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, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS
(Severability)

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QUESTION PRESENTED

The minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, non-exempted federal income taxpayers who fail to maintain a minimum level of health insurance for themselves or their dependents will owe a penalty, calculated in part on the basis of the taxpayer's household income and reported on the taxpayer's federal income tax return, for each month in which coverage is not maintained in the taxable year. 26 U.S.C. 5000A (Supp. IV 2010).

The question presented is whether other provisions of the Act would be severable from the minimum coverage provision in the event the minimum coverage provision were declared unconstitutional.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss

[1] All citations are to the appendix to the federal government's certiorari petition in 11-398.

(Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on the parties' cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's order entering a stay of its declaratory judgment (Pet. App. 369a-393a) is reported at 780 F. Supp. 2d 1307.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petitions for a writ of certiorari were filed on September 27 and 28, 2011, and were granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory provisions are set forth in the appendix to this brief.

STATEMENT

A. Statutory Background

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act, Act, or ACA),[2] to expand access to affordable health care, and to improve the functioning of the national market for health care by regulating the terms on which insurance is offered, controlling costs, and rationalizing the timing and method of payment for health care services. The Act also contains numerous provisions concerning other aspects of health care and a variety of other subjects.

1. For decades, the federal government has made employer-sponsored health coverage more affordable

[2] Amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029.

through favorable tax treatment. In particular, employees generally do not include as income and pay taxes on employers' payments of their health insurance premiums, unlike most other forms of employee compensation. 26 U.S.C. 106 (2006). The Affordable Care Act expands the availability of employer-based insurance. Since January 1, 2010, the Act has provided tax credits for eligible small businesses to further subsidize employee health coverage. See 26 U.S.C. 45R.[3] In addition, beginning in 2014, the Act's employer responsibility provision will impose a tax liability under specified circumstances on large employers that do not offer adequate coverage to full-time employees. 26 U.S.C. 4980H.

2. Congress has repeatedly expanded eligibility for Medicaid to increase access to health care. As a result, between 1966 and 2008, Medicaid enrollment increased from four million to 47.6 million. Centers for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs. (HHS), *2010 Actuarial Report on the Financial Outlook for Medicaid* 19 (2010) (Tbl. 3); see Teresa A. Coughlin et al., *Medicaid Since 1980: Costs, Coverage, and the Shifting Alliance Between the Federal Government and the States* 2, 47-55 (1994). Building on this tradition, Congress in the Affordable Care Act again expanded eligibility for Medicaid. Beginning in 2014, Medicaid eligibility will extend to individuals who have household income up to 133% of the federal poverty level and are not eligible for Medicare based on age or disability. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office (CBO) has projected that this eligibility expansion, by itself, will increase Medicaid

[3] Unless otherwise noted, all citations to the United States Code refer to Supp. IV 2010, and all citations to the United States Code Annotated refer to Supp. 2011.

enrollment by 9-10 million between 2010 and 2019. See Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives 9 (Mar. 20, 2010); CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010) (*CBO's June 2010 Analysis*).

3. The Act provides for creation of health insurance exchanges in 2014 to enable individuals and small businesses to leverage their collective buying power to obtain health insurance at rates competitive with those charged for typical large employer plans. 42 U.S.C.A. 18031-18044.

4. Although federal tax law has long subsidized employer-sponsored health insurance (see pp. 2-3, *supra*), with limited exceptions, health insurance purchased in the individual market has not received favorable tax treatment. CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 9 (2008) (*Key Issues*). The Affordable Care Act will address that imbalance by providing tax subsidies. Beginning in 2014, individuals with household income up to 400% of the federal poverty level can receive federal premium tax credits to help them purchase insurance through a health insurance exchange. 26 U.S.C. 36B. For eligible individuals with incomes up to 250% of the federal poverty level, the Act also authorizes federal payments to insurers to help cover individuals' cost-sharing expenses (such as copayments or deductibles) associated with coverage obtained through an exchange. 42 U.S.C.A. 18071(c)(2).

5. The Act adopts a number of market reforms that will increase access to health care services by removing barriers to affordable health insurance coverage.

a. Many of the Act's insurance reforms have already taken effect. For example, insurers can no longer re-

scind coverage absent fraud or intentional misrepresentation on the part of a policyholder. 42 U.S.C. 300gg-12. Insurers may no longer impose lifetime dollar limits on essential benefits and are subject to restrictions on imposition of annual dollar limits. See 42 U.S.C. 300gg-11(a)(1)(A) and (B).[4] In addition, insurers must provide rebates if their medical loss ratios—*i.e.*, the percentage of premium revenues spent on clinical services and activities that improve health care quality, as opposed to administrative costs or profits—are below specified levels. See 42 U.S.C. 300gg-18(b). The Act also generally requires insurers providing family coverage to cover adult children until age 26. 42 U.S.C. 300gg-14. An additional 2.5 million young adults have gained coverage under this provision. See Office of the Assistant Sec'y for Planning & Evaluation (ASPE), HHS, *ASPE Issue Brief: 2.5 Million Young Adults Gain Health Insurance Due to the Affordable Care Act* (2011).

b. Additional market reforms will take effect in 2014. Before the Affordable Care Act, the federal government regulated employer-based health coverage under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936. See Gov't Minimum Coverage Br. 5 (discussing anti-discrimination provisions in those statutes). Prior law generally did not, however, prevent insurers in the individual market from varying premiums, or denying coverage altogether,

[4] The Act will eventually eliminate annual dollar limits on benefits in most plans, but provides that the Secretary of HHS may establish "restricted annual limits" in the meantime. 42 U.S.C. 300gg-11(a)(1)(B) and (2); see 45 C.F.R. 147.126(d) (increasing minimum annual limits each year until they are eliminated in 2014).

based on the medical condition or history of an individual or an individual's dependent. Free of such regulatory constraints, insurers in the individual market have denied coverage or charged higher rates if individuals or their dependents have any of a variety of common medical conditions. See *id.* at 5-6.

The Act fills the gap in the federal regulatory scheme by barring insurers from denying coverage to any individual because of the medical condition or history of the applicant or applicant's dependents. See 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a). This feature of the Act is known as "guaranteed issue."[5] The Act also will bar insurers from charging individuals higher premiums because of such medical factors. 42 U.S.C. 300gg(a)(1), 300gg-4(b). This feature is known as "community rating."[6]

6. The Act also establishes new tax penalties to be paid by non-exempted individuals who do not maintain a minimum level of health coverage for themselves and

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[5] 42 U.S.C. 300gg-1 will generally require insurers to accept every employer and individual applying for coverage; 42 U.S.C. 300gg-3 will prohibit insurers from excluding coverage for preexisting conditions; and 42 U.S.C. 300gg-4(a) will bar insurers from basing eligibility on "health status-related factors." The prohibition on denying coverage based on preexisting conditions applies now with respect to individuals under age 19. See 42 U.S.C. 300gg-3 note (Effective Date of 2010 Amendment).

[6] 42 U.S.C. 300gg(a)(1) provides that premium rates can vary based only on: whether the coverage is for an individual or family; geographic location (known as a "rating area"); age (the ratio between the highest and lowest age-based rates cannot be greater than three to one); and tobacco use (the rate for such use cannot be more than 50% higher than non-tobacco use rates). 42 U.S.C. 300gg-4(b) prohibits insurers from charging higher premiums to similarly situated individuals and dependents within a group based on "health status-related factor[s]."

their dependents. 26 U.S.C. 5000A. Congress expressly found that this minimum coverage provision is crucial to the viability of the guaranteed-issue requirements that will take effect, along with the minimum coverage provision, in 2014. Congress determined that, without a minimum coverage provision, many individuals would take advantage of the guaranteed-issue and community-rating requirements by "wait[ing] to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I). That practice would drive up premiums and threaten the viability of the individual insurance market. Accordingly, Congress found that the minimum coverage provision is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* Congress also found that the minimum coverage provision "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for." 42 U.S.C.A. 18091(a)(2)(A). The uninsured as a class actively participate in the health care market, and Congress found that their "attempt to self-insure" leads to the consumption of health care for which they cannot pay and the imposition of those costs on other market participants. *Ibid.*; 42 U.S.C.A. 18091(a)(2)(F).

7. The Act makes a number of significant changes to Medicare, many of which are already in effect. For example, the Act changes Medicare payment rates and premiums, see, *e.g.*, 76 Fed. Reg. 21,432, 21,439-24,440 (Apr. 15, 2011) (summarizing some provisions). The Act's major Medicare reforms are expected to reduce costs by $507 billion between 2012 and 2021. Douglas W. Elmendorf, Director, CBO, *CBO's Analysis of the Major*

Health Care Legislation Enacted in March 2010: Prepared Statement for True Cost of PPACA: Effects on the Budget and Jobs: Hearing before the Subcomm. on Health of the House Comm. on Energy & Commerce, 111th Cong., 1st Sess. 25 (Mar. 30, 2011). And the Act will eliminate an anomaly (known as the "donut hole") in the prescription drug benefit under Medicare Part D, under which certain beneficiaries were required to pay all their prescription costs after meeting a certain threshold, until reaching a yearly out-of-pocket limit, when benefits resumed again. See 42 U.S.C. 1395w-102(b) (2006); HCERA § 1101, 124 Stat. 1036.

8. Many other provisions of the Act, only some of which are connected to health coverage, address other critical Congressional objectives, such as controlling costs, reducing waste and fraud, and improving public health. To name a few examples, the Act requires chain restaurants to disclose nutritional information about standard menu items, 21 U.S.C. 343(q)(5)(H); establishes a National Prevention, Health Promotion and Public Health Council, 42 U.S.C. 300u-10; amends the False Claims Act's "public disclosure" bar, see 31 U.S.C. 3730(e)(4); and reauthorizes the Indian Health Care Improvement Act, see ACA § 10221, 124 Stat. 935.

B. Proceedings Below

Petitioners are four individuals, the National Federation of Independent Business (NFIB), and 26 States.[7] They filed suit in the Northern District of Florida, chal-

[7] The original individual petitioners are Mary Brown and Kaj Ahlburg. On January 17, 2012, the Court granted private petitioners' unopposed motion to add two new individuals (Dana Grimes and David Klemencic) as petitioners in this case and as respondents in 11-398.

lenging the constitutionality of several provisions of the Affordable Care Act.

1. The district court held that the minimum coverage provision is not a valid exercise of Congress's Article I powers, and further held that none of the other provisions of the Act are severable from the minimum coverage provision. Pet. App. 288a-367a. But recognizing that immediately halting implementation of the entire Act—many provisions of which were already in effect—"would be extremely disruptive and [would] cause significant uncertainty," the district court subsequently stayed its ruling. *Id.* at 389a; see *id.* at 387a-392a.

2. A divided court of appeals affirmed the district court's merits ruling but reversed on severability. In analyzing severability, the court of appeals did not address the federal government's contention that petitioners lack standing to challenge the vast majority of the Act's provisions as inseverable. See Gov't C.A. Br. 59-60 (citing *Printz* v. *United States*, 521 U.S. 898, 935 (1997)); Gov't C.A. Reply Br. 59.

The court of appeals rejected petitioners' argument that "wholesale invalidation" of the Act was required. Pet. App. 174a-176a. The court observed that "the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance." *Id.* at 174a. It noted that "such wholly unrelated provisions are too numerous to bear repeating," but cited several "representative examples." *Ibid.*

The court of appeals separately addressed the severability of the guaranteed-issue and community-rating provisions that all parties had agreed cannot be severed from the minimum coverage provision. Pet. App. 176a-186a. The court noted Congress's finding that the mini-

mum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* at 177a (quoting 42 U.S.C.A. 18091(a)(2)(I)). It also recognized that the congressional "findings in that paragraph add that if there were no mandate, 'many individuals would wait to purchase health insurance until they needed care.'" *Ibid.* (quoting 42 U.S.C.A. 18091(a)(2)(I)). But concluding that these findings were irrelevant to the severability analysis, the court of appeals concluded that Congress would have enacted the guaranteed-issue and community-rating reforms without the minimum coverage provision because those insurance reforms "help consumers who need it the most," and therefore invalidated only the minimum coverage provision. *Id.* at 185a.

SUMMARY OF ARGUMENT

This case presents no occasion to consider issues of severability because the Affordable Care Act's minimum coverage provision is a constitutional exercise of Congress's Article I powers. If the Court concludes otherwise, however, it should reject petitioners' sweeping claims for relief. Petitioners' contention that the Court should invalidate the entire Act if the minimum coverage provision is found unconstitutional is not properly presented in this case and is meritless in any event.

1. Petitioners may not challenge the myriad provisions of the Act that do not apply to them. Parties must demonstrate standing for each form of relief they seek and, in doing so, cannot rely on the rights of third parties. This Court applied these principles in *Printz* v. *United States*, 521 U.S. 898 (1997). After invalidating a

portion of a statute as unconstitutional, the Court held there that it had "no business" addressing the alleged inseverability of additional provisions that did not "burden" the parties before the Court and that instead involved "the rights and obligations" of absent individuals. *Id.* at 935. The same analysis is called for here. The court of appeals therefore erred in addressing the severability of the myriad provisions that do not apply to petitioners, including the guaranteed-issue and community-rating provisions, because no entity regulated by those provisions is a party here. Applying these principles and certain statutory preclusions of review, if the Court accepts the individual petitioners' claim that the minimum coverage provision is unconstitutional, only the severability of the expansion of eligibility for Medicaid could properly be decided by the Court because the States are subject to that provision. The Court, however, would not be required to resolve that issue here.

2. If the Court nevertheless reaches the question, it should hold that only the guaranteed-issue and community-rating provisions of the Act are inseverable from the minimum coverage provision, and thus uphold the rest of the Act. When this Court identifies a constitutional defect in a portion of a statute, its normal rule requires partial, rather than total, invalidation, in order to respect the judgments of the democratically accountable Branches of government. After excising an unconstitutional provision, the Court therefore leaves in place remaining parts that are "consistent with Congress' basic objectives in enacting the statute" unless it is evident that Congress would not have wanted the remaining provisions to stand. *United States* v. *Booker*, 543 U.S. 220, 258-259, 265 (2005).

Congress in the Affordable Care Act used a number of tools to improve the functioning of the national market for health care by expanding the availability of coverage, regulating the terms on which insurance is offered, controlling costs, and rationalizing the timing and method of payment for health care services. For example, it expanded Medicaid eligibility (as it has done many times before); built on its historic practice of using the tax code to encourage health coverage by establishing tax credits for small businesses and individuals and by imposing taxes in certain circumstances on large employers that do not provide full-time employees adequate coverage; and adopted insurance market reforms (beyond guaranteed issue and community rating) similar to those enacted previously by States. Each of these provisions can operate independently of the minimum coverage provision and would advance Congress's goal of expanding affordable coverage if that provision were invalidated. Moreover, many provisions of the Act, focused on controlling costs, improving public health, and other objectives, have no connection to insurance coverage at all. And Congress directed that much of the Act take effect several years before the minimum coverage provision's effective date, further demonstrating that Congress intended those provisions to operate independently.

By contrast, the minimum coverage provision is essential to ensuring that the Act's 2014 guaranteed-issue and community-rating reforms advance Congress's goals. As Congress expressly found (and as experience in the States confirmed), those provisions would create an adverse selection cascade without a minimum coverage provision, because healthy individuals would defer obtaining insurance until they needed health care, leav-

ing an insurance pool skewed toward the unhealthy. Premiums would increase significantly under that scenario, and the availability of insurance would decline—exactly the opposite of what Congress intended in enacting the Affordable Care Act. The guaranteed-issue and community-rating provisions are therefore inseverable from the minimum coverage provision.

ARGUMENT

Because the minimum coverage provision is a constitutional exercise of Congress's powers, this Court need not consider the issue of severability. If the Court does consider severability, however, it should reject petitioners' extraordinary claim that the entire Act be invalidated. Petitioners have identified no instance in which the modern Court has struck down the entirety of a comprehensive and multi-faceted Congressional enactment like this one based on a finding that one provision exceeds Congress's authority. Petitioners' arguments for doing so in this case are insubstantial, as the court of appeals correctly recognized. The vast majority of the provisions petitioners seek to invalidate do not apply to petitioners. Petitioners therefore do not have a cognizable interest to seek their invalidation on severability (or any other) ground.

In all events, petitioners have fallen far short of meeting their burden of demonstrating that Congress would not have wanted the bulk of the Act's provisions to operate independently of the minimum coverage provision. Many of those provisions are already in effect, several years in advance of the minimum coverage provision's effective date. And those and numerous other provisions advance the Act's core objectives of making affordable health care available to millions more Ameri-

cans, controlling health care costs, and improving public health, irrespective of whether the minimum coverage provision becomes effective. The only provisions that would not advance Congress's goals (and could not function properly) absent a minimum coverage provision are the guaranteed-issue and community-rating provisions that take effect in 2014. As Congress's findings recognized, those provisions would create a serious adverse selection problem without a minimum coverage provision, producing higher costs and less insurance coverage. They are therefore inseverable.

I. THE SEVERABILITY OF MOST PROVISIONS OF THE ACT MAY NOT BE CONSIDERED IN THIS CASE

With the limited exception of state petitioners' argument concerning the Affordable Care Act's expansion of Medicaid eligibility, discussed below, petitioners' severability arguments are not properly presented in this case. Some sections of the Affordable Care Act provide for the assessment and collection of taxes, so pre-enforcement consideration of their validity (whether directly or as part of an inseverability claim) is barred by the Anti-Injunction Act.[8] Other portions of the Act re

[8] The Anti-Injunction Act, 26 U.S.C. 7421(a) (2006), provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." *Ibid.* A direct pre-enforcement constitutional challenge to one of the Affordable Care Act's sections providing for "the assessment or collection of any tax," *ibid.*, would be barred by the Anti-Injunction Act. So too is a challenge to one of those provisions in the form of an inseverability argument, because invalidation of a revenue provision on that basis likewise "would necessarily" prevent the federal government from assessing and collecting its attendant taxes. *Bob Jones Univ.* v. *Simon*, 416 U.S. 725, 731-732 (1974). Accordingly, the Anti-Injunction Act

vise Medicare payment rates and are subject to exclusive administrative and judicial review provisions, which may be invoked only by persons who, unlike petitioners, are directly affected by those portions.[9] Petitioners cannot circumvent those procedures by seeking to invalidate the relevant sections of the Act here.

In addition, and more generally, if the Court were to hold the minimum coverage provision unconstitutional, such a holding would furnish no basis for the Court to consider the continued validity of myriad other provisions of the Act that do not apply to petitioners. Whether viewed as a matter of Article III and prudential standing, a limitation on the scope of equitable relief, application of the principle that facial challenges are disfavored, or simply a matter of judicial restraint, the

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would bar the Court from reaching the question of the inseverability of the Affordable Care Act's many tax provisions, including the employer responsibility provision, 26 U.S.C. 4980H. See Gov't Cert.-Stage Br. 18-19 & n.9 (explaining why employer responsibility provision, but not minimum coverage provision, is covered by Anti-Injunction Act); see also, *e.g.*, 26 U.S.C. 1401(b)(2) (additional Medicare tax on high-income taxpayers); 26 U.S.C. 4980I (excise tax on high cost employer-sponsored health coverage); 26 U.S.C. 5000B (tax on indoor tanning services).

[9] Petitioners' attempt to challenge as inseverable from the minimum coverage provision the Act's provisions reducing spending on Medicare, see, *e.g.*, States' Br. 55, is barred by 42 U.S.C. 405(h) (2006) (as incorporated into the Medicare program by 42 U.S.C. 1395ii (2006)), which provides that "[n]o action against the United States, the Commissioner of Social Security, or any other officer or employee thereof shall be brought under [28 U.S.C. 1331 (2006) or 28 U.S.C. 1346 (2006 & Supp. IV 2010)] to recover on any claim arising under this subchapter." 42 U.S.C. 405(h) (2006); see *Shalala* v. *Illinois Council on Long Term Care*, 529 U.S. 1, 11, 14 (2000); *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (applying bar in Section 405(h) to constitutional challenge to statutory provision).

Court should not consider the validity of provisions of the Act that are not directed to petitioners but instead affect numerous parties not before the Court.

A. A plaintiff seeking to invalidate a federal statute must demonstrate, among other things, an injury in fact. See, *e.g.*, *Raines* v. *Byrd*, 521 U.S. 811, 818-820 (1997). A plaintiff must also satisfy established rules of prudential standing, such as the rule barring reliance on the rights of third parties. See, *e.g.*, *Warth* v. *Seldin*, 422 U.S. 490, 499 (1975). By limiting review to actual cases and controversies and limiting the ability of litigants to assert rights of third parties, these standing rules operate as an important check on using litigation as a forum for airing mere policy or political disagreements. See, *e.g.*, *Arizona Christian Sch. Tuition Org.* v. *Winn*, 131 S. Ct. 1436, 1441-1442, 1449 (2011). There is no basis in this Court's precedents for disregarding those rules simply because a party seeks to invalidate a statutory provision as inseverable from a constitutionally defective provision, rather than as unconstitutional in itself.

This Court has repeatedly held that "[s]tanding is not dispensed in gross." *Davis* v. *Federal Election Comm'n*, 554 U.S. 724, 734 (2008) (quoting *Lewis* v. *Casey*, 518 U.S. 343, 358 n.6 (1996)). "Rather, 'a plaintiff must demonstrate standing for each claim he seeks to press' and 'for each form of relief' that is sought." *Ibid.* (quoting *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 352 (2006)). That rule fully applies when the relief sought is invalidation of a provision of a federal law as inseverable.

In *Printz* v. *United States*, 521 U.S. 898 (1997), the Court rejected a request that it decide the severability of provisions of the Brady Handgun Violence Prevention

Act (Brady Act), Pub. L. No. 103-159, 107 Stat. 1536, that did not burden the parties to the litigation. The Court held that the provisions requiring local law enforcement officers to conduct background checks of prospective gun buyers unconstitutionally commandeered those officers. *Printz*, 521 U.S. at 904-933. The law enforcement officers did not challenge the constitutionality of the separate provisions requiring firearms dealers to notify law enforcement officers of proposed firearms purchases and to wait five days before completing the sale. They did, however, argue that those provisions were inseverable from the invalid background-check requirement. See *id.* at 935.

The Court concluded that it had "no business" addressing severability because the waiting-period provisions "burden only firearms dealers and purchasers, and no plaintiff in either of those categories is before us here." *Printz*, 521 U.S. at 935. The Court declined "to speculate regarding the rights and obligations of parties not before the Court," and on that basis it distinguished *New York* v. *United States*, 505 U.S. 144, 186-187 (1992), which had "address[ed] severability where [the allegedly inseverable provisions] affected the plaintiffs." *Printz*, 521 U.S. at 935. *Printz* thereby gave effect to the established principle that "third parties themselves usually will be the best proponents of their own rights. The courts depend on effective advocacy, and therefore should prefer to construe legal rights only when the most effective advocates of those rights are before them." *Singleton* v. *Wulff*, 428 U.S. 106, 114 (1976) (plurality opinion).

As *Printz* demonstrates, there is no inseverability exception to the rule against adjudicating claims involving only the rights of third parties. "At bottom, 'the gist

of the question of standing' is whether petitioners have 'such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination.'" *Massachusetts* v. *EPA*, 549 U.S. 497, 517 (2007) (quoting *Baker* v. *Carr*, 369 U.S. 186, 204 (1962)); see *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 581 (1992) (Kennedy, J., concurring in part and concurring in the judgment) (Standing requirements ensure that "the legal questions presented . . . will be resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action.") (quoting *Valley Forge Christian Coll.* v. *Americans United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982)). The need for concrete adverseness, by parties whose rights are directly affected, is no less necessary in the context of severability than in any other.

The absence of a properly adversarial presentation infects petitioners' severability argument at every turn. For example, private petitioners argue that a number of insurance reforms beyond guaranteed issue and community rating are inseverable on the ground that those additional reforms would "forc[e] insurers to offer policies on economically unfavorable terms" and, absent a minimum coverage provision, would unfairly "burden[] * * * insurance companies." NFIB Br. 41. Yet the insurance industry itself, which appears as an amicus and is able to identify any unfair burden on insurers and advance the industry's own interests, does *not* argue that any provisions (other than guaranteed-issue and community-rating) are inseverable. See America's Health Ins. Plans Amicus Br. 11-39 (AHIP Amicus Br).

Likewise, petitioners seek to invalidate the Act's tax credits for purchase of health insurance. *E.g.*, NFIB Br. 49; States Br. 45. Nowhere have they explained why they desire—much less established anything approaching a judicially cognizable stake in—invalidation of tax benefits directed to millions of individuals not before the Court. As this Court has observed, a rule permitting parties to challenge the validity of tax credits made available to others would "cast[] the Court in the role of a Council of Revision, conferring on itself the power to invalidate laws at the behest of anyone who disagrees with them." *Arizona Christian Sch. Tuition Org.*, 131 S. Ct. at 1443, 1449.

B. 1. Even assuming that NFIB has standing to represent its members in this case at all (but see Gov't Minimum Coverage Br. 16 n.5), NFIB has made no effort to establish representational standing to advance any interests of its members in invalidating the tax credits or any other provision aside from minimum coverage. To the contrary, NFIB's attack on the Act's tax credits would necessarily invalidate the credits for eligible small businesses that offer health insurance coverage to their employees, 26 U.S.C. 45R, a consequence that presumably would *disadvantage* the NFIB members eligible for such credits. Nor have the individual petitioners made any effort to establish their standing to challenge that or any other provision beyond minimum coverage. Although the federal government raised its standing objection at the certiorari stage, see Gov't Cert.-Stage Br. 29, as it had in the court of appeals, private petitioners ignore the issue.

2. State petitioners, for their part, argue that they do not have to demonstrate that the Act's other provisions burden them because severability is a "*remedial*

doctrine." States' Br. 27. But "remedial" action by an Article III court is taken only when necessary to remedy an injury to a party before the court. State petitioners have no cognizable claim to a remedy with respect to statutory provisions that do not apply to them.

Indeed, state petitioners are particularly ill-positioned to argue that a wide-ranging inquiry into the inseverability of any other provisions of the Act is a suitable "remedy" for the asserted unconstitutionality of the minimum coverage provision. Because that provision does not even apply to them, state petitioners lack standing to challenge it, see Gov't 11-398 Cert.-Stage Reply Br. 9-11, much less to seek invalidation of *other* provisions of the Act as a "remedy" for the invalidity of the minimum coverage provision. Affording them such a remedy would cast aside the established principle that a plaintiff "must demonstrate standing * * * for each form of relief that is sought." *Davis*, 554 U.S. at 734 (internal quotation marks and citations omitted).[10]

State petitioners hypothesize that "*Printz* may reflect nothing more than the unremarkable proposition that courts will not 'speculate' concerning issues that have not been fully developed at each stage of the litigation." States' Br. 31. That is incorrect. The Court in *Printz* stressed that the question of severability had in

[10] Decisions on which state petitioners rely (States' Br. 27-29) are inapposite because they considered the severability of provisions that did burden parties before the Court. See, *e.g.*, *United States* v. *Booker*, 543 U.S. 220, 246, 259 (2005); *New York*, 505 U.S. at 186; *Alaska Airlines, Inc.* v. *Brock*, 480 U.S. 678, 692-697 (1987); *Champlin Ref. Co.* v. *Corporation Comm'n*, 286 U.S. 210, 223 n.*, 234 (1932); cf. *Pollock* v. *Farmers' Loan & Trust Co.*, 158 U.S. 601, 604, 635-637 (1895); see also *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 324, 331 (2006) (addressing severability of specific applications of parental-notice provisions challenged by abortion providers).

fact been "briefed and argued" and noted that it had been decided by the district court. 521 U.S. at 904, 935. The Court nonetheless held that it had "no business answering" the severability question, expressly noting that the allegedly inseverable provisions "burden only firearms dealers and purchasers, and no plaintiff in either of those categories is before us here." *Id.* at 935.

State petitioners contend that, unless this Court now addresses their assertion that every other provision of the Act is inseverable from the minimum coverage provision, no other party would have the opportunity to raise inseverability. See States' Br. 33-34. Petitioners are mistaken.[11] This Court in *Printz* took as a given that firearms dealers and purchasers would be able to challenge the Brady Act's waiting period provisions as inseverable from the unconstitutional background check provision. See 521 U.S. at 935; see also *Frank* v. *United States*, 129 F.3d 273, 275-276 (2d Cir. 1997) (per curiam) (recognizing, post-*Printz*, that challenge to waiting period as inseverable could be "considered" when "the proper parties [were] before this Court"). Similarly, the continued validity of the myriad provisions of the Affordable Care Act that do not apply to petitioners can be challenged (at the appropriate time and in the appropriate way) by others to whom they do apply. Medicare providers and taxpayers, for example, have established mechanisms for raising such challenges (see notes 8 and 9, *supra*), and others may have a cause of action under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.*, or on some other basis, or could assert any non-

[11] This Court has consistently rejected the proposition that a party before the Court should be found to have standing simply because otherwise no party could sue. See, *e.g.*, *Schlesinger* v. *Reservists Comm. to Stop the War*, 418 U.S. 208, 227 (1974).

severability argument as a defense in enforcement or other proceedings.

With respect in particular to the guaranteed-issue and community-rating provisions that take effect in 2014, the United States is on record conceding their inseverability. That position presumably would itself have a significant impact on any future efforts to enforce or invoke those provisions in the event the Court invalidated the minimum coverage provision. If issues nevertheless did arise, they could be raised in a suitable action by a proper party. State petitioners, however, are not such parties.

Finally, state petitioners' attempt to circumvent normal standing rules is not helped by their observation that severability analysis is designed to further congressional intent. *E.g.*, States' Br. 28. For the Court to engage in a wide-ranging severability inquiry, untethered to any need to afford a remedy to parties before the Court and instead for the supposed benefit of Congress, would be to render an advisory opinion. *All* questions of statutory interpretation ultimately turn on congressional intent. That truism does not relieve the courts of their obligation to ensure the presence of a party with standing before they attempt to discern what that intent was. See *DaimlerChrysler*, 547 U.S. at 341. As this Court has emphasized, "[t]he federal courts have abjured appeals to their authority which would convert the judicial process into 'no more than a vehicle for the vindication of the value interests of concerned bystanders.'" *Valley Forge Christian Coll.*, 454 U.S. at 473 (citation omitted). Petitioners' severability arguments present precisely that risk.

C. Other principles reinforce the conclusion that the Court should not entertain petitioners' arguments

against the continued validity of provisions of the Act that do not apply to them or that they have not established standing to challenge. Most fundamentally, because judging the constitutionality of an Act of Congress is "the gravest and most delicate duty that this Court is called upon to perform," *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981) (quoting *Blodgett* v. *Holden*, 275 U.S. 142, 148 (1927) (Holmes, J.)), the Court should proceed with great caution and address the continued validity of provisions other than the one found unconstitutional only when necessary to the disposition of a concrete case before it. Moreover, as relevant here, petitioners brought this suit to seek declaratory and injunctive relief based on the asserted unconstitutionality of the minimum coverage provision. It is well established that an equitable remedy should extend no further than what is necessary to afford relief for an adjudicated violation based on the plaintiff's claim.[12] Finally, petitioners' request that the Court strike down the entire Act is a facial challenge to the entire Act. This Court has made clear that facial challenges are disfavored and that a court should tailor its analysis and resulting remedy to the application of the statute specifically challenged. See *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 328-331 (2006); *Sabri* v. *United States*, 541 U.S. 600, 608-610 (2004).

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[12] See, *e.g.*, *Monsanto Co.* v. *Geertson Seed Farms*, 130 S. Ct. 2743, 2760 (2010) (narrowing injunction in part because plaintiffs "do not represent a class, so they could not seek to enjoin such an order on the ground that it might cause harm to other parties"); *Doran* v. *Salem Inn, Inc.*, 422 U.S. 922, 931 (1975) (noting that "neither declaratory nor injunctive relief can directly interfere with enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs"); see also *United States Dep't of Def.* v. *Meinhold*, 510 U.S. 939 (1993).

D. 1. Because no entity regulated by the guaranteed-issue and community-rating provisions is a party in this case, the court of appeals erred in addressing whether those provisions are severable from the minimum coverage provision. Accordingly, in the event the Court invalidates the minimum coverage provision, it should vacate the portion of the lower court's judgment finding those two provisions severable.

2. This case likewise does not present an appropriate vehicle to consider petitioners' broadside challenge to the myriad other provisions of the Affordable Care Act. Private petitioners presented no evidentiary basis below to establish any cognizable interest in invalidating any provision of the Act other than the minimum coverage provision, nor have they contended that they have independent standing to do so.

The situation is largely the same for state petitioners. If the Court first agrees with the constitutional challenge to the minimum coverage provision advanced by the individual petitioners with standing to bring that challenge, state petitioners, as large employers, would then have standing to challenge the Act's employer-responsibility provision as inseverable, Medicaid J.A. 96-100,[13] although the Anti-Injunction Act would pose an independent bar to that pre-enforcement challenge, see note 8, *supra*. Likewise, if the Court first holds the minimum coverage provision unconstitutional, state petitioners then would have standing to challenge the Act's expansion of Medicaid eligibility as inseverable from the minimum coverage provision. See Medicaid J.A. 70-82. But the Court would not be required to reach or decide that issue here. Resolution of that

[13] Medicaid J.A. refers to the joint appendix filed in No. 11-400.

severability issue concerning Medicaid is not necessary to afford relief to the individual petitioners who have standing to challenge the minimum coverage provision, because they do not claim to be adversely affected by the Medicaid eligibility provisions. And state petitioners cannot insist as a matter of right that the Court resolve that severability issue as a remedy for them in this case, because the minimum coverage provision—even if unconstitutional as to individual petitioners—violates no rights of state petitioners that might in turn form a basis for affording them a remedy in this case. Accordingly, if the Court holds the minimum coverage provision unconstitutional, it could decline to resolve the Medicaid severability issue at this time or in this case as a matter of prudence and judicial restraint.

State petitioners have not asserted any basis for standing to seek invalidation of any of the Act's other provisions. For example, although state petitioners urged in district court that they were burdened by the Act's exchange provisions, the court rejected that challenge because state participation in the exchanges is voluntary. See Pet. App. 452a. State petitioners did not appeal that ruling, and they do not argue that they are burdened by the provisions that give them the option to establish exchanges. Accordingly, the Court should not consider the severability of those provisions or any remaining provisions of the Act.

II. IF THE COURT REACHES THE QUESTION, IT SHOULD HOLD THAT THE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION EXCEPT FOR THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS THAT TAKE EFFECT IN 2014

The minimum coverage provision is key to one component of a comprehensive program of economic regulation and incentives to expand access to affordable health care. See Gov't Minimum Coverage Br. 24-32. And all parties agree that the minimum coverage provision is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms. See *Id.* at 28-30; States' Br. 12, 47; NFIB Br. 36-40. Accordingly, the Court should affirm the constitutionality of the minimum coverage provision, see Gov't Minimum Coverage Br. 24-32, rendering it unnecessary to decide any question of severability.

In the event, however, that the Court does have occasion to address severability (but see pp. 14-25, *supra*), the place of the minimum coverage provision in the larger statutory context would again be relevant. In particular, without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals. They are therefore inseverable from the minimum coverage provision and must be invalidated if the Court finds it unconstitutional. See Point II.C., *infra*.

But those are the only provisions of the Act in that category. Other provisions can operate independently and would still advance Congress's core goals of expanding coverage, improving public health, and controlling costs even if the minimum coverage provision were held

unconstitutional. Petitioners fail to meet their burden of demonstrating that the Congress that enacted the Affordable Care Act would have wanted all of those provisions to fall with the minimum coverage provision, not to mention the many provisions that have nothing to do with health coverage.

A. The Court Invalidates As Inseverable No More Of A Statute Than Is Strictly Necessary

This Court has repeatedly held that, "when confronting a constitutional flaw in a statute," a court must "try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enter. Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (internal quotation marks and citation omitted); see *Ayotte*, 546 U.S. at 329 ("[W]e 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.'") (second brackets in original) (quoting *Regan* v. *Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)). "[T]he 'normal rule,'" therefore, "is that 'partial, rather than facial, invalidation is the required course' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ibid.* (citation omitted).

Accordingly, when this Court invalidates a portion of a statute, it "must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States* v. *Booker*, 543 U.S. 220, 258-259 (2005) (internal quotation marks and citations omitted); see *id.* at 263 (in deciding severability, court must ask "which alternative adheres

more closely to Congress' original objective"); *Time, Inc.*, 468 U.S. at 653 (plurality opinion) (relevant question whether "the policies Congress sought to advance by enacting [the invalidated provision] can be effectuated even though [the provision] is unenforceable"). To invalidate provisions as inseverable under these standards, a party bears the burden of demonstrating that it is "*evident*" that the Congress that enacted the invalid provision "would have preferred" that those additional provisions be invalidated as well. *Free Enter. Fund*, 130 S. Ct. at 3162 (emphasis added; citation omitted); see *Ayotte*, 546 U.S. at 330 ("Would the legislature have preferred what is left of its statute to no statute at all?"); *Booker*, 543 U.S. at 265 (Court must determine Congress's "likely intent *in light of*" the Court's constitutional holding).

B. Petitioners Fail To Demonstrate That It Is "Evident" Congress Would Have Wanted The Entire Act To Fall If The Minimum Coverage Provision Were Invalidated

Petitioners contend that, if the minimum coverage provision is invalidated, the entire Affordable Care Act must fall. As the court of appeals recognized, that contention is meritless. "[T]he lion's share of the Act has nothing to do with private insurance," Pet. App. 174a, and many of its provisions have already gone into effect, years before the minimum coverage provision. Petitioners have not come close to showing that it is evident that Congress would have wanted to undo every single one of the Act's myriad provisions—thereby denying affordable health care to millions of Americans and forgoing hundreds of billions of dollars in cost savings—if that one section were held unconstitutional.

1. Petitioners' argument for complete invalidation fails at the outset because of a fundamental feature of the Act they ignore: Many of its provisions are already in effect, several years before the minimum coverage provision becomes effective in 2014. See, *e.g.*, pp. 4-5, *supra*; see generally Kaiser Family Found., *Health Reform Source: Implementation Timeline*, http://healthreform.kff.org/Timeline.aspx (last visited Jan. 26, 2012). That time lag establishes conclusively that much of the Act operates independently of the minimum coverage provision. One need not speculate whether Congress would have wanted such provisions to operate in a world without the minimum coverage provision. We are in that world now.

Given that many provisions of the Act are now in operation, Congress cannot possibly have intended the extraordinary disruption that a finding of total inseverability would cause in the event a provision not taking effect until 2014 were invalidated. For example, more than 20 sections of the Act made changes to Medicare payment rates for calendar or fiscal years beginning in 2011, see, *e.g.*, 42 U.S.C. 1395w-4(e)(1)(H), and these changes have been implemented through notice-and-comment rulemaking, see, *e.g.*, 75 Fed. Reg. 73,170 (Nov. 29, 2010) (adjusting Medicare physician fee schedule for calendar year 2011, consistent with ACA provisions); 76 Fed. Reg. 73,026 (Nov. 28, 2011) (same for 2012). The Act's Medicare provisions have thus already formed the basis for millions of payments to providers for the benefit of individual beneficiaries. It is not remotely evident that Congress would have intended those provisions to fall (raising the prospect of unwinding countless transactions) in the event a wholly unrelated provision were invalidated.

A ruling of total inseverability would also create other bizarre results. For example, several portions of the Act extended certain pre-existing Medicare payment provisions, such as one involving air ambulance services. See ACA § 3105(b), 124 Stat. 417; ACA § 10311(b), 124 Stat. 943. Congress subsequently extended this provision. See Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, § 106(b), 124 Stat. 3287 (extending provision through 2011); Temporary Payroll Tax Cut Continuation Act of 2011, Pub. L. No. 112-78, § 306(b), 125 Stat. 1285 (extending provision through first two months of 2012). According to petitioners, therefore, Congress intended, in the event the minimum coverage provision were invalidated, for such Medicare payment provisions to be deemed to have lapsed for a year (2010) on inseverability grounds, before springing back to life when later extended through non-invalidated legislation.

Petitioners' total-invalidation argument is similarly irreconcilable with myriad other Affordable Care Act provisions "wholly unrelated" to the minimum coverage provision. Pet. App. 174a (providing examples); see pp. 7-8, *supra*; see also Pet. App. 352a-353a (district court examples). Among those unrelated provisions are those that: "provide[] for more rigorous enforcement" of drug-pricing requirements, *Astra USA, Inc.* v. *Santa Clara Cnty.*, 131 S. Ct. 1342, 1346 (2011); reauthorize various federal programs that were already on the books, *e.g.*, ACA § 4204(c), 124 Stat. 572 (reauthorizing immunization program), § 5603, 124 Stat. 679 (reauthorizating Wakefield Emergency Medical Services for Children Program); and amend the False Claims Act's "public disclosure bar," *Schindler Elevator Corp.* v. *United States ex rel. Kirk*, 131 S. Ct. 1885, 1889 n.1 (2011). In-

deed, petitioner Washington State conceded below that the Act's reauthorization of the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, could be severed from the minimum coverage provision. See States' C.A. Br. 65 n.8. These provisions "have a stand-alone quality and are 'fully operative as a law.'" *West Va. CWP Fund* v. *Stacy*, No. 11-1020, 2011 WL 6062116, at *3 n.2 (4th Cir. Dec. 7, 2011) (Wilkinson, J.) (holding that ACA's amendment to Black Lung Benefits Act, 30 U.S.C. 901 *et seq.*, regarding standard for receiving survivor benefits is severable from minimum coverage provision).[14]

Petitioners cavalierly dismiss such provisions as "various obscure measures that appear independent of [the Act's] major planks," and contend that they should simply be swept away because it would be too difficult to determine whether they are severable. NFIB Br. 54-56. But petitioners make no attempt to explain *why* any such provisions *are* inseverable, thereby effectively conceding that it actually is not difficult at all to find them severable.

In any event, petitioners have their presumptions backwards. Because petitioners bear the burden of demonstrating that it is evident Congress would have wanted these provisions and numerous others to fall in

[14] Many other provisions of the Act have been applied by the courts, further demonstrating how Congress's decision to make them immediately effective has embedded them in the fabric of the law. See, *e.g.*, *Henry Ford Health Sys.* v. *HHS*, 654 F.3d 660 (6th Cir. 2011) (Secretary reasonably exercised authority under ACA in promulgating regulation addressing Medicare reimbursements costs); *United States* v. *Mateos*, 623 F.3d 1350, 1368 (11th Cir. 2010) (O'Connor, J.) (holding that an above-Sentencing Guidelines sentence for health care fraud was reasonable, relying in part on ACA provision directing Sentencing Commission to amend Guidelines to ensure that health care fraud is punished more severely), cert. denied, 131 S. Ct. 1540 (2011).

the event the minimum coverage provision were invalidated, *Free Enter. Fund*, 130 S. Ct. at 3162, any uncertainty must be resolved in favor of leaving the legislation intact. Congress, not the Court, is in the best position to make any necessary adjustments. *Booker*, 543 U.S. at 265.

Petitioners' total-invalidation argument, in short, is groundless. And other than stressing the inseverability of the guaranteed-issue and community-rating reforms from the minimum coverage provision—a position with which the federal government agrees, see Point II.C., *infra*—petitioners eschew any further "provision-by-provision" inseverability claim. NFIB Br. 55; see States' Br. 52 (declining to "examin[e] in isolation particular relationships between discrete components"). Accordingly, if the Court were to invalidate the minimum coverage provision and conclude there is no barrier to resolving the severability of that provision from the guaranteed-issue and community-rating provisions that take effect in 2014, it should declare only those provisions inseverable and allow the rest of the Act to stand.

2. To the extent, however, that the Court addresses any additional provisions of the Act, it should find them severable from the minimum coverage provision. State petitioners attempt to support their inseverability argument by erroneously framing the Affordable Care Act as nothing more than an attempt to "ensure an adequate supply to meet the artificial demand forcibly created by the individual mandate." States' Br. 35. With the minimum coverage provision in the "demand" category, they then attempt to shoe-horn every other provision of the Act into either the "supply" category or a third category of "cost-savings provisions designed to counterbalance the expensive supply-side provisions." *Ibid.* If the "de-

mand" provision falls, the argument continues, then the supply and financing provisions should as well. *Ibid.*

Although that construct serves petitioners' rhetorical purposes, it bears no relation to what Congress was actually doing when it enacted the Affordable Care Act. The Act was not an abstract exercise in stimulating "artificial demand" for health insurance and then matching it with a given level of supply in order to achieve some ideal equilibrium. Quite the opposite. Congress's overriding goal of the Act was to expand affordable coverage for real human beings in the real world so that they could obtain needed health care. Congress found that a core impediment to coverage was discriminatory practices by private insurers, which shut millions of people who wanted health insurance out of the market. It decided to end those practices, and, in order to make that market reform possible, it adopted the minimum coverage provision. In so doing, Congress also rationalized payment for services consumed by the uninsured in the health care market, and thereby dealt with the economic dislocation resulting from the massive cost-shifting that characterized that market. But the Act also includes a variety of other provisions (such as premium tax credits and exchanges) that lower barriers to obtaining health coverage and extend coverage to those who otherwise would not be able to afford it. It is fanciful to suggest that those numerous other provisions are "mere adjuncts," *Williams* v. *Standard Oil Co.*, 278 U.S. 235, 243 (1929), to the minimum coverage provision designed to prop up the supply of available insurance. Each is a stand-alone provision that independently advances in distinct ways Congress's core goal of expanded affordable coverage.

The fact that those other provisions substantially advance the same basic objective as the minimum coverage provision surely does not render them inseverable. Again, the opposite is true: With or without the minimum coverage provision, each would independently remain "consistent with Congress' basic objectives in enacting the statute," *Booker*, 543 U.S. at 258-259, and would continue to further "Congress' basic statutory goal," *id.* at 250. Accordingly, invalidation of the minimum coverage provision "does not require the *total* frustration of Congress' basic purpose," *United States* v. *Jackson*, 390 U.S. 570, 591 (1968) (emphasis added), through invalidation of those other provisions as well. "Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated." *New York*, 505 U.S. at 186. Indeed, a Congress that deployed multiple tools comprehensively to advance its goals would have been all the more committed to those remaining in the event one provision were invalidated.

a. Among the tools Congress used to expand access to health care was the expansion of eligibility for Medicaid. See NFIB Br. 52. This expansion was only the latest in a series since Medicaid's inception in 1965, see p. 3, *supra*, and none of the others was accompanied by a minimum coverage provision. Petitioners fail entirely to demonstrate that it is evident that Congress would have viewed this expansion (alone among all the ones it has initiated in the last four decades) as inextricably tied to such a provision. Nor do petitioners suggest why Congress would have wanted to forgo extend-

ing coverage to millions of previously uninsured Americans, merely because it could not achieve the additional benefits of the minimum coverage provision.

b. Similarly, petitioners fail to demonstrate that it is evident Congress would have wanted the employer responsibility provision, 26 U.S.C. 4980H, to fall if the minimum coverage provision were invalidated. See NFIB Br. 51. This provision is just the latest example of Congress's use of the tax code to encourage employers to provide their employees with affordable health coverage. See pp. 2-3, *supra*. Many past health care reform proposals were based on such employer provisions and did not include a minimum coverage provision. See Gov't Minimum Coverage Br. 13-14. Indeed, for more than 37 years, Hawaii has had an employer responsibility provision without a minimum coverage provision. See Thomas C. Buchmueller et al., *The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii*, Am. Econ. J. Econ. Pol'y, Nov. 2011, at 25, 25-26. Congress is well aware of Hawaii's statute, as it enacted a special provision to save it from preemption under ERISA. See 29 U.S.C. 1144(b)(5) (2006); see also ACA § 1560(b), 124 Stat. 262 (relevant portion of ACA shall not be "construed to modify or limit the application" of Hawaii's ERISA exemption). To be sure, the minimum coverage provision complements the employer responsibility provision (as well as other provisions, both pre-existing and in the Affordable Care Act) by encouraging employees to seek and accept employer-based coverage. See Gov't Minimum Coverage Br. 32. But a mere "relationship" between provisions does not render them inseverable. *Buckley* v. *Valeo*, 424 U.S. 1, 108 (1976) (per curiam).

c. Petitioners have also failed to show that the Act's premium tax credits, 26 U.S.C. 36B, are inseverable from the minimum coverage provision. Cf. NFIB Br. 49-50. Contrary to private petitioners' speculation, the federal government's costs in providing those tax credits would not "skyrocket" if the minimum coverage provision were invalidated. *Id.* at 49. To the contrary, the expense would fall substantially because fewer people would obtain coverage and thus claim the credits. See *CBO's June 2010 Analysis* 2 (exchange subsidies would be $39 billion less without minimum coverage provision); Matthew Buettgens et al., *Why the Individual Mandate Matters* 5 (2010) (Tbl. 2) (government's total outlay for premium tax credits would fall more than 30% without minimum coverage provision). In any event, Congress included two provisions (including a "failsafe" based on a specified share of gross domestic product) that limit the impact of premium growth on the government's total tax credit expenditures. See 26 U.S.C. 36B(b)(3)(A)(ii).[15]

d. The Act's health insurance exchange provisions, 42 U.S.C.A. 18031-18044, are also severable from the minimum coverage provision. Cf. NFIB Br. 51-52.

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[15] While the premium tax credit provision uses premium costs (of the second lowest "silver" plan) in a "rating area" as a basis for calculation, 26 U.S.C. 36B(b)(3)(C); see NFIB Br. 50, the Act's "rating area" provision, 42 U.S.C. 300gg(a)(2), is distinct from the community-rating provision, 42 U.S.C. 300gg(a)(1), and is thus severable from it. See note 23, *infra*. Similarly, the provision establishing the actuarial value requirements for a "silver" plan, 42 U.S.C.A. 18022(d), is independent of community rating. In the absence of community rating, plan premiums could vary based not only on the ages of different household members, the rating area where they reside, and the composition of the household, but also on other factors, including health factors. The premium for the second lowest cost silver plan would be identified in accordance with 26 U.S.C. 36B(b)(3)(C).

While the exchanges would not promote competition and lower costs as effectively without guaranteed-issue and community-rating rules, see Gov't Minimum Coverage Br. 31, they would still operate as "organized and transparent marketplace[s] for the purchase of health insurance where individuals and employers * * * can shop and compare health insurance options." H.R. Rep. No. 443, 111th Cong., 2d Sess. Pt. 3, at 976 (2010) (internal quotation marks and footnote omitted). CBO has estimated that "organiz[ing] purchasers into larger groups" through mechanisms like exchanges could, by itself, lower average policy premiums by three percent. *Key Issues* 71. Indeed, although petitioner Utah has no minimum coverage provision (or guaranteed issue or community rating), it established the "Utah Health Exchange" in 2009 to "serve as a single shopping point allowing consumers to evaluate their health insurance options and execute informed purchasing decisions." Press Release, Utah Governor's Office of Econ. Dev., *Governor's Office of Economic Development to launch the Utah Health Exchange* 1 (Aug. 19, 2009); see State Health Access Data Assistance Ctr., *Issue Brief No. 23*, *Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison* (2010) (discussing pre-ACA exchanges in Utah, Connecticut, Washington, and Massachusetts).[16]

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[16] Several state petitioners have recognized that exchanges would be beneficial even without a minimum coverage provision. See, *e.g.*, Letter from Haley Barbour, Governor of Mississippi, to HHS Secretary Kathleen Sebelius (June 29, 2011) ("I have supported establishing an insurance exchange targeting small businesses since 2008."), attached to Mississippi's *Application for Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges* (June 29, 2011); Colorado Health Benefit Exch., *FAQs*, http://www.

e. Private petitioners make a cursory argument that some of the Act's insurance reforms, beyond guaranteed issue and community rating, are also inseverable from the minimum coverage provision on the ground that, absent that provision, those additional reforms would unfairly burden the insurance industry. See NFIB Br. 40-41; see also Chamber of Commerce Amicus Br. 23-31. As noted above, however, the insurance industry itself does not claim any such burden (and does not contend those additional reforms are inseverable), see p. 18, *supra*, refuting private petitioners' argument. Moreover, Congress directed that many of those additional reforms take effect well in advance of the minimum coverage provision, demonstrating that it intended them to operate separately from that provision. See pp. 4-5, 29, *supra*.

Private petitioners' cursory argument fares no better when those insurance reforms are considered individually. First, there is no reason to believe that a Congress concerned about the cost of health insurance would have wanted the provision authorizing "review" of "unreasonable increases in premiums for health insurance coverage," 42 U.S.C. 300gg-94; see NFIB Br. 11, to fall if the minimum coverage provision were invalidated.

Second, there is no valid case for the inseverability of the requirement that insurers offer a minimum level of "essential health benefits." 42 U.S.C. 300gg-6(a); see NFIB Br. 11, 40. Congress has previously enacted such requirements without a minimum coverage provision, see, *e.g.*, 42 U.S.C. 300gg-4, 300gg-51 (2006) (specified

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getcoveredco.org/FAQs (last visited Jan. 25, 2012) ("Regardless of how these cases [challenging the minimum coverage provision] end, Colorado has chosen to move forward with its own health insurance exchange.").

maternity benefits), and every State has enacted similar rules, see Council for Affordable Health Ins., *Health Insurance Mandates in the States 2010*, at 11-34 (2010).[17]

Third, both federal and state laws have previously placed "limits [on] cost-sharing" (NFIB Br. 40) without a minimum coverage provision. See, *e.g.*, 42 U.S.C. 300e(b)(1) (2006) (health maintenance organizations may require members to make only "nominal payments" for basic health services beyond periodic premiums); Cal. Health & Safety Code § 1373.4 (West 2008) (limiting co-payments and deductibles for maternity services).

Fourth, the prohibition on rescinding coverage absent fraud or intentional misrepresentation by a policyholder, 42 U.S.C. 300gg-12; see NFIB Br. 11, 40, is a basic consumer protection measure,[18] mirroring those enacted by States without a minimum coverage provision, see, *e.g.*, N.M. Stat. § 59A-23E-14 (2000); *id.* § 59A-23E-19.

Fifth, there is no reason to believe Congress would have wanted the Act's prohibition on insurers' setting artificial dollar "limits on coverage" (NFIB Br. 40) to fall without a minimum coverage provision. Congress directed that those reforms take effect several years

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[17] Moreover, HHS has announced that it intends to define essential health benefits based on a benchmark plan selected by each State itself. Center for Consumer Info. & Ins. Oversight, HHS, *Essential Health Benefits Bulletin* 8 (Dec. 16, 2011).

[18] See 75 Fed. Reg. 37,208 (June 28, 2010) (noting that Congress adopted this rule in response to "questionable practices in this area including insurance companies rescinding coverage even when discrepancies are unintentional or caused by others, for conditions that are unknown to policyholders, and for discrepancies unrelated to the medical conditions for which patients sought medical care").

before that provision and, even before passage of the Act (and thus in a market without a minimum coverage provision), annual dollar limits on coverage were not common. See HHS, *Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights* (June 22, 2010) (92% of larger employer plans, 86% of small employer plans, and 81% of individual plans include no annual limits).

Finally, there is no merit to the argument of amicus Chamber of Commerce that the Act's provisions on medical loss ratios (requiring that insurers spend a certain percentage of premium revenue on certain benefits) and risk-adjustment (requiring payments among insurers based on actuarial risk of their insured populations) are inseverable. See Chamber Amicus Br. 25-27, 29-31. These are familiar insurance regulatory tools used in a variety of settings without a minimum coverage provision. See, *e.g.*, 42 U.S.C. 1395w-23(a)(1)(C) (2006) (risk adjustment provision for Medicare managed care organizations); Ross Winkelman & Rob Damler, *Risk Adjustment in State Medicaid Programs*, Health Watch (Health Section, Council of the Soc'y of Actuaries, Schaumburg, Ill.), Jan. 2008, at 14 ("Risk adjustment is a critical tool for the development and sustainability of Medicaid Managed Care Programs."); America's Health Ins. Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Apr. 2010), http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf (last visited Jan. 26, 2012).[19]

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[19] Private petitioners contend that the Act's insurance reforms "will raise insurance costs in the individual market by *27 to 30%*." NFIB Br. 11 (citing Pet. App. 126a n.107) (citing in turn CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and*

3. Private petitioners invite this Court to immerse itself in the politics of the Act's passage and invalidate the entire statute on the ground that, according to private petitioners, there would not have been 60 votes in the Senate in March 2010 to end a hypothetical filibuster of a hypothetical amended Act without a minimum coverage provision. See NFIB Br. 56-61. Severability involves a question of statutory construction, not an exercise in parliamentary probabilities. The supposed political currents and subjective motivations of individual legislators has never formed part of this Court's

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Affordable Care Act 6 (Nov. 30, 2009) (*Health Insurance Premiums*)). That is a mischaracterization of CBO's finding. CBO found that, relative to a baseline without ACA, premiums under ACA in the large group market would be unchanged or decline by up to 3%; in the small group market would range from a 2% decline to a 1% increase; and in the individual market would increase by 10%-13%. *Health Insurance Premiums* 5. (CBO further found that 57% of persons in the individual market would receive subsidies, and that for those individuals, the average premiums after accounting for subsidies would *decline* by 56% to 59%. *Ibid.*) CBO explained that the "difference in unsubsidized premiums" in the individual market "is the *net* effect of three changes." *Id.* at 6 (emphasis added). Private petitioners misleadingly cite only one of those three changes, ignoring the 7%-10% decline attributable to "net reduction in costs that insurers incurred to deliver the same amount of insurance coverage to the same group of enrollees" and the further 7%-10% decline from "a shift in the types of people obtaining coverage." *Ibid.* And private petitioners mischaracterize the one number they cherry-pick: As CBO explained, the 27%-30% increase in premiums (largely offset by the two declines described above, and completely offset for those receiving subsidies) is attributable to the fact that policies in the individual market will "cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits," based in part on *voluntary* decisions "to purchase more extensive coverage." *Ibid.* In other words, some costs that the insured had previously paid out-of-pocket would instead be covered by premium payments.

severability analysis. To the contrary, in *New York*, this Court explicitly recognized that the statute before it, "like much federal legislation, embodies a compromise among the States." 505 U.S. at 183. Nonetheless, the Court held that other provisions of the statute were severable from the provision it invalidated. See *id.* at 186-187.

Rather than the sort of politically-oriented analysis of internal congressional procedures petitioners urge, the Court's severability precedents call for an objective and substantive inquiry, under which it "must retain" all provisions of a statute that are "consistent with Congress' basic objectives in enacting" it. *Booker*, 543 U.S. at 258-259. The task for the Court is to discern, based on tools of statutory construction, what the Congress that actually passed the Act (however large the majority of the Members who voted for it in either House) would have intended if, after passage, a court were to hold a particular provision unconstitutional. See *id.* at 265 (Court must determine Congress's likely intent in light of Court's constitutional holding). Petitioners have pointed to nothing in the Act to suggest that the Congress that passed it would have wanted the entire set of independent measures to fall if one of them was held unconstitutional.

4. Petitioners note that the Affordable Care Act itself has no severability clause, *e.g.*, NFIB Br. 58, but both Houses' drafting manuals expressly provide that such clauses are "unnecessary" and thus need not be included in legislation. Office of the Legislative Counsel, U.S. Senate, *Legislative Drafting Manual* § 131, at 49 (1997); Office of the Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style* § 328, at 33 (1995). The absence

of an "unnecessary" provision has no significance, and this Court has said that the "ultimate determination of severability will rarely turn on the presence or absence of such a clause," *Jackson*, 390 U.S. at 585 n.27.

Moreover, there already *are* severability provisions in the Internal Revenue Code, in which Congress not only placed the minimum coverage provision (and many other parts of the Act) but also expressly provided for the applicability of many of the Act's insurance reforms to group health plans, 26 U.S.C. 9815; the Social Security Act, home to the Act's Medicare and Medicaid amendments, among others; and ERISA, which Congress also amended to expressly provide for the applicability of many of the Act's insurance reforms to group health plans, 29 U.S.C. 1185d. See 26 U.S.C. 7852(a) (2006); 42 U.S.C. 1303 (2006); 29 U.S.C. 1139 (2006). Congress triggered those provisions when it added core provisions of the Affordable Care Act to those pre-existing Acts. Congress thus passed the Act against background rules of *severability* applicable under several of the major statutory schemes affected.

Private petitioners rely on what they incorrectly describe as "the *deletion* of a severability clause from an earlier version of the bill" to support their assertion that "Congress intended this unique legislative deal to rise or fall as a whole." NFIB Br. 29. There was no such "deletion." Private petitioners presumably refer to H.R. 3962, a health care reform bill passed by the House in November 2009. 155 Cong. Rec. H12623, H12967-H12968 (daily ed. Nov. 7, 2009). The Senate never considered that measure, much less made "deletions" from it, instead using a different House bill, H.R. 3590, as the vehicle for the Senate's own health care reform legislation. 155 Cong. Rec. S13890-S13891 (daily ed. Dec. 24,

2009).[20] The House then passed that Senate bill. 156 Cong. Rec. H1891, H1920-H2169 (daily ed. Mar. 21, 2010). Even if the absence of a severability provision in the Senate-enacted bill could somehow be construed as a "deletion," the "unexplained disappearance" of text during the progress of a bill is rarely a "reliable indicator[] of congressional intent." *Mead Corp.* v. *Tilley*, 490 U.S. 714, 723 (1989).

C. The Guaranteed-Issue And Community-Rating Provisions That Take Effect In 2014 Are Inseverable From The Minimum Coverage Provision

Congress enacted the Affordable Care Act to expand access to health care services and control health care costs. One set of provisions in the Act to advance these goals addresses defects in the individual market for health insurance. Key reforms in that market are the Act's guaranteed-issue and community-rating provisions, see notes 5 and 6, *supra*, which will end discriminatory insurance practices that have denied affordable coverage to millions of individuals because of their medical conditions or histories. As the government explains in its minimum coverage brief (at 28-30), and as petitioners concede (States' Br. 12, 47; NFIB Br. 36-40), the minimum coverage provision is necessary to make those reforms effective. Congress's findings expressly state

[20] A comprehensive analysis of differences between the House and Senate health care reform bills at the time made no mention of the absence of a severability clause in the Senate bill. See Tri-Comm. House Staff, *House-Senate Comparison of Key Provisions* (Dec. 29, 2009). That is entirely consistent with both chambers' view of such clauses as unnecessary and entirely inconsistent with private petitioners' theory that the Senate deliberately omitted such a provision because it wanted the entire Act to fall if any of its provisions was invalidated.

that enforcement of those provisions without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the Affordable Care Act. Accordingly, in contrast to the rest of the Act (discussed in Point II.B., *supra*), it *is* evident that Congress would not have intended the guaranteed-issue and community-rating provisions to take effect in 2014 if the minimum coverage provision were held unconstitutional, and those provisions accordingly are inseverable from it.

1. Congress's findings establish that the guaranteed-issue and community-rating provisions are inseverable from the minimum coverage provision. Congress specifically found that in a market with guaranteed issue and community rating, but without a minimum coverage provision, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I).[21] Congress then found that

[21] The relevant sentence says in full: "Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), many individuals would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I). Section 2704 of the Public Health Service Act (as added by Section 1201 of ACA) prohibits insurers from excluding individuals from coverage based on preexisting conditions. See 42 U.S.C. 300gg-3. Section 2705 of the Public Health Service Act (as added by Section 1201 of ACA), prohibits coverage eligibility rules based on "health status-related factors," 42 U.S.C. 300gg-4(a), and prohibits insurers from charging higher premiums to similarly-situated individuals and dependents within a group based on such factors, 42 U.S.C. 300gg-4(b). See ACA § 1201(3)(A), 124 Stat. 154 (adding "individual" market to pre-existing prohibition on charging such differential premiums based on health status-related factors in group market); ACA § 1201(3)(B), 124 Stat. 155 (transferring that provision to redesignated Public Health Service Act Section 2705, 42 U.S.C. 300gg-4(b)); ACA § 1201(4), 124 Stat. 156 (adding prohibition on eligibility rules to Section 2705, 42 U.S.C. 300gg-4(a)).

"[b]y significantly increasing health insurance coverage," the minimum coverage provision, "together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Ibid.* Congress therefore expressly found that the minimum coverage provision is "*essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* (emphasis added); see 42 U.S.C.A. 18091(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

The guaranteed-issue and community-rating provisions ensure that all individuals have access to health insurance priced according to community-wide rates, rather than individual risk factors. Congress understood that, in a market governed by those provisions but lacking a minimum coverage provision, healthy individuals have an incentive to stay out until their need for insurance arises while, at the same time, those with the most serious immediate health care needs have a strong incentive to obtain coverage. Premiums would therefore go up, further impeding entry into the market by those currently without acute medical needs, risking a "marketwide adverse-selection death spiral," Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, Health Affairs, July/Aug. 2004, at 167, 169, and restricting the availability of affordable health insurance—the opposite of what Congress intended. It is evident that Congress would not have intended the guaranteed-issue

and community-rating reforms to stand if the minimum coverage provision that it twice described as "essential" to their success, 42 U.S.C.A. 18091(a)(2)(I) and (J), were held unconstitutional.

2. Congress had firm empirical support for its conclusion that the minimum coverage provision is essential to make the guaranteed-issue and community-rating reforms effective.

a. As evidence before Congress demonstrated, a number of States had enacted guaranteed-issue and community-rating requirements without a minimum coverage provision. "The result in each State was a general destabilization of individual markets, increases in premiums, and declining enrollment." AHIP Amicus Br. 27; see State's Br. 8-9; Maryland Minimum Coverage Amicus Br. 22 (Maryland Amicus Br.); American Ass'n of People with Disabilities Minimum Coverage Amicus Br. 8-13. Based on this record, Congress understood that, "if you put those two mandates on the [insurance] industry," *i.e.*, guaranteed issue and community rating, "you must also mandate the individual to be insured or the market will blow up, as it has in New Jersey" and other States. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways & Means*, 111th Cong., 1st Sess. 9 (2009) (Professor Uwe E. Reinhardt, Princeton Univ.) (*House Hearing*); see Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 11 (Mar. 17, 2009) ("It is well known that community-rating and guaranteed issue coupled with voluntary insurance tends to lead to a death spiral of individual insurance.").

Indeed, the National Association of Insurance Commissioners expressly warned Congress that "[s]tate regulators [could] support" national guaranteed-issue reforms only "to the extent they [were] coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussions on Comprehensive Health Care Reform: Hearings Before the Senate Committee on Finance*, 111th Cong., 1st Sess. 504 (2009) (Sandy Praeger, Kansas Comm'r of Ins., on behalf of the National Ass'n of Ins. Comm'rs); see *id.* at 74 (Praeger) (reform must pair guaranteed issue and community rating with minimum coverage provision because "otherwise you will just wait until you are sick and then buy the coverage").

Illustrative examples from the States are discussed below:

Washington. "Washington actually experienced the 'death spiral' that can occur in the private insurance market when coverage for preexisting conditions is required without universal coverage." Governor of Wash. Minimum Coverage Amicus Br. 11. In 1993, that State prohibited insurers in the individual market from rejecting applicants based on health status. *Ibid.* Premiums rose, and "the major carriers in Washington stopped selling individual plans, leading to the virtual destruction of the individual insurance market." *Id.* at 11-12; see AHIP Amicus Br. 30 (premiums in individual market in Washington rose by as much as 78% in three years, and enrollment fell by 25%). In addition, Washington "became a magnet for patients from around the country who had serious and expensive medical conditions because they knew they could get immediate health insurance coverage." Doug Ericksen & Roger Stark, *What*

Washington, D.C. Could Learn from Washington State on Health Care Reform, Inside ALEC, July 2010, at 21. In 2000, after the only two remaining insurers in the individual market threatened to withdraw, Washington "was forced" to restructure the insurance reforms by once again allowing insurers to deny coverage based on health status. Governor of Wash. Minimum Coverage Amicus Br. 12.

Kentucky. After Kentucky adopted guaranteed-issue and modified community-rating reforms in 1994 without a minimum coverage provision, "40 insurers departed the Commonwealth, leaving only two remaining providers to serve the statewide market." Maryland Amicus Br. 22. In 1997, the state department of insurance called for legislative changes out of "[c]oncern over a possible impending death spiral" in the individual insurance market, and in 1998 the legislature repealed many of the reforms, including guaranteed issue and community rating. Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Pol. Pol'y & L. 133, 155, 158 (2000).

New Hampshire. In 1994, New Hampshire adopted guaranteed-issue and modified community-rating reforms without a minimum coverage provision. David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16 J. Ins. Reg. 399, 400-401 (1998). As a result, there was a "market-wide antiselection spiral," *id.* at 401; all but two insurers withdrew from the State; and premiums increased. AHIP Amicus Br. 29. The State repealed the guaranteed-issue requirement in 2001 and "allowed insurers once again to use medical underwriting for policies sold in the individual market." *Ibid.*

Maine. After Maine in 1993 enacted guaranteed-issue and modified community-rating rules without a minimum coverage provision, the market for individual coverage entered a "death spiral." Maine Bureau of Ins., *White Paper: Maine's Individual Health Insurance Market* 1, 4, 10 (Jan. 22, 2001). Premiums skyrocketed; participation in the individual market plummeted from 102,000 in 1994 to 54,000 in 2000; and most insurers withdrew from the State. *House Hearing* 117 (Phil Caper, M.D., and Joe Lendvai); AHIP Amicus Br. 27.[22]

Massachusetts. In 1996, Massachusetts adopted guaranteed-issue and modified community-rating reforms without a minimum coverage provision. See Blue Cross & Blue Shield of Mass. Minimum Coverage Amicus Br. 11-12. Just as in other States that followed that course, premiums increased and coverage decreased. See *id.* at 12 (enrollment in individual market fell from approximately 135,000 in 1996 to just over 55,000 in 2000). Rather than repealing the insurance reforms, however, Massachusetts in 2006 maintained them and added a minimum coverage provision in order to "prevent the problems of adverse selection, so-called free riders, and associated cost-shifting from defeating the goal of comprehensive health reform." *Id.* at 13. As a result, Massachusetts now has the lowest proportion of

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[22] Other States that in the 1990s enacted guaranteed-issue and community-rating reforms without a minimum coverage provision experienced similar destabilization. AHIP Amicus Br. 32-33 (discussing New Jersey, New York, and Vermont); Pet. App. 230a-231a (Marcus, J., dissenting); see also Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 91-92 (2000) ("There was a dramatic exodus of indemnity insurers from New York's individual market."); *House Hearing* 101-102 (Professor Uwe E. Reinhardt, Princeton Univ.) (New Jersey).

uninsured residents in the Nation. Jon Kingsdale, Executive Dir., Commonwealth Health Ins. Connector Auth., *Prepared Statement for Making Health Care Work for American Families: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 1 (Mar. 17, 2009); Mass. Minimum Coverage Amicus Br. 3, 9, 11. Congress specifically found that "despite the economic downturn, the number of workers offered employer-based coverage" in Massachusetts after it adopted its "similar" minimum coverage provision "has actually increased." 42 U.S.C.A. 18091(a)(2)(D).

3. The court of appeals cited a number of reasons for its conclusion that the minimum coverage provision is severable from the guaranteed-issue and community-rating provisions, but none of them has merit.

a. The court of appeals correctly observed that the Act "include[s] other provisions," separate from the minimum coverage provision, that serve the statute's overall goal of "reduc[ing] the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage." Pet. App. 181a. The court included on that list a number of provisions that are indeed severable for that very reason, including those instituting the health insurance exchanges, federal premium tax credits, federal cost-sharing reduction payments, and the employer responsibility provision. See *ibid.* The court never explained, however, why the existence of those provisions would have led Congress to adopt guaranteed-issue and community-rating reforms without a minimum coverage provision, in light of the well-documented problem of adverse selection in the individual market that would inevitably result from such a scheme.

b. The court of appeals, applying what the dissent below correctly characterized as a form of strict scrutiny review, see Pet. App. 218a, concluded that Congress's choices in structuring the minimum coverage provision "serve[d] to weaken [its] practical influence on the two insurance product reforms." *Id.* at 183a. The court was apparently of the view that, because of the minimum coverage provision's exceptions and enforcement features, it would not be especially effective in stemming adverse selection in a guaranteed-issue and community-rated insurance market, such that invalidating that provision would not make much difference in the success of those insurance reforms. See *id.* at 182a-183a. That analysis was misconceived. The question of severability is one of congressional intent, and Congress expressly found that the minimum coverage provision is "essential" to the guaranteed-issue reforms. 42 U.S.C.A. 18091(a)(2)(I). Whatever the court of appeals might have thought, Congress's judgment controls.

In any event, the court of appeals was wrong in its assessment of the minimum coverage provision's effectiveness. In CBO's expert judgment, by 2019, the Act will reduce the number of non-elderly individuals without insurance by approximately 33 million, resulting in 95% of Americans having coverage (up from 83% today). CBO has attributed about half of that projected decrease in the number of non-elderly uninsured—16 million people—to the direct and indirect effects of the minimum coverage provision. *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011); *CBO's June 2010 Analysis* 2; see States' Br. 46 (acknowledging that half the reduction in the number of uninsured under the Act re-

sults from minimum coverage provision); see also Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care* 7 (2012) (with minimum coverage provision, number of uninsured will fall by 24 million; without it, reduction would be eight to ten million).

The court of appeals also thought that enforcement of the minimum coverage provision would be "toothless." Pet. App. 183a. But the court disregarded that the IRS may employ, among other tools, offsets against federal tax refunds to collect minimum-coverage-provision penalties, a highly effective method of collection. See 26 U.S.C. 6402(a); Gov't Minimum Coverage Br. 54. In any event, it is once again *Congress's* judgment that controls. After balancing competing considerations, Congress concluded both that the guaranteed-issue and community-rating provisions that take effect in 2014 would be viable only with the minimum coverage provision, and that the applicable enforcement measures would be sufficient to give the necessary force to that provision.

The court of appeals' assessment of the effectiveness of the minimum coverage provision suffered from other basic errors. The court thought that the provision's effectiveness was limited by its exceptions, and posited that "illegal aliens *and other nonresidents*" are exempt from the provision. Pet. App. 127a, 183a (emphasis added). Yet that latter group (non-citizens legally in the country) is not exempt. See 26 U.S.C. 5000A(d)(3). The court of appeals also questioned whether the provision would actually expand coverage, on the view that "the cost-shifter uninsured who cannot pay the average $2,000 medical bill also cannot pay the average $4,500 premium." Pet. App. 128a. That assertion completely

ignored the provisions in the Act—discussed elsewhere in the majority's opinion—that furnish refundable tax credits to reduce premium costs for certain low- and moderate-income households. *Id.* at 36a-37a; see *id.* at 36a n.45 ("For a family of four with an income of $33,075 per year, * * * the federal tax credit would be $3,177 per year."); see also Economic Scholars Minimum Coverage Amicus Br. 25-29 (discussing multiple errors in an amicus brief relied upon by Eleventh Circuit in making its judgment about effectiveness of minimum coverage provision).

* * * * *

In sum, if the Court invalidates the minimum coverage provision and concludes that there are no impediments to its reaching the question of severability, it should invalidate only the guaranteed-issue and community-rating provisions that take effect in 2014 as non-severable. The statutory provisions to be invalidated in that event, in addition to 26 U.S.C. 5000A(a)-(d) and (g), are 42 U.S.C. 300gg(a)(1), 300gg-1, 300gg-3 (with respect to adults, see note 5, *supra*), and 300gg-4(a) and (b), as added, or redesignated and amended, by the Affordable Care Act.[23]

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[23] In the event the Court affirms the court of appeals' judgment on the constitutionality of the minimum coverage provision, 26 U.S.C. 5000A(a) and (b) would be invalidated. Subsections (c) (amount of penalty), (d) (individuals to whom penalty applies), and (g) (procedure for imposing penalty) would then have no application. Subsections (e) (exemptions) and (f) (various statutory definitions) would have no application to the minimum coverage provision itself, but those subsections also define terms used in other provisions of the Act that do not involve the minimum coverage provision. See, *e.g.*, 26 U.S.C. 6056(f)(1)(A) (definitional provision of employer reporting requirement cross-referencing definitional provision in 26 U.S.C. 5000A(e)(1)(B)(i)); 42 U.S.C.A. 18011(a)(4)(B)(ii) (requiring grandfathered group plans to

CONCLUSION

In the event the Court invalidates the minimum coverage provision, it should vacate the court of appeals' judgment addressing the severability of provisions of the Act that do not apply to petitioners or are subject to statutory bars to review. To the extent the Court reaches the issue of severability, it should reverse that portion of the judgment of the court of appeals finding the minimum coverage provision severable from the guaranteed-issue and community-rating provisions, but otherwise affirm the judgment of the court of appeals finding the minimum coverage provision severable from the remainder of the Act.

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extend dependent coverage until age 26 based in part on whether child has access to employer-sponsored plan of his own that meets the definitions in 26 U.S.C. 5000A(f)(2)). Therefore, Subsections (e) and (f) of Section 5000A should be severed if the Court were to declare the minimum coverage provision unconstitutional.

In the event the Court reaches the question of the severability of the guaranteed-issue and community-rating provisions, only those provisions identified above and previously, see notes 5 and 6, *supra*, would be invalidated (with the exception of Section 300gg-3 as applicable to individuals under 19, a requirement that is in effect now, see note 5, *supra*, and thus was plainly intended to be severable from the minimum coverage provision). By contrast, 42 U.S.C. 300gg(a)(2) (involving "rating areas") would be severable because that provision is cross-referenced in sections of the Act that do not involve the community-rating requirement. See, *e.g.*, 42 U.S.C.A. 18051(a)(2)(A)(i) (defining eligibility for participation in optional state health program for low-income individuals not eligible for Medicaid based in part on individual's premium cost "in the rating area in which the individual resides"). In addition, pre-Affordable Care Act statutes regulating the group market, see Gov't Minimum Coverage Br. 5, would obviously not be invalidated and would return in their pre-Act form. See *Frost* v. *Corporation Comm'n*, 278 U.S. 515, 526-527 (1921).

Respectfully submitted.

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APPENDIX

1. 26 U.S.C. 5000A (Supp. IV 2010) provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

(1) In general.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.—

(1) In general.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to

whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.—For purposes of paragraph (1)—

(A) In general.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a

month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.—For purposes of this section—

(A) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[**(D) Repealed.** Pub. L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) Applicable individual.—For purposes of this section—

(1) In general.—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions.—

(A) Religious conscience exemption.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry.—

(i) In general.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to

the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage.—

(A) In general.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual

purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

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[1] So in original. Probably should be followed by "the".

(3) Members of Indian tribes.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.—

(A) In general.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.—Any applicable individual who for any month is determined by the Secretary of Health

and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.—For purposes of this section—

(1) In general.—The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

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[2] So in original. The semicolon probably should be a comma.

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan.—Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.—Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.—Coverage under a grandfathered health plan.

(E) Other coverage.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

2. 42 U.S.C. 300gg (Supp. IV 2010) provides:

Fair health insurance premiums

(a)[1] Prohibiting discriminatory premium rates

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this subchapter.

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[1] So in original. No subsec. (b) has been enacted.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this subchapter. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18032(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-

insured group health plans offered in such market) in the State.

3. 42 U.S.C. 300gg-1 (Supp. IV 2010) provides:

Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e)[1], 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.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of Title 29).

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[1] So in original.

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor

relating to such individuals[2] employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health

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[2] So in original

plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

4. 42 U.S.C. 300gg-3 (Supp. IV 2010) provides:

Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such cov-

erage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1)[1] of this section in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f) of this section.

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a

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[1] See References in Text note below.

potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq. 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of Title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of Title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2) of this section) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before February 13, 2011—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3)[2] of this section, a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

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[2] See References in Text note below.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage of-

fered by an issuer in the individual or group group[3] market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual

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[3] So in original.

health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the cer-

tification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss

of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not other-

wise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or dem-

onstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], or child health assistance under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of Title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of Title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance[4] Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social

[4] So in original. Probably should be followed by the word "Program".

Security Act [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide

health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

5. 42 U.S.C. 300gg-4 (Supp. IV 2010) provides in pertinent part:

Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the follow-

ing health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health[1] insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage

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[1] So in original. Probably should be preceded by "a".

to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

* * * * *

6. 42 U.S.C.A. 18091 provides:

Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insur-

ance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the

number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 *et seq.*), the Public Health Service Act (42 U.S.C. 201 *et seq.*), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the

absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The 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.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.