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.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,
v.
UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, et al.,
Respondents.

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

BRIEF OF *AMICI CURIAE* COMPETITIVE ENTERPRISE INSTITUTE, THOMAS P. MILLER, JOSEPH R. ANTOS, CHRISTOPHER J. CONOVER, EARL L. GRINOLS, MICHAEL A. MORRISEY, TOMAS J. PHILIPSON, SCOTT E. HARRINGTON, JAMES C. CAPRETTA, ROBERT KAESTNER, AND JAMES W. HENDERSON IN SUPPORT OF PETITIONERS (SEVERABILITY ISSUE)

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INTEREST OF THE *AMICI*

Amicus Curiae the Competitive Enterprise Institute ("CEI") is a non-profit organization dedicated to advancing the principles of limited government, free enterprise, and individual liberty.[1] Given its institutional mission, CEI has a substantial interest in the validity of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("PPACA"), as amended by Title I of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA," and collectively, "ACA" or "the Act"), including but not limited to the compulsory purchase requirement (referred to as the "individual mandate") found in Section 5000a(a) of the Internal Revenue Code of 1986 ("the Code"), added by ACA Title I, § 1501 ("the mandate").[2]

The individual *Amici Curiae* are Thomas P. Miller, Resident Fellow, American Enterprise Institute;

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[1] Pursuant to Rule 37.6, *Amici* affirm that no counsel for a party authored this brief in whole or in part; no such counsel or any party made a monetary contribution intended to fund its preparation or submission; and no person other than an *Amicus*, its members, or its counsel made such a monetary contribution. Each party has lodged with the Clerk's Office a blanket consent to the filing of briefs *amicus curiae* supporting any party or no party.

[2] CEI's attorneys authored briefs *amicus curiae* supporting Petitioners filed in the courts below. Brief of Governors Tim Pawlenty and Donald L. Carcieri as *Amici Curiae* Supporting Plaintiffs, *Florida ex rel. McCollum v. HHS*, 716 F.Supp.2d 1120 (N.D. Fla. 2010) (No. 10-00091); Brief *Amici Curiae* of Minnesota Legislators and North Carolina Legislative Leaders in Support of Plaintiffs-Appellees/Cross-Appellants, *Florida v. United States Department of Health and Human Services*, 648 F.3d 1235 (11th Cir. 2011) (Nos. 11-11021 & 11-11067) ("*Florida v. HHS*").

Joseph R. Antos, Resident Scholar, American Enterprise Institute; Christopher J. Conover, Research Scholar, Duke University Center for Health Policy & Inequalities Research; Earl L. Grinols Distinguished Professor of Economics, Baylor University; Michael A. Morrisey, Director, Lister Hill Center for Health Policy, School of Public Health, University of Alabama at Birmingham; Tomas J. Philipson, Daniel Levin Professor of Public Policy Studies, The Harris School, University of Chicago; Scott E. Harrington, Alan B. Miller Professor of Health Care Management and Insurance and Risk Management, Wharton School, University of Pennsylvania; James C. Capretta, Fellow, Ethics and Public Policy Center; Robert Kaestner, Professor, Institute of Government and Public Affairs, University of Illinois and Professor, Department of Economics, University of Illinois; and James W. Henderson, Ben Williams Professor in Economics, Baylor University. Each of them is a health care public policy and/or health care law expert who has concluded that Titles I and II of the Act[3] will impede the goal of expanding the percentage of the population with effective and affordable access to healthcare and/or will have adverse economic market consequences disproportionate to any public advantages that might be conferred by the Act.

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[3] The phrase "Title I" as used in this Brief with reference to PPACA is defined to avoid confusion that might result from the fact that Title X of PPACA consists of emendatory instructions with respect to Titles I through IX of PPACA. Accordingly, when used with respect to PPACA, the phrase "Title I" refers to the text resulting from Title I as modified in accordance with Title X. The phrase "Title I," when used in reference to the ACA, means Title I of the PPACA (as defined above), as amended by Title I of the HCERA.

SUMMARY OF ARGUMENT

If the provision of the Act establishing the mandate is unconstitutional, the relief granted cannot be based on severing any part of it from the balance of Title I. That provision cannot be severed from the balance of the Act consistently with *Champlin Refining Co. v. Corporation Comm'n of Oklahoma*, 286 U.S. 210, 235 (1932), because Congress could not have adopted the Act without the mandate, and because the House of Representatives adopted a rule ("the PPACA Rule") requiring itself to vote on the Senate's version of the PPACA only as a package deal, thus disabling itself from adopting the PPACA without the mandate. Thus, the unconstitutional provision cannot be severed from the balance of Title I.

Substantively, the sections of the Act Congress grouped together as Title I are a unified, self-contained, and interrelated set. As a set, they establish and promote healthcare Exchanges created under Title I, Subtitle D. Exchanges are the market-related mechanisms that Congress intended would accomplish the Act's coverage, quality, and affordability goals with respect to a specific subset of the population. By design, Title I's sections function in coordination with each other to achieve these objectives. The substantive interrelatedness apparent from the face of these provisions is confirmed by regulatory guidance under the Act.

The interrelatedness of Title I's provisions, the Congressional findings in the Act, and the remainder of the legislative record establish that without the mandate, Title I would not have been adopted; would not be fully operative as law; and could not function in the manner Congress intended. Severing the mandate from the balance of Title I would entail

denying effect to the PPACA Rule and disregarding Congressional findings in favor of less-reliable evidence on the questions at hand. Both steps are inconsistent with precepts in prior severability opinions of this Court. Prudential concerns also militate strongly against severing the mandate from the balance of Title I.

ARGUMENT

I. IF THE PROVISION ESTABLISHING THE MANDATE IS UNCONSTITUTIONAL, REMAINING PROVISIONS OF TITLE I CANNOT BE DECLARED VALID.

In cases beginning with *Champlin, supra,* this Court has decided the threshold question of severability a now-familiar formulation:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.

286 U.S. at 234. *See, also, e.g.*, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987).

An answer to *Champlin*'s first question can be based on concluding from historical facts that Congress could not have adopted the balance of an act without the unconstitutional provision.[4] There is

[4] When the phrase "would not" is applied in a given case with reference to Congress's "will" (*i.e.*, its intent as manifested by its desires), then *Champlin* analysis can involve a hypothetical. *Ayotte v. Planned Parenthood of Northern New England*, 546

a sufficient basis not to sever an unconstitutional provision from an act if a legislative bargain to include the unconstitutional provision was required to garner majority support for the act. *See, e.g., Leavitt v. Jane L.*, 518 U.S. 137, 141 (1996) (applying Utah law). *Cf. Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (noting importance of considering the role of the unconstitutional provision "in the original legislative bargain"); *cf., also, Legal Services Corp. v. Velazquez*, 531 U.S. 533, 560-62 (2001) (Justice Scalia, dissenting) (objecting to severance remedy that "eliminate[s] a significant *quid pro quo* of the legislative compromise").

Congress would not have adopted the Act without the mandate provision because it *could not* have done so. This conclusion can be drawn directly from the political context in which the Act was adopted, *see, e.g.*, *See, gen'ly, e.g.*, *Brown wins Massachusetts Senate race* (Jan 19, 2010), http://articles.cnn.com/2010-01-19/politics/massachusetts.senate_1_senate-democrats-coakley-senate-seat?_s=PM:POLITICS, ("Brown's victory strips Democrats of the 60-seat Senate supermajority needed to overcome GOP filibusters . . . Senate Democrats needed all 60 votes in their caucus to pass the health care bill, and the loss of one seat imperils generating that support again for a compromise measure worked out with the House."); *and* CNN Transcript, March 21, 2010, http://transcripts.cnn.com/TRANSCRIPTS/1003/21/se.04.html.

Congress's inability to adopt the Act without the mandate provision is established on a more formal basis by the House of Representatives' adoption of

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U.S. 320, 330 (2006) ("After finding . . . a portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?").

H.Res. 1203, 111th Cong., 2d Sess. (Mar. 21, 2010) ("the PPACA Rule"), before it took up and adopted H.R. 3590, as amended by S. Amendment No. 2786 (December 24, 2009) ("the Senate version of PPACA"). H.Res. 1203, ¶¶ 2-3, prohibited amending the Senate version of PPACA, as approved by what at the time was a filibuster-proof Senate. The Senate version of PPACA included the individual mandate in ACA § 1501. By adopting the PPACA Rule, the House limited itself to voting on the Senate version of PPACA on an all-or-nothing basis, including Section 1501. Thus, giving effect to the PPACA Rule, the remainder of Title I cannot be declared valid because the mandate cannot be severed from the balance of the Act as a whole.[5]

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[5] The Court of Appeals' opinion seems to posit a judicial duty, based at least in part on a respect for separation of powers, to salvage acts of Congress by severing unconstitutional provisions from the balance of an act. *Florida v. HHS,* 648 F.3d at 1320-21 ("we *must* 'strive to salvage' acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact.") (emphasis added), *citing Ayotte,* 546 U.S. at 329. However, separation of powers concerns cannot lead to a duty stated in the such absolute terms. Severability is a remedial issue. *See, e.g., Ayotte,* 546 U.S. at 328 ("We turn to the question of remedy. *Cf.* D.H. Gans, *Severability as Judicial Lawmaking*, 76 Geo. Wash. L. Rev. 639, 643 (2008) ("Severance occurs in the remedial moment . . . [S]everability should be seen as part of the federal common law of constitutional remedies . . .") (footnote omitted). As such, its exercise lies within the judicial power just as Congress's adoption of a bill for presentment to the President falls within the legislative power. Thus, taking separation of powers concerns into account on the facts of a given case requires a more nuanced approach. And, as *Carter v. Carter Coal*, 298 U.S. 238, 312-16 (1936), illustrates, the decision to sever can be exercised so as to sever part but less than all of the balance of an act consistently with this Court's precedents. While *Amici* urge that the Act as a whole be declared invalid, they also

II. THE PROVISION ESTABLISHING THE MANDATE SHOULD NOT BE SEVERED FROM THE BALANCE OF TITLE I, BASED ON FOUR CONSIDERATIONS IN ADDITION TO THAT DISCUSSED IN POINT I.

A. The Sections of Title I Constitute a Unified and Discrete Set of Provisions That, Based on their Substance, Are Interrelated in Organization, Structure, Purpose, and Regulatory Method.

Title I is a unified and discrete set of provisions interrelated at a bedrock level by their substance. An especially high degree of confidence attends this conclusion because the interrelationship of Title I's provisions can be shown as to each of four analytically distinct features: their common subject matter; their shared purpose; the carefully integrated timing of their effective dates; and the coordination of their roles in the creation and promotion of an important regulatory mechanism for achieving the Act's overall goals, *i.e.*, the Exchanges created under Title I, Subtitle D, §§ 1311 and 1321.

Especially as seen in the context of the Act's structure, the integration of Title I's provisions is easily recognized. The Act as a whole seeks to expand the percentage of Americans with health coverage meeting a federally determined substantive floor and to make that coverage more affordable. Subgroups of Americans obtain health coverage from

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recognize that the Court might be persuaded by Respondents and their *amici* to fashion declaratory relief based on a more restrained exercise of the power to sever. Point II addresses that possibility.

different sources, depending partly on demographic factors such as age, employment (including self-employment), income, and the like.

Congress drafted the Act so that discrete and largely non-overlapping subsets of its provisions applied to subcategories of Americans defined by the way their members typically obtain coverage. In keeping with this organizational premise, Congress grouped ACA §§ 1001 through 1563 not just into a Title, but into a single set of sections based on the particular group to which its provisions are addressed. That group consists of Americans whose coverage customarily is employment based, (employees, the self-employed, and their dependents),[6] and usually is obtained either in the insurance market or through self-insured employer-sponsored plans.[7]

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[6] As used herein, "employment based" means resulting from employment or self-employment. For brevity's sake, members of this group will be referred to as "employees."

[7] The insurance market consists of the individual market and the group market, and the latter is further divided into the small group market and the large group market. The individual market is very important to self-employed individuals and to some extent also to common law employees of employers that do not sponsor health plans. It is expected that the individual market will play an enhanced role for common law employees under the Act. In An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act (Nov. 30, 2009) ("CBO 11 30 09"), at 20, CBO reported that under the then-current version of the Senate measure that became PPACA, the number of purchasers in the individual market would rise from 14 million to 32 million between 2010 and 2016, and some of the new entrants into that market "would have employment-based coverage . . . under current law." Unfortunately, the analysis did not specify how much of the predicted growth in the individual market CBO attributed to the migration of common law employees from employer-sponsored plans

This structural principle informs every Subtitle of Title I. For example, Subtitle A includes market reforms applicable to individual policies and plans sponsored by employers subject to the Public Health Service Act. *See, e.g.*, ACA, Title I, Subtitle A, § 1001, amending, *inter alia*, Section 2714 of the Public Health Service Act ("PHSA").[8] Subtitle B establishes a funding program to support medical coverage for retired employees. ACA, Title I, Subtitle B, § 1102. Subtitle C adds additional market reforms to those adopted in Subtitle A, including one that prohibits pre-existing condition exclusions. *See* PHSA § 2704, added by Title I, Subtitle C, § 1201.

In the same vein, Subtitle D, which provides for the creation of the Exchanges as health insurance markets, also opens the Exchanges to small employers in 2014 and allows for access by large employers thereafter. ACA, Title I, Subtitle D, § 1312(f) and (2)(B). Subtitle

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to Exchange-purchased individual coverage. As discussed below, Title I includes financial incentives favoring the purchase of individual coverage from an Exchange. *See, e.g.*, Code § 36B, as amended, added by ACA § 1402. The provisions of Code § 36B(c)(2)(C), establishing special rules related to individuals eligible for employer-provided coverage, establish that common law employees are among those for whom the incentives were intended.

[8] Significantly, by adding a new Section 715(a)(1) to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Act causes the PHSA amendments to apply to health plans subject to ERISA. Almost every group health plan sponsored by a private sector employer (other than church plans) is subject to ERISA. *See* ERISA §§ 3(1), (3), and 4, 29 U.S.C. § 1002(1), (3), and 1003. Moreover, ERISA covers these plans precisely because they are employer-sponsored plans covering the employees or former employees of the plan sponsor in their capacities as such. ERISA § 3(1), (4)-(7), 29 U.S.C. § 1002(1), (4)-(7).

E creates a tax credit available for small employers to help defray the cost of providing coverage to employees. Code § 45R, added by ACA Title I, Subtitle E, § 1421. Subtitle F creates an "employer mandate," by establishing that an assessable payment is due from a large employer if any of its full-time employees is certified to the employer by the Exchange as having purchased health insurance through the Exchange under circumstances that triggered an individual tax credit or cost-sharing reduction, if the employer did not offer all its full time employees health coverage or (although the employer does offer health coverage) it does not meet the Act's affordability and value standards. ACA Title I, Subtitle F, § 1512; *see, also*, ACA Title I, Subtitle D, §§ 1301-02, 1311, 1321.

Even Subtitle G, housing so-called "Miscellaneous Provisions," adheres to the same employment-based organizational principle. For example, Title I, Subtitle G, § 1558 amends the Fair Labor Standards Act to add a new Section 18C of the Fair Labor Standards Act. Section 18C is a non-retaliation rule to protect an employee from employer retaliation when the employee "received a credit under section 36B of the Internal Revenue Code of 1986 [added by Title I, Subtitle F, § 1401] or a subsidy under [Title I, Subtitle F] section 1402 of this Act . . ."

The provisions of Title I also are substantively interrelated by their common purpose, the means by which the purpose is accomplished, and the carefully choreographed timing of their effective dates. These interrelationships are most visible by first recognizing that Title I's provisions can be divided into stages based on when they become operative. This approach highlights how the functions of the various sections of

Title I are coordinated with each other, *cf.* CBO 11 30 09 at 1 (noting staging effect), particularly in promoting the role of the Exchanges created under Subtitle D as instrumentalities of reform. Congress considered the role of the Exchanges as new marketplaces for coverage crucial to reforming the markets currently patronized by employees (including for this purpose the self-employed).

The first stage of Title I is embodied largely within Subtitles A and C, which became operative beginning no later than 2011 ("the 2011 stage"). The sections in the 2011 stage stimulate primary demand for coverage among employees by making coverage relatively more valuable. This goal is achieved primarily by a set of provisions in Subtitle A that enhance the perceived and actual value of coverage by: (a) eliminating lifetime benefit maximums; b) restricting annual benefit maximums before phasing them out completely in 2014; (c) effectively extending dependent coverage of children to age 26 without regard to student status, marital status, and economic dependence; (d) requiring first dollar coverage of preventive health services; (e) restricting waiting periods for coverage of pre-existing conditions (as a prelude to prohibiting them altogether); (f) requiring that emergency medical services provided out of network must be covered on a par with such services rendered in network; and other miscellaneous requirements and prohibitions applicable to the terms of coverage. See ACA, Title I, Section 1001, amending PHSA § 2711 *et seq.*, and Subtitle C, § 1201, adding additional PHSA provisions.

These provisions enhance the economic value of being covered in highly visible ways by eliminating or curbing pre-Act terms of coverage employees found

particularly frustrating in the past. This feature of Subtitles A and C serve the goal of making coverage not only more choiceworthy but also more often chosen. For example, PHSA § 2715, added by Title I, Subtitle A, § 1001 requires developing a common format for general use by insurers and employers to explain the terms of coverage they offer, in part to "demystify" insurance terminology. Use of this on the Exchanges will be required under ACA § 1311(d)(4)(E).[9]

The second stage is embodied largely in Subtitles D, E, and F, which become effective beginning on January 1, 2014. Sections of these Subtitles function by (a) increasing the economic level of the Act's stimulation of primary demand, as begun in Subtitles A and C; (b) requiring the establishment of the Exchanges with territorial franchises covering each state; and (c) steering consumers selectively toward

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[9] As part of the first stage, provisions of Title I, Subtitle B include temporary measures to preserve and enhance coverage before the Exchanges open. Significantly, those measures are highly coordinated with the advent of Exchange-available coverage. For example, Title I, Subtitle B, § 1101 provides for subsidies to high risk insurance pools that will transition their program participants to Exchange-based coverage in 2014.

Subtitle B also provides an internet portal or other mechanism "through which a resident of any State may identify affordable health insurance coverage options in that State." Thus, Title I, Subtitle B, § 1103, effectively creates a what might be called this scaled-down prototype of a Subtitle D Exchange. Subtitle D requires that "proto-Exchange" be used as a model for the real thing. *See*, ACA Title I, Subtitle D, § 1311(c)(4) (requiring HHS to "continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal").

the Exchanges as preferred markets for coverage satisfying the statutorily induced demand.

The precise operation of these sections to produce these effects will be discussed below, but this is the appropriate place to note that this is the stage where, when, and how the mandate fits into the picture. The consumer's perceived economic self-interest in being covered is enhanced in the first stage by the actual and consumer-perceived higher value of coverage brought on by the consumer-friendly sections of Subtitles A and C and then intensified by tax subsidies in the second stage. The mandate "teams up" with these economic promptings by adding a legal obligation to have coverage meeting the Ac's standard. The path of least resistance for discharging the obligation of the mandate is the purchase of coverage from an Exchange.

Subtitle E offers tax credits conditioned on purchasing coverage through an exchange. ACA §§ 1401 (individual tax credit) and 1421 (small business tax credit). Subtitle D promotes consumer preference for Exchange-purchased coverage through non-monetary means. For example, Exchanges will provide their clientele free of charge the services of coverage store concierges, called "Navigators," to help customers choose Exchange-available coverage products. ACA, § 1311(d)(4).

In concert with sections in Subtitles A and C, Subtitle D also reduces the availability of non-Exchange coverage, thereby eliminating coverage vehicles that might compete with Exchange-available products. PHSA § 2707(a), added by Title I, Subtitle C, § 1201, prohibits insurers from offering coverage on or off an Exchange unless it meets the floor standards of ACA § 1302(a). Similarly, some provi-

sions of Subtitles A and C will make it increasingly difficult for certain private-sector employers to continue offering coverage under a pre-Act self-insured group health plan, partly because compliance is costly. *See, e.g.,* the more elaborate and expensive claim and review requirements under PHSA § 2719, added by ACA, Title I, Subtitle A, § 1001.[10]

Regulations issued under Subtitle C, § 1251, establish additional impediments to the continuation of pre-Act employer-provided plans into 2014, when they might then compete with Exchanges as an alternative source of the "minimum essential coverage" an individual is required by law to obtain under the mandate. Section 1251 establishes something akin to an individual's right to continue coverage under a pre-ACA plan he or she likes. As interpreted by the Respondents, however, Section 1251 allows for the possibility that a pre-ACA plan can *lose* this grandfathered status as the result of post-enactment events such as increasing copayments, reducing employer subsidization by more than 5%, or even failing to assert grandfathered status. As explained by the Respondents, one purpose of creating these possibilities for losing grandfathered status is reducing the possibility that employees will choose coverage unwisely if an employer-sponsored self-insured plan remains available to them in 2014. *See, e.g.,* Group

[10] Not all of the Subtitle A and C market reforms apply to every employer-provided plan. *See* ACA, Title I, § 1251 (establishing a rule for identifying plans that are not subject or not fully subject to some market reforms in Subtitles A or C, and providing that the term "grandfathered plan" refers to such plans as a result). However, as discussed below, interim regulations promulgated by Respondents will artificially shrink the member of employer provided plans considered to have immunity from portions of these market reforms.

Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rules With Requests for Comments, Preamble, 75 FR 34538, 34548 (June 17, 2010) ("Grandfather Preamble").[11]

In fact, these provisions represent a legislative "twofer," because they do more than help to increase the Exchanges' market-share, thereby bolstering the Exchanges' ability to reduce the cost of coverage by adding to their bargaining clout with carriers. They also simultaneously serve Congress's substantive goal of promoting coverage subject to a higher floor than the one established by Subtitles A and C alone.

Thus, the provisions of Title I reflect a choreographed and integrated strategy for regulating the terms, value, marketing, purchase, and operation of individual and employer-provided group coverage through government-established Exchanges that will enforce federally established or federally approved rules. *See* Act, Title I, Subtitle D, Part II, § 1311 (relating to the establishment of Exchanges by a State) and Part III, § 1321 (federally established Exchanges). One additional function of Exchanges

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[11] Respondents' concerns about bad employee coverage choices were based on the work of behavioral scientists that documents the existence of an "inertia effect" which might lead employees to re-register time after time to continue coverage under their pre-ACA employer-sponsored plans, despite the availability of coverage alternatives objectively better suited to their needs. Grandfather Preamble, 34548. The Grandfather Preamble attributes the behavioral anomaly of subjective choices that vary from objective realities to various sources such as resistance to change, procrastination, a lack of relevant information, or a simple desire to avoid what they perceive as a risk associated with switching to a new plan. *Id.*

harks back to the ACA's basic organizational principle (defining subgroups of the American population by demographic factors determining how they typically obtain coverage): an Exchange is required to shunt would-be insurance customers to state programs for which the Exchange determines they are eligible. ACA § 1311(d)(4)(F).

Staging effects aside, there is another factor at work here. Substantively, the entire set of provisions in Subtitles A, C, and F that stimulate primary demand for coverage is, in turn, just one element of a larger set of provisions in Title I designed to encourage patronage of the Exchanges created under Subtitle D to satisfy that demand. For example, Title I, Subtitle E, §§ 1401-1402 stimulate demand specifically for Exchange-available coverage by subsidizing the cost (and in some cases also enhancing the value) of individual coverage only if purchased on an Exchange. *Id.*, Subtitle E, §§ 1401-1402. No corresponding subsidies are available for the purchase of individual coverage outside the Exchanges. In a similar vein, Subtitle E creates a small-business tax credit for small employers, but it is conditioned on the purchase of employee group coverage from an Exchange. *See* Code § 45R, added by Title I, Subtitle E, § 1421.[12] Perhaps of the greatest significance in this regard, the penalty for violation of the employer

[12] The cost of the added demand stimulus created under Subtitle E was expected to be offset in part by funds received under Code § 5000a(b), added by Title I, Subtitle F. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Hon. Harry Reid, Senate Majority Leader, Chart 2, p. 6 (Dec. 19, 2009), http://www.cbo.gov/doc.cfm?index=10868&type=1. This expectation, in turn, was the basis for PPACA's deficit-reduction finding in Title I, Subtitle G, § 1563.

mandate is triggered if and only if one or more of the employer's employees purchases subsidized coverage from the Exchange.

To summarize: just as the last of the interim measures in Subtitle B is scheduled to wink out of existence, the Exchanges established under Subtitle D will open. Using the market clout conferred on them by the combined effects of Subtitles A, C, and F, and by the monetary subsidies directed their way under Subtitle E, the Exchanges in their capacity as markets will become the primary agencies that administer and enforce federally mandated coverage provisions, market regulations, access rules, disclosure requirements, price-and profit-controls, and the other permanent regulatory apparatus created under Title I. As if to testify to the inseparability of the provision creating the mandate from the related language creating the Exchanges, the Act provides that the Exchanges will decide in the first instance whether a person is exempt from the mandate. Not surprisingly, this authority is the result of a feature or provision of the Act, the language of which is distributed among sections found in several Subtitles of Title I. *See* Code Section 5000a(a) (coverage mandate for "applicable individuals"); (d)(1) and (2)-(4) (defining "applicable individual" with respect to three exempt categories); Title I, Subtitle D, § 1311(d)(4)(H)(ii) (requiring an Exchange to issue certificates attesting that an individual is exempt from the individual mandate because he or she satisfies the criteria for an exemption from the category "applicable individual" as defined in Code

§ 5000a(d)(2)-(4)), *and cf.* Title I, Subtitle E, § 1411 (review of exemption certifications).[13]

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[13] Title I, in turn, is related organizationally and substantively to sections Congress chose to place in other Titles. One potentially significant example of that phenomenon can be found in the effective dates of a provision of Section 1902 of the Social Security Act ("SSA"), 42 USC § 1396a(gg), added by ACA, Title II, § 2001. As amended by the Act, Section 1902 conditions each state's continued eligibility for federal payments under SSA § 1903(a) on the state's compliance with a requirement not to have in effect any "eligibility standards, methodologies, or procedures under the State [Medicaid] plan" that are more restrictive than their pre-PPACA counterparts. This condition is applicable from the date of PPACA's enactment until the date "the Secretary determines that an Exchange established by the State under [PPACA §] 1311 . . . is fully operational." The fact that this provision of Title II relates to a term defined in Title I does not detract from *Amici*'s characterization as largely self-contained. Sections do not bear a one-to-one correspondence with provisions, except perhaps by coincidence, and Congress was not required to repeat the words in Section 1311 in Title II as part of a provision encompassing Section 2001.

The significance of the end date of the "maintenance of effort" provision in SSA § 1902 is best appreciated by considering how an Exchange may be created under the Act. Section 1311 authorizes and requires each state to establish an Exchange. ACA § 1311(b)(1). Section 1321 permits Respondent HHS to create an Exchange within a state as soon as HHS determines that the state is not making sufficient progress toward complying with Section 1311's mandate by 2014. Because the establishment of an Exchange under ACA § 1321, unlike the establishment of an Exchange under ACA § 1311, does not cause the condition in SSA § 1902 to lapse, ACA § 2001 could be considered part of a provision that prods state legislatures and executives to adopt promptly measures needed to establish an Exchange under ACA § 1311 that will meet with HHS's approval. If such a provision of the Act as set forth in Sections 1501 and 2001 (among others) is unconstitutional on both the grounds advanced by the States and the other Petitioners, *Amici* urge that the minimum appropriate remedy would include invalidating every remaining

The interrelationship of the mandate with the balance of Title I is not the result of happenstance. The public legislative record shows that, from the outset, the individual mandate was one component of a set of measures the Congressional Budget Office predicted to the incoming 111th Congress would stimulate primary demand for health coverage. *See* Internal Revenue Code of 1986, § 5000a(a), added by Title I, Subtitle F, § 1501, and *cf., Key Issues in Analyzing Major Health Insurance Proposals*, 53-54 (Congressional Budget Office, December 2008) ("*Key Issues*") (noting a base level of compliance with a rule of law that can be enhanced by enforcement). The Act's findings confirm that Congress anticipated this very effect. Title I, Subtitle F, § 1501(a)(2).

Consider, for example, the "consumer protection" standards of Subtitles A and C. These were understood in advance as mechanisms to stimulate primary demand for coverage among employees in precisely the fashion evident from the text of those standards. *Key Issues, supra*, 43-53. This is so because these standards enhance the perceived value of individual and employer-provided coverage by restricting eligibility waiting periods, opening dependent coverage to children up to age 26, mandating additional claims procedures, banning lifetime maximums, and requiring other value-added substantive and procedural provisions. *Cf. Key Issues, supra,* at 51-53. Assessable payments under Code § 5000a(b) to be made by certain individuals who fail to have minimum essential coverage as defined in Subtitle F, is a financial

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inseparable provision of the Act, which in this scenario would include all of Title I plus other portions of the Act considered inseparable from that part of the offending provision contained exclusively within Section 2001.

disincentive for non-covered status and was understood in advance as a means to make non-covered status comparatively less attractive financially. *Cf. Key Issues, supra,* at 51-53. Although Code § 5000a(b) is not the mandate proper, Code § 5000a(b) is related to the rest of Title I in precisely the same fashion as the mandate, *i.e.*, as one of several means working in tandem to increase the percentage of employees and their dependents with minimum essential coverage by affecting their behavior.

Title I's status as an integrated whole also is confirmed by temporary and proposed regulations issued under the authority of its sections. For example, the preamble to interim final rules under Section 1251 explicitly refers to reconciling that Section's provisions with other policy goals (presumably appearing in other sections). Grandfather Preamble, *supra*, 75 FR at 34548. The IFR creates rules under Section 1251 of the PPACA to ease the transition to "market reforms" embodied in various other provisions in Title I of the Affordable Care Act.

In one case, Respondent Department of the Treasury issued proposed regulations under Code Section 36B, added by ACA § 1401(a) (amended by a provision in Title X when the Senate adopted the PPACA), the substance of which is quite literally ruled out by Code § 36B's language. *See* Code § 36B(b)(2) and subparagraph (A) (always resulting in a tax credit equal to zero if coverage otherwise triggering the tax credit is purchased from an Exchange established by HHS under Section 1321 instead of an Exchange established by a state under Section 1311). *Cf.* Preamble to Prop. Treas. Reg. §§ 1.36B-1 *et seq.*, 76 Fed. Reg. 50931 (Aug. 17, 2011) ("The proposed regulations provide that a taxpayer is eligible for the

credit for a taxable year if . . . enrolled in one or more qualified health plans through an Exchange established under section 1311 or 1321"). While no explanation for this statement was given, negating the text of an ACA section could only have been based on taking other sections of the Act or policies emanating from them into account.

The structure of the Act as a whole also suggests that its individual titles be treated as indivisible for purposes of severability. First, the subject matter of the Act is so broad that it all but required addressing coverage and cost issues separately with respect to employees (once again understood to include the self-employed); pre-retirement age beneficiaries of public programs such as Medicaid; and the Medicare-eligible population, which correspond to sections of the Act as grouped into Titles. Second, section-by-section parsing is particularly unattractive as an alternative, especially considering the extraordinarily high number of sections in the Act. Third, treating Title I as a unit for severability purposes hews more closely than section-by-section parsing to at least one possible explanation of the use of the singular forms of the words "bill" and "law" in Article I's description of the law-making process. Moreover, it was Congress that chose to divide the provisions of the Act into Titles, grouped together by subject matter. Aggregating interrelated provisions on that basis certainly is not irrational. Thus, Congress's division of the ACA into Titles provides a textual basis in the Act for this Court to consider severability of those provisions on the same basis.

B. Congressional Findings Confirm That Title I Was Intended and Designed to Function Only As a Whole.

The indivisibility of Title I is confirmed by Congress's statutory findings that

> (C) The requirement [*i.e.,* the individual mandate], 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 . . .
>
> (F) . . . By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums. . . . [and]
>
> (I) . . . [I]f 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.

42 U.S.C. § 18091(a)(2), added by ACA, Title I, Subtitle F, § 1501(a)(2). Indeed, the conclusion that Congress would not have adopted the Act without the individual mandate can rest entirely on Congress's finding that the individual mandate is "essential" to creating what Congress called "effective health insurance markets." The findings place the individual mandate in sharp contrast to the limited, discrete and independent provisions that this Court has severed without any additional modifications to the underlying statute. *Cf., e.g., Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684-85 (1987) (discrete legislative veto provision severed from unrelated statutory provisions); *United States v. Jackson*, 390 U.S. 570, 585-591 (1968) (single criminal penalty severed from criminal statute containing numerous alternative penalties). Moreover, the findings also show that the balance of Title I cannot function as intended without the mandate, confirming Respondents' concession to that effect, even if that concession applies only to some but not all of the balance of the sections in Title I.

C. Title I Would Not Have Been Adopted Without the Individual Mandate.

Congress simply would not have adopted Title I without the individual mandate. This conclusion follows from H.Res. 1203 and the other parliamentary maneuvers attending the Act's passage, even if the sole purpose those maneuvers was to protect only Title I of the PPACA from amendment. Moreover, it follows from Congress's findings that it did not wish to adopt Title I unless the mandate were included.

It is difficult to escape the conclusion that Title I *inevitably* would include the mandate. The individual mandate was part of the very atmosphere in which all of the 111th Congress's healthcare reform measures

were considered. The inclusion in the Act of Section 1501, the bearer of the mandate, cannot be accurately understood as an historical fact if it is considered to be merely a by-product of the parliamentary necessities confronting the Act's supporters following Sen. Brown's election. More than a year before the Massachusetts special Senatorial election, the CBO published an extensive model for healthcare reform which stressed the importance of an individual mandate. *See, Key Issues, supra*, Chapter 2, 27-57, and esp. 48-54. The analytical approach in the *Key Issues* document was employed throughout the ensuing legislative process. *See, e.g.,* CBO 11 30 09, *supra*, at 10 n.11; 11 n.13,; 17 n.25; 19 n.27; and 20 n.28. Most significantly for the interrelatedness of the mandate with other language in Title I, the November 30, 2009 report confirms the discussion in *Key Points* that the simple existence of the mandate itself would lead some people to obtain coverage, while the "penalties that would be levied" under a version of Code § 5000a(b) would induce compliance by others. *See* CBO 11 30 09 at 20, first bullet point; *and cf. Key Issues* at 53 ("Many individuals . . . would comply with a mandate, even in the absence of penalties, because they believe in abiding by the nation's laws."). Moreover, an individual mandate was included in the only competing version of a healthcare reform bill adopted by either chamber during the 111th Congress. *See* the Affordable Health Care for America Act (H.R. 3962), Title V, § 501, as adopted by the House on November 7, 2009.

D. Prudential Considerations Militate Strongly Against Disregarding Either Congress's Findings or the PPACA Rule in Applying the Power to Sever to Fashioning a Remedy in this Case.

Finally, a court may decline to sever an invalid provision from other unobjectionable portions of an enactment, even if the other provisions can function independently, if "the invalidated provision could be regarded as part of a legislative compromise, extracted in exchange for the inclusion of other provisions of the statute." *Leavitt v. Jane L.*, 518 U.S. 137, 141 (1996) (applying Utah law). *Cf. Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (noting importance of considering the role of the unconstitutional provision "in the original legislative bargain"). The less open and transparent the lawmaking process, the less confident this Court can be in expecting to identify all the provisions that would not be present in an Act but for a legislative compromise. Moreover, without a public record of each step in hammering out the final text of an act, no one reasonably could expect this Court to decide whether it has fully achieved the goal of respecting the results of legislative compromises because, in principle, that goal could require an unpredictable number of recursive applications of that precept to an indeterminate series of ever smaller versions of an act.

Title I as adopted by the Senate resulted from negotiations conducted behind closed doors among members of a 60-person majority in the Senate. HCERA's amendments to Title I resulted from negotiations behind closed doors between the leadership of the Senate and House majorities. Unlike the House-Senate conference committee process that might

have been anticipated when the Senate adopted PPACA, there is no public record of the processes by which the final text of the ACA was hammered out. Congress effectively (if unintentionally) precluded access to the information necessary for reaching a conclusion on the basis of "political realities" differing from Congress's own assessment that the individual mandate is "essential" to the creation of the Exchanges and integral to the goals of Title I as a whole (if not the entire Act). Viewed in light of these considerations, taking the Act's findings at face value and giving effect to the PPACA Rule entails neither surrendering to empty formalism nor indulging in "poetic justice." Instead it directly serves the fundamental bases of severability as a remedial device.

CONCLUSION

An unconstitutional provision of the Act should not be severed from the remainder of the Act. At a minimum, it should not be severed from those portions of the remainder of the Act (including at least the balance of Title I) from which it is inseparable under *Champlin*.

Respectfully submitted,

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