Nos. 11-393 and 11-400

In The Supreme Court of the United States

NAT'L FEDERATION OF INDEPENDENT BUSINESSES, ET AL.,

Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

STATE OF FLORIDA, ET AL.,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF FOR *AMICI CURIAE* AMERICAN MEDICAL STUDENT ASSOCIATION; DOCTORS FOR AMERICA; NATIONAL HISPANIC MEDICAL ASSOCIATION; NATIONAL MEDICAL ASSOCIATION; NATIONAL PHYSICIANS ALLIANCE; AND SOCIETY OF GENERAL INTERNAL MEDICINE IN SUPPORT OF THE UNITED STATES ON SEVERABILITY

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INTERESTS OF *AMICI CURIAE*[1]

Amici are diverse health care provider organizations representing tens of thousands of health care professionals throughout the country. *Amici* believe that the Affordable Care Act is a significant achievement for the patients that their members serve because it ensures greater protection against losing or being denied health insurance coverage. It promotes better access to primary care and to wellness and prevention programs. It helps ensure that all areas of the nation have adequate access to health providers, and it enables essential research that allows health providers to better treat their patients.

Because *amici*'s members work throughout the continuum of care and in all settings within the health care industry – from direct care to hospital administration – *amici* have a uniquely broad and informed perspective on the impact of the Affordable Care Act. Specifically, they have the capacity to offer an expert perspective on how multiple goals – ranging from ensuring that patients can afford care to ensuring adequate access to providers to ensuring

[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

that those providers are well-informed about the most effective ways to treat their patients – are advanced by the Affordable Care Act, and to explain why Congress would not have wanted any of these goals to be left unaddressed.

SUMMARY OF ARGUMENT

Especially in light of Private Petitioners' admission that the Patient Protection and Affordable Care Act's, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") minimum coverage provision is an essential element of the ACA's broader regulation of the health insurance market, this Court should not reach the severability question. Private Petitioners claim that the minimum coverage provision "works to counteract the powerful inflationary impacts" of the ACA's insurance regulations, "which would otherwise make premiums in the individual insurance market prohibitively expensive." NFIB Brief at 36-37.[2] This and other arguments presented in their brief on severability constitute an outright admission that the minimum coverage provision is an "essential part of a larger regulation of economic activity," and thus must be upheld under Congress' Commerce and Necessary and Proper powers. *Gonzales v. Raich*, 545 U.S. 1, 17

[2] This brief will refer to the Brief for Private Petitioners on Severability as the "NFIB Brief" and the Brief for State Petitioners on Severability as the "States Brief."

(2005) (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995)).

Should this Court reach the severability issue, however, its inquiry should be bound by both the constraints of judicial modesty articulated in longstanding precedents and by Congress' decision to expressly draw an outer bound around the severability inquiry in this case. Because the balance of the Affordable Care Act would remain "fully operative as a law" even if the minimum coverage requirement were excised, this Court's precedents establish an unusually strong presumption in favor of severability. This Court "must sustain" the balance of the law "'[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid].'" *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987)) (alterations in original).

It is not at all "evident" that Congress would not have enacted the lion's share of the ACA absent a minimum coverage provision. To the contrary, Congress' express findings place an outer bound around the scope of this Court's severability inquiry should it accept Petitioners' novel challenge to the minimum coverage requirement. Congress explicitly states in the ACA's findings that only those provisions of the ACA which ensure that "health insurance products . . . are guaranteed issue and do not exclude coverage of pre-existing conditions" are linked to the minimum coverage provision. ACA § 10106(a). This finding is

powerful evidence that Congress did not believe that the balance of the law should not exist in the absence of a minimum coverage provision. *See Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 174 (1803) ("Affirmative words are often, in their operation, negative of other objects than those affirmed. . . .")

Additionally, Petitioners misread the ACA as solely focused on a "core" or "single central" goal of expanding access to affordable health insurance coverage. NFIB Brief at 46; States Brief at 54. While this is, indeed, an important purpose behind the ACA, the law also serves equally important purposes such as ensuring that underserved regions and populations have sufficient access to health providers, encouraging more physicians to enter general family practice or general pediatric practice, enabling nurses to take a greater leadership role in providing medical services, and improving health outcomes by fostering research into medical best-practices. It is not "evident" that Congress would have preferred not to address these issues if it could not have enacted the ACA in its entirety.

ARGUMENT

I. PRIVATE PETITIONERS' SEVERABILITY ARGUMENTS ARE A LENGTHY CONCESSION THAT THE MINIMUM COVERAGE PROVISION IS AN "ESSENTIAL PART OF A LARGER REGULATION OF ECONOMIC ACTIVITY," AND THEREFORE CONSTITUTIONAL

When an individual provision of law is an "essential part of a larger regulation of economic activity," it fits within Congress' enumerated authority under the Commerce and Necessary and Proper Clauses even if that provision could not have been enacted as a stand-alone law. *Raich*, 545 U.S. at 17. The minimum coverage provision easily clears this bar because, as Congress explained, such a provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." ACA § 10106(a).

Private Petitioners, however, allege that the minimum coverage provision is an even more essential element of the Affordable Care Act's regulation of the health care and health insurance markets than Congress believed it to be. To reach the conclusion that invalidating the minimum coverage provision necessarily requires this Court to invalidate the entire Act, Private Petitioners play an elaborate game of "the house that Jack built" that begins by demonstrating that Congress correctly determined that the minimum coverage provision is essential to many of

the ACA's insurance reforms. By the time they are done building this house, they have not only conceded that the minimum coverage provision is essential to those insurance reforms identified by Congress, Private Petitioners have also claimed that the minimum coverage provision is an essential part of the ACA's larger regulation of employment and of its health insurance exchanges – which themselves regulate trade in health insurance.

- *First*, Private Petitioners begin their argument by admitting that the minimum coverage provision is an essential part of the ACA's larger regulation of insurers' interactions with patients who have preexisting conditions. As Private Petitioners concede, the minimum coverage provision "works to counteract the powerful inflationary impacts" of the ACA's insurance regulations, "which would otherwise make premiums in the individual insurance market prohibitively expensive." NFIB Brief at 36-37. Thus, Private Petitioners agree with Congress' determination that the minimum coverage provision is an essential part of a larger regulation of economic activity.

- *Second*, having effectively conceded the constitutionality of the minimum coverage provision, *Raich*, 545 U.S. at 17, Private Petitioners then argue that the minimum coverage provision is essential to the Act's subsidies for consumers in the individual health insurance market. According to Private Petitioners, the "powerful inflationary

impacts" that would result without a minimum coverage provision would render those subsidies prohibitively expensive. NFIB Brief at 49-50. Having thus attempted to undermine the subsidies, Private Petitioners then link the minimum coverage provision to two other regulations of economic activity.

- *Third*, Private Petitioners argue that the minimum coverage provision is an essential element of the ACA's regulation of employment. The ACA's employer responsibility provision regulates employment by imposing a monetary assessment on large employers who do not provide a minimum degree of health benefits to their full-time employees who qualify for subsidies within the individual market. ACA § 4980H. Private Petitioners, however, claim that this provision "is inextricably intertwined with the subsidies described above." NFIB Brief at 51. Because they have previously claimed that the minimum coverage provision is essential to the subsidies, their attempt to link the employer responsibility provision to the minimum coverage provision is an argument that the latter is an essential part of a broader regulatory scheme that includes the former.

- *Finally*, Private Petitioners link the minimum coverage provision to the ACA's provisions creating regulated health insurance exchanges. These exchanges, Private Petitioners argue, also require the subsidies to function because "[w]ithout the subsidies driving demand within the exchanges

> insurance companies would have absolutely no reason to offer their products through exchanges, where they are subject to far greater restrictions." *Id.* at 51-52. Because Privative Petitioners have already claimed that the minimum coverage provision is essential to these subsidies, they effectively argue that it is an essential element of the exchanges' regulation of the health insurance market.

This Court need not accept each link in this increasingly attenuated chain in order to recognize the significance of the Private Petitioners' concession.[3] It is only necessary to recognize that the very first link of this chain admits that Congress correctly found the minimum coverage provision to be an essential part of a larger regulation of economic activity. Should this Court agree with the Private Petitioners' severability argument, then it will not be necessary for the Court to even reach the severability question because the Private Petitioners' assertions

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[3] Indeed, the second link in this chain rests upon a factually inaccurate assumption. The only reason why premium inflation will occur in the absence of a minimum coverage provision is because, in the absence of such a provision, the ACA's insurance regulations permit individuals to wait until the moment they become ill or injured to purchase insurance and then draw benefits from an insurance pool they have not paid into – a phenomenon known as "adverse selection." *See* Brief for *Amici Curiae* American Nurses Association, *et al*. on the Minimum Coverage Provision at 12. Absent those insurance regulations, adverse selection will not occur and thus insurance premiums will not increase.

necessarily lead to the conclusion that the minimum coverage provision is constitutional. *See Raich*, 545 U.S. at 17; *Lopez*, 514 U.S. at 561.

II. PETITIONERS' SWEEPING CALL TO INVALIDATE THE ENTIRE ACA CANNOT BE SQUARED WITH THIS COURT'S PRECEDENTS REQUIRING JUDICIAL MODESTY

This Court's precedents establish two presumptions, both of which favor the Affordable Care Act. First federal courts are "obliged . . . to presume that acts of Congress are constitutional." *Seven-Sky v. Holder*, 661 F.3d 1, 18 (D.C. Cir. 2011) (citing *United States v. Morrison*, 529 U.S. 598, 607 (2000)). Thus, this Court should uphold the minimum coverage provision so long as "Congress had a rational basis for believing that failure" to enact this provision "would leave a gaping hole" in the ACA's economic regulatory scheme. *Raich*, 545 U.S. at 22.

In the context of severability, the ACA enjoys an even stronger presumption in favor of leaving laws largely intact. "[T]he 'normal rule' is that 'partial, rather than facial, invalidation is the required course,' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 329 (2006) (quoting *Brockett* v. *Spokane Arcades, Inc.,* 472 U.S. 491, 504 (1985)). Because the balance of the Affordable Care Act would remain "fully operative as a law" even if

the minimum coverage requirement were excised, the presumption in favor of severability is particularly strong – this Court "must sustain" the balance of the law "'[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid].'" *Free Enterprise Fund*, 130 S. Ct. at 3161 (quoting *Alaska Airlines*, 480 U.S. at 684) (alterations in original).

Thus, when this Court considers a law's constitutionality, judicial modesty counsels against "infring[ing] on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Turner Broadcasting Sys. v. FCC*, 520 U.S. 180, 196 (1997). Likewise, when this Court does conclude that a provision of law exceeds Congress' authority, the same judicial modesty counsels against "nullify[ing] more of a legislature's work than is necessary, for we know that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'" *Ayotte*, 546 U.S. at 329 (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)).

Petitioners, however, ask the Court to cast such modesty aside. They ask this Court to cast a skeptical eye upon Congress' determination that the minimum coverage provision is an essential part of a larger regulation of the health insurance market for purposes of determining whether the minimum coverage provision exceeds Congress' enumerated powers, then immediately turn around and claim that the provision's tentacles reach so deeply into the

ACA's foundation that the entire statute must be cast aside. Simply put, Petitioners cannot have it both ways.

With respect to the question of constitutionality, Petitioners urge this Court to affirm a decision which determined that the minimum coverage provision is not essential to the ACA's insurance regulations because the Eleventh Circuit believed that this provision does not include a sufficiently effective enforcement mechanism. *See Florida v. U.S. Dept. of Health & Human Services*, 648 F.3d 1235, 1311 (11th Cir. 2011). The wealth of empirical evidence contradicting this determination is ably documented by an *amicus* brief submitted on the minimum coverage question currently before this Court, *see* Brief of American Association of People with Disabilities, *et al*. as *amicus curiae* (minimum coverage provision) 18-26, and does not need to be restated here. It should be noted, however, that the Eleventh Circuit's decision to substitute its own policy judgment about the efficacy of a federal statute for that of Congress "looks startlingly like strict scrutiny review," *Florida*, 648 F.3d at 1343 (Marcus, J., dissenting), and cannot be reconciled with the judicial modesty urged by this Court's precedents.

Petitioners' severability arguments similarly urge this Court to abandon its modest role and "frustrate[ ] the intent" of elected representatives in Congress by invalidating the product of more than a year of legislative effort. This urging not only requires the Court to turn on a dime from considering

the minimum coverage provision to be ineffective and insignificant for purposes of constitutionality to suddenly deem it to be the keystone that holds the entire law together for purposes of severability, it also ignores what may be one of the strongest presumptions that exists in all of U.S. law. This Court may not invalidate any portion of the ACA which it deems constitutional unless it is "evident" that Congress would not have enacted those provisions independent of the provisions this Court deems unconstitutional. *Free Enterprise Fund*, 130 S. Ct. at 3162.

The word "evident" indicates that this Court must have a very high degree of certainty regarding Congress' preference before it invalidates an entirely constitutional provision of law. *See* American Heritage Dictionary of the English Language, *American Heritage Dictionary Entry: Evident* at http://ahdictionary.com/word/search.html?q=evident ("Easily perceived or understood; obvious"). Yet it is far from clear what Congress would have enacted had it believed this Court would embrace the novel constitutional theory advanced by Petitioners. Even the State Petitioners, who admit that their proposed inquiry is "inherently counterfactual and speculative," concede this point. States' Brief at 57. If the result of an inquiry inherently relies upon speculation, then the proper outcome of that inquiry is, almost by definition, not "evident."

As Private Petitioners correctly point out, "if the severability analysis really must proceed provision-by-provision, courts would be faced with the impractical,

unrealistic task" of combing through a lengthy statute and ruling on the continued viability of each provision. NFIB Brief at 55. This argument, however, does not lead to the conclusion Petitioners suggest. Rather, this Court has already made allowances for the unwieldiness of such a task by applying such a heavy presumption in favor of severability. By requiring Petitioners to overcome an unusually high bar in order to remove any constitutional provision from the bill, this Court's precedents already insulate the judiciary from the "unrealistic task" of combing line by line through an Act of Congress.

More importantly, Petitioners' briefs demonstrate why this Court's strong presumption in favor of judicial modesty in severability cases is wise, not only because it prevents severability cases from becoming a Sisyphean enterprise, but also because it prevents the judicial branch from engaging in inquiries that it is ill-suited to perform. Petitioners ask this Court to weigh such extraneous factors as the potential impact of insurance industry lobbyists on lawmakers' decisions, States' Brief at 9; NFIB Brief at 2, whether, given the choice between retaining provisions that shrink the budget deficit or losing the entire law, Congress would prefer more federal debt to less, States' Brief at 55, or the impact of Congressional procedural rules on attempts to amend the law, NFIB Brief at 59-61. It is difficult to imagine questions that are more clearly political in nature than how much influence a particular interest group has upon a particular legislative debate, or how large the federal

government's budget deficit should be.[4] Similarly, any attempt by this Court to interpret Congress' own rules of proceeding raises serious concerns that the judiciary is intruding upon an area that is textually committed to another branch of government. *See* U.S. Const. Art. I, § 5 ("Each House may determine the rules of its proceedings. . . .")

Just as this Court's precedents require it to treat Acts of Congress with a presumption of constitutionality in order to avoid judicial intrusion into areas beyond the judiciary's competence, the strong presumption in favor of severability serves a similar role. Without either, the Court runs the risk of substituting its preferences for those of men and women who are chosen by the people to govern. Ultimately, Petitioners ask this Court to ignore both of these presumptions in order to "frustrate[ ] the intent of the elected representatives of the people." *Ayotte*, 546 U.S. at 329. The Court should not take them up on this invitation.

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[4] Indeed, at a recent Senate Judiciary Committee hearing, Justice Scalia laughed openly at the suggestion that judges play a role in "making budgetary choices" responding that "of course it's not" their proper role to do so. *Considering the Role of Judges Under the Constitution of the United States*, 112th Cong. (Oct. 5, 2011) at http://www.judiciary.senate.gov/hearings/hearing.cfm?id=8bbe59e76fc0b6747b22c32c9e014187.

III. PETITIONERS' PROPOSED ANALYSIS FRUSTRATES CONGRESS' EXPRESS INTENT AND IGNORES THE ACA'S DIVERSE PURPOSES

The Affordable Care Act is not, as State Petitioners suggest, single-mindedly focused on the "central goal of buying and paying for 'near-universal coverage,'" States' Brief at 54 (quoting ACA § 1501(a)(2)(D)), although achieving such coverage is indeed a purpose of many parts of the ACA. Rather, the Act recognizes that America's health care system faces a diversity of challenges that must be addressed in addition to the problem of uninsurance. As explained in detail below, a short list of the ACA's purposes includes ensuring that underserved regions and populations have sufficient access to health providers, encouraging more physicians to enter general family practice or general pediatric practice, enabling nurses to take a greater leadership role in providing medical services, and improving health outcomes by fostering research into medical best-practices. Even if this Court were to strike down the entirety of the law's provisions expanding access to health insurance coverage, it is not the least bit "evident" that Congress would have preferred for rural areas to have inadequate access to health professionals or for patients to receive expensive and unreliable treatments in the absence of the ACA's provisions expanding insurance coverage.

Lest there be any doubt, however, there is also no support for Petitioners' suggestion that this Court

must sweepingly invalidate the ACA's coverage-expanding provisions if the minimum coverage provision should fall. To the contrary, the ACA's findings expressly preclude the result Petitioners suggest.

A. The ACA's Findings Expressly Place An Outer Limit On This Court's Severability Inquiry

Both State and Private Petitioners attempt to weave elaborate webs linking the minimum coverage provision to the ACA's entire apparatus for expanding access to the health insurance market. *See supra* Part I; States' Brief at 54. It is not necessary, however, for this Court to even consider whether these webs actually exist. This is because, as Petitioners repeatedly remind this Court in their briefs, "[t]he 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 Congress expressly placed an outer limit on this Court's severability inquiry in the ACA's text.

Congress explicitly states in the ACA's findings that only those provisions of the ACA which ensure that "health insurance products . . . are guaranteed issue and do not exclude coverage of pre-existing conditions" or which create "effective health insurance markets that do not require underwriting and eliminate its associated administrative costs" are linked to the minimum coverage provision. ACA § 10106(a). Especially in light of the strong presumption favoring

severability, *Free Enterprise Fund*, 130 S. Ct. at 3162, Congress' statement that only provisions related to specific, limited purposes depend on a minimum coverage provision to function is powerful evidence that it did not believe that the balance of the law should not exist in the absence of a minimum coverage provision. *See Marbury*, 5 U.S. (1 Cranch) at 174 ("Affirmative words are often, in their operation, negative of other objects than those affirmed. . . .") Because Congress expressly stated which provisions it might not have enacted if it could not have also enacted a minimum coverage provision, that express statement of legislative intent must define the outer limits of this Court's severability inquiry.

B. Petitioners Misstate The Purpose of The ACA's Provisions Which Are Irrelevant To Insurance Coverage

In addition to exceeding these congressionally-defined outer limits, Petitioners attempt to minimize the significance of what Private Petitioners refer to as the "menagerie of tag-along provisions that will remain" after the ACA's "pillars" are removed. NFIB Brief at 55. As both Private and State Petitioners read the statute, the ACA's "core" or "single central" goal is expanding access to affordable health insurance coverage, *id.* at 46; States Brief at 54, and the hundreds of pages of legislative text which are irrelevant to this goal must not be something Congress would have preferred to be law in the absence of a minimum coverage provision. This reading of the law,

however, minimizes both the complexity of the health care system and the diverse array of problems the ACA was enacted to address.

Drastically reducing the problem of uninsurance is, indeed, one of the problems the ACA is intended to address. Approximately 50 million non-elderly Americans are uninsured, Kaiser Family Foundation, *The Uninsured: A Primer* 1 (Oct. 2011), a problem which resulted in more than 44,000 deaths in 2005. Likewise, sixty-two percent of all personal bankruptcies are caused in part by medical expenses, ACA § 10106(a), and thousands of workers forgo a new job opportunity or the chance to start a business because they cannot afford to leave a job that provides them with health insurance. Kevin T. Stroupe, *et al.*, *Chronic Illness and Health Insurance Related-Job Lock*, 20 J. Pol'y Analysis & Mgmt. 525, 525 (2001). Congress intended the ACA's insurance coverage provisions address these issues.

Yet inadequate access to health insurance is far from the only problem facing the American health care system. America must also have enough doctors, nurses and other medical professionals to meet the needs of ill or injured patients. Likewise, those professionals must be adequately distributed throughout the nation to enable patients in underserved areas to still obtain care. Care delivery models that rely excessively on expensive medical specialists not only drive up the cost of care, they often lead to inferior health outcomes than could be achieved with greater access to primary care providers. Finally, medical

professionals often prescribe care that is ineffective or even harmful to their patients because they lack adequate research informing them of the most effective treatments for a particular medical condition. If America were to achieve universal insurance coverage tomorrow, but remain inadequate to the task of solving these remaining problems, then thousands of Americans would continue to die or suffer other avoidable health consequences each year despite their perfect access to insurance.

The ACA contains provisions addressing each of these issues, all of which function completely independently of the law's insurance coverage provisions. It is not at all "evident" that Congress would have chosen to leave unaddressed each of these separate and independent problems facing the nation's health care system had it believed that just one component of its preferred method of achieving near-universal coverage was off the table.

Access to health professionals: Despite the central role that the problem of uninsurance plays in the rhetoric surrounding health policy, significantly more Americans are impacted by shortages of health professionals than are by a lack of insurance. In 2007, nearly 64.5 million individuals lived in regions designated a "Health Professional Shortage Area" (HPSA) – a designation the Secretary of Health and Human Services may apply to regions where the ratio of residents to primary care physicians exceeds 3,000 to 1, 42 CFR Pt. 5 Appendix A(I)(D) – and 96 million people resided in regions designated under

the somewhat more expansive definition for "Medically Underserved Areas" (MUA). Sara Rosenbaum, *et al.*, *George Washington Univ. Sch. of Public Health and Health Servs., National Health Reform: How Will Medically Underserved Communities Fare?* 2 (July 9, 2009). Seventy-two percent of residents in Medically Underserved Areas were insured in 2006. *Id.* at 4.

In some of these regions, health provider shortages are so intense that it is virtually impossible to obtain care. According to a 2008 report, three neighboring counties in Texas have not had a single medical doctor for more than twenty years. Tim Weldon, Council of State Governments, *Physician Shortages and the Medically Underserved* 1 (August 2008). Fully one-third of Idaho's counties are designated HPSAs, but even states that are rich with medical professionals include pockets of shortage. *Id.* Massachusetts has the most physicians per capita of any state in the nation, but only three of these physicians serve Nantucket County – one-third of what it should have according to the federal Health Resources and Services Administration. *Id.* These shortages result in "longer waits in busier doctors' offices, increased travel times to see physicians, less exposure to preventive strategies and poorer outcomes following traumatic injuries and illnesses." *Id.*

Many Americans also lack access to adequate nursing care. Beginning in 1998, the United States entered a decade-long nursing shortage that peaked when "hospital nurse vacancy rates reached a national average of 13 percent and an estimated 126,000

full-time-equivalent (FTE) RN positions were unfilled, forcing many hospitals to close nursing units and restrict operations." Peter I. Buerhaus, *et al*., *The Recent Surge in Nurse Employment: Causes and Implications*, Health Affairs w657 (2009). Although this shortage started to abate during the recent recession, *id.*, there are worrying signs that these gains are unsustainable. In 1983, approximately 50 percent of the nursing workforce was between the ages of 20 and 34, while only 17 percent was over 50. By 2009, however "the number of nurses over age 50 more than quadrupled, and the number of middle-aged nurses (aged 35-49) doubled to approximately 39 percent (977,000). These older and middle-aged nurses now represent almost three-quarters of the nursing workforce, while nurses younger than 34 now make up only 26 percent." Institute of Medicine, *The Future of Nursing*: *Leading Change; Advancing Health* 125 (2011) ("Future of Nursing"). In part because of looming retirements caused by an aging nursing workforce, America is projected to experience a shortage of 260,000 registered nurses by 2025. *Id.* at 258.

Several provisions of the ACA address the problem of inadequate access to health professionals. The Act expands an existing Nursing Student Loan Program, § 5202 and enables grants to improve the training and retention of nurses, § 5309. It provides loan repayment to pediatric physicians who commit to practice in underserved areas, § 5203, and expands a scholarship program for disadvantaged health

professional students from schools with a demonstrated record of placing graduates in medically underserved communities. § 5402(b). Additionally, it creates a commission that provides annual reports making recommendations to Congress "concerning national health care workforce priorities, goals, and policies" so that Congress can be well-informed about how to address health provider shortages in the future. § 5101(d)(2). It is not "evident" that Congress would not have enacted these provisions in the absence of a minimum coverage provision.

Fostering primary care: Primary health care providers play an essential role in achieving positive health outcomes. Primary care providers exist to evaluate their patients' health generally, and thus are prone to discover a health concern that has not yet been recognized by the patient, Institute of Medicine, *Primary Care: America's Health in a New Era* 53-54 (1996), and could be missed by a specialist who is not accustomed to evaluating patients holistically. Similarly, while patients typically seek specialty care to treat discrete medical conditions, primary care providers enjoy an "ongoing relationship" with their patients. *Id.* at 56. This lasting relationship not only fosters trust between the patient and the provider, it also enables primary care providers to familiarize themselves with the patient's health history and thus make treatment decisions that are informed by intimate details specific to each patient. *Id.*

A relationship with a primary care provider is particularly important for patients with chronic

conditions. Such patients often must "modify[ ] their behavior, monitor[ ] their condition and participat[e] in treatment regimens" in order to keep their condition under control. Institute of Medicine, *Care Without Coverage: Too Little, Too Late* 57 (2002). Such tasks require patients to develop a complex understanding of their condition and to master tasks that do not come naturally to persons without education or training in the health sciences. Thus, a patient's continuing relationship with a single provider who can answer their questions and monitor their care is "a key to high-quality health care" for persons with chronic conditions. *Id.*

Yet, despite the crucial role played by primary care providers, our current system discourages new medical graduates from becoming such providers. One survey of medical students found that only 2 percent plan careers in general internal medicine. Future of Nursing at 257. Doctors practicing internal or general pediatric medicine earned approximately one quarter of the salary earned by the highest paid specialists in their first year out of residency. Laura Yao, *How Much Do Rookie Doctors Make? The Latest Scorecard*, Wall Street Journal (June 17, 2009). New primary providers earn approximately half what new anesthesiologists earn, and as much as $97,500 less than neurologists. *Id.* Over the course of a career in primary care, the average physician will earn $2.5 million less than if they had become a cardiologist. Shirley S. Wang, *Study: Primary Care Career Wealth*

Gap Totals Over $2.5 Million, Wall Street Journal (May 4, 2010).

Moreover, as this pay gap discourages new medical doctors from becoming primary care providers, the growing shortage makes the job increasingly difficult for those primary care providers who remain. The smaller pool of primary care providers must handle a larger and larger slate of patients in order to keep up with demand. As a result, primary care providers "are aptly compared to hamsters on a treadmill, struggl[ing] to provide prompt access and high-quality care." Thomas Bodenheimer, *et al*., *A Lifeline for Primary Care*, 360 New England J. of Med. 2693, 2693 (2009). Worse, as the quality of primary care providers' work life diminishes, "the work-related stresses felt by primary care physicians tags primary care as the career with more work at less pay." *Id.* The result is a vicious cycle where primary care is viewed as an increasingly less desirable career path, which diminishes the pool of doctors willing to pursue this path, which in turn makes the path less desirable.

One positive trend that could provide a counterbalance to this shortage of primary care physicians is the emergence of alternative models for primary care providers. Today, approximately 83,000 nurse practitioners work as primary care providers, totaling just under one quarter of the nation's primary care professionals, and the number of health professionals who become primary care nurse practitioners is trending upward. Future of Nursing at 88.

The ACA contains several provisions that encourage medical graduates to pursue a career in primary care or provide new opportunities for nurse-driven care models. As mentioned above, one provision provides loan repayment to pediatric physicians who practice in underserved areas, including pediatricians who provide primary care. § 5203. The ACA also authorizes grants to train additional physicians in the fields of family medicine, general internal medicine and general pediatrics. § 5301. And it authorizes grants to nurse-managed health clinics that are managed by advanced practice nurses such as nurse practitioners and "provide[s] primary care or wellness services to underserved or vulnerable populations." § 5208. It is not "evident" that Congress would not have enacted these provisions absent a minimum coverage provision.

Comparative effectiveness research: Medicine is, at its heart, a science. It relies upon observing the impact of various possible treatments in order to assess which therapies are appropriate to treat which conditions. The ability to weigh data from thousands of patients in order to determine how best to provide care is what separates modern health providers from their forebearers who relied upon bloodletting and leeches.

Yet, in many cases, health providers lack access to cutting edge research which would give them the information they need to save lives or avoid unnecessary complications from outdated treatments. For

this reason, the use of less effective, ineffective or even harmful treatments is surprisingly common.

In the 1990s, for example, it was common for women with metastatic breast cancer to be treated with high-dose chemotherapy instead of the standard treatment which relied on much lower doses. Michael S. Lauer, Commentary: *Will Academia Embrace Comparative Effectiveness Research?*, 86 Academic Medicine 671, 671 (2011). The side effects of these high doses are horrific, requiring an invasive transplant subsequent to treatment in order to replace bone marrow damaged by the toxic chemotherapy drugs, and yet it is estimated that more than 30,000 women received this treatment at a cost of $3 billion. *Id.* In 2000, a study in the *New England Journal of Medicine* revealed that "[t]he median survival in the group treated with high-dose chemotherapy and stem cells was 24 months, with a 3-year survival rate of 32 percent. The median survival in the conventional-chemotherapy group was 26 months, with a 3-year survival rate of 38 percent." Edward A. Stadtmauer, *et al.*, *Conventional-Dose Chemotherapy Compared With High-Dose Chemotherapy Plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 New England J. of Med. 1069, 1073 (2000). For years, doctors had treated their patients with enormous doses of toxic chemicals, only to learn that, if anything, this painful treatment produced slightly worse health outcomes than the alternative.

Nor was this experience with high-dose chemotherapy an isolated incident. A seminal 2003 study examined the health outcomes of over one million Medicare patients treated for hip fractures, colorectal cancer or heart attacks in hospitals nationwide. Elliott S. Fisher, *et al*., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Accessibility of Care*, 138 Annals of Internal Medicine 273, 273 (2003). It divided each of the patients into five groups depending on the amount of Medicare spending in the area where they were treated. Medicare spent, on average, only 61 percent as much on patients in the lowest quartile as it spent on those in the top quartile, *Id.* at 276, and patients in the highest spending regions received about 60 percent more care than those in the lowest spending regions. Once again, the patients who received the greatest amount of treatment experienced slightly worse health outcomes than those in the lowest spending areas. Elliot S. Fisher, *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 Annals of Internal Medicine 288, 293 (2003). The upshot of this study is that every day, hundreds of health providers in the higher treatment regions administered tests, proscribed drugs and provided other therapies that had no visible impact on their patients' health. The study's authors concluded that

> If the United States as a whole could safely achieve spending levels comparable to those

> of the lowest-spending regions, annual savings of up to 30% of Medicare expenditures could be achieved. Such savings could provide the resources to fund important new benefits, such as prescription drugs or expanded Medicare coverage to younger age groups, or to extend the life of the Medicare Trust Fund to better cover the health care needs of future retirees.

Id. at 298.

In order to improve patient outcomes and reduce the cost of care, the ACA authorizes a newly-created non-profit corporation entitled the "Patient-Centered Outcomes Research Institute" to draw funds from a federally-funded trust fund. § 6301(a). The new Institute shall "advanc[e] the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed. . . ." *Id.* In other words, the Institute seeks to produce research such as the seminal chemotherapy study which taught health providers to stop using a treatment that was both expensive and painful without achieving improved health outcomes. If it succeeds in doing so, it will drive down the cost of care while simultaneously achieving better health outcomes for patients across the nation.

It is not "evident" that Congress would have preferred not to create this Institute absent a minimum coverage provision.

CONCLUSION

Because the Affordable Care Act is entirely constitutional, this Court should not reach the severability question. Should it do so, however, the Court should respect the outer limits on that inquiry as laid out in Congress' express findings, and allow the bulk of the ACA to be implemented.

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