsetting the loss of federal reve-

[5] *See infra* at 12 ($40 billion in DSH cuts); *id.* at 16 (at least $7.1 billion in readmissions penalties); *id.* at 22 (at least $156 billion in productivity adjustments and market-basket cuts).

nues for hospitals and allowing them to continue serving patients while still making ends meet. Without that understanding, the ACA would not have been enacted in its current form. Moreover, Congress explicitly linked some of the cuts to the mandate, making clear that it wanted them implemented only in a world where the mandate had sharply reduced the nation's uninsured rate.

These links between the mandate and the three Medicare and Medicaid provisions place the provisions in a different category than any others in the ACA. Without the mandate, the provisions would no longer "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. Congress's careful trade-offs would be undone, and the ACA transformed into a one-sided budget cut that would deeply harm hospitals and the patients they serve. Congress did not intend that result. If the mandate falls, these cuts should fall too.

A. DSH Cuts.

1. Medicare and Medicaid Disproportionate Share Hospital, or "DSH," payments provide assistance to safety-net hospitals that serve a large number of low-income patients, including the uninsured and those enrolled in Medicaid. National Health Policy Forum, *The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments* 1 (June 15, 2009) ("*The Basics*").[6] These payments are in addition to the regular payments that all hospitals receive for treating Medicare and Medicaid patients. They compensate safety-net hospitals for the cost of caring for the

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[6] *Available at* http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

uninsured and underinsured and help hospitals maintain the resources to care for those patients, many of whom have nowhere else to turn for medical assistance. L. Fishman & J.D. Bentley, *The Evolution of Support for Safety-Net Hospitals* 34-35, Health Affairs (July 1997).

The importance of DSH payments to inner-city and rural safety-net hospitals cannot be overstated. In 2009, the federal government allocated $11.3 billion for Medicaid DSH payments and $10.1 billion for Medicare DSH payments. *See* Health Industry Distributors Ass'n, *Disproportionate Share Hospital (DSH) Payments*, *Health Care Reform* 1 (Sept. 2010) ("*HIDA Report*").[7] These payments are the largest source of federal funding for uncompensated care and the largest source of public funding for many hospitals. *The Basics* 1. And they are necessary for safety-net hospitals to cover their costs: Absent Medicaid DSH payments, the average NAPH member hospital's margin in 2009 would have dropped from 2.5 percent to *negative* 5.5 percent. NAPH, *2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times* 5-6 (Feb. 2011).[8] Without DSH payments—or something to replace them—many safety-net hospitals could not keep operating.

2. The ACA imposes deep cuts on both the Medicaid and Medicare DSH programs. Section 3133 of

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[7] *Available at* http://www.hida.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13765.

[8] *Available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Characteristics-Survey-Research-Brief.aspx?FT=.pdf.

the Act, 42 U.S.C. § 1395ww(r), cuts Medicare DSH payments by 75 percent and then adjusts that number somewhat based on reductions in the number of uninsured. The cuts are estimated to reduce hospitals' Medicare DSH program by $22.1 billion over 10 years. *See* American Hospital Ass'n, *Summary of 2010 Health Care Reform Legislation* 34 (Apr. 19, 2010) ("*AHA 2010 Summary*").[9] Section 2551 of the ACA, 42 U.S.C. § 1396r-4(f)(7), in turn, reduces federal Medicaid DSH spending by $18.1 billion over 11 years. *AHA 2010 Summary* 35. That is a 50 percent reduction from 2009 funding levels. *See HIDA Report* 1.

3. The key point for severability purposes, however, is not that Congress cut DSH funding in the ACA; it is that Congress chose to do so *in reliance on the individual mandate*. Congress knew that the mandate would sharply reduce the number of uninsured Americans—by some 18 million people over and above what other ACA provisions would accomplish, according to one recent estimate. *See* M. Buttgens *et al.*, Robert Wood Johnson Foundation, *Why the Individual Mandate Matters* 3 (Dec. 2010) ("Buttgens").[10] And Congress expected that reduction to allow a transition from the current system of government payments to offset uncompensated-care costs—*i.e.*, DSH payments—to a system where formerly uninsured patients have insurance coverage and can pay for services themselves. As one member of Congress said in describing a similar change enacted in Massachusetts: "[T]hey said we are

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

[10] *Available at* http://www.rwjf.org/files/research/71601.pdf.

giving all of this money to hospitals for disproportionate share payments, what if we just took that money and helped people buy insurance? *Everybody is insured, and then you don't need to provide the disproportionate share payments any longer*." 156 Cong. Rec. H2204 (daily ed. Mar. 22, 2010) (statement of Rep. Burgess) (emphasis added).

That intimate connection between the DSH cuts and the individual mandate is apparent in the statutory text itself and throughout the legislative history. To begin with the text: The ACA's Medicaid DSH provision sets forth defined annual DSH cuts—$5 billion in 2018, $5.6 billion in 2019, and so forth[11]—but instructs CMS to make two categories of states bear the brunt of those reductions: those with "the lowest percentages of uninsured individuals," and those that fail to direct their DSH grants to hospitals with the highest uncompensated-care levels. 42 U.S.C. § 1396r-4(f)(7)(B)(i). That is concrete evidence of Congress' intent to tie DSH cuts to the higher percentage of insured patients, and reduced uncompensated-care burden, that the individual mandate would bring. But without the mandate, Congress's careful balance would be undone: *All* states would have much higher uninsurance rates than Congress assumed, and *all* DSH hospitals would bear a much larger uncompensated care burden than Congress assumed—and yet the full $18.1 billion in Medicaid DSH reductions would remain in place. Congress' clear intent to tie DSH cuts to an increase in coverage would be foiled.

The Medicare DSH provision is to the same effect. That provision cuts Medicare DSH payments by 75

[11] *See AHA 2010 Summary* 35.

percent but then partially restores them with an additional payment based on the hospital's uncompensated-care load. 42 U.S.C. § 1395ww(d)(5)(F), (r)(1). And the formula for allocating additional payments is explicitly tied to Congress' assumptions about the rate of uninsured in a world with the individual mandate: Section 1395ww(r)(2) specifies that additional payments are to be calculated by multiplying three factors, and one of those factors is the decrease in the national uninsured rate from 2013 (the base year) to the year in question. *See id.*; *see also id.* § 1395ww(r)(2)(B). But Congress told CMS to calculate that decrease in the uninsured rate based on the Congressional Budget Office's 2010 predictions about how much the uninsured rate would drop each year *with the individual mandate*. *See id.* § 1395ww(r)(2)(B)(i). Absent the mandate, the uninsured rate would drop much less than Congress expected—and yet Medicare DSH payments would still be cut to levels that Congress thought appropriate for a world of near-universal coverage. Congress' choice to tie Medicare DSH cuts directly to the mandate's expansion of coverage shows that Congress would not have wanted the DSH cuts to stand if the mandate fell.

The legislative history only underscores that Congress and the executive branch expected DSH payment reductions and mandate-driven insurance coverage to work in concert. President Obama explained the proposed DSH reductions this way: "As health reform phases in, *the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered*." White House Fact Sheet, *Paying for Health Care Reform* (June 13, 2009) (emphasis

added).[12] One of the House reports on what became the ACA anticipated that later in the decade, CMS would develop reports "discuss[ing] the extent to which there is a continued role for Medicaid DSH payments in light of the effectiveness of the health reforms * * * in reducing the number of uninsured individuals." H.R. Rep. 111-299, pt. 1, at 612 (2009). The House report on the reconciliation bill that gave the DSH cuts their final form anticipated further DSH payment reductions in 2017 "[i]f there is a significant decrease in the national rate of uninsurance as a result of this legislation[.]" H.R. Rep. 111-443, pt. 1, at 316 (2010). And the same report emphasized that *"[t]he committee is reluctant for any Medicare DSH cuts to go into effect until a drop in the uninsured rate occurs*." *Id.* (emphasis added).

These statements all drive at the same point: Congress understood that the deep DSH cuts included in the ACA made sense only in light of the mandate. Indeed, Congress even chose to *calculate* the DSH cuts on the assumption that the mandate would be in place. Without the mandate, but with the DSH cuts, hospitals serving the most vulnerable populations would be stripped of billions of dollars in funding, with a reduced prospect of income from privately insured patients to offset it. The safety net might not survive.

Congress could not have intended that result—and in fact, the statutory text and legislative history make clear that it did not. If the mandate falls, the DSH cuts must fall too.

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[12] *Available at* http://www.politico.com/politicopulse/0609/politicopulse12.html (follow "Read the Whole Post" hyperlink).

B. The Readmissions Program.

The ACA's readmissions reduction program, 42 U.S.C. § 1395ww(q), financially penalizes hospitals whose patients are readmitted after initial discharge at higher-than-expected rates. The penalties can be significant, costing a hospital up to 3 percent of its total Medicare reimbursements. *See id.* The Medicare Payment Advisory Commission, a government-sponsored advisory group, first proposed a readmissions program in its June 2007 report to Congress. *See* Medicare Payment Advisory Comm'n, *Report to the Congress: Promoting Greater Efficiency in Medicare* 111-14 (June 2007).[13] However, it was not until the ACA that Congress enacted the program, and attached financial penalties to it, as a way to press hospitals to further "enhance [the] quality of care" they provide. H.R. Rep. No. 111-299, pt. 2, at 339. Congress expected the penalties to save the federal government billions of dollars—some $7.1 billion, according to a recent estimate—over ten years. *See* N. Levey, *Hospitals Give Health Reform A Boost*, L.A. Times, July 9, 2009 ("Levey"); *see also AHA 2010 Summary* 27.

This indirect funding cut was part and parcel of the trade-off that undergirded all of the ACA's Medicare and Medicaid funding reductions, as we discuss in detail below: Congress recognized that hospitals could withstand the package of cuts if and only if the individual mandate helped offset the hospitals' lost federal revenues. *See infra* at 20-21; *see also* Levey, *supra* (hospitals agreed to $155 billion in Medicare and Medicaid cuts, including "savings * * * from new

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[13] *Available at* http://www.medpac.gov/chapters/Jun07_Ch05.pdf.

incentives for hospitals to prevent patients from having to be readmitted," on the condition that Congress "succeeded in extending health insurance to tens of millions of people who are now without coverage").

But the readmissions program also is tied to the individual mandate in a second, related way. Enhancements necessary to reduce readmissions can be costly, both in terms of hospital resources and capital investment. Studies show that to achieve improvements in readmissions, hospitals must invest in new care-coordination and discharge procedures. *See* American Hospital Ass'n, *Examining the Drivers of Readmissions & Reducing Unnecessary Readmissions for Better Patient Care* 10 (Sept. 2011). New technologies have been shown to help. *See*, *e.g.*, *Overcoming Rural Health Care Barriers: Use of Innovative Wireless Health Technology Solutions: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 111th Cong. 13, 24-25 (2010). But they, too, require a substantial source of funding.

Congress was well aware of these facts when it enacted the readmissions program. The ACA itself recognized that hospitals would need to "implement * * * comprehensive program[s] for hospital discharge," including "patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional," in order to "prevent hospital readmissions." 42 U.S.C. § 300gg-17(a)(1). Members of Congress spoke about the programmatic investments required to reduce readmissions, stating, for example, that hospitals had succeeded by "creating a transitional model that makes sure that

when patients leave the hospital, they do so with a coach" who "helps them go from the emergency room to their primary care physician, their mental health provider, making sure they get the care they need over a period of time, making sure they don't forget their prescriptions[.]" 155 Cong. Rec. S13663 (daily ed. Dec. 21, 2009) (statement of Sen. Bennet); *see also* 155 Cong. Rec. S12135 (daily ed. Dec. 2, 2009) (statement of Sen. Whitehouse) (hospitals will need to "invest and improve on the front end" to avoid excess readmissions). And hospitals and other providers drove it home at Congressional hearings on readmissions, explaining that new care-coordination methods can reduce readmissions—but that Congress needed to "invest money in it" to make the goal a reality. *Achieving Health Reform's Ultimate Goal: How Successful Health Systems Keep Costs Low and Quality High: Hearing Before the S. Special Comm. on Aging*, 111th Cong. 110 (2009) (statement of Dr. Arnold Epstein).

Congress thus understood that hospitals—and especially resource-strapped hospitals, many of which serve urban or rural areas—can invest in programs that reduce readmissions only if they have the funds required to do so. The individual mandate, and its creation of a larger market of insured patients, helps provide those funds. Without the mandate, and with the readmissions program still in place, struggling hospitals will struggle more: They will be left with reduced Medicare payments and insufficient resources to replace them. That will hurt patients—particularly the minority and lower-income patients who often rely on safety-net hospitals for their care. *See* Kaiser Health News, *KHN Used CMS Readmission Rates And Patients' Income*

For Analysis (Dec. 19, 2011) (hospitals treating a higher proportion of low-income and minority patients "are more likely than others to have higher readmission rates").[14] Congress, with its overarching goal of "enhanc[ing] quality of care," H.R. Rep. No. 111-299, pt. 2, at 338-339, could not have intended that result.

C. The "Productivity Adjustment" And Market-Basket Cuts.

Finally, the ACA's so-called "productivity adjustment," 42 U.S.C. § 1395ww(b)(3)(B)(xi), and the related reduction in "market basket" rates, *id.* § 1395ww(b)(3)(B)(xii), should be excised if the mandate falls. The Obama administration and Congress included these massive funding cuts in the ACA—and representatives of the nation's hospitals agreed that they were financially feasible—on the express understanding that the individual mandate would help the hospitals offset their losses. Without the mandate, the productivity adjustment and market-basket cuts would not have been included in the legislation.

1. Congress provides Medicare payments to hospitals and other healthcare providers to compensate them for the services they provide to Medicare recipients. The ACA changes the formula used to calculate those payments in two significant ways. First, it reduces the Medicare update for inflation by a percentage pegged to the 10-year rolling average of productivity gains in the economy. 42 U.S.C. § 1395ww(b)(3)(B)(xi). Second, it reduces the "mar-

[14] *Available at* http://www.kaiserhealthnews.org/Stories/2011/December/20/Readmissions-Methodology.aspx.

ket basket" rates used to annually adjust Medicare payments. *Id.* § 1395ww(b)(3)(B)(xii). The effect of these changes is to further divorce Medicare payments from the actual cost of services. As the cost of providing care increases over time, the payments to healthcare providers will not keep up.

2. The Congressional Budget Office estimated that the productivity adjustment and market-basket reductions will cut payments to providers by $156 billion over ten years, while CMS' actuary pegged the reduction at $233 billion. B. Semro, The Bell Policy Center, *Potential Impacts of New Federal Policies on Provider Reimbursement Rates* (Nov. 1, 2011).[15] These cuts are very large; hospitals with tight margins could not absorb such a substantial reduction in revenue without something to offset it.

Congress and the administration recognized as much. *See*, *e.g.*, 155 Cong. Rec. S11092 (Nov. 4, 2009) (statement of Sen. Grassley) (productivity adjustment "show[s] why there is genuine concern that health care for Medicare beneficiaries will suffer greatly because of health care reform"). That is why they publicly announced that hospitals would be asked to accept such cuts only on the understanding that the individual mandate would offset the loss. In July 2009, Vice President Biden announced that "three associations representing the hospital industry" had agreed to productivity and market-basket cuts, as well as the other provisions discussed above, "as part of a health overhaul *that assumes coverage of 95 percent of the American people*." J. Reichard, *Biden Announces Deal With Hospitals to Cut Medi-*

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

care, Medicaid Payments by $155 Billion, CQ Healthbeat, July 8, 2009 (emphasis added) ("*Biden Article*").[16] Biden stated that the agreement "*calls for payments to be shaved as more patients treated by hospitals obtain coverage*." *Id.* (emphasis added). AHA officials offered the same perspective on the cuts, stating that "hospitals had agreed to about $150 billion in savings after securing assurances that lower reimbursements would come after an insurance expansion that would guarantee that more patients pay their bills." D. Herszenhorn & S. Stolberg, *Health Deals Could Harbor Hidden Costs*, N.Y. Times, July 8, 2009.[17] And that agreement became the basis for a Senate Finance Committee markup that introduced the cuts into the ACA for the first time. *See Biden Article*, *supra*; *see also* S. 1796, 111th Cong. § 3401 (2009) (Senate Finance Committee bill linking cuts, in part, to levels of uninsured).

The productivity adjustment and market-basket cuts, in short, were justified by the individual mandate; without the mandate, they would never have been included in the legislation. Moreover, in their practical operation, the provisions are tied to the mandate. The ACA provides federal subsidies to help the uninsured pay for the coverage required by the mandate, and it uses the productivity adjustment and market-basket cuts to pay for those subsidies. *See*, *e.g.*, M. Janiszewsk, *Responding to Reform, 5*

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

[17] *Available at* http://www.nytimes.com/2009/07/08/health/policy/08health.html.

Strategies for Reinventing the Revenue Cycle, hfm Magazine (May 2011) (noting that "[f]unding to expand insurance coverage will come from Medicare and Medicaid cuts," with "[$]156 billion" in these cuts coming "through Medicare market basket productivity adjustments and reductions to the update factor").[18] In a world with no mandate, the subsidies would remain in place, but they would not be fully utilized because fewer uninsured individuals—some 18 million fewer—would seek coverage. *See* Buttgens 3. Healthcare providers thus would suffer a substantial reduction in Medicare reimbursements without *anyone* receiving the offsetting benefit those cuts were designed to fund.

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The three provisions discussed above were at the heart of the ACA's grand bargain. Striking the mandate but retaining these provisions would unbalance the arrangement of benefits and burdens anticipated by Congress when it fashioned the ACA. The provisions would become a penalty with no offset; they no longer would "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. If the mandate falls, the three provisions should fall as well. To leave them in place absent the mandate would be a crippling blow for America's hospitals.

CONCLUSION

This Court should uphold the individual mandate. But if it strikes down the mandate it should make the decision regarding severability itself, without a

[18] *Available at* http://www.hfma.org/Templates/Print.aspx?id=27057.

remand, and it should find that the provisions discussed above are not severable from the mandate.

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