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Nos. 11-393 and 11-400

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *et al.*,
Petitioners,

v.

KATHLEEN SEBELIUS, *et al.*,
Respondents.

STATE OF FLORIDA, *et al.*,
Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, *et al.*,
Respondents.

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

BRIEF FOR COURT-APPOINTED AMICUS CURIAE SUPPORTING COMPLETE SEVERABILITY (SEVERABILITY)

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QUESTION PRESENTED

Whether, if the minimum coverage provision of the Patient Protection and Affordable Care Act is held unconstitutional, it is evident that Congress would want the Act's guaranteed issue and community rating provisions – or the rest of the Act in its entirety – to be declared void and unenforceable.

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for the Eleventh Circuit**

**BRIEF FOR COURT-APPOINTED
AMICUS CURIAE SUPPORTING
COMPLETE SEVERABILITY
(SEVERABILITY)**

INTEREST OF THE *AMICUS CURIAE*

This brief is submitted in response to the Court's order of November 18, 2011, appointing counsel to

brief and argue in support of the judgment of the United States Court of Appeals for the Eleventh Circuit that the minimum care provision of the Patient Protection and Affordable Care Act, 26 U.S.C. § 5000A, is severable from the entirety of the remainder of the Act.

SUMMARY OF ARGUMENT

1. Petitioners and the United States are asking this Court to invalidate perfectly lawful provisions of a federal statute. But the Court undertakes that kind of extreme judicial intervention only in rare cases. In fashioning a remedy for an unconstitutional statutory provision or application, the Court generally "refrain[s] from invalidating more of [a] statute than is necessary," *United States v. Booker*, 543 U.S. 220, 258 (2005) (internal quotation marks omitted), instead "severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (internal quotation marks omitted). Thus, so long as the remaining provisions of a statute are "fully operative as a law," *New York v. United States*, 505 U.S. 144, 186 (1992) (internal quotation marks omitted), the Court allows the valid parts of a statute to continue in effect "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Id.* (internal quotation marks omitted).

Relying on language from *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), petitioners argue that the ultimate severability inquiry should be "whether the statute [without the unconstitutional provision] will function in a *manner* consistent with the intent of Congress." *Id*. But that language, read literally, would point the analysis in precisely the

wrong direction. Because Congress naturally intends a statute to "function" with all of its provisions intact, petitioners' suggested approach would invite a judicial comparison between the statute without the unconstitutional provision and the statute in its original form. As the Court has frequently made clear, however, that is not the right inquiry: the proper severability question is whether "the legislature [would] have preferred what is left of its statute to *no statute at all*." *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 330 (2006) (emphasis added); *Free Enterprise Fund*, 130 S.Ct. at 3161-62; *Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam). Here, therefore, the precise question before the Court is whether it is "evident" that, faced with the unconstitutionality of the minimum coverage provision, Congress would prefer to have no Affordable Care Act at all – or, to take the United States' narrower position, an Act with no guaranteed issue and community rating provisions – rather than an Act with only the minimum coverage provision removed.

2. Although the United States argues, as a threshold matter, that the Court cannot – or, alternatively, should not – conduct severability analysis with respect to provisions that do not directly affect the plaintiffs, its reasoning is unconvincing. To begin with, to the extent that the United States bases its argument on a lack of Article III power, it is mistaking the place of severability analysis in the resolution of a given case. When the Court considers whether invalidation of one statutory provision should lead to invalidation of some or all of the remaining provisions, it is not deciding a new case or controversy, or a new claim for relief, but rather is seeking to fashion an appropriate remedy for the

violation it has found. *See Ayotte*, 546 U.S. at 330. That traditional exercise of equitable powers requires the Court, not just to weigh the effect of possible remedies on the parties before it, but "also [to] take account of the public interest," *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 513 U.S. 18, 26 (1994), an obligation that, in this context, requires an examination of whether Congress – which has a fuller perspective on all the relevant statutory interests – would want the remaining provisions to stand. *See Ayotte*, 546 U.S. at 330 ("a court cannot use its remedial powers to circumvent the intent of the legislature") (internal quotation marks omitted). Severability analysis is thus a necessary component of the Court's remedial authority, and nothing in *Printz v. United States*, 521 U.S. 898 (1997) – which makes no reference to either standing or Article III – requires a separate standing determination before undertaking it.

As for remedial discretion: we agree with the United States that the Court is not *required* to decide the severability question in this case. But, in our view, the Court should decide it, just as the courts below did. Deferral of the severability question will lead to needless uncertainty about the enforceability of other provisions of the Act, putting in question the legitimacy of already effective provisions as well as casting doubt over ongoing preparation for statutorily required changes in the health insurance market. It would be a more fitting use of the Court's remedial discretion to address those issues now, rather than to leave them for resolution at a later time.

3. The primary severability question advanced by petitioners and the United States is whether Congress would want the guaranteed issue and commu-

nity rating provisions to stand independently of the minimum coverage provision. We think that the answer is yes. As the United States itself recognizes, the guaranteed issue and community rating provisions "were the Act's core reforms of the insurance market," US Brief 24 (Minimum Coverage Provision), and they were put in place specifically to open the health insurance market to millions of people who had been unable to acquire affordable coverage because of their poor health. Even leaving aside the usual presumption in favor of severability, therefore, it seems improbable that, if the minimum coverage provision were to be held unenforceable, Congress would prefer to put many of these consumers back where they were before passage of the Act, facing the prohibitively high costs and outright denial of coverage that were standard features of the market that Congress was trying to change. At the very least, the Court should require clear evidence to that effect.

That kind of evidence is lacking here. Although petitioners (but not the United States) initially rest their inseverability argument on the fact that Congress included a severability clause in a different health care bill but not in the one that became law, that fact does not mean much for several reasons. First, there is no explanation for the difference in treatment, and congressional silence is almost always a poor indicator of congressional intent. *See Mead Corp. v. Tilley*, 490 U.S. 714, 723 (1989). Second, both the House and Senate drafting manuals state that it is not necessary to include severability clauses in legislation, acknowledging that the Court applies a presumption in favor of severability anyway.

Petitioners (now joined by the United States) also rely on the Act's express findings about the centrality of the minimum coverage provision to health care reform, *see* 42 U.S.C.A. §§ 18091(a)(1), (2)(A)-(J), but those findings are of limited value on the question of severability. That is because the findings, by their terms, are aimed at a very different question: whether the minimum coverage provision is so "essential" to other provisions of the Act (as well as to other laws) that it should be regarded as part of a broader regulatory scheme for purposes of Commerce Clause analysis. The findings plainly demonstrate that Congress saw the minimum coverage provision as integral to its regulation of interstate commerce, but it would be entirely possible for Congress to take that position and yet hold the complementary view that, if the minimum coverage provision were found unconstitutional, the remaining provisions of the Act should continue in force. Indeed, that congressional preference for severability seems particularly likely for those provisions of the Act – like guaranteed issue and community rating – that were regarded as the principal means of bringing new insureds into an otherwise risk-based insurance market.

Finally, petitioners and the United States rely on an empirical argument of sorts, asserting that, without the minimum coverage provision, future health insurance markets would be severely distorted by adverse selection, resulting in a potential "death spiral" that Congress would have sought to avoid. But the Congressional Budget Office has recognized that the Act contains a number of provisions that "would tend to mitigate that adverse selection." Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (2009). For example, the Act

permits insurers to establish limited enrollment periods each year to discourage the uninsured from waiting until they are sick before purchasing insurance. *See* 42 U.S.C.A. § 300gg-1(b)(1). And, even more importantly, the Act provides generous subsidies to enable low-income people – many of whom are young and in relatively good health – to purchase insurance. *See* 26 U.S.C.A. § 36B. As a consequence, various estimates of premium increases in an insurance market with continued guaranteed issue and community rating, but without the minimum coverage provision, range from approximately 10 percent to slightly more than 25 percent, falling short of the kind of "death spiral" that petitioners and the United States are warning about.

Petitioners and the United States also point to the pre-Act experiences of several States that adopted guaranteed issue and community rating without a coverage mandate, suggesting that Congress would be wary of having the former without the latter. But the dramatic premium increases cited for those States are well beyond those predicted under the federal Act without the minimum coverage provision, presumably in part because none of the States provided for subsidies of the kind and magnitude contemplated by the federal law. And, it is noteworthy that, despite their experiences, a number of the States in question have elected not to do away with guaranteed issue and community rating, or to impose a mandate, indicating that removing barriers to coverage of the uninsured remains of central importance. Petitioners and the United States have not presented clear evidence that Congress would make a different choice.

4. Apart from its severability clause argument, petitioners' case for invalidating the entire Act rests upon an initial premise that the guaranteed issue and community rating provisions will themselves be invalidated, causing a chain reaction of inseverability with respect to the remainder of the Act. Since that premise is incorrect, the rest of the Act should stand. Moreover, it is apparent that other provisions of the Act can continue to operate even without the minimum coverage provision. *See* US Br. 28-40. For example, while implementation of the new Medicaid provisions and the provisions related to employer-subsidized insurance will be affected to some extent if the minimum coverage provision is not in place, those provisions – which cover the majority of insured Americans – will still be able to achieve much of what Congress sought to accomplish. And there is no good justification for striking down any of the numerous provisions of the Act that are totally unaffected by the existence or non-existence of the minimum coverage provision.

ARGUMENT

It is a striking use of judicial power for a federal court to declare that perfectly valid provisions of a law passed by Congress are void and unenforceable. Before taking such action, therefore, the Court should have clear evidence that Congress, faced with the unconstitutionality of one part of a statute, would have wanted some or all of the remaining parts struck down as well. But there is no such evidence here. The provisions that the United States and petitioners together seek to have invalidated – the guaranteed issue and community rating provisions – were specifically designed by Congress to provide important benefits to many uninsured people, often

with serious pre-existing conditions, who have been denied (or quoted extremely high prices for) needed insurance coverage. And, while it is true that Congress expected those provisions to work in concert with the minimum coverage provision, it is far from evident that the benefits of extending coverage to those previously excluded from the insurance market cannot still be realized, to a significant degree, even if the minimum coverage provision is held invalid. The guaranteed issuance and community rating provisions thus should remain in place, and, if they do, the case for striking down all of the remaining provisions – most of which have little or nothing to do with the minimum coverage provision – essentially falls of its own weight. As a result, this Court should limit its excisions from the statute to the minimum coverage provision – along with its related penalty provisions – and nothing more.[1]

I. THE COURT SHOULD SELDOM INVALIDATE STATUTORY PROVISIONS THAT ARE NOT THEMSELVES UNCONSTITUTIONAL

A. This Court has made clear that, in eliminating unconstitutionality from a federal statute, it "must 'refrain from invalidating more of [a] statute than is necessary.'" *United States v. Booker*, 543 U.S. 220,

[1] The United States points out that invalidation of the minimum coverage provision would naturally lead to invalidation of the textually dependent penalty provisions, which are specifically triggered by failure to obtain or maintain minimum coverage. *See* US Br. 54-55 n.23. (Citations to all briefs are to Severability briefs unless otherwise noted.) For simplicity, references in this brief to invalidation of the minimum coverage provision should be read to include the penalty provisions as well.

258 (2005), quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion). As the Court recently observed, "'[g]enerally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem,' severing any 'problematic portions while leaving the remainder intact.'" *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010), quoting *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 328-29 (2006). Thus, for example, when a statutory provision is constitutional as applied to one set of facts but unconstitutional as applied to another, the Court has said 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*, 546 U.S. at 329, quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985). Likewise, "[w]henever an act of Congress contains unobjectionable provisions separable from those found to be unconstitutional, it is the duty of this Court to so declare, and to maintain the act in so far as it is valid." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (internal quotation marks omitted); *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909).

This basic rule is sound for several reasons. To begin with, a reluctance to strike down valid statutory provisions fits most closely with the justification for judicial intervention in the first place. The Court is not "a body with revisory power over the action of Congress," *Muskrat v. United States*, 219 U.S. 346, 361 (1911), but invalidates federal statutes only in the performance of its "most important and delicate duty" to determine whether a federal statute conflicts with the supreme authority of the Constitution. *Id.*

In that context, the Court, while necessarily overriding the congressional will, is exercising a recognized Article III power to assure that the legislative branch has acted within constitutionally prescribed limits. *See United States v. Raines*, 362 U.S. 17, 20-21 (1960); *Marbury v. Madison*, 1 Cranch 137, 177-180 (1803). By contrast, use of the judicial power to strike down entirely constitutional provisions of a statute has no independent Article III grounding, and should typically be invoked only when it is plain that the Court is, in fact, carrying out the intention of Congress itself.

Second, and relatedly, the rule favoring severability is more consistent with fundamental remedial principles. It is well accepted that, when government action has been found to conflict with the Constitution, "[t]he scope of the remedy must be proportional to the scope of the violation, and the order must extend no further than necessary to remedy the violation." *Brown v. Plata*, 131 S.Ct 1910, 1940 (2011). Thus, while the Court, in fashioning an equitable remedy, can and does take account of the broader public interest, *see, e.g.*, *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 513 U.S. 18, 26 (1994); pages 20-24 *infra*, the basic rule is that the "remedy must . . . be limited to the inadequacy that produced the injury in fact that the plaintiff has established." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 353 (2006). Applying that principle, it will be clear in many cases – including this one – that the Court can redress the plaintiff's injury simply by prohibiting enforcement of the statutory provision that offends the Constitution.

Third, a remedy striking down only the unconstitutional provision does the least amount of damage to

the statute that Congress enacted. In explaining its severability doctrine, the Court has emphasized that "we try not to nullify 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*, 468 U.S. at 652 (plurality opinion). By including an inseverability clause, Congress can always specify that it prefers to have broader nullification, but the scarcity of inseverability clauses suggests that Congress is generally willing to have its laws remain effective and enforceable, even if they must operate without provisions found to violate the Constitution. And, in that event, the future legislative work of revising the statute to account for the Court's decision – if Congress elects to follow that course – can begin with almost all of the original statute already in place.

B. To implement these principles of limited judicial invalidation, the Court has adopted a demanding test. So long as the remaining provisions of the statute are "'fully operative as a law,'" *New York v. United States*, 505 U.S. 144, 186 (1992), quoting *Alaska Airlines*, 480 U.S. at 684, the Court will allow the provisions to function "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *New York*, 505 U.S. at 186. *See Free Enterprise Fund*, 130 S.Ct. at 3161 (same).

In the past half-century, the Court has applied that standard with considerable rigor, rarely finding distinct statutory provisions to be inseverable. Indeed, it is notable that, while petitioners rely heavily on *language* from recent severability cases, they rely far less on *holdings* in such cases. *See* States Br. 36-42;

NFIB Br. 30-36. They cite only one case decided in the past 70 years – *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172 (1999) – in which the Court could have eliminated the illegal portion of a law simply by excising it but nevertheless went on to strike down other parts of the law as well. For the most part, petitioners' invocation of recent authority points either to cases where the Court severed the unconstitutional provision or application and left the rest of the law untouched (*see, e.g., Free Enterprise Fund*, 130 S.Ct. at 3161-62*; Ayotte*, 546 U.S. at 328-31*; New York*, 505 U.S. at 186-87*; Alaska Airlines*, 480 U.S. at 684-97*; INS v. Chadha*, 462 U.S. 919, 931-36 (1983); *Regan*, 468 U.S. at 652-55 (plurality opinion)) or to cases where the Court, while not limiting its remedy to a single provision or application, went further only because it concluded that fixing the unconstitutionality would require it to add words to the statute or otherwise rewrite the statute in unacceptable ways. *See, e.g., Randall v. Sorrell*, 548 U.S. 230, 262 (2006); *see also Wyoming v. Oklahoma*, 502 U.S. 437, 459-61 (1992); *Bowsher v. Synar*, 478 U.S. 714, 734-36 (1986). The first type of case does the opposite of what petitioners seek here, and the second deals with a problem that is not present in this case.

Petitioner NFIB and some amici curiae stress, in various ways, that the Act without the minimum coverage provision is not precisely the Act passed by Congress and signed by the President. *See* NFIB Br. 32-36; Family Research Council Amicus Br. 26-28; Assoc. of American Physicians Amicus Br. 9-30. But, if they mean by this to argue that, upon invalidation of one provision, all remaining provisions should automatically be deemed inoperative, their argument runs contrary to the fundamental premise on which

severability law has long been founded: that "[t]he unconstitutionality of a part of an act does not necessarily defeat or affect the validity of its remaining provisions." *Champlin Refining Co. v. Corporation Comm'n of Okla.*, 286 U.S. 210, 234 (1932); *see also Free Enterprise Fund*, 130 S.Ct at 3161. Moreover, any such rule would cause needless upheaval. Given the breadth and complexity of much modern legislation, a rigid requirement of inseverability not only would dismantle large parts of the United States Code but – because it likely would turn on whether the lawful and unlawful provisions were contained within a single bill – also would produce arbitrary and inconsistent results.

If NFIB's and amici's argument is that Congress should be presumed to want only the law that it passed, that, too, is an idea whose time has come and gone. As their cited cases demonstrate, this Court has sometimes taken the position that a law enacted by Congress is presumptively indivisible. *See, e.g., Carter v. Carter Coal Co.*, 298 U.S. 238 (1936); *Williams v. Standard Oil of La.*, 278 U.S. 235 (1929). In *Carter Coal*, for instance, the Court declared that "[i]n the absence of [a severability] provision, the presumption is that the Legislature intends an act to be effective as an entirety – that is to say, the rule is against the mutilation of a statute; and if any provision be unconstitutional, the presumption is that the remaining provisions fall with it." 298 U.S. at 312. That statement of the rule reflected the Court's similar approach in a prior case, where, while noting its duty "to maintain the act in so far as it is valid," *El Paso*, 215 U.S. at 96, the Court nevertheless stated that the burden was on those seeking severability to show that "it is plain that Congress would have enacted the legislation [if the unconstitu-

tional provision were omitted]." *Id.* at 97. But that is no longer the law. As we have noted, the Court now applies the opposite presumption, leaving otherwise valid provisions in force "[u]nless it is evident that the Legislature would *not* have enacted those provisions" without the invalid one. *Free Enterprise Fund*, 130 S.Ct. at 3161 (emphasis added) (internal quotation marks omitted).

Petitioner NFIB tries a variation on the "one bill" theme, suggesting that the Court should be concerned about the risk that severing unconstitutional provisions will amount to "judicial usurpation." NFIB Br. 34. But it is an odd theory of deference that calls upon the Court to invalidate all of Congress's work, rather than just the part that is contrary to the Constitution.[2] And, while NFIB is certainly correct that the Court has been careful not to intrude too far into the legislative domain – by, say, inserting new language to eliminate a constitutional problem, *see Randall*, 548 U.S. at 262 (declining to "write words into the statute") – the Court need have no concern about engaging in such legislative-type activities in this case because enjoining operation of the minimum coverage provision will, without any additional rewriting of the Act, eradicate the alleged unconstitutionality.

C. Petitioners' primary attempt to tilt the balance against severability is to insist that the ultimate inquiry is "whether the statute [without the uncon-

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[2] NFIB relies upon *Clinton v. City of New York*, 524 U.S. 417 (1998), a case striking down a line-item veto by the President. *See* NFIB Br. 34. But that case cuts against NFIB's position. In utilizing a line-item veto, the President is actually deleting lawful provisions of legislation passed by Congress, just the kind of questionable invalidation that NFIB is seeking here.

stitutional provision] will function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685 (emphasis in original). *See* States Br. 38, 42, 44, 50, 52; NFIB Br. 31, 37, 39, 40, 42, 45. But that broad formulation – which the Court has not relied upon in any subsequent decision – must be approached with caution, lest it swallow the basic rule of severability. Taken literally, the inquiry suggested by *Alaska Airlines* would mean that only the most trivial provisions of a law could be deemed severable, given that excision of anything more significant would inevitably change the "manner" in which the statute as a whole was meant to operate. It is very doubtful that *Alaska Airlines* – which, after all, emphasized the Court's duty to "refrain from invalidating more of the statute than is necessary" (*id*. at 684) and set forth the proper severability-favoring standard ("whether it is evident that the Legislature would not have enacted those provisions," *id*.) – meant to restrict severability to that extent.

A second problem with an overly literal application of the *Alaska Airlines* language is that it would focus attention on the wrong question. By its terms, the quoted phrase invites a comparison between the judicially modified statute and the statute originally enacted by Congress, which presumably demonstrated the "manner" in which Congress intended the statute to work. But that is not the right comparison. As the Court has noted, the relevant question is whether "the legislature would have preferred what is left of its statute to *no statute at all*." *Ayotte*, 546 U.S. at 330 (emphasis added); *Free Enterprise Fund*, 130 S.Ct. at 3161-62.

The decision in *Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam), makes clear just what the proper

inquiry should be. There, the Court rejected an argument that, in conducting severability analysis, it should be guided by the legislature's "unified intent" in passing the statute as a whole, stating that "[t]his mode of analysis, if carried out in every case, would operate to defeat every claim of severability." *Id*. at 143. As the Court observed, "[e]very legislature that adopts, in a single enactment, provision A plus provision B intends (A+B); and that enactment, which reads (A+B), is invariably a 'unified expression of that intent,' so that taking away A from (A+B), leaving only B, will invariably 'clearly undermine the legislative purpose' to enact (A+B)." *Id*. The critical point, of course, is that the desired option of having the entire statute, including the unconstitutional provision ("A"), is no longer available. So, "[t]he relevant question is whether the legislature would prefer not to have B if it could not have A as well." *Id.*

The Court's decisions since *Alaska Airlines* demonstrate that the "*manner* consistent with the intent of Congress" language was not meant to rewrite basic severability analysis. In *Booker*, for example, the Court replaced a system of mandatory criminal sentencing with a discretionary sentencing system, even though it was readily apparent that Congress had intended the system to work in a mandatory "manner." *See generally* 543 U.S. at 246-67. Indeed, the Court acknowledged that both its remedy and another proposed remedy "would significantly alter the system that Congress designed," *id*. at 246, and frankly stated that its role was to decide which of the possible remedies "would deviate less radically from Congress' intended system." *Id*. at 247. Similarly, in *Free Enterprise Fund*, the Court eliminated a provision protecting members of the Public Company

Accounting Oversight Board from removal by the Securities and Exchange Commission, 130 S.Ct. at 3161-62, despite the fact that Congress had taken considerable pains to insulate the Board from removal by the Commission. Again, the critical question was not whether the modified statute would still operate in the intended manner – in that respect, it plainly would not – but whether "Congress, faced with the limitations imposed by the Constitution, would have preferred *no Board at all* to a Board whose members are removable at will." 130 S.Ct. at 3162 (emphasis added).

Severability analysis thus must begin with a recognition that the statute as enacted by Congress cannot stand. And, once it is acknowledged that the law inevitably will be altered, a preference for preserving the valid portions of the statute is the best of the possible options. After all, Congress enacts legislation because it believes that pre-existing law is inadequate, and it often seeks to attack various aspects of an unacceptable prior situation in the same legislation. A severability doctrine that returns the law to its earlier state, therefore, is likely to frustrate at least some of Congress's objectives, and should be avoided unless Congress itself has provided a strong indication – that is, unless it is "evident" (*Free Enterprise*, 130 S.Ct. at 3161) – that it would rather have the old law rather than the valid portions of the new one. As we discuss in sections III and IV below, that kind of strong evidence is lacking here.

II. THIS COURT HAS THE POWER TO ADDRESS, AND SHOULD ADDRESS, WHETHER THE REMAINDER OF THE ACT CAN CONTINUE IN EFFECT WITHOUT THE MINIMUM COVERAGE PROVISION

Before turning to the question whether the guaranteed issue and community rating provisions can stand independently of the minimum coverage provision, we must first address the United States' argument that the Court has no power to reach that issue.[3] Relying on *Printz v. United States*, 521 U.S. 898 (1997), the United States claims that petitioners, despite their standing to challenge the minimum coverage provision, cannot seek invalidation of other provisions of the Act unless those provisions have an identifiable effect on them. The Eleventh Circuit did not expressly discuss this issue, but must be taken to have rejected the United States' position since it resolved the severability question on its merits. And, in the end, we think that the court of appeals was right to reject it: although the Court has the flexibility not to reach severability issues in appropriate cases, it necessarily has the power to decide them in the exercise of its remedial authority.

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[3] The United States' argument is not limited to a lack-of-power theme, *see* US Br. 15-16 (referring to "prudential standing," "equitable relief," "facial challenges," and "judicial restraint"), and we address the Government's position that the Court "should not" consider severability issues at pages 22-23 *infra*. However, the United States asserts in the relevant section heading that the Court "may not" address severability issues, US Br. 14, and its reliance on concepts like "Article III," US Br. 15, "injury in fact," US Br. 16, and "cases and controversies," US Br. 16, appears to be part of a challenge to the Court's power to decide severability in this case.

Insofar as the United States is arguing that Article III bars the Court from considering the validity of provisions that do not affect petitioners, its view misapprehends the role of severability analysis in the resolution of an ongoing case. When the Court considers whether other, independently valid provisions of a statute should remain in force, it is not deciding a new "claim" for relief, or a request for a "different form" of relief, both of which would require the plaintiffs to establish standing anew. *See, e.g., DaimlerChrysler*, 547 U.S. at 352 ("a plaintiff must demonstrate standing for each claim he seeks to press"); *Friends of the Earth, Inc. v. Laidlaw Environ. Serv.*, 528 U.S. 167, 185 (2000) ("a plaintiff must demonstrate standing separately for each form of relief sought"). Rather, it is deciding the proper scope of equitable relief for the constitutional violation that the plaintiffs have already established. *See Ayotte*, 546 U.S. at 330. And, in making that determination, the Court is not limited to considering the interests of the plaintiffs and defendants. To the contrary, because the Court is exercising equitable powers, it must examine how various remedies might affect the public interest. *See U.S. Bancorp.*, 513 U.S. at 26 ("[a]s always when federal courts contemplate equitable relief, our holding must also take account of the public interest"); *United States v. Morgan*, 307 U.S. 183, 194 (1939) ("[i]t is familiar doctrine that the extent to which a court of equity may grant or withhold its aid, and the manner of moulding its remedies, may be affected by the public interest").

To carry out its remedial duties in proper fashion, therefore, the Court must consider, not just whether a particular remedy might be overly broad, but also whether too narrow a remedy – that is, an order limited just to invalidation of the unconstitutional

provision – will adversely affect the larger public interest. And, because Congress is typically better positioned to recognize if removal of one provision in a statute would rightly lead to the incapacity of other provisions, the Court looks to see whether Congress has expressed any clear indication that the remaining provisions should be deemed unenforceable as well. *See Ayotte*, 546 U.S. at 330 ("a court cannot use its remedial powers to circumvent the intent of the legislature") (internal quotation marks omitted); *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 497 (2001) ("[a] court sitting in equity cannot ignore the judgment of Congress, deliberately expressed in legislation") (internal quotation marks omitted). To be sure, as we have discussed, *see* pages 9-18 *supra*, it will usually be the case that the judicially altered statute can still advance worthwhile statutory goals, even without the stricken provision, and thus the Court commonly leaves the remaining provisions undisturbed. But, in rare cases, removal of just the unconstitutional provision may so disrupt other interests, including those of parties not before the Court, that the better remedial course is to invalidate some or all of the remaining provisions as well. Either way, severability analysis is an essential component of determining what the proper remedy should be.[4]

[4] Under the United States' view, the Court apparently could never take into account Congress's intention regarding statutory provisions that do not affect the plaintiffs, no matter how clear its intention might be. That rule would potentially lead to the strange situation in which the remaining provisions of a statute continued in full effect, even though Congress had included an express inseverability clause to prevent just such an outcome.

This case illustrates the point. Even as it makes its Article III argument, the United States also asserts that continued enforcement of provisions like guaranteed issue and community rating, in the absence of the minimum coverage provision, would seriously distort segments of the health insurance market. *See* US Br. 47-51. Yet, as we discuss later, *see* pages 25-29 *infra*, the effect of *deleting* those provisions would be to impose hardship on numerous uninsured people who stand to gain access to the insurance market as a result of insurance reform. Thus, the scope of the Court's remedial order is of considerable significance to third parties. And, regardless of how the Court ultimately weighs the potential consequences of different remedial choices, it would be an incomplete exercise of its equitable authority for the Court simply to disregard those consequences, restricting its consideration of possible benefits and burdens to the parties before it.

Finally, however, we note that remedial power is always characterized by flexibility. *See, e.g., Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944) ("[f]lexibility rather than rigidity has distinguished [equity jurisdiction]"). We thus agree with the United States insofar as it asserts that the Court is not *required* to decide the severability issues that petitioners raise. In general, if the Court believes that resolution of severability issues requires the perspective of parties not before the Court, nothing precludes the Court from deciding, on that remedial ground, to limit its invalidation to the unconstitutional provision or application itself. *See, e.g., United States v. National Treasury Employees Union*, 513 U.S. 454, 477-78 (1995). Equally, the Court may postpone any definitive severability analysis if, in the exercise of prudent discretion, it sees no particular harm to third party

interests as a result of a remedy aimed simply at redressing the injury to the plaintiffs in the immediate case. Both of those resolutions amount to a kind of *de facto* severability – pending future challenges[5] – and remain among the remedial choices that the Court may elect in an appropriate case.

In our view, however, this is not an appropriate case. Postponement of a severability determination necessarily creates uncertainty about the governing law, and that kind of uncertainty would be especially detrimental here. As the United States points out, US Br. 29-30, many of the Act's provisions are already in effect, and many other provisions, such as those establishing the new insurance exchanges, require extensive advance planning. Still more provisions – in particular, the guaranteed issue and community rating requirements – are intended to provide new or expanded benefits to millions of people in need of health care. It would not be an optimal use of this Court's remedial discretion to leave the validity of those provisions in continuing doubt.

The decision in *Printz* did not change these basic remedial principles. Although the Court in *Printz* declined to address the severability of certain statutory provisions with no apparent effect on the plaintiffs, the relevant part of its opinion is limited to a single paragraph – not the usual format for announc-

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[5] Contrary to the States' position, it is not especially difficult to imagine "what claim [a third party] would bring." States Br. 33. Plaintiffs could seek an injunction against a statutory provision that causes them injury, alleging that the provision is a) inseverable from a provision that has already been struck down on constitutional grounds and b) thus unenforceable against them.

ing an important new doctrine – and the Court did not invoke either "standing" principles or "Article III," instead defining the issue as "a severability question." 521 U.S. at 935. Moreover, while the Court's observation that it "ha[d] no business answering" the severability question can certainly be read as suggesting a lack of power to answer it, that language can also be read as describing a proper exercise of discretion under the circumstances, where the potential impact of a limited decree on third parties (*i.e.*, leaving in place various waiting periods and notification requirements) was likely to be modest. Thus, despite the United States' submission, we believe that the Court has the power to decide – and should decide – the severability issues that petitioners have raised.

III. THE GUARANTEED ISSUE AND COMMUNITY RATING PROVISIONS SHOULD REMAIN IN EFFECT EVEN WITHOUT THE MINIMUM COVERAGE PROVISION

The central severability question in this case is whether the guaranteed issue and community rating provisions should continue in effect even if the minimum coverage provision is struck down. *See* 42 U.S.C.A. §§ 300gg-1, 300gg-2, 300gg-3, 300gg-4(a) (guaranteed issue); 42 U.S.C.A. §§ 300gg(a)(1), 300gg-4(b) (community rating). *See also* US Br. 6 nn. 5&6, 54-55 n. 23. The United States and petitioners take the position that they should not, saying that the guaranteed issue and community rating provisions are so intertwined with the minimum coverage provision that they cannot stand independently. *See* US Br. 44-54; States Br. 47; NFIB Br. 36-40. In support, they make essentially three arguments: 1) that the absence of a severability clause – described by NFIB

as the "removal" of a severability clause – shows that the provisions are interdependent (an argument that the United States rejects); 2) that Congress's express findings establish that the provisions are inseverable; and 3) that, as a practical matter, an insurance market with guaranteed issue and community rating, but without a minimum coverage provision, cannot function effectively because it will suffer from severe adverse selection, possibly producing a "death spiral."

In the end, these arguments are insufficient. Although the guaranteed issue and community rating provisions were meant to work together with the minimum coverage provision, and likely will operate less ideally without the minimum coverage provision, it does not follow that Congress, confronted with that prospect, would prefer to return to the prior health insurance system, where large numbers of people, in need of insurance but with pre-existing illnesses or conditions, were excluded from the market. That conjecture might be plausible if it were clear that a true "death spiral" would occur without the minimum coverage provision – driving so many healthy consumers out of the market that less healthy consumers would face unmanageable prices anyway – but, as we discuss in some detail, *see* pages 35-41 *infra*, that outcome is not at all certain. The Court thus should decline the invitation to strike down these important, lawful provisions. *See Regan*, 468 U.S. at 655 (plurality opinion) (declining to declare lawful provisions inseverable where "Congress' intent can in large measure be fulfilled without the [unconstitutional] requirement").

A. To assess whether Congress would prefer to go back to an insurance system without guaranteed issue and community rating, it is necessary to under-

stand why Congress included those provisions in the first place. Although the majority of Americans get their health insurance through their employers (*see* Kaiser Family Foundation, *The Uninsured: A Primer*, at 3 (October 2011)) – where various forms of guaranteed issuance and community rating tend to be the rule, at least for large employers – individuals and families outside the employer-insurance market have traditionally faced a more unsettled marketplace. As the law stood before passage of the Act, insurers in most States were permitted to deny health insurance to people in poor health or with pre-existing conditions. *See* Linda J. Blumberg & Karen Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 2 (Urban Institute 2009). Moreover, if insurers did offer coverage, it was often at very high prices and might include a rider denying coverage for specified conditions. *See id.* To determine the risks for particular policies, insurers engaged in a process of medical underwriting that itself was costly, thus raising insurance prices. Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report*, at 4 (2009).

The cumulative impact of these risk-specific practices was substantial. The Department of Health and Human Services recently estimated that "12.6 million non-elderly adults – 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market – were in fact discriminated against because of a pre-existing condition in the previous three years." Dept. of Health and Human Services, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind*, at 1 (2009). The HHS report noted that "a pre-existing condition does not have to be a

serious disease like cancer or heart disease," and that "[e]ven relatively minor conditions like hay fever, asthma, or previous sports injuries can trigger high premiums or denials of coverage." *Id*. Given that expansive definition of pre-existing illnesses, it is not surprising to find that large numbers of people have them, or can expect to have them in the foreseeable future. Another Department of Health and Human Services analysis stated that "50 to 129 million (19 to 50 percent) of non-elderly Americans have some type of pre-existing health condition," up to 25 million of whom are uninsured. Dept. of Health and Human Services, *At Risk: Pre-existing Conditions Could Affect 1 in 2 Americans*, at 1 (2011). *See also id.* ("15 to 30 percent of people in perfectly good health today are likely to develop a pre-existing condition over the next eight years").

Congress was well aware of these coverage problems. A House Report discussing an earlier health care bill (H.R. 3200) recognized that "health insurers – particularly in the individual market – have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy." H.R. Rep. No. 299, 111 Cong., 1st Sess. Pt. 3, at 92 (2009). The House Report listed a number of such practices, including "denying health coverage based on pre-existing conditions or medical history, even minor ones; charging higher, and often unaffordable, rates based on one's health; [and] excluding pre-existing medical conditions from coverage . . . ." *Id*. It noted that these and other actions by insurers have "severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured." *Id*.

Congress thus made it a primary objective of the Act to remove insurance barriers for consumers in relatively poor health. Of particular relevance here, the Act requires that, subject to limited exceptions, "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." 42 U.S.C.A. § 300gg-1(a). Furthermore, the Act specifies that an insurer "may not impose any preexisting condition exclusion with respect to such plan or coverage." 42 U.S.C.A. § 300gg-3(a). And, to prevent denials-in-fact caused by high premiums tied to health status, the Act imposes a community rating system, restricting (though not entirely eliminating) insurers' ability to vary their rates according to individual circumstances. *See* 42 U.S.C.A. §§ 300gg(a)(1)-(5), 300gg-4(b). The United States itself refers to these provisions as "the Act's core reforms of the insurance market . . . " US Br. 24 (Minimum Coverage Provision). *See also* H.R. Rep. No. 443, 111th Cong. 2d Sess. Pt 2, at 975-76 (2010) ("to protect families struggling with health care costs and inadequate coverage, the bill ensures that insurance companies can no longer compete based on risk selection").

The severability position taken by petitioners and the United States would put an end to these "core reforms." But that backwards-looking proposition properly carries a heavy burden. Indeed, even if there were no general presumption in favor of severability, it would still seem appropriate for the Court to insist upon a clear indication of Congress's intent before concluding that the severability result most consistent with congressional policy would be to deny coverage to many people that Congress

indisputably meant to help. The arguments put forth by the United States and petitioners do not meet that standard.

B. At the outset, it is worth noting that the Act does not contain an inseverability clause, either a general one or one limited to the guaranteed issue and community rating provisions.[6] Although that omission does not merit great weight – Congress uses inseverability clauses infrequently enough that the absence of one is not especially probative – the fact remains that an inseverability clause is the clearest way for Congress to declare its intention that parts of a statute must stand or fall together. Congress could have availed itself of that opportunity in the Act, but it did not. Moreover, as petitioners point out, Congress fully anticipated legal challenges to the constitutionality of the minimum coverage provision, s*ee* States Br. 5-6, 58, so the lack of an inseverability provision cannot be attributed to the element of unforseeability.

Petitioners (opposed by the United States) do try to fashion a kind of makeshift inseverability clause, contending that prior "removal" (NFIB Br. 58) of a severability clause reveals Congress's intent to have the entire Act – not just the guaranteed issue and community rating provisions – treated as indivisible. *See* NFIB Br. 58; States Br. 58. But there are several problems with this argument. In the first place, the

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[6] Neither the United States nor petitioners dispute that the guaranteed issue and community rating provisions can still be "fully operative as a law," *New York*, 505 U.S. at 186, in the relevant sense that there is no textual dependency on the minimum coverage provision. Cf. *Booker*, 543 U.S. at 245 (striking down review provision with no function other than to enforce unconstitutional provision). *See also* Note 1 *supra*.

term "removal" is not an apt characterization of the drafting history. To be clear: the bill that was enacted into law never contained a severability clause and thus no severability clause was, or could have been, removed from it. Severability clauses were contained in (and not removed from) two different health-care bills, H.R. 3200 and H.R. 3962, but neither of those bills became the final version of the Act.

To be sure, the inclusion of a severability clause in some bills and its absence in another bill might indicate that Congress did not want provisions of the latter bill to be severed. *See* States Br. 58. But it is hard to draw that inference here. The legislative record offers no explanation for why some health-care bills had severability clauses and the particular bill that became law did not, and speculation based on nothing more than congressional silence is properly regarded as treacherous. *See Kimbrough v. United States*, 552 U.S. 85, 103 (2007). Indeed, even if Congress had actually removed a severability clause from the law-making bill, that action, without any indication of the reason, would still carry little weight. As this Court has remarked, "'mute intermediate legislative maneuvers' are not reliable indicators of congressional intent." *Mead Corp. v. Tilley*, 490 U.S. 714, 723 (1989), quoting *Trailmobile Co. v. Whirls*, 331 U.S. 40, 61 (1947).

The general reluctance to rely on legislative silence makes especially good sense in the present context. As the Eleventh Circuit noted, both the House and Senate drafting manuals state that it is not necessary to include a severability clause in proposed legislation. *See* US Pet. App. 175a-76a. *See also* US Br. 42-43. Even without a severability clause, it is

well understood that the Court will usually strike down only the invalid parts of a statute and leave the valid parts intact, thereby doing what a severability clause would instruct anyway. *See Free Enterprise Fund*, 130 S.Ct. at 3161; pages 9-18 *supra*. Thus, while the presence of a severability clause might help to reinforce the Court's customary practice, the absence of one hardly suffices to justify striking down a vast, multi-part statute in its entirety.

C. Petitioners (joined on this point by the United States) also rely on a seemingly more telling expression of congressional intent: explicit findings about the vital role of the minimum coverage provision. *See* States Br. 11-14, 45-46; NFIB Br. 36; US Br. 45-47. Those findings declare, among other things, that the coverage requirement 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." 42 U.S.C.A. § 18091(a)(2)(I). Furthermore, in the same finding, Congress explains that, "[b]y significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id*. According to petitioners and the United States, these and other findings demonstrate that Congress saw the minimum coverage provision as inseverable from the guaranteed issue and community rating provisions.

This is a perfectly reasonable argument, but it has a significant weakness: the findings were not addressed to the issue of severability. Rather than providing guidance about what should happen if the

minimum coverage provision were held unconstitutional, the evident purpose of the findings was to support Congress's position that the minimum coverage provision was, in fact, constitutional. The heading for the relevant subsection is "Effects on the national economy and interstate commerce," 42 U.S.C.A. § 18091(a)(2), and the nature of the findings themselves demonstrates Congress's intent to show the close relationship between the minimum coverage provision and interstate commerce. *See* 42 U.S.C.A. §§ 18091(a)(1), (2)(A)-(J). Indeed, the United States, in its separate minimum coverage brief, relies on these findings for just that purpose: to demonstrate that the minimum coverage provision "is an integral part of the Act's comprehensive regulation of the market in health care and health care financing." US Br. 27 (Minimum Coverage Provision).

This view of the findings is reinforced by several other textual clues. First, Congress's use of the term "essential" echoes the language of *United States v. Lopez*, 514 U.S. 549 (1995), where the Court, in holding that Congress had exceeded its power to regulate interstate commerce, specifically found that the object of Congress's regulation was, among other things, "not an essential part of a larger regulation of economic activity." 514 U.S. at 561. Given that background, the Act's findings were plainly drafted to set forth Congress's view that the minimum coverage provision should not be treated as a freestanding requirement for Commerce Clause purposes, but rather as an integral part of a larger regulatory scheme. As further support for that point, Congress also used the term "essential" to connect the minimum coverage provision to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, and the Public Health Service Act, 42 U.S.C. § 201 *et*

seq., saying that the coverage requirement was "an essential part of this larger regulation of economic activity," 42 U.S.C.A. §18091(a)(2)(H), language that tracks the *Lopez* wording exactly. As the Eleventh Circuit noted, however, no one argues that those Acts should be deemed inseverable from the minimum coverage provision. *See* US Pet. App. 184a-85a. It is thus apparent that, in the Act's findings, Congress was seeking to defend its reliance on Commerce Clause powers, not declaring its views about severability.

It is reasonable, of course, to ask whether the findings, though directed at the antecedent constitutional question, can also be read to answer the severability question. But the two questions are not the same. It is one thing to say that certain provisions of the Act are so interconnected that they should be considered as one activity for Commerce Clause purposes (the constitutional question), quite another to say they are so interconnected that, if Congress cannot have all of them, it would rather have none (the severability question). As we have discussed, if confronted with the severability question by itself, Congress in most cases will prefer to have an imperfect solution rather than no solution at all, and that seems particularly likely here, where the result of having no solution would be the denial of coverage to many people that Congress unquestionably wanted to assist.

D. Apart from the congressional findings, the bulk of the United States' and petitioner States' argument, joined for the most part by petitioner NFIB, rests upon an assertion that, as a practical matter, guaranteed issue and community rating cannot work in an acceptable way without the countervailing effects of

the minimum coverage provision. *See* US Br. 45-51; States Br. 44-45; NFIB Br. 36-40. According to this view, the lack of a mandate to acquire insurance will result in various forms of adverse selection among people deciding whether to carry insurance, leading to higher premiums and to an unfavorable, even ruinous, skewing of the pool of insured people. To support this theory, petitioners and the United States rely on a handful of studies about the possible impact of a mandate-less health care system and on the experience of certain States that provided for guaranteed issue and community rating without a requirement to obtain health insurance. They then conclude that it is "evident" that Congress would not have wanted guaranteed issue and community rating without the minimum coverage provision.

Before responding to this argument in detail, however, we note that it calls for a severability analysis quite unlike any that the Court has undertaken before. The guaranteed issue and community rating provisions do not go into effect until 2014, and the portrayal of insurance markets facing a "death spiral" thus requires a heavy dose of conjecture. *See* Douglas W. Elmendorf, Director, CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 9 (March 30, 2011) ("[t]he projections of the budgetary impact and other impacts of health care legislation are quite uncertain because assessing the effects of making broad changes in the nation's health care and health insurance systems . . . requires assumptions about a broad array of technical, behavioral, and economic factors"). Furthermore, this kind of predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence. *See generally Turner Broad. Sys., Inc v.*

FCC, 521 U.S. 622, 655 (1994). Those concerns might be alleviated, of course, if all the relevant studies showed that eliminating the minimum coverage provision by itself was so calamitous that no rational Congress could favor that limited remedy, but the studies are far from that definitive. To the contrary, they offer considerable reason for believing that the Act can achieve much of what Congress sought, even without the minimum coverage provision.

1. The United States and petitioners (in part) argue that, without the minimum coverage provision but with guaranteed issue and community rating, the health care market will be distorted by two forms of adverse selection. First, people with higher-than-average health care costs will sign up for insurance, raising the premiums for, and discouraging the purchase of insurance by, people with lower-than-average health care costs. Carried to extremes, this mutually reinforcing process can result in a "death spiral," producing an insurance market largely populated by unhealthy people paying extremely high premiums. Second, people will postpone their purchases of health care insurance until they are sick. That delay burdens insurance companies with the cost of paying for their resulting care without the compensating offset of premiums paid before they need care.[7]

The Congressional Budget Office has recognized, however, that the Act contains a number of provisions – of which the minimum coverage provision

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[7] Petitioner NFIB does not support this argument, stating that "Congress' concerns about this kind of 'adverse selection' are both highly implausible and completely speculative." NFIB Br. 15 n.18. *See also* NFIB Br. 39 ("Congress greatly exaggerates this problem").

is just one – that will substantially restrain these effects. Thus, in a November 2009 report, the CBO first noted just what petitioners and the United States assert: that changes like guaranteed issue and community rating, viewed by themselves, "would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care." Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (2009) (CBO: *Analysis of Health Insurance Premiums*). The CBO went on, however, to point out that "several other provisions of the proposal would tend to mitigate that adverse selection." *Id*. For example, the CBO stated, "[t]he legislation would establish an annual enrollment period for new nongroup policies similar to that typically used by employers, which would limit opportunities for people who are healthy to wait until an illness or other health problem arose before enrolling." *Id*. *See also* NFIB Br. 15 n.18.

The enrollment provision referred to by the CBO directly addresses the second of the adverse selection concerns noted above: that the uninsured will wait to buy insurance until it is needed. By its terms, that provision permits insurance companies to "restrict enrollment in coverage . . . to open or special enrollment periods." 42 U.S.C.A. § 300gg-1(b)(1). If the uninsured choose to forego enrollment during the specified period, they must bear the risk of illnesses suffered prior to the next enrollment period. Even though that restriction will not eliminate all incentive for delaying insurance purchases – the uninsured would still receive emergency care if they

cannot pay – it sharply raises the potential consequences of doing so.

Even more importantly, the CBO report observed that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people." CBO, *Analysis of Health Insurance Premiums*, at 19. Moreover, because of the subsidies' structure, "[t]he premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees (though federal subsidy payments would have to rise to make up the difference)." *Id*. at 20. According to the CBO, "[t]hat arrangement would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." *Id.* Indeed, taking these mitigating influences into account, along with the minimum coverage provision, the CBO predicted that the extent of adverse selection "is likely to be limited, and many nongroup enrollees would be in fairly good health." *Id*.

The role of the premium subsidies – along with cost-sharing subsidies to limit out-of-pocket costs – is significant in several ways. Especially for those with the lowest income, and thus the greatest government support, the existence of the subsidies markedly changes the point at which it makes economic sense to purchase insurance. For potential purchasers, the relevant question about acquiring insurance is no longer whether their projected health costs will exceed the amount of the insurance premium, but whether their projected health costs will exceed *their share* of the insurance premium. Furthermore, given that uninsured low-income individuals are dispropor-

tionately young, *see* Kaiser Family Foundation, *The Uninsured: A Primer*, at 6 ("[y]oung adults whose low incomes make it more . . . difficult to afford insurance are especially likely to be uninsured"), it may be expected that, when they obtain insurance, their health care costs will be less than their total premiums (*i.e.*, their payment plus the government subsidy), creating a surplus for insurance companies writing the policies.

Several studies, in fact, have pointed out the suppressive effect that government subsidies are likely to have on premium increases, even without the minimum coverage provision. For example, a January 2012 Urban Institute study, comparing expected premiums under the Act without the minimum coverage provision to premiums under the Act with the minimum coverage provision, specifically noted that "[t]he effects of adverse selection in the exchange are mitigated by the large subsidized population." Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care*, at 6 (Urban Institute 2012) (Buettgens & Carroll: *Eliminating the Individual Mandate*). Relatedly, an earlier Urban Institute report had noted that "[t]hose eligible for subsidies are on average younger than the population at large and have lower average costs." Matthew Buettgens, Bowen Garrett & John Holahan, *Why the Individual Mandate Matters*, at 6 (Urban Institute 2010). The authors thus concluded that "there would be a large pool of lower-than-average-cost enrollees in the exchanges with or without a mandate, moderating the effects of adverse selection." *Id.*

A study by the Lewin Group drew similar conclusions. *See* John F. Sheils & Randall Haught, *Without*

The Individual Mandate, The Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted, 30 Health Affairs No. 11, at 5 (Lewin Group 2011) (Sheils & Haught: *Without the Individual Mandate*). In that report, the authors stated that their simulation model showed "the stabilizing effect that premium subsidies can have on premiums and coverage." *Id*. Like the CBO, they recognized that the structure of the premium subsidy – covering the amount of the premium above a stated percentage of the recipient's income – meant that "people receiving premium subsidies under the act would be protected against most or even all of the premium increase." *Id*. That protection would, in turn, increase the take-up rate for coverage: "Because two-thirds of people with nongroup coverage are projected to receive subsidies, the effect of premium increases on coverage would be greatly reduced." *Id*. at 5-6.[8]

There is reason, therefore, to doubt whether, in the absence of the minimum coverage provision, a real "death spiral" actually will result. For its part, the January 2012 Urban Institute study estimated that "[w]ithout a mandate, but with robust exchange participation, overall nongroup premiums [would] rise

[8] Petitioner NFIB argues that, without the minimum coverage provision, the Government's cost for premium subsidies would "skyrocket." NFIB Br. 49. But a CBO evaluation of the Act without the provision estimates that the cost of exchange subsidies would *decline* by $39 million. *See* Cong. Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010) (CBO: *Effects of Eliminating the Individual Mandate*); US Br. 40-41 n.19. That is because fewer people would sign up for insurance, a change in behavior that, while not advancing the goal of greater coverage, does reduce Government expenditures.

about 10 percent due to adverse selection," Buettgens & Carroll: *Eliminating the Individual Mandate*, at 6, a figure that goes up to 12 percent if a low exchange preference is assumed. *Id.* (If the model is revised to assume a low degree of subsidy take-up as well, the figure jumps to 20 percent. *Id.*). The Lewin Group study, also comparing expected premiums under the Act without the minimum coverage provision to premiums with the provision, found that average premiums would increase by 12.6 percent. *See* Sheils & Haught: *Without the Individual Mandate*, at 5.[9] Noting that the estimate was "much lower than might be expected," *id.* at 7, the authors again explained that the figure reflected the high percentage of people eligible for subsidies and the protection against higher premiums built into the subsidy framework. Those factors "would reduce the coverage loss from lifting the mandate and restrain premium increases in the nongroup market." *Id.*

Two other studies have estimated somewhat larger premium increases without the mandate, at least compared to the first two Urban Institute figures.[10] The CBO has predicted that, if the minimum coverage provision were removed from the Act, "adverse selection would increase premiums for new non-group

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[9] Breaking down that number more precisely, the Lewin Group study estimated that the price increases would be much higher for people not receiving subsidies – ranging from 26.2 percent to 34.9 percent, depending upon whether they purchase insurance through the exchanges – but considerably lower (7.7 percent) for people who did receive subsidies. *Id.*

[10] The figures in the various studies are not strictly comparable because, among other things, they reflect different time periods. *See* Buettgens & Carroll: *Eliminating the Individual Mandate*, at 3. Nevertheless, they provide a rough picture of what pricing changes might occur.

policies (purchased either in the exchanges or directly from insurers in the non-group market) by an estimated 15 to 20 percent relative to current law" (*i.e.*, the law with the mandate). CBO, *Effects of Eliminating the Individual Mandate*, at 2. And Professor Jonathan Gruber projected that premiums for individual policies would rise by 27 percent if the mandate were eliminated, *see* Jonathan Gruber, *Health Care Reform without the Individual Mandate*, at 2 (2011), although he found that premiums for family policies would increase by only 12.3 percent. *See* Jonathan Gruber, *Health Care Reform Is a Three-Legged Stool*, at 4 (Table) (2010); *see also id*. at 5 ("[t]he impact on family policies is more modest, as the selection effects are much stronger for young healthy singles").[11] Even those numbers, however, fall short of demonstrating that the health insurance market will be so negatively affected that Congress would plainly prefer a return to a market without guaranteed issue and community rating.

2. Petitioners and the United States also say that Congress would not have wanted to have guaranteed issue and community rating requirements without the minimum coverage provision because of the experiences of certain States that followed that course. *See* States Br. 12, 46; NFIB Br. 14 n.16; US Br. 47-

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[11] Taking a different tack, the Economists' amicus brief seeks to quantify the financial benefits to insurance companies that would be lost without the minimum coverage provision. Economists Amicus Br. 11-13. But, because the Economists combine benefits from the mandate and benefits from premium subsidies into a single figure, Economists Amicus Br. 12 n.6, they do not offer any figure for lost benefits occasioned by absence of the minimum coverage provision alone. Given the large subsidy amounts, the figures for removal of just the minimum coverage provision would be significantly lower.

51. *See also* America's Health Insurance Plans Amicus Br. 26-35; Texas Public Policy Foundation Amicus Br. 26-30. The immediate difficulty with that argument, however, is that the just-discussed studies reveal a substantial disparity between the cited States' experience and the projected experience under the federal Act without the mandate. Thus, while some States saw "skyrocketing premiums" as a consequence of adverse selection, *see* Texas Public Policy Foundation Amicus Br. 28 (discussing Washington), none of the estimates of premium increases under the Act without the minimum coverage provision contemplate that kind of dramatic change. Indeed, as we have noted, one study described the likely effects of adverse selection on premium rates as "much lower than might be expected." Sheils & Haught: *Without the Individual Mandate*, at 7.

The possible reasons for the differences in outcome, real and projected, are not hard to fathom. As far as we can tell, no State providing for guaranteed issue and community rating bolstered its insurance reforms with subsidies of the particular type and magnitude contemplated by the federal Act. *See, e.g.*, Buettgens & Carroll: *Eliminating the Individual Mandate*, at 1 ("New York does not have the provision under the ACA that provides subsidized coverage in the exchanges"). Yet, both the amount of the subsidies and their particular structure – which essentially shelters subsidized purchasers from premium increases that might otherwise result from adverse selection – play an important role in assuring that younger and healthier people become part of the insurance pool. An insurance program that does not mirror those incentives cannot expect the same results.

There are also differences between rules that are limited to a single State and rules that operate nationwide. For example, the United States says that, after implementing its plan with guaranteed issue and community rating, the State of Washington attracted sick people from other States who were seeking immediate coverage, resulting in rapidly increasing premiums. *See* US Br. 48-49. But, even leaving aside the fact that the federal Act allows for the imposition of limited annual enrollment periods, uniform requirements of guaranteed issue and community rating throughout the country would forestall migration that might occur under a varying state-by-state system where consumers could move from States that do not have such requirements to States that do. And States are free, under the Act, to establish multi-State Exchanges if they so desire. *See* 42 U.S.C.A. § 18054.

In any event, even if the States' experience were regarded as a reliable benchmark for what might be expected under the Act, it would still not prove the point that petitioners and the United States are trying to make: that Congress would prefer to have no guaranteed issue and community rating requirements, rather than have them without a minimum coverage provision. If that assumption were correct, one would expect history to show that, having observed the consequences of their laws, all the States either added a minimum coverage provision or repealed their guaranteed coverage and community rating provisions. But that is not what happened. A few States did end the requirements of guaranteed coverage and community rating, but other States left their systems largely in place or made relatively modest changes to lessen the effects of adverse selection. Only Massachusetts enacted a mandate.

In the end, therefore, four of the cited States (Maine, New Jersey, New York, and Vermont) have continued to operate health care systems with guaranteed issue and community rating but no requirement to purchase insurance, although Vermont has provided for higher deductibles and allowed insurance companies to impose waiting periods before coverage takes effect. *See* Kaiser Family Foundation, *Individual Market Guaranteed Issue* (statehealthfacts.org/comparetable.jsp?ind=353&cat=7); *Individual Market Rate Restrictions* (statehealthfacts.org/comparetable.jsp?ind=354&cat=7). *See also* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, at 5-46 (2007) (reviewing state laws). Washington has amended its law to allow for longer waiting periods and the exclusion of particularly high-risk applicants (who are placed in a separate high risk pool). *See* Governor of Washington Amicus Br. 12. But only New Hampshire and Kentucky have done what petitioners and the United States urge the Court to do here: eliminate guaranteed issue and community rating completely. Thus, despite premium increases considerably greater than might be expected under the federal Act, legislatures in a number of reform States have apparently decided that the benefits of guaranteed issue and community rating remain worth having. Indeed, a former Governor of Vermont has expressed his view, based on the experience in that State, that "an individual mandate is not essential either to achieve near universality or to have a stable insurance market." Howard Dean, *Health Care Reform Will Succeed Without Individual Mandate*, at 2 (Huffington Post, January 13, 2012).

E. Elimination of the guaranteed issue and community rating provisions would also interfere with operation of the new insurance exchanges. Yet, establishment of those exchanges was unquestionably an important objective of federal health care reform. Through the Act, Congress sought to create a central marketplace where individuals and small businesses (and, perhaps, large businesses) could shop for, and purchase, health insurance. As envisioned, the Act "would make purchasing health insurance easier and more understandable by creating state-based web portals, or 'exchanges,' that would direct consumers to all available health plan options." S. Rep. No. 89, 111th Cong., 1st Sess., at 4 (2009) (discussing S. 1796).

A critical feature of those exchanges, however, was the greater standardization of health insurance policies. Rather than having health insurance companies continue to offer the complex, multi-factored policies that often issued under the prevailing system of individual underwriting – with frequent exclusions for pre-existing conditions and widely varying premium charges – greater standardization of policies would "force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and [would] ensure[ ] that every policy offered in the individual and small group market provides meaningful coverage for essential services." *Id.* at 4. In turn, information about health care policies would become more uniform and accessible. "The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials." *Id.*

Those basic goals would be significantly frustrated by invalidation of the guaranteed issue and community rating provisions. As conceived, the Act would lead to easily comparable policies precisely because the policies would cover similar services and, with only a few exceptions, would not vary according to the individual characteristics of the insured. Elimination of the guaranteed issue and community rating provisions, by contrast, would reinstate medical underwriting, where insurance companies can tailor their policies to reduce the risk presented by a particular insured's anticipated health care costs. Although the exchanges could still serve in some fashion as a central marketplace, the lack of standardized products would make comparisons difficult for many consumers, thus undermining much of what Congress hoped to achieve.

Petitioners argue that the close connection between the exchange provisions, on the one hand, and the guaranteed issue and community rating provisions, on the other, is proof that Congress would want all of those provisions struck down along with the minimum coverage provision. *See* States Br. 47-50; NFIB Br. 46-47. But we think that petitioners are drawing the wrong conclusion. Because the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited to just those provisions, the potential spillover effect makes it even less likely that Congress would intend for them to be deemed inseverable. In that case, the consequences would not be just the denial of insurance to many people with the greatest need for it, but disruption of the new insurance marketplace, thus weakening two of the Act's central reforms.

Taken as a whole, therefore, the evidence does not establish that the Court should take the extraordinary step of striking down the guaranteed issue and community rating provisions. Although the United States asserts that "enforcement of those provisions without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable," US Br. 45, that broad claim overlooks the fact that, for many people faced with high health care costs as a result of pre-existing illnesses or other risk-related factors, the expense of obtaining insurance under the Act, even without the minimum coverage provision, will be much lower than under the system that Congress was seeking to replace. Thus, while Congress undoubtedly intended the minimum coverage provision to play a role in controlling insurance prices, if that option is taken off the board, it cannot be said with the necessary degree of confidence that Congress would prefer "no law at all." *Free Enterprise Fund*, 130 S.Ct at 3161. The guaranteed issue and community rating provisions thus should stand.

IV. THE REMAINDER OF THE ACT SHOULD BE LEFT INTACT

Petitioners do not make an independent argument that all other provisions of the Act should be invalidated even if the guaranteed issue and community rating provisions continue in force. Apart from their severability clause theory, *see* pages 29-31 *supra*, petitioners' argument for invalidating the Act in its entirety depends upon a chain of accumulating inseverability, beginning with the minimum coverage provision and proceeding through the guaranteed issue and community rating provisions as well as the exchange provisions, until it reaches an undefined

point at which Congress supposedly would not regard the rest of the Act as sufficient to exist on its own. As we have just explained, however, the process of invalidation properly stops, once and for all, with the minimum coverage provision. So, under that theory, the rest of the Act should stand, not fall.

In any event, the United States persuasively explains why elimination of the minimum coverage provision does not justify striking down the Act as a whole. *See* US Br. 28-40. Compared to the guaranteed issue and community rating requirements, the remainder of the Act has far less connection to the minimum coverage provision – in many instances, none whatsoever – and petitioners have made little attempt to demonstrate that the Act in general, or specific provisions in particular, cannot function in an effective manner without the minimum coverage provision alone. That shortage of proof is enough to foreclose any further invalidation. And, even if it were not, it is apparent that many important parts of the Act can operate quite well without the minimum coverage provision.

Two examples will illustrate the point. First of all, a significant portion of the Act was designed to address the fact that many uninsured people have low incomes but are nevertheless ineligible for Medicaid. As a Kaiser Family Foundation report explained, Medicaid and the Children's Health Insurance Program (CHIP) primarily cover "four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities." Kaiser Family Foundation, *The Uninsured: A Primer*, at 4. "Individuals who do not fall into one of these groups – most notably adults without dependent children – are now generally ineligible

for public coverage regardless of their income." *Id*. Indeed, "adults without dependent children comprise the majority of the uninsured largely because they are the least likely to qualify for Medicaid . . . ." *Id.*

The Act deals with this problem by, among other things, expanding the criteria for Medicaid eligibility. Under the new provisions, which are scheduled to take effect in 2014, Medicaid coverage will effectively be available to those with incomes at or below 138 percent of the Federal Poverty Line. *See id.* (In 2011, the Federal Poverty Line was $10,890 for an individual and $22,350 for a family of four). Various estimates indicate that these changes to Medicaid will result in substantial enrollment increases even without a mandate. For example, the CBO projects that Medicaid enrollment will increase by approximately 10 million people by 2017 without the minimum coverage provision in effect. *See* Cong. Budget Office, *Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate*, Table 4 (March 20, 2010) (Medicaid enrollment would increase by 16 million in 2017 with the mandate); CBO, *Effects of Eliminating the Individual Mandate*, at 2 (compared to the Act with the mandate, "about 6-7 million fewer individuals with Medicaid or CHIP coverage"). The January 2012 Urban Institute study estimates that coverage would increase by 12.9 to 13.9 million people without a mandate, Buettgens & Carroll: *Eliminating the Individual Mandate*, at 3 (Table 1), while the Lewin Group study estimates that there would be an increase of 13.4 million people without the minimum coverage provision. Sheils & Haught: *Without the Individual Mandate*, at 6 (Exhibit 2). Of course, invalidation of the minimum coverage provision would mean that enrollment in

Medicaid would be voluntary – thus accounting for the lower numbers of new enrollees without it – but that is no reason to deny Medicaid coverage to the 10 million or more people who want to have it.[12]

The provisions with respect to employer-provided insurance also can operate effectively in the absence of the minimum coverage provision, provided that the guaranteed issue and community rating provisions (and the exchanges) remain in place. Although employer-subsidized insurance has long been a central feature of the health insurance market, the availability of employer-subsidized insurance is not uniform among large and small businesses. *See* Kaiser Family Foundation: *The Uninsured: A Primer*, at 17-18 ("[n]early all businesses (99%) with at least 200 workers offer health benefits to their workers in 2011, but only 59% of firms with less than 200 workers offer these benefits"). To build upon the existing system, therefore, the Act made several changes. For the largest firms (at least 200 full-time employees), which overwhelmingly offer insurance to their workers anyway, the Act requires automatic enrollment of workers to increase the already high rate of acceptance. *See* 29 U.S.C.A. § 218a. For large employers (at least 50 full-time employees), the Act provides penalties for firms that do not offer adequate health insurance plans and that have at least one employee purchasing subsidized insurance through an exchange. *See* 26 U.S.C.A. § 4980H(a). Finally, for small employers (fewer than 25 full-time employees), the Act establishes a program of em-

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[12] Expanded Medicaid eligibility is intended to work in concert with the premium subsidies discussed earlier, which can also function without the minimum coverage provision. *See* US Br. 36.

ployer subsidies to encourage them to offer insurance. *See* 26 U.S.C.A. § 45R.

The minimum coverage provision was undoubtedly intended to increase the effectiveness of this modified employer-based insurance system, but its absence, again, does not mean that Congress would have chosen to forego the reforms entirely. One study estimates that, even without a mandate, the percentage of workers at firms offering insurance would increase from 84.6 percent to 92.7 percent, with especially large increases in firms with 10 or fewer workers (45.3 percent to 70.1 percent) and firms with between 11 and 25 workers (62.6 percent to 85.7 percent). *See* Christine Eibner et al., *Establishing State Health Insurance Exchanges*, at 19 (Table 3.3) (status quo figures), 25 (Table 3.11, Column 7) (Rand 2010). Although the number would be still greater with the minimum coverage provision in effect, *see id.* at 25 (Table 3.11, Column 1), the substantial increase in workers at firms offering health insurance would nevertheless be a significant step towards achievement of Congress's goals. As with Medicaid, therefore, it is doubtful that Congress would want the Court to nullify its attempts to bolster employer-sponsored insurance, simply because the gains would be less than expected under the full Act.

Finally, we submit that, insofar as the rest of the wide-ranging Act is concerned, the usual judicial reluctance to find inseverability should be at its strongest when the question is whether to strike down provisions – such as one, noted by the district court, requiring employers to provide a separate room for nursing mothers (*see* US Pet. App. 353a; 29 U.S.C.A. § 207(r)(1) – that have no apparent connection at all, let alone an inextricably close connection,

to the minimum coverage provision. To be sure, the district court did strike down the entire Act, including the nursing mother provision, but it did so in part on the ground that Congress had intended to make the entire Act inseverable by removing a severability clause, a rationale that, while incorrect, at least offers a coherent basis for invalidating provisions that are totally unrelated to the minimum coverage provision. *See* US Pet. App. 354a-356a. Apart from that rationale, however, it is difficult to see any reasonable justification for striking down completely separate statutory provisions. And, that description fits most of the Act.

All in all, therefore, petitioners and the United States have not demonstrated that any of the Act's lawful provisions should be declared unenforceable. The Court can remedy the unconstitutionality of the minimum coverage provision by severing that provision from the remainder of the statute, providing full redress to the plaintiffs while "maintain[ing] the act in so far as it is valid." *Alaska Airlines*, 480 U.S. at 684 (internal quotation marks omitted). Having "limit[ed] the solution to the problem," *Free Enterprise Fund*, 130 S. Ct. at 3161, the Court should decline to go any further.

CONCLUSION

If the Court determines that the minimum coverage provision is unconstitutional, the judgment of the Court of Appeals for the Eleventh Circuit that the provision is severable from the remainder of the Patient Protection and Affordable Care Act should be affirmed.

Respectfully submitted,

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