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.

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

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

BRIEF OF *AMICUS CURIAE* NATIONAL RESTAURANT ASSOCIATION IN SUPPORT OF PETITIONERS (SEVERABILITY)

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QUESTION PRESENTED

Whether the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, 124 Stat. 109 (2010) (collectively the "Act"), must be invalidated in its entirety because it is not severable from the Act's individual mandate, 26 U.S.C. § 5000A, that exceeds Congress's limited and enumerated powers under the Constitution.

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INTERESTS OF *AMICUS CURIAE*[1]

This brief is submitted on behalf of the National Restaurant Association (the "Association") in support of petitioner. The Association is the leading business association for the restaurant and food service industry. The industry comprises 960,000 restaurant and food service outlets employing 12.8 million people who serve 130 million guests daily.[2] The restaurant industry is the nation's second-largest private-sector employer; more than nine percent of the U.S. workforce is employed in this industry.

The restaurant and food service industry is unique for several reasons. First and foremost, small businesses dominate the industry – with more than seven out of ten eating and drinking establishments being single-unit operators. This industry also employs a high proportion of part-time, seasonal, and temporary workers, with fluctuating and unpredictable work hours, as well as unpredictable lengths of service. The workforce is typically young, with nearly half of its employees being under the age of 25. The restaurant industry also has a high

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[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* certifies that no counsel for any party authored this brief in whole or in part, and that no person other than amicus, its members, or its counsel made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Supreme Court Rule 37.3, amicus states that all counsel of record for all parties have filed with the Clerk's office letters of blanket consent to the filing of amicus briefs.

[2] *2011 Restaurant Industry Forecast*, National Restaurant Association.

workforce turnover rate relative to other industries with a 75 percent average turnover rate in 2008 compared to a 49 percent average turnover rate for the overall private sector. In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.

This brief focuses on only one of the issues before the Court, the severability of the individual mandate from the other provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, 124 Stat. 109 (2010) (collectively, the "Act").[3] In the event this Court finds that Congress exceeded its Constitutional authority in enacting the individual mandate, the Eleventh Circuit's decision regarding severability must be reversed, and the entire Act must be invalidated.

The Eleventh Circuit's decision incorrectly applies this Court's severability jurisprudence and fails to recognize the congressional objectives in passing the Act with numerous interrelated provisions. Moreover, if the Eleventh Circuit's decision on severability prevails, the Act will produce a U.S. health care system that no longer provides any risk-pooling mechanism and that is certain to accelerate dire financial impacts on those who provide health insurance, and on the restaurant industry in

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[3] The Association does not take a position as to whether the individual mandate is constitutional.

particular. These results contravene the congressionally-declared purposes of the Act.

SUMMARY OF THE ARGUMENT

In the event the individual mandate in the Act is found unconstitutional, it cannot be severed from the whole and the entire Act is invalid. The Act was designed and intended by Congress as an integrated remedy to the shortcomings of the U.S. health care coverage system. As such, congressional intent will not be served by severing the individual mandate and leaving in place the remnants of the Act that are not being directly challenged here. If the other provisions of the Act remain in effect without the individual mandate, the Act will actually exacerbate many of the very problems Congress sought to ameliorate, and the cost of health care coverage will significantly increase. The restaurant industry will be hit especially hard, by virtue of the demographics of its workforce and the characteristics of its employers.

Particular features of the Act, such as the ban on preexisting condition exclusions, the ban on lifetime and annual limits, and the requirement for coverage of adult children will, in the absence of the individual mandate, result in increased health insurance costs for employers and individuals seeking insurance coverage. In response, many restaurant industry employers will no longer be able to afford to provide *any* health care coverage to their employees, forcing those employees to seek coverage from government-subsidized sources, which will increase the burden on U.S. and state taxpayers, and undermine the private employer-based health insurance system.

ARGUMENT

I. THE INDIVIDUAL MANDATE IS NOT SEVERABLE FROM THE ACT

Introduction

The Act is one of the most far-reaching and complicated statutory regimes enacted by Congress in recent memory. The nearly 2,700 pages of statutory language and the thousands of attendant regulations impose (or will impose) countless intertwined obligations on individuals, employers and state governments. The Act's mandate that individuals must purchase health insurance is the central element of this regime to which virtually all of the other reforms in the Act directly or indirectly relate. Without the individual mandate in place to facilitate and fund the Act's other insurance and health care reform provisions, those remaining provisions cannot fulfill Congress's stated goals in passing the Act.

The district court found the individual mandate to be contrary to Congress's power under the Constitution and, after considering this Court's precedents on the severability doctrine, correctly determined that the individual mandate could not be severed from the rest of the Act.

The Eleventh Circuit, in reversing the district court's decision on severability, incorrectly applied this Court's severability jurisprudence and failed to properly recognize the congressional intent in crafting the Act's provisions to function as an interrelated whole.

A. The Presumption of Severability Does Not Apply to the Act

This Court recently reaffirmed the doctrine of severability by noting that "[g]enerally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.,* 561 U.S. ——, ——, 130 S.Ct. 3138, 3161 (2010) (citation and internal quotations omitted).

This presumption of severability of the offending provision has also been characterized as the "normal rule that partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades, Inc.,* 472 U.S. 491, 504 (1985).

The Court's use of the terms "generally speaking" in *Free Enterprise Fund,* and "normal rule" in *Brockett* necessarily implies that there are instances when severability is not the proper remedy for a constitutionally flawed statute. The unprecedented reach of the Act and the dramatic effects its interrelated provisions have (or will have) on one-sixth of the U.S. economy is a clear indication that this is not a typical case involving a question of whether to sever a discrete statutory provision. Indeed, if this case does not present the circumstances mandating departure from the "normal rule" of severability, it would be difficult to imagine the scenario warranting such a departure.

Determining whether an unconstitutional provision can be severed from the remainder of the statute hinges on whether the provisions that would remain

can function "in a *manner* consistent with the intent of Congress" in passing the Act. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis in original).

Although many remaining provisions of the Act may technically function[4] in the absence of the individual mandate, it is clear that they would not function in accord with Congress's overall objectives and intent in passing the Act.

B. Congress Intended the Act's Provisions to Function as an Interrelated Whole

1. Congress Declared the Mandate Essential to Achieving the Purposes of the Act

The Act is a carefully crafted legislative compromise consisting of numerous provisions each of which, by virtue of its inclusion in the Act, was necessary to the design and ultimate passage of the interrelated reforms devised by Congress to address the ills in the U.S. health care system.

The lynchpin of these myriad reform provisions is the individual mandate, which the congressional findings accompanying the Act repeatedly refer to as the "essential" element upon which achievement of the Act's objectives depends. *See, e.g.*, 42 U.S.C. § 18091(a)(2)(I) ("the requirement [to purchase insurance] is essential to creating effective health insurance markets").

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[4] Indeed some provisions of the Act have already gone into effect.

Congress described its objectives in the Act's findings, which include adding millions of new consumers to the health insurance market, 42 U.S.C. § 18091(a)(2)(C); achieving near-universal coverage and strengthening the private employer-based health insurance system, 42 U.S.C. § 18091(a)(2)(D); lowering health insurance premiums, 42 U.S.C. § 18091(a)(2)(F); improving financial security for families, 42 U.S.C. § 18091(a)(2)(G); and broadening the health insurance risk pool to include healthy individuals, 42 U.S.C. § 18091(a)(2)(I). Each of the congressional findings notes that these objectives were to be accomplished either solely by the individual mandate or by the individual mandate operating in conjunction with other provisions of the Act.

Indeed, the Act's most wide-ranging objective of adding millions of new consumers to the health insurance market through the individual mandate would likely lead to the fulfillment of the other objectives given Congress's realization that healthy individuals make up a significant portion of the currently uninsured and their insurance premiums would offset additional costs associated with the Act's other reforms that expand coverage.

2. Severing the Mandate Conflicts with Congress's Intent that the Act Function as an Integrated Whole

"[T]he touchstone for any decision" about whether to sever an offending provision from the rest of the Act, "is legislative intent." *Ayotte v. Planned Parenthood of N. New Eng.,* 546 U.S. 320, 330 (2006). In crafting the Act, Congress recognized that without an individual mandate, "many individuals would wait to purchase

health insurance until they needed care." 42 U.S.C. § 18091(a)(2)(I). Individuals who forego the advance purchase of insurance and who later need medical care are those who are often excluded from the insurance market as a result of pre-existing conditions and/or are those who often have their medical expenses shifted to others in the health care system.

Congress addressed these uninsured and cost-shifting problems in the Act by requiring individuals, including those who are healthy, to purchase and maintain health insurance. The individual mandate also serves to achieve near-universal coverage that broadens the risk pool and provides financing to cover costs associated with other reforms in the Act, including the guaranteed issue provision, the prohibition on insurance eligibility based on health status, and the community rating provision. *See* 42 U.S.C. §§ 300gg-1(a), 300gg-4, 300gg-(a)(1).

The objectives underlying the Act plainly reveal Congress's intent that the individual mandate is designed to work in conjunction with other provisions in the Act to solve the identified shortcomings in the health care system. Thus, the absence of the individual mandate as part of that reform regime "pose[s] a critical problem" for the Act to function as intended. *United States v. Booker*, 543 U.S. 220, 260 (2005).

Indeed, severing the individual mandate would leave in place a set of reforms untethered from their anchor that, rather than fulfill Congress's objectives in passing the Act, would actually exacerbate the problems Congress set out to ameliorate. *See* discussion *infra* Part II.

Such a result surely satisfies the requirement that for the entire Act to be invalidated, it be "evident that Congress, faced with the limitations imposed by the Constitution, would have preferred no [Act] at all" to the Act that remains. *Free Enter. Fund*, 130 S.Ct. at 3161 (internal quotations and citations omitted).

C. Attempting to Assess Whether Additional Provisions Should be Severed Would Require the Court to Infringe on the Role of the Legislature

Although it may be theoretically possible to parse every line in the 2,700 page statute in an attempt to determine congressional intent with respect to each provision, and whether and to what extent each is related to the individual mandate, and should be severed from the Act, such an exercise would overstep the purview of the Court and infringe on the role of the legislature. *See Ayotte*, 546 U.S. at 329-30 ("making distinctions . . . where line-drawing is inherently complex, may call for a 'far more serious invasion of the legislative domain' than we ought to undertake").

Therefore, rather than attempting to determine congressional intent with regard to every provision and its relation to the individual mandate, the entire interrelated Act should be invalidated, so that Congress may exercise its proper role and determine whether any of the remaining provisions should be enacted absent the individual mandate.

II. SEVERING THE INDIVIDUAL MANDATE FROM THE ACT WILL LEAD TO RESULTS CONGRESS DID NOT INTEND

Introduction

The Act is Congress's attempt at a comprehensive approach to implementing reform in the health insurance market. The provisions are complex and intertwined, because Congress determined that only an integrated approach could address the various problems affecting the health care system.

Congress sought to address what it identified as two major shortcomings in the current system: (1) that many Americans who want or need coverage cannot obtain it, or can only obtain part of the coverage they need; and (2) that the risk pooling system is flawed because many healthy people do not elect to be covered. The Act addressed these problems by extending coverage generally and broadening the scope of coverage to those already covered; and by mandating certain employers make coverage available to individuals, and by mandating that each individual maintain coverage. Much of the first part of these reforms has already become effective or will become effective before 2014, with universal availability of insurance and the individual mandate becoming effective in 2014.

Of the various provisions of the Act, the individual mandate is the most critical because it is the primary mechanism to achieve near-universal health insurance coverage, including among the relatively young and healthy. Without the mandate, the Act creates a perverse system offering widespread availability and

a broad scope of coverage without any true functioning "insurance" mechanism. Instead of obtaining insurance in *advance* as a hedge against potential future health care costs, the insurance could be accessed "just in time" by individuals right before medical care is needed.

A lack of near-universal coverage and corresponding influx of insurance premiums from relatively healthy individuals, who would otherwise largely opt-out of medical insurance absent the mandate, will deprive the system of needed revenue to finance the expanded coverage mandated by the Act. This will undoubtedly lead to a spiraling increase in medical costs, particularly as more individuals with costly pre-existing conditions are provided insurance at rates unrelated to their actual health risk.

The rising costs of health care will make insurance premiums increasingly expensive, which will, in turn, force more individuals from the private insurance market and into government-sponsored plans, thereby shrinking the risk pool and causing insurance costs to rise even more.

In other words, the Act without an individual mandate creates a system that is more expensive because there is no true risk pool where the health care costs of the participants can be financed by the insurance premiums of both the healthy and the sick. Instead, it produces a system that mandates only the sick and injured be covered and, therefore, only those individuals will be paying insurance premiums in advance to finance health care. Such a regime is unsustainable.

Another indication of the individual mandate's central role in the Act is the inclusion of staggered effective dates for many of the health insurance provisions, with the substantive health insurance reforms going into full effect in 2014, when the individual mandate becomes effective. For example, the Act requires preexisting condition exclusions to be eliminated for dependent children for plan years beginning on or after September 23, 2010, but requires preexisting condition exclusions to be eliminated for *all* participants by 2014, when the individual mandate is scheduled to be effective. *See* 42 U.S.C. § 300gg-3.[5] Similarly, the Act prohibits health plans from including lifetime limits on essential health benefits for plan years beginning on or after September 23, 2010, and permits only reasonable annual limits on essential health benefits until 2014. *See* 42 U.S.C. § 300gg-11(a)(1)(A), (b). Beginning in 2014, however, when the individual mandate is scheduled to go into effect, the Act prohibits *all* annual limits on essential health benefits. *Id.*[6]

Congress's decision to tie the effective dates of various provisions to the effective date of the individual mandate reflects the central importance of

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[5] For dates effective as to children and then adults, *see* Pub. L. No. 111-148, Title I, § 1255 (formerly § 1253), 124 Stat. 162 (2010) (renumbered § 1255 and amended, Pub. L. No. 111-148, Title X, § 10103(e), (f)(1), 124 Stat. 895 (2010), and codified in note to 42 U.S.C. § 300gg-3).

[6] In addition, the Act permits grandfathered plans to exclude adult dependent children who are eligible to enroll in their own employer-sponsored plan from coverage, but only until 2014 when the individual mandate goes into effect. *See* 42 U.S.C. § 18011.

the mandate to the effective implementation of the Act's other reforms. Without the individual mandate, the rest of the provisions in the Act produce unbalanced changes that are unable to achieve Congress's objectives for reform of the health care and insurance system.

A. The Remaining Provisions of the Act Would Create Dire Consequences for the Health Insurance Market

If the individual mandate is found unconstitutional and the rest of the Act continues in effect, the health insurance market would suffer a significant adverse financial impact contrary to Congress's intent in passing the Act.[7]

The Act's prohibition on preexisting condition exclusions and lifetime limits (which were common practices in the health insurance market before passage of the Act) while expanding coverage for adult children, drastically increases the potential liabilities for those who provide health insurance. With the individual mandate, this financial impact would be

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[7] *See* Brief of America's Health Insurance Plans as *Amicus Curiae* in Partial Support of Certiorari Review in this case, pp. 6-8, 15-22 ("Empirical evidence thus strongly indicates that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market and, over time, would substantially reduce access to affordable coverage."); *see also* 42 U.S.C. § 18091(a)(2)(I) ("By significantly increasing health insurance coverage, the requirement [to purchase insurance]. . . will broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums").

somewhat offset by the increased number of healthy individuals obtaining coverage and thus contributing premiums without consuming health care services.

Without this individual mandate, however, this drastic increase in liabilities for those who provide health insurance is not offset at all. Indeed, healthy individuals may not purchase any type of health care insurance until they are actually sick, and at that point the Act requires group health plans to provide them coverage. Thus, implementing the rest of the Act's provisions related to health insurance without the individual mandate would have a significant negative economic impact on insurers and employers providing health insurance coverage.

The preventive service provisions of the Act also underscore how the individual mandate is inextricably linked to the overall solution crafted by Congress. When individuals receive preventive services, the cost of health care in the long run is reduced.[8] The Act requires group health plans to provide 100 percent coverage for preventive services. *See* 42

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[8] *See* Preamble to *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act,* 75 Fed. Reg. 41726, 41735 ("Increasing the provision of preventive services is expected to reduce the incidence or severity of illness, and, as a result, reduce expenditures on treatment of illness. ….Researchers at the Centers for Disease Control and Prevention (CDC) … found that every dollar spent on immunizations in 2001 was estimated to save $5.30 on direct health care costs and $16.50 on total societal costs of the diseases as they are prevented or reduced (direct health care associated with the diseases averted were $12.1 billion and total societal costs averted were $33.9 billion)).

U.S.C.§ 300gg-13(a).[9] Although this expanded coverage would represent additional costs to the health care system, the individual mandate could be expected to help offset these costs. This would occur because individuals with coverage (as a result of the mandate) would be more likely to avail themselves of preventive care, enabling doctors to identify and treat ailments earlier and at a much lower cost than if such conditions were discovered and treated in later stages as a serious health condition.

Without the individual mandate, however, individuals can drop in and out of coverage only when they think they need medical care and, without continuous coverage, will be less likely to seek out preventive services. As a result, the Act's expanded coverage for preventive services will increase costs in the health care system without the counterbalancing reduction in costs attained through early treatment of ailments among those who fail to maintain coverage and access to preventive care.

Congress recognized the critical nature of the individual mandate and the dangers posed by this

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[9] The Act provides that plans with minimal changes, considered "grandfathered" are not required to meet this requirement, but the Department of the Treasury, Department of Labor and Department of Health and Human Services estimated that by 2013 up to 80 percent of small employer plans would lose grandfathered status. *See* Preamble to 26 C.F.R. 54.9815-1215T, *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as Grandfathered Health Plan and the Patient Protection and Affordable Care Act,* 75 Fed. Reg. 34553 (June 17, 2010). Thus, this requirement would apply to most restaurant industry group health plans.

adverse selection. In fact, Congress explained in the Act's findings its intent for the individual mandate to "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).

B. The Restaurant Industry Will Be Particularly Impacted by the Remaining Burdensome Provisions of the Act

The demographics of the restaurant workforce and the characteristics of most restaurant employers means the industry would be subject to a particularly negative impact if the individual mandate is severed from the rest of the Act.

1. Younger Workers are More Likely to Forego Coverage

With the individual mandate in place, more people, including relatively healthy people, will be in the insurance pool and contributing to the cost of coverage. Without the individual mandate, however, individuals could take a "wait and see" approach and elect coverage under an employer's plan only after being diagnosed with a serious illness or experiencing an accident that requires rehabilitative treatment.

This adverse selection concern would be most prevalent among younger, healthier individuals, with more limited income. Absent an individual mandate, workers who fit this profile are likely to decline health care coverage until they have an immediate need for care.

This result would have a disproportionate impact on restaurant employers because so much of their workforce is made up of precisely this demographic. Nearly half of the workers in the restaurant industry are under age 25 and the vast majority are employed on an hourly basis. An internal 2007 industry survey revealed that nearly three-fourths of the industry's hourly workforce does not elect to participate in employer-provided health plan coverage.

In addition, restaurant employees often work fewer hours and earn less compensation, on average, than the overall United States workforce. Thus, the cost of health care coverage would take up even more of these employees' disposable income and, without the individual mandate, they would have little incentive to enroll in their employers' health plans until they actually needed coverage for a particular condition. In fact, in the absence of the mandate, these individuals will have even *less* incentive to enroll than they do now because the employers' future health plans will be more expensive as the remaining reforms in the Act drive up costs (with a higher proportion of unhealthy people in the risk pool worsening that trend), and the downside to waiting to elect coverage (i.e., that preexisting conditions would not be covered) is eliminated.

If an individual needed health care at a certain point, the individual could either wait for the employer's annual enrollment period to become covered by the employer's plan, or, in light of the high turnover rates in the restaurant industry, the individual could instead obtain employment with a new employer and become enrolled immediately without waiting for the annual enrollment period.

In either case, the result is that restaurant plans are more likely to experience low enrollment with the majority of the employees who elect coverage being those requiring expensive medical treatment. This scenario would lead to steep increases in the cost of coverage and many restaurant owners no longer being able to provide *any* coverage whatsoever to their workforce. This result would undermine the employer-provided health care system, contrary to Congress's intent in passing the Act. *See, e.g.,* 42 U.S.C. § 18091(a)(2)(D) ("the requirement [to purchase insurance] achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system").

2. Industry Employers Will Be Adversely Affected by the Cost of Partial Implementation of Health Care Reform

The restaurant industry is composed overwhelmingly of small employers. Congress's goal of helping small employers provide health coverage would be impeded by the large increase in the cost of health care coverage, which would result if the rest of the Act stands without the individual mandate requirement. Congress's intent to help small employers provide health coverage is evidenced by numerous provisions of the Act.[10] If the Act is

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[10] For example, the Act provides a small business tax credit for qualifying employers' contributions toward their workers' health insurance premiums, 26 U.S.C. § 45R; authorizes grants to small employers to create wellness programs, 42 U.S.C. § 280l; and, creates a safe harbor from certain nondiscrimination testing rules for small employers through the use of a simple cafeteria plan for pre-tax contribution funding, 26 U.S.C. § 125(j). In addition, the

implemented without the individual mandate, however, it would affirmatively place small employers, and their employees, in a *worse* position than they were before passage of the Act. The Act's other reforms would increase the cost of coverage so much that many small employers will not be able to afford to offer their employees any coverage. Thus, the special provisions targeted to help small employers provide health care coverage to their employees would be largely useless.

In addition, employers subject to the employer mandate would be even *more* likely to be subject to additional penalties if the Act is implemented without the individual mandate. The Act requires that an employer with the equivalent of at least 50 full-time employees must either offer its full-time employees and their dependents the opportunity to enroll in "affordable" minimum essential coverage or pay a penalty. *See* 26 U.S.C. §§ 36B, 4980H. While many restaurant employees are considered part-time, the Act requires that any employee working only 30-hours per week would be considered full-time, and an employer meeting the threshold of 50 employees would either need to offer these individuals affordable coverage or face a penalty.

As noted above, the other remaining requirements of the Act would greatly increase the cost of coverage, but the Act's "affordability" restriction on employers means they cannot charge an employee more than 9.5

Act requires the creation of State Exchanges as a means for small employers to have access to affordable health care coverage for their employees. *See* 42 U.S.C. § 18031.

percent of the employee's household income for coverage.

Restaurant employers, whose workforce tends to have lower household incomes, would need to keep the employee premium at an even lower relative dollar amount to meet this 9.5 percent threshold. Consequently, restaurant employers would inevitably have to absorb a disproportionately high share of the dramatic price increases caused by the Act or pay penalties for not offering coverage. In either case, the private employer-based health insurance system will be weakened, rather than strengthened as Congress intended. *See, e.g.,* 42 U.S.C. § 18091(a)(2)(D).

3. Without the Individual Mandate, the Offerings for Small Employers in the State Exchanges Would Be More Expensive

Congress included provisions in the Act for States to create health care Exchanges through which individuals and small employers would be able to purchase coverage beginning in 2014. *See* 42 U.S.C. § 18031.

As described above, the Act's expansion of insurance coverage to the previously uninsured generally increases the cost of health insurance. With the individual mandate, the insurance risk pool would dramatically expand, enabling insurers to distribute costs across the wider pool and offer lower-cost premiums. The Exchanges would, thus, help small employers, like many of those in the restaurant industry, access insurance coverage for their employees.

Without the individual mandate, however, fewer individuals will be included in the risk pool pricing for insurance available on the Exchanges. As a result, the Exchanges will not function as intended to provide small employers with additional insurance coverage options for their employees.

CONCLUSION

Should this Court find Congress exceeded its authority in enacting the individual mandate, the judgment of the Eleventh Circuit severing the mandate from the rest of the Act must be reversed and the entire Act must be invalidated.

Respectfully submitted,

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