Nos. 11-393 & 11-400

In The
Supreme Court of the United States

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

Petitioners,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services, *et al.*,

Respondents.

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

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

BRIEF FOR THE STATES OF CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MARYLAND, NEW MEXICO, NEW YORK, OREGON, AND VERMONT, THE DISTRICT OF COLUMBIA, AND THE GOVERNOR OF WASHINGTON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS ON SEVERABILITY

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QUESTION PRESENTED

To what extent (if any) can the individual mandate provision of the Affordable Care Act be severed from the remainder of the Act?

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

OTHER AUTHORITIES

TABLE OF AUTHORITIES – Continued

INTEREST OF AMICI STATES

Amici, the States of California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, New Mexico, New York, Oregon, and Vermont, the District of Columbia, and the Governor of Washington (collectively, "Amici States"), have a vital interest in protecting the health and welfare of their citizens, interests that are advanced by the Patient Protection and Affordable Care Act. This Act comprehensively reforms the American health care system. As the Amici States explained in their briefs supporting the United States on the constitutionality of the minimum coverage provision, the Amici States' interests are best served through application of the Affordable Care Act in its entirety, including the requirement that non-exempt adults maintain adequate health insurance coverage. Even if that provision is determined to be an unconstitutional exercise of Congress's Commerce Clause authority, the remainder of the Affordable Care Act is crucial to assisting States in ensuring that their citizens have access to affordable health care.

Since the Affordable Care Act was passed in 2010, the States have begun to implement substantial portions of the Act, such as prohibiting insurance companies from denying coverage to children with pre-existing conditions, allowing States to better regulate insurance rates, and helping States establish high risk pools for their citizens. Today, these reforms are bringing real relief to States, medical providers, and families across the country. The reforms are also helping all States grapple with the serious problem of the high number of uninsured citizens. While the

minimum coverage provision unquestionably advances the Congressional goal of comprehensive health care reform in general and private health insurance reform in particular, the minimum coverage provision operates independently of the vast majority of the Affordable Care Act, which should remain in effect.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Affordable Care Act (ACA)[1] is a needed measure to assist States in grappling with the nation's health care crisis. The minimum coverage provision, which starting in 2014 will require non-exempt adults to maintain adequate health coverage, is but one provision of a 2700-page comprehensive health care reform law intended to increase Americans' access to affordable health care. As Respondents and Amici States argued in their briefing on the constitutionality of the minimum coverage provision, that provision is a justifiable exercise of Congress's Commerce Clause authority. If, however, this Court determines that the minimum coverage provision is unconstitutional, it should be severed from the ACA. While its invalidation would mean that fewer Americans would have access to affordable private health

[1] ACA refers to the Patient Protection and Affordable Care Act, Pub. Law No. 111-148, 124 Stat. 119 (2010) and the Health care and Education Reconciliation Act of 2010, Pub. Law No. 111-152, 124 Stat. 1029.

insurance than would otherwise be the case, the remainder of the ACA would still operate to ensure access to affordable health care for Americans across the country.[2]

In addressing the effect of an unconstitutional provision, the Court retains the portions that are constitutionally valid, capable of functioning independently, and consistent with Congress's goals in enacting the statute. *United States v. Booker*, 543 U.S. 220, 249, 258 (2005). In this case, the vast majority of the ACA is unquestionably constitutional and capable of functioning independently of the minimum coverage provision. Congress's goal when it enacted the ACA was to increase the availability and accessibility of affordable health care. Congress intended the other ways in which the ACA expands health insurance coverage – through Medicaid, the private market, and employer-sponsored plans – to remain intact. So too did Congress intend to preserve the myriad health care reforms that are unconnected to the minimum coverage provision. Indeed, many of those reforms are already in effect and had been previously considered by Congress in stand-alone bills.

Although this litigation has focused on the minimum coverage provision and related sections, the

[2] Respondents have conceded that the guaranteed issue and community rating provisions that go into effect in 2014 should be invalidated if the Court concludes the minimum coverage provision is unconstitutional. Amici States do not seek to challenge this concession.

ACA represents a system-wide reform of health care throughout the United States. Broadly speaking, the ACA can be divided into six distinct categories: (1) increasing access to health insurance in the private market; (2) reforming the health insurance industry through the inclusion of consumer protections; (3) increasing access to and the quality of care offered by Medicaid; (4) improving the quality and efficiency of health care generally; (5) improving public health and preventing chronic disease; and (6) supporting the health care workforce. The ACA regulates subjects as diverse as diabetes care, breast cancer, elder abuse, and access to pharmaceuticals in clinical trials. 42 U.S.C. §§ 247b-9a; 280m; 1397j *et seq*., ACA, Title VII, §§ 7001 *et seq*. It makes many reforms to Medicare and Medicaid to improve the quality of care given to beneficiaries, as well as to reduce costs to federal and state governments. ACA, Title II, §§ 2001 *et seq*. It encourages individuals to enter the nursing profession and doctors to practice in rural areas. ACA, §§ 5202 and 5208; 42 U.S.C. §§ 296p-1, 2970, 2963, 2391 *et seq*. These varied reforms are just a few of the changes to the provision of affordable health care in the United States that have nothing to do with the minimum coverage provision or even private insurance coverage generally.

Even within the category of expanding coverage, the minimum coverage provision is only one of several ways in which Congress ensured greater access to affordable health insurance. In addition to requiring non-exempt adults to maintain adequate health

coverage, the ACA expands access to employer-sponsored health insurance by requiring large businesses to cover their employees and by providing incentives for small businesses to do so. 26 U.S.C. §§ 45R, 4980H. The ACA also increases the number of Americans with health insurance by expanding Medicaid eligibility to include individuals below 133 percent of the federal poverty line. 42 U.S.C. § 1396a. And many of the reforms to the private insurance market, such as requiring that health plans cover certain preventative services, 42 U.S.C. § 300gg-13, prohibiting rescission except in specified circumstances, 42 U.S.C. § 300gg-12, and various reporting requirements have nothing to do with the minimum coverage provision. Health insurance reforms like these are completely independent of the minimum coverage provision and can still operate as Congress intended, even in the absence of that provision. The Court should not, as Petitioners suggest, engage in a wholesale invalidation of this important and monumental health care reform effort.

Moreover, the underlying purpose of severability analysis – to give as much effect as possible to the acts of the people's elected representatives – is doubly implicated in this case. States throughout the nation have taken up Congress's request that States immediately begin to implement the ACA. Congress was well aware at the time it passed the ACA that the minimum coverage provision would be challenged in court: indeed, lawsuits were filed the same afternoon President Obama signed the ACA into law. The fact

that Congress nevertheless encouraged States to pass legislation, apply for grants, and begin implementing the ACA even before the minimum coverage provision went into effect shows that Congress intended the minimum coverage provision to be severable. Similarly, Congress's direction that many provisions of the ACA should take effect prior to the minimum coverage provision demonstrates that these provisions can and should operate independently of the minimum coverage provision.

Finally, many States and individuals have made decisions and committed resources in reliance on the continued application of the ACA. Wholesale invalidation of the ACA would upend these decisions, waste unquantifiable resources, and wreak havoc on States, local governments, and private citizens across the country. States, for instance, have budgeted for anticipated grants, entered into contracts with private individuals, and overhauled their health care regulations, all in reliance on provisions that are completely independent of the minimum coverage provision. So too have individuals undoubtedly made important, life-altering decisions in reliance on the ACA's provisions, including how they will obtain and pay for health care. This upheaval would have disastrous independent costs that would be avoided by severing the minimum coverage provision as Congress intended.

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ARGUMENT

I. THE REMAINDER OF THE AFFORDABLE CARE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION

A. Courts Presume That An Unconstitutional Provision Is Severable If The Remainder Of The Act Can Function Independently And In Accordance With Congressional Intent

The minimum coverage provision is severable from the vast majority of the Patient Protection and Affordable Care Act (ACA). Petitioners' view that the 2700-page Affordable Care Act (ACA) should be struck down in its entirety if this Court determines that one provision is unconstitutional ignores the well-settled principle that courts "should refrain from invalidating more of the statute than necessary." *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). Even in the absence of a severability provision in an act, this Court has stated that it prefers "to sever its problematic portions while leaving the remainder intact." *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 328-29 (2006).

The effort to salvage as much of a statute as possible arises from the presumption of the constitutionality of a statute and the fact that a "ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Regan*, 468 U.S. at 652. Accordingly, the burden is on the party arguing for total invalidation to show that, if faced

with the unconstitutionality of one provision, Congress would have preferred no Act at all. *See, e.g., Free Enterprise Fund v. Public Company Accounting Oversight Board*, 130 S.Ct. 3138 (2010); *United States v. Booker*, 543 U.S. 220, 249 (2005). Consistent with this standard, the Court should "retain those portions of the Act that are (1) constitutionally valid, (2) capable of 'functioning independently,' and (3) consistent with Congress's basic objectives in enacting the statute." *Booker*, 543 U.S. at 258. Petitioners cannot meet their burden or this standard.

B. The Remainder Of The ACA Can Function Independently Of The Minimum Coverage Provision

In this case, the constitutionality of the vast majority of the ACA is unquestioned. Moreover, there is no reasonable dispute that the vast majority of the ACA is capable of operating independent of the minimum coverage provision. The minimum coverage provision is just one of several ways in which Congress intended to ensure that more Americans were given access to health care and that the quality of health care is improved. Many of Congress's goals bear little or no relation to the minimum coverage provision: reforming Medicaid; improving the quality of health care generally; improving public health and preventing chronic disease; and supporting the health care workforce. The minimum coverage provision is also independent of the majority of the reforms that increase access to health insurance in the private

market. Requiring large businesses to offer health insurance to employees and encouraging small businesses to do so do not depend on the minimum coverage provision for their operation. Neither do many of the reforms to the health insurance industry depend upon the minimum coverage provision, such as restricting the practice of rescission, allowing beneficiaries to appeal adverse coverage decisions, or permitting States to review insurance rates.

Moreover, as is the case with many omnibus bills, the ACA contains parts that are in fact separate acts generally related to health care that were included in a comprehensive health care bill. Indeed, many of the provisions of ACA were originally introduced as entirely separate bills that did not even conceive of the minimum coverage provision and which could operate independently of it. Section 6701, for instance, is titled the Elder Justice Act of 2009, and incorporates many provisions of S. 795, also called the Elder Justice Act of 2009. The Elder Justice Act establishes an Elder Justice Coordinating Counsel to coordinate federal, state, and local efforts to combat the abuse of elder individuals, and provides grants to establish elder abuse, neglect, and exploitation forensic centers. The Elder Justice Act has nothing to do with the minimum coverage provision or private health insurance generally. Section 10407, known as the Catalyst to Better Diabetes Care Act of 2009, closely tracks many bills that were previously introduced in the 111th Congress, including S. 1473, 111th Cong. (2009) and H.R. 1402, 111th Cong. (2009). The ACA is replete

with provisions that are referred to as independent acts, many of which were separately introduced, and all of which would have been effective if enacted separately.[3] Each of these is independent of, and severable from, the minimum coverage provision.

Petitioners' assertion that the entire ACA should fall with the minimum coverage provision (if it is declared invalid) rests upon the false premise that if Congress could not ensure that non-exempt adults maintain adequate health insurance coverage, it would rather that no additional individuals be covered and that none of the ACA's other general health care reforms take effect. *Cf. New York v. United States*, 505 U.S. 144, 186 (1992). Nothing in the text, structure, or legislative history of the ACA indicates that Congress intended that the invalidation of one way of expanding health care required invalidation of the rest, particularly since many of the ACA's provisions have nothing to do with the private health insurance market.

[3] *See, e.g.,* § 7001, Biologics Price Compensation and Innovation Act of 2009; § 10409, Curses Acceleration Network Act of 2009; § 10410, Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009 or the ENHANCED Act of 2009; § 10411, Congenital Heart Failure Act; § 10413, Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009 or the EARLY Act.

II. THE MANNER IN WHICH THE AFFORDABLE CARE ACT HAS BEEN IMPLEMENTED SHOWS THAT THE MINIMUM COVERAGE PROVISION IS SEVERABLE

Examining the Affordable Care Act as a whole shows that Congress intended for its disparate parts to act separately even while they all worked toward a common goal: increasing access to affordable and reliable health care. Congress left a substantial role for the States in implementing the ACA, a role that many of the Amici States have already begun to fulfill. Congress would not have intended the States to expend significant effort in implementing provisions of the ACA that would be stricken if the minimum coverage provision were declared unconstitutional. The structure of the ACA also shows that its many provisions were intended to operate independently of the minimum coverage provision. While the minimum coverage provision does not go into effect until 2014, many provisions of the ACA are already in operation, showing that they are capable of functioning independently of the minimum coverage provision and that Congress intended for them to remain in effect.

A. Ongoing State Implementation Of The Affordable Care Act Supports Severance Of The Minimum Coverage Provision

Since its passage, the States have actively implemented many provisions of the ACA, further illustrating that its provisions are severable from the minimum coverage provision. As demonstrated in the

Amici States' brief on the constitutionality of the minimum coverage provision, the ACA embodies cooperative federalism, a manner of legislating in which Congress "allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory program, structured to meet their own particular needs." Brief of the States of Maryland, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, New Mexico, New York, Oregon, and Vermont, the District of Columbia, and the Virgin Islands As Amici Curiae in Support of Petitioners (Addressing Minimum Coverage Provision) at p. 29-30 (quoting *Hodel v. Virginia Surface Min. and Reclamation Ass'n, Inc.*, 452 U.S. 264, 289 (1981)). By authorizing States to establish Health Insurance Exchanges, enforce reforms governing insurance providers, and implement various other programs authorized under the ACA, Congress indicated its intent that these programs survive any constitutional challenge to the minimum coverage provision. Congress would not have encouraged States to spend massive amounts of resources, both financial and human, in implementing provisions that it intended to be invalidated should the minimum coverage provision be stricken.

The fact that many States – including both Amici and Petitioner States – have passed legislation implementing the ACA distinguishes this case from many of this Court's past severability cases and provides an even stronger reason why the Court should

salvage as much of the ACA as possible. The animating principle behind the Court's severability analysis is based on separation of powers and the judiciary's desire to interfere as little as possible with the actions of the people's elected representatives. *See Regan*, 468 U.S. at 652. Invalidating any action of Congress is a drastic step, and one that is only taken when the unconstitutionality of a provision is clear. *See, e.g., Clinton v. City of New York*, 524 U.S. 417, 447 n. 42 (1998) ("When this Court is asked to invalidate a statutory provision that has been approved by both Houses of the Congress and signed by the President, particularly an Act of Congress that confronts a deeply vexing national problem, it should only do so for the most compelling constitutional reasons.") Severability analysis, which seeks to preserve as much of a Congressional act as possible, is an extension of the respect this Court pays to a coordinate branch of government, particularly that which is politically accountable. *See* John C. Nagle, *Severability*, 72 N.C. L. Rev. 203, 250 (1993).

In this case, the wholesale invalidation of the ACA would not simply frustrate an act of Congress, but also the many legislative acts of the democratically-elected officials of the States that have implemented the ACA. Since the Court strives to preserve legislative action wherever possible, there should be an even stronger presumption of severability where the acts of multiple legislatures are at issue. Similarly, principles of federalism, and the respect which the legislative acts of sovereign States are due, also counsel

against wholesale invalidation of the ACA and the resulting nullification of many State statutes.

The many statutes enacted by the States pursuant to Congressional authorization and encouragement thus support the Eleventh Circuit's decision that the minimum coverage provision should be severed. Such active State involvement at this stage suggests Congress intended for the provisions implemented by the States to remain in force. It also illustrates that they are capable of functioning independent of the minimum coverage provision. The following are just some examples in which States have been implementing the Affordable Care Act.

1. The ACA Encourages States To Establish Health Benefit Exchanges

Congress gave States wide latitude to establish and operate Health Benefit Exchanges, which can operate independently of the minimum coverage provision under State oversight. 42 U.S.C. §§ 18031 *et seq*. The Exchanges are intended to allow individuals and small businesses to pool resources in order to purchase health insurance on more favorable terms. By bringing these entities together to form a large risk pool, the Exchanges will allow them to enjoy premiums and discounts similar to those routinely given to larger employers. The ACA permits (but does

not require) States to establish their own Exchanges,[4] which many States have already begun to do. Oregon, for instance, passed a bill in June 2011 that established the Oregon Health Insurance Exchange Corporation, charged with administering that State's exchange. Senate Bill 99 (2011). Pursuant to that legislation, Governor Kitzhaber nominated, and the Oregon Senate confirmed, the nine members of the Exchange Corporation's Board.[5] The Board has already presented a preliminary business plan to Oregon lawmakers in late December 2011; a final version is due February 1, 2012.[6]

California officials have also been busy establishing that State's exchange. The California Health Benefit Exchange was created by two pieces of legislation: Assembly Bill 1602 (Ch. 655, Stats. 2010) and Senate Bill 900 (Ch. 659, Stats. 2010). California's exchange is comprised of five voting members, two appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly; the Secretary of the California Health and Human Services or his designee serves as the fifth

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[4] If a State declines to establish a health care exchange, the federal government will operate one in that State. 42 U.S.C. § 18041(c).

[5] http://governor.oregon.gov/Gov/media_room/press_releases/p2011/press_092211.shtml.

[6] Associated Press, *Health Insurance Exchange Submits Details to Salem* (Dec. 27, 2011). The draft business plan is available online at https://orhix.org/uploads/orhix_business_plan.pdf.

voting member. These members have been conducting regular Board meetings since April 2011 and have hired an executive staff including the Exchange's Executive Director, Chief Operations Officer, and General Counsel. It has already awarded key contracts for its business and operations, and is soliciting contracts for the design of the federally-mandated web-based eligibility portal. Many States have followed the lead of Oregon and California; 49 States plus the District of Columbia have been awarded Exchange Planning Grants and 13 States plus the District of Columbia have been awarded Exchange Establishment Grants.[7]

2. States Have Begun Expanding Access To Medicaid And Implementing Other Changes To Medicaid Permitted By The ACA

States have already begun implementing the ACA's expansion of Medicaid to cover individuals whose income is at or below 133 percent of the federal poverty line (FPL). California, for instance, was one of the first States to request a waiver from the federal government so that it could begin covering those individuals prior to 2014 through its Bridge to Reform Waiver granted pursuant to 42 U.S.C. § 1315. California's Bridge to Reform is a demonstration program

[7] http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

that allows California to provide health care coverage through county-based Low Income Health Programs to adults ages 19 to 64, with incomes at or below 133 percent of FPL who do not otherwise qualify for Medi-Cal under the usual rules. The demonstration also provides for alternative and enhanced funding for hospital care and public health initiatives. As of October 2011, 221,058 Californians were covered through the Low Income Health Programs, with an expected enrollment of 512,000 when the program is fully operational in 2012.

Many States have begun implementing provisions in the ACA that aim to streamline care both to reduce costs and to make it easier for individuals to get the care they need. Section 2602 of the ACA, for instance, established the Federal Coordinated Health Care Office (FCHCO), which is charged with helping States develop programs to integrate service delivery and financing of care for persons who are dually eligible for Medicare and Medicaid. New York, along with California, Connecticut, and Oregon, has received a grant to develop models to integrate service for dually eligible individuals.[8] This program is especially important for New York. While dually eligible individuals account for a small portion of New York's total Medicaid enrollees – about 700,000 out of 5 million – they represent 45 percent of total Medicaid spending and an estimated 41 percent of

[8] http://www.hhs.gov/news/press/2011pres/04/20110414a.html.

Medicare spending in New York. The establishment of the FCHCO is thus already helping States reduce their Medicaid and Medicare costs.

Oregon officials are currently in the process of implementing a program under section 2703 of the ACA, which is designed to help Medicaid beneficiaries coordinate their care. Many Medicaid recipients suffer from multiple or severe chronic conditions and would benefit from better coordination and management of the health and long-term services they receive. Such coordination avoids overlapping or conflicting care, makes it easier for individuals to obtain care, and leads to better health outcomes. Section 2703 of the ACA authorizes the Centers for Medicare and Medicaid Studies (CMS) to provide States such as Oregon with federal funding to support the development of these coordinated services.

Similarly, the ACA authorizes States to use Accountable Care Organizations (ACOs) to help coordinate care among doctors, hospitals, and other health care providers. In June 2011, the Oregon Legislature passed House Bill 3650, which established the Oregon Integrated and Coordinated Health Care Delivery System and authorized ACOs in that State. The Oregon Health Policy Board has already developed a draft implementation proposal, which will be finalized and sent to the Oregon Legislature in February

2012.[9] Illinois has also adopted an ACO model of care. Under House Bill 5420, signed into law by Governor Quinn on January 25, 2011, 50 percent of all individuals who are eligible for comprehensive medical benefits administered by Illinois must receive those benefits from an ACO. 215 Ill. Comp. Stat. 106/23. By helping providers coordinate care, States can help improve health, improve the quality of care, and lower costs. While complementing Congress's intent to increase the number of insured individuals through the minimum coverage provision, these goals are independently worthwhile and have been adopted by the States at Congress's expressed invitation, even though the minimum coverage provision has not yet gone into effect.

3. States Have Made Changes To Their Laws To Incorporate Reforms To The Health Insurance Market

States have also used their authority under the ACA to strengthen their review of the rates charged by insurance companies. Oregon, for instance, has received federal funding to contract with a consumer-advocacy group to help represent consumers. The ACA also made available funds that allowed Oregon to add staff members to provide a more in-depth and timely review of rate changes. The California

[9] http://health.oregon.gov/OHA/OHPB/meetings/2012/2012-0110-cco.pdf.

Department of Insurance similarly has used the authority granted by the ACA to benefit consumers in that State. In 2010, the California Legislature enacted Senate Bill 1163 (Ch. 661, Stats. 2010), which subjects any rate increases filed after January 1, 2011 to review by the Department of Insurance or the Department of Managed Health Care. Because of the additional authority granted to state officials under the ACA, Blue Shield of California was forced to rescind proposed rate increases that would have increased some rates by as much as 87 percent.[10]

States have also enacted legislation incorporating into state law many of the consumer protections in the ACA. On July 20, 2011, New York Governor Andrew Cuomo signed Chapter 29, Laws of New York (2011), which brings various provisions of New York's Insurance Law and Public Health Law into compliance with the ACA's reforms. Among other things, Chapter 29 requires insurance policies to cover children until the age of 26 (§§ 2, 24, 31, 35); bans lifetime limitations on coverage (§§ 10, 12, 42); bars insurers from excluding children from coverage based on pre-existing conditions (§§ 23, 43, 50); and provides for expedited external appeals (§§ 54, 57, 64, 67). Many other States have followed suit.

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[10] R. Abelson, *Insurer to Forego Rate Rise*, N.Y. TIMES B1 (Mar. 17, 2011).

4. California's Experience Illustrates How Many Provisions Of The ACA States Have Begun To Carry Out

Although each of the Amici States has devoted a significant amount of time, energy, and resources in implementing the ACA to benefit their citizens, a more detailed examination of one State illustrates the extent to which States have implemented the ACA consistent with Congressional intent. As the State with the largest uninsured population in the country, California has been aggressive in putting the ACA into operation. California has passed at least eleven separate pieces of legislation implementing provisions of the ACA:

- Senate Bill 51 (Ch. 644, Stats. 2011) (requires that health plans and insurers meet federal annual and lifetime benefit limits and to issue rebates to consumers when health plans or insurers fail to meet specified medical loss ratios)
- Assembly Bill 2470 (Ch. 658, Stats. 2010) (prohibits health plans and insurers from rescinding or canceling coverage, except under specified circumstances)
- Assembly Bill 2345 (Ch. 657, Stats. 2010) (requires that health plans and insurers cover certain preventative services)
- Senate Bill 1088 (requires, with specified exemptions, that health plans and insurers offer coverage for dependent children under the age of 26)

- Assembly Bill 2244 (prohibits health plans and insurance companies from imposing pre-existing condition exclusions on coverage for children under the age of 19)
- Assembly Bill 922 (transfers Office of the Patient Advocate from Department of Managed Health Care to California Health and Human Services and makes other changes to conform with 42 U.S.C. § 300gg-93, concerning health insurance consumer assistance offices)
- Assembly Bill 1163 (Ch. 661, Stats. 2010) (subjects rate increases filed after January 1, 2011 to review by the Department of Managed Health Care or the Department of Insurance)
- Assembly Bill 1887 and Senate Bill 227 (Ch. 31, Stats. 2010 (implements California's Pre-Existing Condition Insurance Plan)
- Senate Bill 900 (Ch. 659, Stats. 2010) and Assembly Bill 1602 (Ch. 655, Stats. 2010) (establishes California's Health Benefits Exchange)

In addition to the time and effort spent by the California Legislature in enacting these provisions, each statute mandates action by state officials, including the Department of Managed Health Care, Department of Insurance, and Department of Health Care Services, to mention just a few. Pursuant to the ACA and California legislation, officials have established an entirely new agency (the California

Health Benefits Exchange), negotiated a wide-ranging Medicaid waiver and implemented an expansion of Medicaid, begun planning a massive expansion of California's public health infrastructure, and established the California Pre-Existing Condition Insurance Plan (PCIP).

California is just one example among the many States that have already begun to implement the ACA. As discussed, many Amici States have enacted legislation establishing health benefit exchanges, incorporating protections for consumers into state law, granting their insurance officials authority to review insurance rate increases, and taking advantage of provisions in the ACA that allow for state innovation in Medicaid. Collectively, the Amici States have spent a tremendous amount of resources implementing portions of the ACA that are unquestionably constitutional. The States undertook these efforts in good faith: were they to wait until the challenges to the minimum coverage provision were resolved, there would be insufficient time to prepare for the full implementation of the ACA, and the citizens of the Amici States would have been denied the full protections of the ACA in the interim.

The fact that Congress designed the ACA to allow States to implement many of its provisions shows that these provisions can, and were intended to, operate independently of the minimum coverage provision. Congress was well aware when it passed the ACA that a constitutional challenge to the minimum coverage provision was likely. Congress surely would

not have encouraged state legislatures and state public health officials to spend considerable time, money, and energy implementing diverse provisions such as Medicaid reform, establishment of health exchanges, and consumer protection provisions if it thought that those provisions would be invalidated along with the minimum coverage provision or if it thought that those provisions could operate only in coordination with the minimum coverage provision. Rather, the significant involvement of state officials, as specifically contemplated and encouraged by the ACA, shows that Congress intended for those provisions to survive even if a challenge to the minimum coverage provision were successful.

B. The Many Provisions Of The ACA That Are Already Effective Indicate Congress Intended Them To Operate Independently Of The Minimum Coverage Provision

While the minimum coverage provision does not go into effect until 2014, Congress directed that many important reforms take effect well before then. Congress thus envisioned that these reforms were independent of, and should survive a constitutional challenge to, the minimum coverage provision. Individuals in the Amici States are already benefitting from these important provisions, which have expanded the availability of insurance while making it more affordable. Congress was well aware of the potential for constitutional challenge to the minimum

coverage provision, and its decision to make provisions effective well before 2014 indicates it intended them to survive any such challenge.

Specifically, the ACA provides immediate benefits for children and young adults that should survive any challenge to the minimum coverage provision. Effective September 23, 2010, children cannot be denied insurance coverage based on a pre-existing condition. ACA § 1255; 42 U.S.C. § 200gg-1. Also effective on that date is a requirement that insurance companies permit parents to insure their children until the age of 26. 42 U.S.C. § 300gg-14.

Senior citizens also received immediate benefits under the ACA. For instance, the ACA has already begun to close the so-called "donut hole" in prescription drug coverage that costs seniors millions of dollars each year. The donut hole refers to a gap in coverage between what is covered by Part D (Medicare prescription drug coverage) and what is covered by catastrophic coverage. In 2012, this gap in coverage required seniors to pay up to $4700 each for their prescription medications.[11] The ACA gradually eliminates this gap in coverage in two ways such that by 2020, Medicare recipients will have to pay only 25 percent of the cost of prescription drugs in the donut

[11] CMS Office of Public Affairs, Final 2012 Payment Policies For Medicare Drug And Health Plans Would Maintain Beneficiary Choice, Improve Quality, And Lower Part D Cost-Sharing (April 4, 2011).

hole. 42 U.S.C. § 1395w-114a. For 2012, Medicaid beneficiaries will only pay 50 percent of the cost of brand-name drugs, and 86% of the cost of generic drugs within the donut hole.[12] In addition to these prescription drug benefits, the ACA provides for free preventive care for seniors, as well as reinsurance for early retirees, 42 U.S.C. § 18002. These provisions protecting seniors are in effect now, they have no relation to the minimum cov-erage provision, and there is no indication Congress intended for those benefits to expire if the minimum coverage provision were invalidated.

Congress also enacted provisions ending certain abusive insurance practices that have already gone into effect, all of which operate independently of the minimum coverage provision. One important reform is the ban on rescission, a common practice in which insurance companies rescinded coverage, often on the pretext of a technicality, when an individual suffered a catastrophic illness that the insurance company would be otherwise required to cover. Since it became effective on September 23, 2010, section 2712 of the ACA (codified at 42 U.S.C. § 300gg-12) prohibits insurance companies from rescinding coverage except in cases of fraud or intentional misrepresentation of a material fact. In addition, the ACA slows the rise in premiums by requiring that 85 percent of premiums

[12] Centers for Medicare and Medicaid Studies, Closing the Coverage Gap – Medicare Prescription Drugs Are Becoming More Affordable (Nov. 2012).

in the large group market be used for health care and quality improvement. 42 U.S.C. § 300gg-18(b)(1). And as of September 23, 2010, insurance companies may not impose a lifetime limit on benefits. 42 U.S.C. § 300gg-11(a)(1)(A). Finally, the ACA guarantees beneficiaries the right to appeal the adverse coverage determinations of insurance providers. 42 U.S.C. § 300gg-19.

As each of these provisions is currently in effect, Petitioners cannot claim that their proper functioning is dependent upon ensuring that individuals maintain insurance coverage. The fact that Congress directed they become effective prior to the effective date of the minimum coverage provision reflects Congress's determination that they can and should operate freestanding. Each of them, and the myriad other provisions of the ACA already in force, should be severed from the minimum coverage provision if this Court concludes it is unconstitutional.

III. STATES AND INDIVIDUALS HAVE RELIED ON THE REFORMS IN THE AFFORDABLE CARE ACT

Both States and individuals have made decisions and committed resources in reliance on the implementation of the ACA. Wholesale invalidation would mean these resources are lost and decisions are upended. This upheaval will itself incur additional fiscal and human costs for States and individuals. Petitioners have failed to meet their burden of showing that the

majority of the ACA cannot function independently of the minimum coverage provision or in a manner that is inconsistent with Congressional intent. The fact that States have relied on the ACA in changing their laws and in applying for and being awarded grants is another reason this Court should preserve the vast majority of the ACA in the event the minimum coverage provision is invalidated.

Like those of many States, officials in California have relied on numerous grants made pursuant to the ACA. As discussed above, California has obtained a waiver to begin offering Medicaid to individuals whose incomes are under 133 percent of the FPL; ACA grants that have already been awarded to the State make the agreement between California and the federal government possible. If the ACA is stricken down in its entirety, it is unclear whether the federal government will still be required to provide the funds anticipated by the Medicaid waiver or whether California will be released from its obligations. Hundreds of thousands of individuals could thus face losing their health insurance.

Independent of its Medicaid expansion, California has been awarded $232.8 million in grant funding under the ACA.[13] These grant funds are being used for a variety of activities, from upgrading state and local hospital infrastructure, to training California's primary care workforce, to establishing new community

[13] http://www.healthcare.gov/law/resources/ca.html.

health centers in underserved areas. California officials have begun to use those grants for their intended purposes, and should the ACA be invalidated, they could be rescinded.

Moreover, in reliance on those grants and the requirements of the ACA, California and other states have started entering into contracts with third parties, all of which may be void if the ACA is struck down in its entirety. California has already begun solicitation of a multi-million dollar contract to implement California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). Section 1413 of the ACA (codified at 42 U.S.C. § 18083) requires that States operating an exchange establish a single website whereby individuals can apply for any State health programs, including Medicaid, the Children's Health Insurance Program, or insurance through the Exchange. The scope of California's 160-page solicitation, which was issued by the California Health Benefits Exchange, the Department of Health Care Services, and the Managed Risk Medical Insurance Board, illustrates how much effort States have taken in implementing the ACA. California's solicitation is but one of many instances where States are entering into agreements with third parties.[14] Should this Court invalidate the entire ACA, millions of dollars would be wasted and litigation over the validity of contracts such as this would invariably ensue.

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[14] http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20CalHEERS%20Dev%20and%20Ops%20Services.pdf.

Many consumers are benefitting from the ACA's reforms. Hundreds of thousands of individuals could immediately lose their health insurance if this Court invalidates the ACA in its entirety. Children and young adults under the age of 26 who are covered under their parents' insurance could be dropped from their carrier. Newly-eligible Medicaid recipients, or members of the high risk insurance pools could see their insurance coverage disappear. Individuals who would have otherwise reached the lifetime cap on benefits would once again be effectively forced to pay for all their medical coverage out-of-pocket. Seniors will pay more for their prescription medications, and insurance companies will be free to raise their rates without the fear of additional state oversight.

Undoubtedly, many of the individuals who have benefitted from the ACA are relying on these reforms to obtain needed medical care. For instance, a young adult might have decided to take a position with a small business that did not offer health care, secure in the knowledge that she could remain covered under her parents' insurance policy until she was 26. If the ACA were invalidated in its entirety, she, among countless individuals, could stand to lose health insurance on which they now rely. An individual in the middle of his cancer treatment could be forced to halt his care if lifetime limits were reinstated and individuals in high-risk groups could once again find themselves without health insurance, subjecting them to increased illness and financial hardship.

Hospitals are also beginning to make decisions based on the ACA that would be called into question should it be invalidated in its entirety. For instance, hospitals around the country are being encouraged to create additional residency training programs in primary care. ACA § 5503. The hospitals that have done so are relying on millions of dollars of grant funding provided by the ACA over the next four years to pay for these positions. If the ACA were invalidated in its entirety, the hospitals could lose that funding and would be faced with either eliminating these additional positions or paying for them with scarce hospital resources. Moreover, hospitals are beginning to plan and implement changes in the way health care is provided. For instance, under the Hospital Value-Based Purchasing Program, Medicaid will pay hospitals not just on the quantity of acute inpatient care, but also on its quality. 42 U.S.C. § 1395ww(o). There are many changes to how Medicaid and Medicare will pay providers, all of whom are adjusting to the new rules under the ACA.

So too are medical professionals changing their practices as a result of the ACA. As an example, the ACA seeks to encourage doctors and nurses to practice in rural areas through scholarships and loan repayment programs and training grants. 42 U.S.C. § 293m. For a doctor who decided to move to a rural area and practice medicine based on the promise that the government would help pay back his loans and make it more affordable to practice in a rural area, invalidation of the ACA could mean that the doctor

would be faced with more expenses than anticipated. Or he might choose to leave, affecting the hospital that hired him and the patients that had been seeing him.

Small businesses may also suffer if the ACA is struck down in its entirety. Many small businesses are already relying on the ACA's tax credits, which make it financially feasible for smaller businesses to offer health insurance. 26 U.S.C. § 45R. If this provision of the ACA is invalidated with the minimum coverage provision, the companies that had offered their employees health coverage would be forced to decide between paying the extra money it costs to insure their employees, which might be cost prohibitive, passing along those costs to their employees, or dropping health coverage altogether.

In sum, many States, third parties, businesses, and individuals will be adversely affected if the entire ACA is invalidated, a result that is inconsistent with Congress's intent and is not required by any of this Court's precedents. The toll on individuals who will lose their insurance because of the ACA's invalidation cannot be overstated. The health consequences are obvious: diseases that could have been prevented with routine medical care will go unchecked. People will be forced to forego needed medical care for chronic illnesses. Many individuals will be denied lifesaving treatments. The financial toll is equally clear: many individuals will lose their jobs because they are sick, or be forced into bankruptcy because they are unable to pay their medical bills. Hundreds of thousands of

individuals are already relying on the health care reform instituted in the ACA, well before the minimum coverage provision has gone into effect. While the invalidation of the minimum coverage provision would cause much hardship, this Court can forestall further damage by severing the minimum coverage provision from the remainder of the Act as Congress intended.

CONCLUSION

The minimum coverage provision is constitutional. If, however, the Court invalidates the minimum coverage provision, the Court should sever it from the remainder of the ACA.

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Respectfully submitted,

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