Nos. 11-393 & 11-400

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, ET AL.

STATES 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 OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF REVERSAL AS TO THE SEVERABILITY ISSUE

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(*Counsel of Record*)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

Attorneys for Amicus Curiae

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

CASES

FEDERAL STATUTES

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF REVERSAL AS TO THE SEVERABILITY ISSUE

This brief is submitted on behalf of the Chamber of Commerce of the United States of America in support of reversal as to the severability issue.[1]

INTEREST OF *AMICUS CURIAE*

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation, representing the interests of 300,000 direct members and indirectly representing an underlying membership of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. More than 96 percent of the Chamber's members are small businesses with one hundred or fewer employees. The Chamber advocates on issues of vital concern to the nation's business community and has frequently participated as *amicus curiae* before this Court and other courts. The Chamber participated as *amicus curiae* in support of the Petitions for Certiorari in these cases, as well as in litigation concerning the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA" or "the

---

[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amicus*, its members, or its counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

Act"), in the Courts of Appeals for the Fourth, Eleventh, and District of Columbia Circuits.

Prompt resolution of the fate of the PPACA is of critical importance to Chamber members. Many of the Chamber's members provide health insurance to their employees. More generally, the PPACA imposes a myriad of costly obligations on the business community—as well as on states and consumers. Uncertainty over the future of the PPACA seriously undermines the ability of American businesses to plan for the future, and to make informed decisions concerning investment in growth and hiring. Accordingly, a swift resolution of the constitutionality of the individual mandate, and clarification as to which portions of the PPACA, if any, will survive if the individual mandate falls, are crucial to Chamber members.

INTRODUCTION AND SUMMARY OF ARGUMENT

The PPACA contains an extensive set of reforms primarily intended to make health insurance available to millions of uninsured Americans and to increase the scope of coverage for all Americans. The Act seeks to accomplish this goal in large part through regulation of the market for private health insurance.[2] Although the Act's health insurance reforms are vast in scope and complexity, *see* PPACA, Pub. L. No. 111-148, tit. I, they include several core, interrelated features. First, the Act includes comprehensive reforms of the health insurance industry,

[2] The Act also expands public insurance programs, most notably Medicaid and Medicare. *See* PPACA, Titles II & III.

regulating the way issuers fund and structure their policies, as well as the form and content of the policies issuers are required to provide. Most prominently, the Act's "guaranteed-issue" provisions require insurance providers to issue health insurance to all comers and prohibit exclusions for preexisting conditions, while the "community-rating" provision requires insurance providers to price premiums based on the health risks of the community, rather than the individual. But the Act also contains a plethora of additional industry regulations, including a prohibition on offering policies in the individual and small-employer markets with less than comprehensive coverage.

Second, the Act establishes health insurance Exchanges. The Exchanges are intended to provide centralized information to consumers concerning insurance prices and offerings, and to allow individuals who do not receive coverage through large employers to nevertheless enter a pool of similarly situated individuals, so as to lower the cost of insurance for all participants. The Act establishes federal subsidies, administered through the Exchanges, for whom Congress believed the comprehensive policies issuers will now be required to offer would be too expensive. *See* Appendix to the Petition for a Writ of Certiorari, *U.S. Dep't of Health & Human Servs. v. Florida*, No. 11-398, at 26a-38a ("U.S. Pet. App.").

These and other insurance reforms are highly interdependent and built upon one central provision: the requirement that individuals maintain minimum essential coverage. PPACA § 1501(a) (codified at 26 U.S.C. § 5000A(a)). This so-called "individual mandate" is indispensible to the operation of the health

insurance reforms in the Act. Congress understood that simply requiring issuers to provide coverage to all applicants at the same price and under the same terms without regard to their health status would be impractical unless healthy individuals were also required to purchase coverage. Standing alone, these new requirements would lead to less affordable health insurance because significant numbers of healthy individuals would wait to purchase health insurance until they absolutely needed it, forcing issuers to raise premiums for everyone else. Congress included the individual mandate in the PPACA to prevent such strategic consumer behavior, which is often referred to as "adverse selection."

By requiring essentially all individuals to maintain health coverage, Congress sought to prevent the adverse selection that would otherwise undermine the Act's new insurance requirements. Congress also adopted the individual mandate to mitigate the upward pressure on premiums created by other aspects of the law, like the requirement of comprehensive coverage in the individual and small-employer markets or limits the law imposes on enrollee cost-sharing. Through the individual mandate, the law was structured to allow guaranteed-issue, community rating, required minimum coverage levels, the Exchanges, federal subsidies, and other insurance reforms to function in the manner Congress intended. As Congress explained in the Act, the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(a)(2)(I).

The Chamber takes no position on the constitutionality of the individual mandate. If, however, the Court strikes the individual mandate as unconstitutional, determining promptly whether, and to what extent, the remainder of the PPACA will remain in force is of crucial importance to the business community and to the Nation as a whole. Given the scope and complexity of the PPACA, and given that its most far-reaching provisions are imminently scheduled for implementation, the Chamber submits that the most responsible course would be to hold the individual mandate non-severable from the remainder of the Act, in its entirety.

Certainly, the Eleventh Circuit's conclusion that the mandate could be severed from the remainder of the Act is untenable, and will wreak havoc on the health insurance market if left to stand. A proper application of this Court's severability jurisprudence requires a finding that, *at the very least*, the guaranteed-issue and community-rating provisions are non-severable from the individual mandate and must necessarily fall with it.

All of the parties agree that the Eleventh Circuit's severability analysis is fundamentally flawed. For instance, the United States has explained that the Eleventh Circuit's "conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect." Consolidated Brief for Respondents at 10, *Nat'l Fed'n of Indep. Bus. v. Sebelius* and *Florida v. Dep't of Health and Human Servs.* (Nos. 11-393 & 11-400) (U.S.). In the absence of the mandate, individuals will have no reason to purchase insurance until they become sick, which will drive up insurance

premiums for the remaining consumers. This increase in premiums would in turn cause more healthy individuals to stop purchasing (or refrain from obtaining) health insurance, causing premiums to rise still further. This "premium spiral" has been experienced in various states—such as New York, Kentucky, and Washington—where similar health insurance reforms were enacted without an accompanying individual mandate. The legislative record confirms that Congress understood this market dynamic and the destabilizing effect of guaranteed-issue and community-rating reforms in the absence of an individual mandate.

Contrary to the government's position, however, the health insurance reforms that depend upon the individual mandate extend far beyond the guaranteed-issue and community-rating provisions. The Act's health insurance requirements generally presuppose and depend upon a fully insured (or near-fully insured) populace—achieved through the individual mandate—and a guaranteed-issue regime premised on aggregate (as opposed to individual) pricing. Those fundamental concepts are the foundation for the Act's highly complex and interdependent set of insurance reforms.

For example, the Act requires that health insurers offer comprehensive coverage in the individual and small group markets, and limits the amount of deductibles, co-pays, and other cost-sharing that issuers may require of enrollees. These new requirements will have an obvious—and, according to the Congressional Budget Office, significant—upward impact on premiums. The Act's principal method of mitigating that upward pressure on premiums is

through the individual mandate, which requires healthy individuals who currently forego health insurance to purchase it or face a penalty, thus lowering issuers' aggregate risk. Without the individual mandate, then, the Act's other insurance reform provisions would lead to a much higher increase in premiums than Congress anticipated. Further, because the Act's premium subsidies are directly tied to premium levels, in a world without the individual mandate the subsidies would cost taxpayers much more than Congress ever anticipated. And if the subsidies do not work properly, then neither do the Exchanges. And so on. The individual mandate is the proverbial string that, once pulled, causes the remainder of the Act's insurance reforms to unravel.

Thus, contrary to the United States' position, none of the Act's major remaining reforms of the private insurance market will function in the manner Congress intended if the mandate and its closely associated guaranteed-issue and community-rating provisions are invalidated. If the mandate is held unconstitutional, far more than the guaranteed-issue and community-rating provisions must fall with it.

The difficulty presented by legislation as sweeping and complex as the PPACA is determining precisely which additional provisions must fall. As the examples above illustrate, the PPACA's interlocking insurance reforms critically depend on each other to operate properly. But the sheer scope and complexity of the law make it impractical—and, given the inherently legislative choices that would be required, inappropriate—for the Court to determine all of the provisions that must fall if the mandate is invalidated. In other words, while it is easy to demonstrate

that the guaranteed-issue and community-rating provisions are non-severable from the mandate, it will be more challenging for the Court to determine precisely how far beyond those provisions the chain of unintended effects extends.

Under different circumstances, the Court might consider a remand for further factfinding by the district court in order to determine with some level of precision whether every other provision of the PPACA would operate as Congress intended in the absence of the mandate. Indeed, the Chamber suggested remand in its brief to the Eleventh Circuit below. But given the expected timing of this Court's decision, and the considerable time it would take for the lower courts to work through the complexities of the analysis that would be required, remand is no longer a viable option. The business community needs certainty regarding the fate of the many costly requirements in the PPACA before businesses can make rational decisions concerning investment in growth and in jobs. A remand for further factfinding, and the ensuing appellate process, would surely run up against—if not past—the Act's 2014 implementation date, which would only prolong the uncertainty, and serve as a further impediment to economic growth.

Given the timetable established by Congress for the implementation of this sprawling legislation, the only appropriate course is to hold the entire Act non-severable from the mandate. This outcome would both avoid the significant market disruptions that would result from invalidating the mandate but leaving the remainder (or parts) of the statute in place, and would give American businesses and con-

sumers much needed clarity on what the law will be going forward. This approach also best respects a proper conception of the separation of powers. Within the bounds of the Constitution, Congress is the institution best suited to craft national policies on the regulation of health insurance markets. With all respect, the Judicial Branch lacks the institutional expertise and capacity to properly analyze the market consequences of excising the core element of a highly complex project to reshape nearly 20% of the national economy. If Congress has surpassed constitutional bounds by enacting the PPACA, then only Congress can decide how to recalibrate its effort to formulate the Nation's healthcare policy without jeopardizing the very market for health insurance that the Act seeks to expand.

ARGUMENT

I. THE PPACA INSTITUTES A MASSIVE AND HIGHLY COMPLEX REORGANIZATION OF THE MARKET FOR PRIVATE HEALTH INSURANCE

The PPACA is one of the most significant and complicated congressional enactments in decades. It "comprehensively reform[s] and regulate[s] more than one-sixth of the national economy," "via several hundred statutory provisions and thousands of regulations that put myriad obligations and responsibilities on individuals, employers, and the states." U.S. Pet. App. 391a. Indeed, "the Act's nine Titles contain hundreds of new laws about hundreds of different areas of health insurance and health care." U.S. Pet. App. 21a.

Nevertheless, the heart of the Act's "comprehensive and complex regulatory scheme," U.S. Pet. App. 22a, is indisputably the reform of the private market for health insurance. *E.g.*, U.S. Pet. App. 356a-358a. Indeed, the Act states that it seeks to achieve "near-universal coverage by building upon and strengthening the private employer-based health insurance system." 42 U.S.C. § 18091(a)(2)(D). The Act's health insurance reforms, principally found in Title I, fall into several discrete, though interrelated, categories, as explained below.

A. Health Insurance Industry Reforms

In an attempt to "reduce the number of the uninsured, the Act heavily regulates private insurers and reforms their health insurance products." U.S. Pet. App. 26a.

1. *Guaranteed-Issue and Community Rating*

Some of the most prominent health insurance industry reforms involve a shift away from traditional medical underwriting—by which issuers evaluate risk, and decide whether and on what terms to indemnify against medical costs, on an individual basis—to a system where issuers *must* offer policies to all comers, and *must* price those policies on the basis of community (rather than individual) risk.

In particular, the PPACA's guaranteed-issue provisions require issuers to accept every applicant for health insurance coverage, and bar issuers from denying coverage based on preexisting conditions or medical history. *See, e.g.*, 42 U.S.C. §§ 300gg-1(a), 300gg-4(a). The PPACA's community-rating provision prescribes that issuers may not charge higher

premiums based on preexisting conditions and certain other factors, and also states that (except for age, geography, and tobacco use) premiums must be based on the actuarial risk of a community "rating area," rather than the individual. *See* 42 U.S.C. § 300gg(a)(1). Therefore, those provisions limit the traditional underwriting factors issuers may consider in pricing and offering coverage.

2. *Other Health Insurance Industry Reforms*

The PPACA also includes a vast array of other reforms that go to the core of how the health insurance industry structures and operates its business. There is no need here for an exhaustive list, but several examples help illustrate the thrust of the reforms: Insurers that offer coverage to individuals and small groups are required to provide a so-called "essential health benefits package," 42 U.S.C. § 300gg-6(a), a "comprehensive coverage" package (U.S. Pet. App. 29a) the contents of which are prescribed by statute and regulation, 42 U.S.C. § 18022. These policies must have guaranteed renewability, *id.* § 300gg-2, and can be rescinded only under very limited circumstances, *id.* § 300gg-12. The Act places limits on cost-sharing by enrollees (such as deductibles and copays) for many health plans, *id.* §§ 300gg-6(b), 18022(a), (c), and precludes health plans from having lifetime or annual limits on essential health benefits, *id.* § 300gg-11(a). Issuers must also maintain certain specified ratios of revenue dollars spent on medical care versus administrative and other overhead expenses. *Id.* § 300gg-18 (medical loss ratio).

B. Exchanges and Federal Subsidies

By January 1, 2014, each state must establish health-insurance Exchanges, "which are insurance marketplaces where individuals, families, and small employers can shop for the Act's new insurance products." U.S. Pet. App. 32a (citing 42 U.S.C. § 18031(b)). The Exchanges are meant to create "new marketplaces through which individuals, families, and small employers … can competitively purchase the new insurance products" that insurers must offer. U.S. Pet. App. 15a. With limited exceptions, the plans sold in the Exchanges must cover the "essential health benefits package." 42 U.S.C. § 18021(a)(1)(B).

The PPACA further establishes significant subsidies (in the form of tax credits) designed to aid certain individuals to purchase insurance through the Exchanges. In particular, the Act establishes a subsidy for those individuals with household incomes between 1 and 4 times the federal poverty limit who purchase health insurance through an Exchange. 26 U.S.C. § 36B. The amount of the subsidy is determined by the premium amount within the enrollee's rating area, for a specified variant of the "essential health benefits package." *Id.* § 36B(b).

C. Individual Mandate

The individual mandate is a "central pillar" of the PPACA.[3] The mandate requires that all individu-

---

[3] Jonathan Gruber, *Health Care Reform Without the Individual Mandate*, Center for American Progress (Feb. 9, 2011), http://www.americanprogress.org/issues/2011/02/gruber_mandate.html.

als—with certain limited exceptions, most notably for individuals who cannot afford coverage, 26 U.S.C. § 5000A(e)—obtain and maintain "minimum essential coverage," either on the individual market or through the individual's employer. *Id.* § 5000A.[4]

Congress intended for the mandate to further three separate but related objectives. First, and most generally, the mandate is one of Act's main tools to achieve near-universal coverage. The mandate, "together with the other provisions of th[e] 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." 42 U.S.C. § 18091(a)(2)(C). The mandate will help "achieve[] near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide." *Id.* § 18091(a)(2)(D).

Second, the mandate is intended to help lower premiums—and to counteract premium increases caused by other requirements in the Act—by increasing the pool of insureds, particularly healthy individuals. *See id.* § 18091(a)(2)(F). The mandate helps restrain premium increases in large part because it "essentially requires low-risk individuals to cross-subsidize high-risk individuals." Amy B. Monahan,

---

[4] The Act also requires larger employers to provide their employees the option to purchase comprehensive health insurance, or else to pay a penalty. 26 U.S.C. § 4980H. The penalty is assessed if at least one of the employer's employees participates in an Exchange and is eligible for a tax credit or subsidy under the Act. *Id.* § 4980H(a).

On Subsidies and Mandates: A Regulatory Critique of ACA, 36 J. Corp. L. 781, 787 (2011).

Third, and maybe most important, the mandate serves to remove the incentives for adverse selection that are created by other provisions of the Act, most notably the guaranteed-issue and community-rating requirements. With guaranteed-issue and community rating, but no coverage mandate, "many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the [mandate], 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." 42 U.S.C. § 18091(a)(2)(I).

Thus, in the Act, Congress stated clearly that the individual mandate "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.* Indeed, as demonstrated more fully below, the individual mandate is the glue that holds the remainder of the PPACA's insurance reforms together. Without the mandate, the reforms of the health insurance market in Title I, which are the heart of the entire Act, cannot operate in the manner Congress intended. For the reasons explained below, if the mandate is held unconstitutional, then the PPACA should be invalidated in its entirety.

II. THE INDIVIDUAL MANDATE IS NON-SEVERABLE FROM THE REMAINDER OF THE PPACA

This Court has explained that when a particular statutory provision is stricken on the ground that it exceeds Congress's constitutional powers, and Congress has not declared its intentions in a severability clause, the remaining provisions must also fall if "it is evident that the Legislature would not have enacted those provisions ... independently of that which is [invalid]." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quotation omitted; omission and alteration in original). In other words, the question is whether Congress would have enacted the remaining provisions in the absence of the invalid one. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) ("[T]he unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted."). That overarching question turns on an assessment of whether the remaining provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the invalidated provision. *Id.* (emphasis in original).

In the ordinary case where, as here, Congress has not provided direction in a severability clause, there is a presumption in favor of severability. This presumption rests on the logic that leaving as much of a statute in place as possible will be most faithful to congressional intent and separation-of-powers principles. But the PPACA is no ordinary statute. Excising the individual mandate from the remainder of the Act would undermine the intended operation of the health insurance reforms in Title I of the Act.

Indeed, the sheer complexity and interlocking nature of the reforms Congress adopted make it virtually impossible to trace all of the market-dislocating impacts of excising the mandate. Any mistake in drawing these lines could lead to significant distortions of a market that represents almost one-fifth of the U.S. economy. Because such a perilous effort is far outside the judicial ken, separation-of-powers principles counsel in favor of returning these difficult judgments to Congress. In sum, if the mandate is excised from the Act, then the remainder of the Act also must fall.

A. The United States Concedes That The PPACA's Guaranteed-Issue And Community-Rating Provisions Are Non-Severable From The Individual Mandate

A proper application of the severability principles described above demonstrates that the court of appeals erred in holding the individual mandate severable from the PPACA's guaranteed-issue and community-rating provisions.

1. The PPACA's guaranteed-issue provisions require that insurance providers issue health insurance to all comers, and that they do not reject any applicants based on preexisting conditions. The community-rating provision requires that insurers issuing policies to individuals and employees of small employers assess risk for purposes of premium calculation based on the aggregate risk of large, predetermined "rating areas," rather than on the basis of the applicant's risk profile. *See supra* Part I.A.1.

Those provisions would not remotely "function in a *manner* consistent with the intent of Congress"

without the individual mandate. *Alaska Airlines*, 480 U.S. at 685. Without the individual mandate, the guaranteed-issue and community-rating provisions would produce rampant adverse selection, because a significant percentage of currently healthy individuals would defer purchasing health insurance until they became ill, leading to a sharp increase in premiums for consumers choosing to maintain health coverage voluntarily. It is thus no surprise that the United States has conceded, as it must, that the PPACA's guaranteed-issue and community-rating provisions cannot survive without the individual mandate. *See, e.g.*, Consolidated Brief for Respondents at 10 ("[T]he [Eleventh Circuit's] conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect.").

Congress fully recognized the interrelationship between those reforms and the mandate in the express terms of the Act:

> [I]f there were no [coverage] 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.

42 U.S.C. § 18091(a)(2)(I). As the United States has starkly explained, "'[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance.'" Consolidated Brief for Respondents at 32 (quoting Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 111th Cong. 11 (Mar. 17, 2009)[5]). In light of Congress's own statement of its intent, the guaranteed-issue and community-rating provisions are plainly non-severable from the individual mandate.[6]

---

[5] *Available at* http://democrats.energycommerce.house.gov/Press_111/20090317/testimony_reinhardt.pdf.

[6] Experts in the health care field share the view that the individual mandate is essential to the intended operation of the PPACA's guaranteed-issue and community-rating provisions. *See, e.g.*, Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the PPACA*, 364 New Eng. J. Med. 16e (Mar. 10, 2011) ("Although they are politically popular, these community-rating and guaranteed-issue provisions can reduce the stability of private health insurance markets.... The primary purpose of the individual mandate is to mitigate this adverse selection...."); Anthony T. Lasso, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market*, National Institute for Health Care Management Foundation, at 2 (Jan. 2011), *available at* http://nihcm.org/pdf/EV-LoSassoFINAL.pdf (stressing the "distortions that can result from community rating and guaranteed issue regulations in the non-group market when there are no

Congress's concern about an implosion of health insurance markets is further reinforced by the actual experience of various states that have implemented comparable community-rating and guaranteed-issue provisions without an individual mandate. Seven states have enacted guaranteed-issue laws without an accompanying mandate. Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (1994) (repealed 1998); Me. Rev. Stat. tit. 24-A, § 2736-C(3); N.H. Rev. Stat. § 420-G:6; N.J. Stat. § 17B:27A-22; N.Y. Ins. L. §§ 3231, 3232; Vt. Stat. Ann. tit. 8, § 4080B(d)(1); Wash. Code § 48.43.012(1). Studies in those states reveal precisely the type of adverse selection that Congress sought to avoid in the PPACA. *See* Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol., Pol'y & L. 71, 97 (2000) ("Following reform, the overall percentage of the population with insurance has worsened…."); Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 Suffolk U. L. Rev. 1271, 1291 (1993) (New York's community-rating requirement "has led to an increase in rates for young, healthy insureds" and "many of them have dropped their health insurance coverage"). Indeed, the Kentucky Legislature repealed its market reforms because they destabilized the health insurance market. *Cf.*

---

provisions in place to keep people enrolled in coverage"); Jonathan Gruber, *Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer With Higher Premiums*, Center for American Progress, at 1 (Apr. 8, 2010), *available at* http://www.americanprogress.org/issues/2010/04/pdf/individual_mandate.pdf ("Without the individual mandate, the entire structure of reform would fail.").

Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol., Pol'y & L. 133, 151 (2000) ("The Kentucky reform experience has become notorious for the mass exit of insurers from its market.").

There is no basis in logic or experience to doubt Congress's express understanding that the individual mandate is "essential" to the proper functioning of a health insurance market that includes the PPACA's guaranteed-issue and community-rating provisions. 42 U.S.C. § 18091(a)(2)(I). The individual mandate and those reforms are tightly interwoven and must therefore stand or fall together. *Cf. Carter v. Carter Coal Co.*, 298 U.S. 238, 315-16 (1936) ("These two sets of requirements are not like a collection of bricks, some of which may be taken away without disturbing the others, but rather are like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole.").

2. The Eleventh Circuit's holding to the contrary seriously misunderstands the PPACA, and this Court's severability jurisprudence. The Eleventh Circuit held the individual mandate severable from the guaranteed-issue and community-rating provisions because the mandate that Congress enacted would, in the court's view, not be sufficiently effective in achieving its goal of combating adverse selection, and Congress thus would have enacted the guaranteed-issue and community-rating provisions without it. U.S. Pet. App. 179a-186a.

The Eleventh Circuit's analysis of the effectiveness of the mandate is contradicted by the expert analysis cited above, the repeated experience of states who saw premiums rise drastically without an individual mandate, and the position of the United States. But even assuming the court's estimation of the mandate's effectiveness were correct, the court's severability analysis is nevertheless flawed because it asks the wrong question. This Court's severability jurisprudence does not call on courts to engage in the quintessentially legislative function of deciding how effective a particular congressional enactment will be in achieving its stated goal. Rather, the ultimate question, as explained, is whether the guaranteed-issue and community-rating provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the individual mandate. *Alaska Airlines*, 480 U.S. at 685.

Here, Congress itself provided the answer to that question. Again, Congress explained that the mandate is "essential" to the guaranteed-issue and community-rating reforms. 42 U.S.C. § 18091(a)(2)(I). What is more, Congress explained why: "if there were no [mandate], many individuals would wait to purchase health insurance until they needed care," thus leading to a rise in premiums. *Id.* The Eleventh Circuit's own judgment to the contrary cannot trump Congress's express finding.

Further, Congress was fully aware of the failed attempts by various states to enact a guaranteed-issue and community-rated insurance regime without an individual mandate, and had testimony prominently before it that guaranteed-issue and community rating in the absence of a mandate will lead to

adverse selection and sharply increased premiums. *See supra* at 18-20. Indeed, if Congress could have enacted guaranteed-issue and community-rating reforms that would function as intended without the highly controversial individual mandate, it surely would have done so.

In sum, Congress enacted the individual mandate because it believed that it was "essential" to counteracting the adverse selection costs of the guaranteed-issue and community-rating reforms. Whether those reforms could, in some sense, operate independently of the mandate—as the Eleventh Circuit believes they could—there is no plausible argument that they would "function in a *manner* consistent with the intent of Congress" in the absence of the individual mandate. *Alaska Airlines*, 480 U.S. at 685.

Accordingly, as the United States concedes, the PPACA's guaranteed-issue and community-rating provisions are non-severable from the individual mandate. As demonstrated below, however, the mandate is "essential" to much more of the Act than the guaranteed-issue and community-rating reforms.

B. All Of The Health Insurance Reforms In Title I Of The Act Depend, Either Directly Or Indirectly, On The Individual Mandate

Although the United States has agreed that the guaranteed-issue and community-rating provisions of the Act cannot stand without the individual mandate, it has (at least thus far) argued that the remainder of the PPACA can remain intact, as enacted. That position is wholly untenable. The Act's central innovation—a massive reordering of the

market for private health insurance—is anchored on the existence of the near-fully insured market that would be created by the mandate, and on its associated guaranteed-issue and community-rating requirements. Absent those key interdependent provisions, none of the PPACA's other reforms of the private insurance market will operate as Congress intended.

1. *Insurance industry reforms beyond guaranteed-issue and community rating*

The individual mandate and its associated guaranteed-issue and community-rating provisions are tied directly to the PPACA's industry reform provisions generally, and to particular provisions more specifically.

(a) Health insurance industry reforms generally

As explained above, the PPACA imposes a vast array of new requirements on how private issuers are to operate, and the structure of the plans they must offer. *See supra* Part I.A. Those insurance market reforms are built upon the foundation of the individual mandate. For example, with very few exceptions, insurers will be required to offer in the individual and small-employer markets only policies that include a comprehensive benefits package—the so-called "essential health benefits package." 42 U.S.C. §§ 300gg-6(a), 18022. The Act also (among many other things) requires guaranteed renewability, imposes sharp restrictions on the circumstances under which policies can be rescinded, imposes limits on cost-sharing by enrollees, precludes lifetime or annual limits on "essential health benefits," and re-

quires issuers to maintain high ratios of dollars spent on medical care as compared to administrative costs. *See supra* Part I.A.2.

These provisions, among other things, will force an increase in the actuarial value of every plan, and will (without countervailing requirements) lead inexorably to sharp increases in premiums. Indeed, the Congressional Budget Office found that—independent of the guaranteed-issue and community-rating provisions—the expansion of benefits, reduction in cost-sharing, and other industry reforms would alone lead to premium increases in the individual and small-employer markets of *27 to 30 percent*.[7]

The individual mandate is the principal tool (along with the Exchanges and subsidies) that Congress chose to mitigate the dramatic increase in premiums that will result from the required expansion of benefits and decrease in cost-sharing by enrollees. The mandate "essentially requires low-risk individuals to cross-subsidize high-risk individuals," Monahan, *supra*, at 787, thus putting downward pressure on premiums. *See also* 42 U.S.C.

---

[7] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009) ("CBO, *Premiums*"), available at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf. This increase in premiums assumes the existence of the individual mandate, but the 27-30% figure does not include the mandate's mitigating effect on premiums, which are calculated separately. Thus, the 27-30% figure does *not* include any premium increases that would result from adverse selection prompted by guaranteed-issue and community-rating requirements in the absence of a mandate.

§ 18091(a)(2)(F) ("By significantly reducing the number of the uninsured, the [mandate], together with the other provisions of this Act, will lower health insurance premiums."); CBO, *Premiums*, at 6. Thus, without the individual mandate's mitigating effects on premiums, the health insurance regulations in the Act would not operate even remotely in the manner Congress intended.[8]

Moreover, beyond the general, sharp increase in premiums that would result from affirming the Eleventh Circuit's severability analysis, the mandate and/or the guaranteed-issue and community-rating provisions are specifically tied to several of the insurance market reforms, as shown directly below.

(b) The risk-adjustment provision

The PPACA's risk-adjustment provision, 42 U.S.C. § 18063, would not function as Congress intended without the individual mandate and its associated guaranteed-issue and community-rating provisions. Under a community-rating system, health plans generally obtain the same premium per subscriber, regardless of a subscriber's health status, gender, or other demographic factors. Issuers with healthier subscribers may receive a windfall because they earn an identical premium (per subscriber) to plans that must pay more in claims. *See* Robert Kuttner, *The Risk-Adjustment Debate*, 339 New Eng. J. Med. 1952, 1952 (Dec. 24, 1998) ("If plans receive the same unadjusted premium for each subscriber,

[8] The subsidies provided in the Act would also be much more expensive than Congress expected, since they are directly tied to premiums. *See infra* at 32-33.

then the plan with healthier members reaps an unearned windfall."). This type of regulatory system often creates incentives for so-called "cream skimming," i.e., efforts to attract healthier subscribers and discourage riskier individuals, instead of rewarding the provision of quality service. *Id.*

The PPACA's risk-adjustment provision counteracts those incentives by reallocating premiums in a manner proportional to the actuarial risk of each health insurer's subscribers. Under the risk-adjustment provision, states must levy a charge on insurers whose level of actuarial risk falls below the statewide average. 42 U.S.C. § 18063. States then transfer those funds to issuers carrying an actuarial risk exceeding the statewide average. By aligning premium revenues with actuarial risk, the risk-adjustment mechanism diminishes the incentive to target healthier populations. *See* General Accounting Office, *Health Care Reform: Considerations for Risk Adjustment under Community Rating*, GAO/HEHS 94-173, at 1 (Sept. 22, 1994), *available at* http://archive.gao.gov/t2pbat2/152795.pdf (risk adjustment is meant to "reduce the undesirable effects of community rating on insurers' incentives").

If the individual mandate and the associated community-rating reforms were invalidated, the risk-adjustment provision would not function as Congress intended. Without community rating, health insurers would apply traditional underwriting principles, varying premium rates based on health risk and other relevant factors. In such market conditions, an issuer's premiums should already reflect the actuarial risk of its subscribers. Thus, imposing a risk-adjustment mechanism in a market

which permits traditional medical underwriting would perversely transfer premium dollars from issuers who accurately assessed the actuarial risk of their subscribers to other issuers who misjudged their risk pools. In fact, it would create a disincentive for issuers to make appropriate investments in underwriting capacity, and instead choose to rely on the risk-adjustment mechanism to recoup any losses they may have sustained. That, in turn, would create gross inefficiencies unintended by Congress and it would be contrary to one of the central aims of the PPACA: promoting affordable health care.

(c) The bar on annual limits for benefits

The PPACA severely restricts, and upon the effective date of the mandate prohibits, issuers from imposing annual limits on the benefits paid to subscribers. 42 U.S.C. § 300gg-11. These restrictions currently dictate that annual limits may not be less than $750,000 per person. Interim Final Rule, 75 Fed. Reg. 37,188, 37,191 (June 28, 2010). That floor increases to $1.25 million per person in September, 2011, to $2 million per person in September, 2012, and plans with annual limits will be phased out entirely by 2014, when the individual mandate becomes effective. *Id.*[9] This new provision will eliminate plans with low annual limits, including so called "mini-med" or "limited benefit" plans, often

[9] Section 300gg-11 imposes similar restrictions on lifetime limits on the benefits to be paid to subscribers, which are tied to the individual mandate for the same reasons as the annual limits.

the most affordable plans for individuals with limited income.[10]

This prohibition against annual limits only functions as intended when considered alongside the individual mandate and guaranteed-issue reforms. As previously noted, a primary purpose of the individual mandate is to avoid the potential spiral of continually deteriorating risk pools and escalating premiums. Congress understood that the mandate was critical to minimizing "adverse selection and broaden[ing] the health insurance risk pool to include healthy individuals … [in order to] lower health insurance premiums." 42 U.S.C. § 18091(a)(2)(I). But if the bar on annual limits were enforced in the absence of the individual mandate and guaranteed-issue reforms, it would eliminate one of the most affordable health insurance options for lower income individuals and thereby expand the pool of uninsured individuals contrary to Congress's intent.

While the implementation of the PPACA's restrictions on low annual limits has already commenced, the Secretary of HHS has liberally granted waivers to enable low-cost plans to continue operating until the mandate and guaranteed-issue provisions become effective in 2014. *See Health Care Issues Involving the Center for Consumer Information and Insurance Oversight: Hearing of the Oversight & Investigations Subcomm. of the H. Energy & Commerce Comm.* 111th Cong. (Feb. 16, 2011) (statement of Steven Larsen, Director, Ctr. for Consumer Info.

---

[10] *See, e.g.*, David R. Henderson, *Mini-Med Plans*, Nat'l Ctr. for Policy Analysis, (Oct. 21, 2010), *available at*, http://www.ncpa.org/pdfs/ba727.pdf.

& Ins. Oversight, Ctrs. for Medicare & Medicaid Servs.) ("[I]n establishing the waiver process … we did want to make sure that people who have that coverage … can continue that coverage"). As of June 2011, the Secretary has granted nearly 1500 waivers to plans with annual limits below the current $750,000 threshold, exempting them from the Act's annual limit requirements.[11] The Secretary's granting of waivers to these plans demonstrates that the regulation of annual limits cannot function as intended without the individual mandate and guaranteed-issue reforms.

(d) Medical loss ratio regulation

The PPACA's Medical Loss Ratio ("MLR") requirement, 42 U.S.C. § 300gg-18, is another example of a provision that is inextricably linked to the individual mandate. "Medical Loss Ratio" refers to the percentage of each premium dollar expended by an issuer on the provision of health care to its subscribers and certain quality improvement measures, as opposed to other expenses such as administrative costs, salaries, advertising, and profits. The PPACA establishes a minimum MLR of 80 percent for individual and small group coverage, and 85 percent for large group coverage. *Id.* § 300gg-18.

Congress predicated the MLR provision on the reduction in medical underwriting and other administrative costs that would accompany the individual mandate and guaranteed-issue reforms. *Id.*

---

[11] *See* Marli D. Riggs, *More PPACA Waivers Granted; Tally Increases to 1,471*, Employment Benefit Adviser (July 19, 2011), *available at* http://eba.benefitnews.com/news/health-care-obama-waivers-ppaca-hhs-2715651-1.html.

§ 18091(a)(2)(J) ("By significantly increasing health insurance coverage and the size of purchasing pools … [PPACA] will significantly reduce administrative costs and lower health insurance premiums."). Conversely, absent the mandate's expanded risk pool and its associated community-rating provisions (provisions which have the effect of reducing underwriting costs), administrative costs will necessarily be higher. *See id.* (pre-PPACA, "[a]dministrative costs for private health insurance … are 26 to 30 percent of premiums in the current individual and small group markets," an amount greater than the administrative costs contemplated under applicable MLR caps). The MLR provision effectively assumes the existence of a market without medical underwriting.[12]

It is therefore no surprise that seventeen states have requested exemptions from the individual-market MLR requirements in the PPACA until the individual mandate takes effect.[13] And the Secretary has thus far granted such an exemption, in whole or in part, to Georgia, Iowa, Kentucky, Maine, New Hampshire, and Nevada, while five states' ap-

---

[12] To be sure, the Exchanges are likewise intended to lower administrative costs. As explained below, however, the Exchanges will not operate properly if the mandate and its associated guaranteed-issue and community-rating provisions are invalidated as all the parties urge. *See infra* at 31-33.

[13] *See* Dep't of Health and Human Servs., *Medical Loss Ratio*, *available at* http://cciio.cms.gov/programs/marketreforms/mlr/index.html ("HHS, MLR Website").

plications remain pending.[14] For instance, the Secretary granted Maine an exemption from the Act's MLR requirements, adjusting Maine's individual health insurance market MLR rate to sixty-five percent through 2013. Letter from Steven B. Larsen to Mila Kofman, Me. Superintendent of Ins. (Mar. 8, 2011).[15] The ruling that granted Maine's waiver request explicitly noted that "there is a reasonable likelihood" that issuers "would exit the Maine individual market in the absence of an adjustment to the 80 percent MLR standard." *Id.* at 16. These waivers, along with those that are sure to be granted in the near future, are compelling evidence that the long-term operation of the Act's MLR provision is predicated on the individual mandate and community-rating provisions, and cannot function as intended without those provisions.

These examples are illustrative, not exhaustive. They serve to demonstrate only that the individual mandate is indispensable to a vast array of the Act's insurance market reforms, not just the guaranteed-issue and community-rating reforms.

2. *Exchanges and subsidies*

The mandate's reach goes far beyond the PPACA's insurance industry reforms. Invalidation of the individual mandate and/or its associated

---

[14] *See* HHS, MLR Website. The Secretary denied the applications of Delaware, Indiana, Florida, Louisiana, Michigan, and North Dakota. *Id.*

[15] *Available at* http://cciio.cms.gov/programs/marketreforms/mlr/states/maine/maine_decision_letter_3_8_11.pdf.

guaranteed-issue and community-rating provisions would also undermine the intended operation of the other major aspect of private insurance reform: the Act's Exchanges, and the federal subsidies available to certain individuals who obtain coverage in the Exchanges.

(a) Exchanges

The Exchanges would not function as Congress intended without community rating. The Exchanges are meant to allow consumers to "compare prices and buy coverage from one of the Exchange's issuers" at reduced cost. U.S. Pet. App. 32a-33a. But with traditional medical underwriting, where each policy's level of benefits and premiums is based on individual risk, the Exchanges would not decrease administrative costs to the extent Congress envisioned. Indeed, PPACA's Exchange provisions expressly assume a community-rating regime: each Exchange must be "at least as large as a rating area" used to calculate community-rated premiums. 42 U.S.C. § 18031(f)(2).

(b) Subsidies

Further, excising the individual mandate and/or its associated guaranteed-issue and community-rating provisions will undermine the Exchanges by interfering with the operation of one of the Exchanges' central foundations: federal subsidies to help individuals purchase insurance through the Exchanges. The subsidies cannot operate as intended without the individual mandate and its associated provisions for several reasons.

Most obviously, the tax-credit subsidies are directly tied to a community-rating regime, and to the "essential health benefits" requirement. The subsidy due to any individual is calculated based on the premiums charged for the "second lowest cost silver plan"—i.e., a plan that offers "essential health benefits," 42 U.S.C. § 18022(d)—within the individual's "rating area." 26 U.S.C. § 36B(b). The statutory provision establishing the subsidies is thus literally senseless without community rating or the "essential health benefits" requirement.

The subsidies could technically be administered without the mandate, of course, if the community-rating provision and the "essential health benefits" requirement were preserved. But all parties agree that community rating cannot survive without the mandate, and as explained above, retaining either community rating, or the "essential health benefits" requirement, or both, without the countervailing effect of a mandate would put sharp upward pressure on premiums in a manner contrary to congressional intent. And because the size of the subsidies is tied to premiums within a rating area, a sharp rise in those premiums would entail a sharp rise in subsidies. Further, an increase in premiums will inevitably lead even more people into the Exchanges, and in particular will lead more people to seek subsidies. Thus, the cost of those subsidies to taxpayers would be far higher than Congress ever intended, and the subsidies would thus not "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted).

C. If The Mandate Is Held Unconstitutional, The Appropriate Remedy, Consistent With The Separation Of Powers, Is To Invalidate The PPACA In Its Entirety

As the above discussion demonstrates, invalidation of the individual mandate will cause many of the Act's insurance reforms—beyond guaranteed-issue and community rating—to function in a manner different than Congress intended. While space constraints make it impossible for the Chamber to detail the full extent to which striking only the mandate will destabilize the health insurance markets regulated by the Act, the examples discussed above illustrate the interdependent nature of the PPACA's many complex provisions. The Chamber submits that pulling this one thread—the individual mandate—must unravel many other provisions of the Act.

The question, then, is the proper approach to determine which portions of the PPACA, beyond those described above, must be invalidated if the individual mandate is held unconstitutional. One possible approach would be to hold each of the provisions discussed in the preceding section non-severable, and to remand the remaining portions of the Act for a detailed factual determination about the precise effect of the stricken provisions on each of the PPACA's remaining provisions.

But that approach is no longer practical, for several reasons. First, Congress has directed that most provisions of the Act take effect less than two years from the filing of this brief. This Court's decision concerning the constitutionality of the mandate will

not likely be issued until late June 2012. And if there were a remand, the severability question would not be decided at the district court level for many more months, with final resolution (including exhaustion of appeals) likely occurring years from now. In the meantime, as the Chamber explained in its certiorari-stage amicus brief (at 7-10), the uncertainty over which provisions of the PPACA will remain continues to act as an enormous drag on American businesses and the economy. Swift resolution of the severability question is critically important, and this Court should therefore provide a definitive answer now, without the necessity for remand.

Second, while the severability analysis as to some provisions—like guaranteed-issue and community rating—is easy, determining how the loss of the mandate would affect hundreds of other provisions of the PPACA is an unprecedented task ill-suited to the judiciary, given the Act's complexity and interlocking nature, and given the large portion of the economy it seeks to regulate. Attempting to decipher how the market for health insurance will respond when one "essential" thread is pulled, in a statute this complicated and this vast, is a task that Congress is institutionally much better situated to undertake. As shown above, and contrary to the government's past positions, the functional importance of the mandate extends far beyond the guaranteed-issue and community-rating provisions, but the complex and interrelated nature of the PPACA's many provisions makes the task of determining which provisions *can* operate as intended without the mandate exceedingly difficult for a court. The mandate *at least* is essential to the operation of the private insurance re-

forms in Title I of the Act, but there can be no doubt that invalidating the mandate will also affect the remainder of the Act's operation, and its overarching purpose of expanding coverage to nearly all Americans.[16] And even if the effects of the mandate could definitively be said to stop at Title I, the PPACA without the insurance reforms in Title I is simply a different statute—there is no plausible basis to believe that Congress would have enacted the remainder of the statute without those reforms.

Any judicial attempt to decide just how far the individual mandate's effects reach, but no further, is especially treacherous because the stakes are so high—a wrong decision could seriously distort a market reflecting nearly 20% of the Nation's economy. Accordingly, the appropriate and practical option that will avoid potentially serious consequences for the healthcare and health insurance markets is to strike down the PPACA in toto, and allow Congress to decide how best to balance its policy preferences in a manner consistent with the Constitution.

Furthermore, the invalidation of the PPACA as a whole best comports with the separation of powers. This Court has in some cases stated that, because of separation-of-powers concerns and deference to Con-

---

[16] *See, e.g.*, CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf ("Under current law, CBO and JCT have estimated that about 23 million nonelderly residents will be uninsured in 2019. By eliminating the individual mandate to obtain coverage, the proposal would increase the number of uninsured by about 16 million people, resulting in an estimated 39 million uninsured in 2019.").

gress, "the 'normal rule' is that 'that partial, rather than facial, invalidation is the required course.'" *Free Enter. Fund*, 130 S. Ct. at 3161 (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). This, however, is far from a "normal" case, and the PPACA is certainly not a "normal" statute. To begin, the individual mandate is not, as in *Alaska Airlines*, an "uncontroversial" provision of "relative unimportance" to the PPACA. 480 U.S. at 694 n.18, 696. On the contrary, Congress itself explained that the mandate is "*essential* to creating effective health insurance markets," 42 U.S.C. § 18091(a)(2)(I) (emphasis added), which is one of the PPACA's central objectives.

More important, the PPACA's sheer complexity, the interdependence of its provisions, and its immense regulatory reach render it unlike any statute at issue in the Court's modern severability jurisprudence. Unlike, for example, certain challenged provisions of the Airline Deregulation Act, *see Alaska Airlines*, 480 U.S. at 680, a portion of Sarbanes-Oxley creating an accounting oversight board, *Free Enter. Fund*, 130 S. Ct. at 3147, or a statute regulating the disposal of nuclear waste, *New York v. United States*, 505 U.S. 144, 149 (1992), the PPACA comprehensively restructures nearly 20% of the Nation's economy. It does so through "hundreds of new laws about hundreds of different areas of health insurance and health care." U.S. Pet. App. 21a. And those laws—particularly the ones governing the market for private insurance—do not (and are not intended to) operate independently. On the contrary, as described above, the PPACA's various regulations of health insurance are complex, intertwined,

and interdependent. Retaining any portion of the Act without the mandate would not be saving Congress's work, but rather rewriting it. And courts "are not free to rewrite the statute that Congress has enacted." *Dodd v. United States*, 545 U.S. 353, 359 (2005).

Accordingly, to the extent there is any "presumption … in favor of severability" generally, *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion), that presumption should easily be overcome in the unique circumstances here. Judicial restraint and a candid recognition of the institutional limitations of the judiciary require rejecting the claim that the "essential" aspect of such a vast and complex regulatory scheme can be severed without consequence, and fully in keeping with congressional intent. Whatever Congress's intent, it was not to delegate to the courts the authority to make health care policy.

In short, if this Court finds that the individual mandate exceeds Congress's authority under the Constitution, it is at the very least clear that the Act's guaranteed-issue and community-rating reforms must also fall, as the United States concedes. But as demonstrated above, the individual mandate is "essential" to much more than just those two sets of reforms. For the reasons explained, the approach that best preserves the separation of powers would be to invalidate the Act in its entirety, and to allow Congress to balance its policy preferences to address the Nation's healthcare problems within constitutional boundaries.

CONCLUSION

For the foregoing reasons, if this Court finds that the individual mandate is unconstitutional, it should also hold that the remainder of the PPACA is nonseverable from the mandate.

Respectfully submitted,

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(*Counsel of Record*)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

January 2012