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Nos. 11-393 and 11-400

IN THE

Supreme Court of the United States

NAT'L FEDERATION OF
INDEPENDENT BUSINESS, *ET AL.*,
Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY OF
HEALTH AND HUMAN SERVICES, *ET AL.*,
Respondents.

STATE OF FLORIDA, *ET AL.*,
Petitioners,

v.

DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,
Respondents.

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

**BRIEF FOR *AMICI CURIAE* ECONOMISTS
IN SUPPORT OF PETITIONERS
REGARDING SEVERABILITY**

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INTEREST OF THE *AMICI CURIAE*[1]

Amici Curiae are 103 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. *Amici* include Nobel laureates, former senior government officials, and faculty from research universities around the country. *Amici* support the need for reform but believe that the Affordable Care Act ("ACA" or the "Act") will likely exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. A complete list of *amici* can be found in the Appendix, beginning on page 1a.

Amici previously filed a brief with the Court of Appeals for the Eleventh Circuit addressing the economic premises on which the Government relied in seeking to defend the ACA's individual mandate as a regulation of interstate commerce. The Eleventh Circuit expressly relied upon *amici*'s analysis in finding the mandate unconstitutional. *See Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1299 & nn.108-111, 113 (11th Cir. 2011). *Amici* intend to file similar briefs addressing the economic issues relating to the constitutionality of the individual mandate and the Act's Medicaid expansion according to the schedule this Court has ordered.

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief. *See* Sup. Ct. R. 37.6. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court.

Amici submit this brief in support of Petitioners' position that the Court of Appeals erred in holding that the individual mandate, which, along with related subsidies and the Act's Medicaid expansion, benefits private insurance companies, can be severed from the many other provisions of the Act that impose substantial costs on those private insurers. *Amici* seek to assist the Court in understanding the economic interconnectedness of the many complex provisions of the ACA. Those economics demonstrate the individual mandate's true centrality to the Act, as well as the shortcomings in the Eleventh Circuit's ruling that the individual mandate could be severed from the rest of the ACA.

SUMMARY OF ARGUMENT

The individual mandate cannot be severed from the rest of the Affordable Care Act because Congress would not have intended the economic effects of the Act without the mandate. Specifically, numerous provisions of the Act impose significant costs on healthcare market participants, primarily health insurance companies. Congress would not have imposed such costs without the countervailing benefits provided by the individual mandate, not just as a matter of politics, but because such an imposition would undermine the central goal of the Act to make health care more affordable. As a result, the ACA fails the severability test of whether the Act would function in a "*manner* consistent with the intent of Congress" absent the individual mandate. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis in original).

The economic analysis advanced by *amici* economists demonstrates that the ACA depends on

the individual mandate to provide a significant portion of the benefit necessary to counterbalance the enormous costs the Act otherwise imposes on health insurance providers.

Using the best available economic data and the same projection methods employed by the Department of Health and Human Services, *amici* have estimated the impact of the most salient healthcare reforms, looking at both the costs and benefits to the health insurance industry. Without the individual mandate and related subsidies, the Act is projected to impose total net costs of $360 billion on health insurance companies from 2012 through 2021. With those provisions, however, the Act would provide a net $6 billion benefit over that same time period. In other words, from an economic perspective, the benefits of the individual mandate and subsidies to health insurance companies, along with benefits provided by the Act's Medicaid expansion, are projected to balance, nearly perfectly, the costs that the Act's various regulatory mandates impose on insurers.

The Government concedes that certain provisions of the Act, namely the community rating and guaranteed issue reforms, must stand or fall with the individual mandate. Yet this economic analysis demonstrates that the mandate is needed to counterbalance numerous provisions in the Act beyond those two reforms. The benefits to health insurance providers of expanded private coverage under the individual mandate and subsidies for insurance purchase far outweigh the costs imposed by the community rating and guaranteed issue reforms, taken alone. Congress understood the individual mandate to counterbalance a broader set of impositions on the

insurance industry that include taxes such as the so-called "Cadillac" excise tax on high-cost health plans that appear elsewhere in the Act.

Insurance companies are not the only market actors that would bear the significant costs that the individual mandate is needed to counterbalance. First, and most obviously, a steep increase in insurers' costs would necessarily result in an increase in the premiums that those insurers charge consumers. Accordingly, to invalidate only the individual mandate, while maintaining the ACA's other, highly burdensome regulatory provisions, would strip away the provision of the Act that is essential to enable private insurers to provide consumers with anything close to affordable insurance. Indeed, Congress explicitly found that the purpose of the individual mandate was to reduce premiums. *See* ACA §§ 1501(a)(2)(F), (I), (J), 42 U.S.C. § 18091(a)(2)(F), (I), (J). Without the individual mandate, the ACA's reforms, including but not limited to guaranteed issue and community rating, would cause a steep *increase* in premiums – the opposite of Congress's express intent.

Second, the Act includes trade-offs for other actors in the healthcare system. For instance, hospitals and drug manufacturers face reduced reimbursement for certain Medicare expenditures, but those costs are offset in part by the increase in demand for health care manufactured by the individual mandate. As with health insurers, it is reasonable to expect that if these actors were required to bear significant new costs, they would seek to pass along those costs to healthcare consumers – a result diametrically opposed to Congress's intent, embodied

in the very title of the Act, to make health care more affordable. Thus, Congress would not have intended to enact those provisions without providing the affected market participants with the countervailing benefit supplied by the individual mandate.

As a result, because the individual mandate is the key to the economic viability of so many provisions of the Act, this Court should not engage in a line-by-line analysis of whether particular individual provisions of the 2,700-page Act are or are not sufficiently independent from the individual mandate to be severed from it. As the District Court found under this Court's precedents, particularly *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 329-30 (2006), such an exercise would be a more intrusive incursion into legislative prerogative than simply striking down the entire Act and leaving it to Congress to rewrite the statute. *See Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1303-05 (N.D. Fla. 2011). In view of the interdependence among the various regulatory provisions under the Act, if this Court finds that the individual mandate is unconstitutional, then the Act's broader regulatory impositions, which depend in large part on the projected revenues generated by the individual mandate, must fall as well.

ARGUMENT

The individual mandate is the centerpiece of the Affordable Care Act. By compelling relatively healthy consumers to purchase health insurance at premiums exceeding the value of the health services they can expect to receive, the individual mandate directly subsidizes insurers. The purpose of that subsidy, both economically and politically, is to coun-

terbalance the significant costs that many other provisions of the Act impose on insurers, and thus to enable insurers to offer health insurance at premiums that, while greater than they would be absent the Act, nonetheless remain affordable to consumers.

In ruling that the individual mandate could be severed from the rest of the Act, the Court of Appeals misread *Alaska Airlines*, 480 U.S. 678. In *Alaska Airlines*, this Court recognized that where, as here, the remaining provisions of a statute are literally *capable* of functioning independently from the constitutionally infirm provision, "[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Id.* at 685 (emphasis in original).

In the ACA, Congress attempted to create a carefully calibrated scheme of interrelated costs and subsidies to expand access to health insurance while keeping costs affordable. *See Florida*, 780 F. Supp. 2d at 1299-1300. In order to understand the individual mandate's place in this scheme, it is necessary to see precisely how Congress struck the balance in the ACA. As an economic analysis of these provisions demonstrates, absent the individual mandate, the Act could not function in a "manner consistent with the intent of Congress," *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted), and thus the mandate cannot be severed from the rest of the Act.

I. AS A MATTER OF BASIC ECONOMICS, THE ACA CANNOT FUNCTION "IN A MANNER CONSISTENT WITH THE INTENT OF CONGRESS" WITHOUT THE INDIVIDUAL MANDATE

A. Without The Economic Subsidy The Individual Mandate Would Provide, The Remainder Of The ACA Would Impose Huge Uncompensated Costs On Health Insurance Companies

Amici's economic analysis of the ACA, as detailed below and in the Appendix to this brief, demonstrates that the Act includes various provisions that impose significant costs on health insurance companies and that the individual mandate, related subsidies, and Medicaid expansion provide counterbalancing benefits to those companies, in effect providing insurers with a subsidy that allows them to lower costs to the consumers who voluntarily choose to purchase health insurance.[2]

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[2] The ACA's impact on the health insurance industry is described in greater detail in the industry's brief filed in support of certiorari. *See* Brief of America's Health Insurance Plans as *Amicus Curiae* in Partial Support of Certiorari Review at 3, *Nat'l Federation of Indep. Bus. v. Sebelius*, *U.S. Dep't of Health & Human Servs. v. Florida*, *Florida v. U.S. Dep't of Health & Human Servs.*, Nos. 11-393, 11-398, and 11-400 [hereinafter AHIP Certiorari Brief] ("At the root of this litigation are the individual mandate and its relationship to [the] ACA's remaining provisions. Taken together, those provisions will fundamentally shift the way that health insurance is configured, financed, marketed, and sold, eliminating many of the risk management measures upon which insurers have relied for decades."); *id.* at 7 (ACA will cause "seismic changes" for health

To determine the costs and benefits of the ACA to health insurers, *amici* employed the same projection model used by the Department of Health and Human Services based on data sources including claims data from several nationwide employers, as well as the Government's own authoritative Medical Expenditure Panel Survey (MEPS), specifically the Medical Expenditure Panel Survey Household Component (MEPS-HC) and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).[3] A complete chart of *amici*'s projections, along with a more detailed explanation of these sources and methodologies, is attached hereto in the Appendix, beginning at page 10a.

Based on this economic analysis, the centrality of the individual mandate, along with related subsidies, is clear: With it, insurance companies can be expected essentially to break even under the provisions of the Act over the course of the decade from 2012 through 2021. Without it, insurance companies would be subjected to estimated net costs of $360 billion over that same time period, which they would largely pass on to consumers in the form of higher premiums. In other words, without the individual mandate, the Act would result in dramatically in-

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insurers); *id.* at 8 (ACA's insurance reforms "requir[e] health plans to undertake a wholesale and fundamental overhaul of their methods for offering insurance").

[3] MEPS is collected and maintained under the auspices of the U.S. Department of Health and Human Services. *See* Medical Expenditure Panel Survey ("MEPS"), U.S. Dep't of Health & Human Servs., http://meps.ahrq.gov/mepsweb (last visited Jan. 4, 2012).

creased healthcare costs – the opposite of what Congress intended. Thus, the various regulatory burdens that the ACA imposes on insurers cannot be severed from the individual mandate because the mandate is the keystone that holds together the economic viability of the entire "carefully-balanced and clockwork-like statutory arrangement" that is the ACA. *Florida*, 780 F. Supp. 2d at 1299.

1. The ACA's insurance reforms and taxes will impose significant costs on health insurers

Absent the offsetting benefits from the individual mandate, related subsidies, and the Medicaid expansion, the costs the Act would impose on insurers are staggering. The Act's major insurance reforms and taxes would cost insurers an estimated total of more than $715 *billion* from 2012 through 2021. From a low of approximately $10 billion in 2012, before many of the major reforms such as guaranteed issue take effect, these costs are projected to rise every year, exceeding $100 billion per year in 2019 and $170 billion per year in 2021. *See* Appendix at 10a; *see also* Douglas Holtz-Eakin, Stephen T. Parente & Michael J. Ramlet, *The Economic Implications of Severing the Individual Mandate*, American Action Forum, Jan. 5, 2012, http://bit.ly/EIoStIM.

For comparison, IBISWorld estimates the health insurance industry's nationwide revenue at $677.3 billion in 2011 with a profit margin of 4.5%, or roughly $30.5 billion. *See* Sophia Snyder, *IBISWorld Industry Report 52411b: Health & Medical Insurance in the US* 7, 8, 45 (Dec. 2011). Even taking into account the annual inflation-adjusted revenue

growth of 5.0% for health insurers projected from 2011 through 2016, *see id.* at 5, 11, the $71.5 billion in average annual costs that the ACA would impose on health insurers (if the benefits from the individual mandate and the Medicaid expansion were excluded, as described below) constitutes a very substantial percentage of their revenue and an amount that would dwarf their current profit margin.[4]

Based on *amici*'s analysis, the costs imposed by the Act include:

- expansion of dependent coverage to age 26 ($77 billion over ten years), ACA § 1001, 42 U.S.C. § 300gg-14(a);
- elimination of annual and lifetime out-of-pocket coverage limits ($51 billion), ACA §§ 1001, 10101(a), 42 U.S.C. § 300gg-11;
- an excise tax on health insurers ($90 billion), ACA §§ 9010, 10905, Health Care and Education Reconciliation Act of 2010 (HCERA) § 1406;
- the so-called "Cadillac" tax on high-cost health plans ($218 billion), ACA § 9001, 26 U.S.C. § 4980I; and
- the expanded essential health benefits package, which consists of the prohibition on consideration of pre-existing conditions, guaranteed issue, and community rating ($280 bil-

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[4] Indeed, as America's Health Insurance Plans has pointed out, the ACA, if left standing in whole or in part, will force health insurers to transform their business models fundamentally. *See* AHIP Certiorari Brief at 3, 7, 8.

> lion), ACA §§ 1201, 1255, 42 U.S.C. §§ 300gg (community rating), 300gg-1 (guaranteed issue), 300gg-3(a) (pre-existing conditions).

See Appendix at 10a.[5] *See also generally Florida*, 648 F.3d at 1365-71 (Appendix A to Eleventh Circuit Majority Opinion describing overall structure of the Act, by Title).

Accordingly, the expanded essential health benefits package – which consists of the core insurance reforms that even the Government concedes are not severable from the individual mandate – accounts for only about 39 percent ($280 billion of $715 billion) of the total costs to health insurers that *amici* predict. Other ACA provisions, such as the "Cadillac" tax, account for the rest of these costs. Thus, the Government's position that only the guaranteed issue and community rating provisions are not severable from the individual mandate is untenable in light of the economic realities that multiple other provisions of the Act will create for the health insurance industry.

2. The individual mandate will provide counterbalancing benefits to health insurers

On the other side of the ledger, expanded private coverage under the individual mandate and re-

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[5] In addition, other provisions of the Act, such as the requirements that plans cover certain preventive care for children, ACA § 1001, 42 U.S.C. §§ 300gg-13(a), are likely also to impose direct or indirect costs on insurers, but their effects are more difficult to quantify.

lated subsidies would *benefit* insurers by approximately $366 billion during that same 2012 to 2021 time period.[6] Notably, this benefit of $366 billion far exceeds the cost of $280 billion from the expanded coverage reforms – once again belying the Government's position that only the core insurance reforms of guaranteed issue and community rating cannot be severed from the individual mandate.

In particular, the individual mandate and related subsidies would provide annual benefits ranging from $51 billion in 2014, the first year of the mandate, to approximately $41 billion in 2021.[7] This benefit will occur because the mandate will push

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[6] The benefits projected to accrue to health insurers under the individual mandate include the refundable and advanceable premium credits and cost-sharing subsidies that the Act provides to uninsured individuals and families with incomes from 133 percent to 400 percent of the Federal Poverty Level who purchase health insurance on the new exchanges the Act creates. *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071. Because the total amount of these subsidies depends upon enrollment, including compulsory enrollment, it is not practicable to disaggregate the benefits associated with the individual mandate from those associated with these related subsidies. In addition, the mandate is designed to, and may be expected to, encourage consumers to purchase health insurance for reasons other than purely economic calculations, that is, because they wish to comply with the law.

[7] *Amici* project that the benefit to insurance companies as a result of the individual mandate and related subsidies will decrease over time because the rate of medical care cost growth, and therefore the rate of health insurance cost increases, is likely to outpace the penalties for non-compliance with the mandate and the subsidies the Act provides for those buying health insurance.

people who had previously made a rational economic decision not to purchase health insurance – that is, people who could expect the premiums they would pay to exceed the economic benefit they would receive from coverage – to enter the health insurance market.[8] Insurers, standing on the other side of that mandated transaction, would directly benefit from an exchange in which premiums they take in from newly mandated enrollees are likely to be greater than benefits they pay out. Thus, by compelling these consumers to purchase health insurance at disadvantageous prices, the individual mandate would subsidize the health insurance industry, which is necessary to counteract the costs otherwise imposed by the Act.

3. The Medicaid expansion also will provide a benefit to health insurers

In addition to the individual mandate, *amici* project that private insurers will receive a substantial benefit from the Act's expansion of Medicaid eligibility. To administer Medicaid, the States have increasingly turned to managed care, in which private insurance companies provide Medicaid benefits to individuals in return for fixed monthly payments from the States for each Medicaid patient. The Centers for Medicare and Medicaid Services (CMS) esti-

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[8] In particular, the individual mandate targets relatively young and healthy consumers, whose income exceeds the expanded class of those entitled to Medicaid and for whom the purchase of insurance at premiums set by community rating will in nearly all cases prove to be a bad economic bet.

mates that as of July 1, 2010, approximately 71 percent of Medicaid recipients were in managed care programs, up from 57 percent in 2001. *See* Centers for Medicare & Medicaid Services, *National Summary of Medicaid Managed Care Programs and Enrollment as of July 1, 2010*, https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2010Trends.pdf.

The move to managed Medicaid has increased even during the past year. Seventeen States already require non-long-term care Medicaid enrollees to sign up for managed care; six require long-term care recipients to enroll in managed care plans; and at least 10 others, including Florida, Maryland, New Jersey, and Rhode Island, are considering introducing or expanding the use of managed care to long-term care. *See* Phil Galewitz, Kaiser Health News, *States Turn to Private Insurance Companies for Managed Care*, USA Today, Feb. 21, 2011.

The ACA provides that Medicaid coverage will be expanded to cover those with incomes of up to 133 to 138 percent of the Federal Poverty Level beginning in 2014. *See* ACA §§ 2001, 2002, 42 U.S.C. § 1396a. This expanded coverage is projected to increase enrollment by as many as 16 to 20 million individuals and to increase costs by $428 billion between 2014 and 2019. *See* Centers for Medicare & Medicaid Services, *2010 Actuarial Report on the Financial Outlook for Medicaid*, i, iv, 27-28 (Dec. 21, 2010) [hereinafter CMS 2010 Report], https://www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf; Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, House of Reps. 9 (Mar. 20, 2010),

http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf (16 million additional enrollees in Medicaid and Children's Health Insurance Program (CHIPS)). In its projections of Medicaid costs, the CMS "assum[es] that many of the newly eligible Medicaid enrollees in 2014 will be enrolled in Medicaid managed care plans, as has been true of currently enrolled children and adults." CMS 2010 Report at 20; *see also id.* at 24 (referring to "the increasing proportion of the adult Medicaid population enrolled in managed care plans").

As a result of the ACA's Medicaid expansion, private insurance companies are projected to benefit from $35 billion in 2014 up to nearly $56 billion in 2021, net of the industry's expected loss of some customers that previously had private insurance but will switch to non-managed care Medicaid, for a total benefit of $356 billion.[9]

4. The individual mandate and Medicaid expansion will provide benefits proportionate to the increased regulatory costs under the ACA

Taken together, the Act's Medicaid expansion and the individual mandate and related subsidies will provide a total benefit to health insurers of approximately $721 billion from 2012 to 2021. These benefits will effectively neutralize the increased costs

[9] As a result of this significant benefit supplied by the Medicaid expansion, this economic analysis also supports the conclusion that those provisions, like the individual mandate, is non-severable from the rest of the Act.

the Act imposes on health insurers. Before the individual mandate and Medicaid expansion go into effect in 2014, and also before most of the corresponding cost-imposing provisions go into effect, the Act is estimated to cost insurers about $10 billion per year. (The fact that both the benefit and the cost provisions phase in over time provides further evidence that these provisions were intended to work hand in hand.) Then, from approximately 2014 to 2017, the Act will provide a net benefit to insurers of $31 to $42 billion per year. In 2018, insurers can be expected to break even, relatively speaking, and then starting in 2019, the Act's costs will again increasingly exceed its benefits.[10] *See* Appendix at 10a.

Consistent with Congress's intent to expand health insurance coverage while minimizing the increase in premiums, the total costs and benefits from this snapshot of the Act's complex economic effects nearly balance each other out, leaving just a $5.8 billion total net benefit to insurers during the decade from 2012 through 2021. *See* Appendix at 10a. This is not a coincidence. Removing the individual mandate from this carefully balanced accounting would thus fundamentally upset the legislative design of the Act.

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[10] This cost/benefit imbalance will result largely because, with rising healthcare costs, more and more healthcare plans will fall within the range that is subject to the "Cadillac" tax. *See* Appendix at 10a.

B. The Individual Mandate Also Mitigates The Costs That The ACA Would Impose On Other Market Participants

1. The benefit to insurers from the individual mandate would translate into decreased premiums for consumers

Amici's economic analysis as presented in the Appendix has focused upon the direct impact that, *ceteris paribus*, the ACA can be projected to have on insurance companies. Yet the individual mandate's subsidy to insurers is not an end in itself. As Congress was well aware, the individual mandate was necessary to ensure that the costs of the Act's regulatory mandates are not passed on to consumers.

As the Congressional Budget Office (CBO) reported in late 2009, without the individual mandate, the ACA's reforms, including but not limited to the guaranteed issue and community rating reforms, would cause a substantial increase in the premiums consumers could expect to pay. *See* Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 5, 6 (Nov. 30, 2009), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf (analyzing a Senate proposal very similar to the ACA as enacted and estimating that average premiums in nongroup market would be 27 to 30 percent higher because of expanded coverage but 7 to 10 percent lower because of additional enrollees and an additional 7 to 10 percent lower because of other rule changes affecting insurance companies). In fact,

seven months after providing this analysis, the CBO, along with Congress's Joint Committee on Taxation (JCT), estimated that eliminating the individual mandate would result in "adverse selection," which "would increase premiums for new non-group policies . . . by an estimated 15 to 20 percent relative to current law [with the ACA fully intact]." Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

Eliminating the individual mandate would increase premiums because insurers can be expected to attempt to pass along new costs to consumers who purchase health insurance. The size of the premium rate increases that insurance providers will actually be able to charge, however, will likely be limited by several factors, including competition from the exchanges the ACA sets up, 42 U.S.C. § 18031, new and more stringent medical loss ratio requirements under the ACA, *id.* § 300gg-18, and State and federal monitoring of premium increases, *id.* § 300gg-94.

To the extent that increased costs for insurers are ultimately borne by consumers of health insurance in the form of elevated premiums, Congress would not have intended to pass a law that would cause such premium increases without the countervailing force of the individual mandate and related subsidies exerting downward pressure on premiums. The individual mandate is widely projected to mitigate that increase in premiums for precisely the reason that Congress intended: The individual mandate

forces healthy people who are not participants in the health insurance market to join that market.

The intent of Congress to take advantage of this link between the individual mandate and lower health insurance premiums is beyond dispute, as Congress explicitly found that

> [b]y significantly increasing health insurance coverage, the [individual mandate] requirement, together with the other provisions of this Act, will minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. 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.

ACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I); *see also* ACA § 1501(a)(2)(F), 42 U.S.C. § 18091(a)(2)(F) ("By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums."); ACA § 1501(a)(2)(J), 42 U.S.C. § 18091(a)(2)(J) (the individual mandate will increase economies of scale, thereby lowering premiums); Petition for Writ of Certiorari of U.S. Department of Health and Human Services at 7, 24, *U.S. Department of Health & Human Servs. v. Florida*, No. 11-400 (quoting ACA § 1501(a)(2)(I), 42

U.S.C. § 18091(a)(2)(I)).[11] If the individual mandate is invalidated as unconstitutional, then the link between the mandate and these premium reductions would be broken and Congress's objective of lowering premiums would be thwarted.

2. The individual mandate would also offset costs the ACA imposes on other market participants

The individual mandate can also be expected to subsidize other market participants that are subject to costs as a result of other provisions of the Act. For instance, hospitals and drug manufacturers face several provisions that will reduce their revenue, including lower Medicare payments for hospitals "because of productivity adjustments to the annual 'market-basket' updates" and lower Medicare payments for drug manufacturers in Medicare Part D's so-called donut hole. Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, 364 New England Journal of Medicine e16 (Mar. 10, 2011), http://www.nejm.org/doi/full/10.1056/NEJMpv1101519. As Herring points out, drug manufacturers, medical device manufacturers, and health insurers will each also be subject to a new flat fee or tax under the ACA. *See id.*

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[11] In addition, as America's Health Insurance Plans has pointed out, Congress legislated in the shadow of the adverse experiences of numerous States that have enacted community rating and guaranteed issue reforms but not individual mandates. *See* AHIP Certiorari Brief at 19-22.

The individual mandate provides a subsidy to these market actors that mitigates the effects of these provisions: "These [cost-imposing] provisions seemed politically possible because the healthcare industry was willing to make concessions on prices and fees in return for the large increase in the number of people with insurance that was expected to occur under the ACA," *id.*, because of the individual mandate, related subsidies, and Medicaid expansion. "A large body of research suggests" that an increase in the ranks of America's insured would likely lead to greater healthcare consumption. *Id.* This would provide a boon to hospitals and drug manufacturers.

Indicative of the Act's sprawling and interconnected structure, the cost-imposing provisions Herring highlights are *not* located within Title I of the Act, the title dealing explicitly with insurance regulation. *See, e.g.*, ACA § 3301, codified at, *e.g.*, 42 U.S.C. §§ 1395w-102(b), 1395w-114a, 1395w-153 (Title III of the Act, which, among other changes to Medicare, "revises the Medicare Part D prescription drug program and reduc[ing] the so-called 'donut hole' coverage gap in that program," *Florida*, 648 F.3d at 1368). *See generally Florida*, 648 F.3d at 1365-71 (Appendix A to Eleventh Circuit Majority Opinion describing overall structure of the Act, by Title).

II. GIVEN THAT THE INDIVIDUAL MANDATE IS TIED TO SO MANY SECTIONS OF THE ACT, THERE IS NO PRACTICAL WAY FOR THE COURT TO SEVER THE MANDATE AND PRESERVE THE ACT

The preceding discussion demonstrates that the individual mandate provides an essential coun-

terbalance to what would otherwise be substantial costs to market participants including health insurance companies, consumers of insurance, hospitals, and drug manufacturers. As this Court has noted, when courts evaluate remedies, including severability, when part of a statute is unconstitutional, they must, among other considerations, "restrain [themselves] from 'rewrit[ing] [a] law to conform it to constitutional requirements' even as we strive to salvage it." *Ayotte*, 546 U.S. at 329 (quoting *Virginia v. Am. Booksellers Ass'n*, 484 U.S. 383, 397 (1988)) (second alteration in original); *see also Florida*, 780 F. Supp. 2d at 1303 (quoting *Ayotte*).

Thus, "where" – as here – "line-drawing is inherently complex," engaging in a provision-by-provision analysis to invalidate many of the Act's provisions but perhaps not others "may call for a 'far more serious invasion of the legislative domain' than we ought to undertake." *Ayotte*, 546 U.S. at 330 (quoting *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479 n.26 (1995)). The District Court understood that this principle requires the ACA to be invalidated in its entirety once the individual mandate has been adjudged unconstitutional. *Florida*, 780 F. Supp. 2d at 1303-05. As that court correctly observed, without the individual mandate, the Act

> cannot function as originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions – which, as noted, were the chief engines that drove

> the entire legislative effort – for me to try and dissect out the proper from the improper, and the able-to-stand-alone from the unable-to-stand-alone. Such a quasi-legislative undertaking would be particularly inappropriate in light of the fact that any statute that might conceivably be left over after this analysis is complete would plainly not serve Congress' main purpose and primary objective in passing the Act.

Id. at 1304-05.

Amici's economic analysis reinforces this conclusion by demonstrating the economic reality that the individual mandate is intertwined with a host of ACA provisions, not simply the core insurance reforms. As a result, the mandate cannot be severed from the remainder of the ACA.

CONCLUSION

For the foregoing reasons, if the Court upholds the Eleventh Circuit's judgment that the individual mandate is unconstitutional, then the decision as to severability should be reversed.

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Appendix

FINDINGS AND METHODOLOGY

Economic Analysis of the Impact of Severability to Insurers Under the Patient Protection and Affordable Care Act

COSTS TO INSURERS ($ Billions):	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021
Expanding Dependent Coverage to Age 26	$ (5.57)	$ (5.96)	$ (6.38)	$ (6.83)	$ (7.31)	$ (7.82)	$ (8.37)	$ (8.95)	$ (9.58)	$ (10.25)	**$ (77.01)**
Eliminating Annual/Lifetime Out-of-Pocket Limits	$ (4.10)	$ (4.39)	$ (4.16)	$ (4.45)	$ (4.76)	$ (5.10)	$ (5.45)	$ (5.83)	$ (6.24)	$ (6.68)	**$ (51.16)**
Excise Tax on Health Insurers	$ -	$ -	$ (6.10)	$ (9.30)	$ (9.50)	$ (11.40)	$ (11.70)	$ (12.10)	$ (13.92)	$ (16.00)	**$ (90.02)**
"Cadillac" Tax on High-Cost Health Plans	$ -	$ -	$ -	$ -	$ -	$ -	$ (24.40)	$ (39.04)	$ (60.51)	$ (93.79)	**$ (217.75)**
Expanded Essential Health Benefits Package	$ -	$ -	$ (27.25)	$ (29.15)	$ (31.20)	$ (33.38)	$ (35.72)	$ (38.22)	$ (40.89)	$ (43.75)	**$ (279.55)**
TOTAL	**$ (9.67)**	**$ (10.35)**	**$ (43.89)**	**$ (49.73)**	**$ (52.76)**	**$ (57.69)**	**$ (85.63)**	**$ (104.14)**	**$ (131.14)**	**$ (170.48)**	**$ (715.49)**

BENEFITS TO INSURERS ($ Billions):	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021
Revenue from Expanded Private Coverage Under the Individual Mandate	$ -	$ -	$ 50.75	$ 49.23	$ 47.75	$ 46.32	$ 44.93	$ 43.58	$ 42.27	$ 41.01	**$ 365.83**
Revenue from Medicaid Expansion (Net of Crowd-Out of Other Insurance)			$ 34.65	$ 37.08	$ 39.67	$ 42.45	$ 45.42	$ 48.60	$ 52.00	$ 55.64	**$ 355.50**
TOTAL	**$ -**	**$ -**	**$ 85.40**	**$ 86.30**	**$ 87.42**	**$ 88.77**	**$ 90.35**	**$ 92.18**	**$ 94.27**	**$ 96.65**	**$ 721.34**
NET TO INSURERS	**$ (9.67)**	**$ (10.35)**	**$ 41.51**	**$ 36.57**	**$ 34.66**	**$ 31.07**	**$ 4.71**	**$ (11.96)**	**$ (36.86)**	**$ (73.83)**	**$ 5.84**
NET WITHOUT INDIVIDUAL MANDATE	**$ (9.67)**	**$ (10.35)**	**$ (9.24)**	**$ (12.66)**	**$ (13.09)**	**$ (15.25)**	**$ (40.21)**	**$ (55.54)**	**$ (79.14)**	**$ (114.84)**	**$ (359.99)**

Appendix

This analysis was completed using the HEPSS-ARCOLA economic forecasting model, which is designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the U.S. population with respect to health insurance coverage and the financial impact of the proposed changes.

The model is built on a foundation of data sources including claims data from several nationwide employers, the Medical Expenditure Panel Survey Household Component (MEPS-HC), and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

This model was first used by the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on how quickly and how many consumers would adopt high-deductible health plans in the individual health insurance market. *See* Roger Feldman, Stephen T. Parente, Jean Abraham, et al., *Health Savings Accounts: Early Estimates Of National Take-Up*, 24 Health Affairs 1582 (Nov./Dec. 2005); Stephen T. Parente & Roger Feldman, *Continuation of Research on Consumer Directed Health Plans: HSA Simulation Model Refinement, Final Technical Report for DHHS Contract HHSP23320054301ER*, i (Jan. 21, 2007). The model was later refined to incorporate the effect of prior health status on health plan choice in order to predict enrollment more accurately. The current model uses insurance expenditures from actual health in-

surance claims data and Medicaid to estimate the state and federal impact of health policy changes.

The data used for this analysis are the Medical Expenditure Panel Survey (MEPS), ehealth.com, the 2011 Kaiser survey of health plans, and proprietary commercial insurance claims as well as benefit design information from several employers.

By inputting updated premium data into the model and then running the model through an iterative process, *amici* were able to estimate, for a ten-year projection period, the response of individuals to new health insurance choices, premium rates, plan participation, and other financial information in the presence of the ACA's various provisions. *See also* Douglas Holtz-Eakin, Stephen T. Parente & Michael J. Ramlet, *The Economic Implications of Severing the Individual Mandate*, American Action Forum, Jan. 5, 2012, http://bit.ly/EIoStIM.