Nos. 11-393 and 11-400

In the Supreme Court of the United States

National Federation of Independent Businesses, *et al.*,
Petitioners,
v.

Kathleen Sibelius, Secretary of Health and Human Services, *et al.*,
Repondents.

States of Florida, *et al.*,
Petitioners,
v.

Department of Health and Human Services, *et al.*,
Respondents.

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

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Amicus Brief of Michigan Legal Services, Inc. and other Michigan Non-profit Corporations in Support of Government's Position on Severability

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Table of Contents

Table of Authorities

Cases:

Statutory Provisions:

Other Sources:

Introduction and Dedication

The Patient Protection and Affordable care Act [ACA hereinafter] expanded health care coverage in several ways by reforming the health care financing and delivery system. These reforms benefit all of us.

Amici have attempted to put the ACA in context. The so-called 'mandate' is only one tool, and not the most important one, in the ACA. The ACA has already taken effect in major ways, with one of its most basic provisions already implemented [Medical Loss Ratio limits].

Our present system burdens ordinary Americans and does not deliver services to millions who need them. Bankruptcy, medical debt, and morbidity and mortality all increase in the system as it is now. If there is a 'liberty' interest here it is in those who will be free of the burdens the present system imposes and who will be able to live fuller lives, living up to their full potential, because of the ACA.

We dedicate this brief to those who have suffered under the present system – especially to the thousands who have died because they had no insurance and no access to affordable care.[1]

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[1] All parties have consented to this *Amicus curiae* brief and letters of consent have been filed with the Clerk. Pursuant to Rule 37.6, *Amicus* represents that no counsel for a party authored this brief in whole or in part, and no person or entity other than *Amicus* and its counsel made a monetary contribution to the preparation or submission of this brief.

Statements of Interest

Michigan Legal Services has represented persons at or below 200% of the Federal Poverty Level for over thirty years. The Affordable Care Act [ACA] significantly increases access to health insurance and health care to that population through many provisions of the ACA. We argue that people need to be free from the present business model so that we can all live full and productive lives. The ACA, with or without the 'mandate' will allow more Americans to live such lives.

People with higher incomes also are significantly impacted by the cost of insurance on the individual market. MichUHCAN [Michigan Universal Health Care Access Network, Inc.] has been an advocate for people at all income levels. MichUHCAN is a grass roots organization with members throughout the State.

Michigan Consumers for Healthcare represents more than 110 community and healthcare advocacy organizations, and works collaboratively with a diverse alliance of consumers, partners, and policymakers to attain affordable, accessible, quality healthcare for everyone in Michigan through education, outreach, advocacy and stakeholder engagement. MCH recognizes the Affordable Care Act (ACA) as the nation's most comprehensive healthcare reform effort in our history, presenting our best opportunity to make the vision of affordable, robust, and universal healthcare coverage a

reality. ACA is a historic turning point in American healthcare, and its survival and implementation are crucial for the protection and advancement of consumer health.

The Center for Civil Justice is a non-profit law firm that advocates for low-income people in mid-Michigan who face challenges accessing basic human needs and services, including health care. In the area of health care, the Center's clients are uninsured or underinsured, low-income individuals and families who face difficulty qualifying for, or benefiting from, governmental healthcare programs like Medicaid and Medicare. In addition to direct legal representation of low income individuals and families, the Center works closely with private, non-profit human services providers throughout mid-Michigan that attempt to fill the gaps when low income individuals are uninsured or lack the health care coverage that they need to access necessary medical care. The Center receives a local grant to provide intensive advocacy and increase access to governmental health insurance programs for low income clients in Genesee County (Flint) Michigan.

The 'severability' issue affects more people represented by these organizations than does the 'mandate.'

For example – BL had a heart valve repair with a valve replacement. The after care did not go as planned and the valve leaked and caused pain, anemia and angina. Further surgeries occurred and now BL must take an anti-rejection medication that

costs over $3,000 a month. She gets a pension and has been able to maintain health insurance with a premium of over $2,000 a month through Blue Cross, Michigan's 'insurer of last resort. After she pays the premium she has no money left for basic needs and is dependent on relatives.

Michigan's system with an 'insurer of last resort' has worked for years, but the high cost of care for those with pre-existing conditions has made that system less viable for consumers.

BL is awaiting 2014 when she can get health insurance coverage without regard to her pre-existing condition through an exchange the same rate at which healthy people her age are insured – less than $500 a month.

MLS, MichUHCAN, the Center for Civil Justice and MCHA come across dozens of people every month who are at or below 138% of the Poverty Level who would become eligible for Medicaid. The ACA would benefit almost everyone these organizations represent. That is our interest in the 'severability' issue. The public focus on the mandate is out of proportion to both what the 'mandate' really says, and to its effect on the ACA.

Amici will try not to re-hash the case law as the Court will receive many briefs regarding precedents. This brief will not re-hash most of the statistical data for the same reason.

Summary of Argument

The 'mandate' should be severed because several sections of the ACA are already in effect and are clearly meant to 'stand alone.' Other portions have to do with changing the delivery system for health care which the mandate does not affect. The ACA contains many 'moving parts' designed to correct a myriad of problems with our health care financing and delivery systems and, in fact, the Medicaid expansion provides coverage to more people than the mandate does.

The ACA is designed so that some parts of the Act do support others, but none of these 'moving parts' are so important that the failure of one or two should result in the entire ACA being declared unconstitutional. The two provisions that are most connected to the mandate – pre-existing condition exclusions being prohibited and guaranteed issue and re-issue – are stand alone sections in several states. It is not 'evident' that without the mandate Congress would not have enacted the insurance reforms.

We all have a 'liberty interest' in maintaining the rights granted under the ACA. Americans have the right to live a full life with the opportunity to fully develop their talents. The ACA enhances and protects that right to life, liberty, and the pursuit of happiness.

Argument: The Patient Protection and Affordable Care Act's Individual Responsibility Section is Not so Important to the Other Provisions of the ACA that if it is Declared a Violation of the Constitution's Commerce Clause, it Should be Severed from the Rest of the PPACA.

Background

Much of the history of health insurance; health care delivery; and efforts at reform are undisputed and will appear in many briefs. Even analyses of problems with the present system are, in large part, agreed upon by all parties.

In the last Presidential election both candidates argued that the present model of providing health insurance must change. Insurance companies, to remain solvent, deny coverage to people with pre-existing conditions; rescind coverage when people became ill, and therefore expensive to care for; place 'caps' on coverage to make more predictable their obligations under their insurance agreements with individuals and groups; and engage in other behaviors that undercut the insurance model. While Sen. McCain focused on costs and inflation as problems; then-Sen. Obama focused on access to coverage and care.[2]

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[2] Sen. McCain did present proposals to increase the number of walk-in clinics and to use FQHC's and high-risk pools to cover the hard to insure. http://www.issues2000.org/Celeb/John_McCain_Health_Care.htm

In order to remain financially viable health insurance companies now 'cut their losses' by not paying for health care for the most ill people they insure. This problem especially affects the individual and small group markets.

Insurers argued, in the legislative process, that if the government denied them the right to engage in these financially driven behaviors, they needed a larger pool of people to buy insurance – a pool that included people who would not be using health care services.

If a company insures 100 people at $100 a year they have $10,000 to spend on health care. If one of their 100 people is diagnosed with cancer all that money will be quickly used up and the company will suffer a loss. So, in defense of their bottom line, the company has these choices –

Drop coverage of the cancer victim; or

Increase premiums for everyone to cover the necessary care; or

Find more people who are healthy to add to the pool, for example another group of 100 bringing in another $10,000; or

Some combination of the above choices.

Administratively the first option is the easiest and the one that most surely will cut the "Medical Loss Ratio" [MLR][3].

The ACA is the government's response to this business model.

History of Health Insurance

The United States has a unique system of health insurance. It was developed at Baylor Hospital by a provider who realized that it could have a more secure cash flow if it got paid through a system of pre-paid insurance. The group policy was born.[4]

Today, these policies are often offered by large employers. At one point around 65% of Americans were insured through group policies through this Employer Sponsored Insurance [ESI]. From the beginning of our health insurance system employers and providers were the driving forces. Health care and health care finance are closely intertwined.

Today slightly less than 50% of the population has ESI. Cost of coverage has become prohibitive. Those that do have ESI are often employed by larger employers that self-insure. These large groups usually do not engage in the behaviors that the ACA changes – rescission; denying policies for pre-

[3] MLR is the rate at which premium dollars are paid out to medical care providers. A low MLR means the company is not spending as much of the premium dollars on its insured lives as a higher MLR would indicate.
[4] Cohn, Jonathan; *Sick*; Harper-Collins (2007); pp. 7-10.

existing conditions; etc. – because their groups are so large they can increase premiums more easily or can add healthy people. Generally large employers behave in the way the ACA requires all insurers to behave.

Large employers also may encourage their employees to engage in healthy behaviors – smoking cessation; exercise; weight loss are all common programs. Wellness plans are designed to make those who are insured healthier. Healthier people equals less expensive care.

Large groups can also contract with providers to pay lower fees. Often uninsured people are billed at rates 2 to 3 times higher than large insurers, or Medicare or Medicaid.

But there is a market for people who have no group – the individual market – and a market for smaller businesses – the 'small group' market. Neither of these markets have the same ability to control medical fees or to encourage the people they insure to engage in healthy behavior. In these markets the ability to cut losses means denying people the benefits for which they contracted or denying them coverage in the first instance for a pre-existing condition - the very condition for which they need care. Their pools were smaller and their premiums higher.

Government Already Covers the Highest Risk Populations

In 1964 Medicare and Medicaid were enacted. Medicare cares for the elderly and the disabled. Medicaid cares for some of the poor and for poor women and their children and for another group of disabled [SSI recipients]. Later the Childrens' Health Insurance Program (CHIP) was enacted with bi-partisan support.

The government makes sure children, the disabled, and the elderly have health coverage and, as a result, access to health care. The middle segment of the population – between 18 and 65 – are left to fend for themselves, unless they are disabled. It is this coverage scheme that the ACA attempts to adjust through private market reforms.

49% of Americans have ESI. Medicaid covers 17% of the population and Medicare 12%. Private, individual coverage is 5% and uninsured 16%. [5] The mandate would not apply to 78% of the population – those with ESI, Medicare or Medicaid. Those who have individual coverage may also be exempt. Many of the uninsured will either receive Medicaid, or remain uninsured. The mandate affects a relatively small slice of the population especially when the exceptions and exemptions in the ACA relieves millions of the duty to buy coverage or pay the penalty.

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[5] Kaiser Family Foundation - http://facts.kff.org/chart.aspx?ch=477

The government response, in the past, has been to insure through public programs the aged; the disabled; and children. Even that is in danger because of the cost of care. So the ACA was enacted and its Exchanges and other reforms are designed to be able to act to control medical inflation, as well as cover more people. Without the extra coverage, particularly of healthy people, there is less market influence by insurers and less ability to control costs. Without the added coverage there is also less ability to create incentives for 'wellness' programs.

Liberty Interest Protected by the ACA

This system covers favored populations and leaves others without insurance; and without affordable access to primary or preventive care. It is true that emergency departments must provide stabilizing care, but that does not provide care for chronic disease that would keep the individual out of the hospital. This is high cost care, when lower cost, primary care would be better for the patient, and would free the patient as much as possible f rom the effects of disease allowing them to live a fuller, more productive life.

For example, C has diabetes; works part time in a cafeteria; makes too much to qualify for Medicaid; is not 'disabled'; and cannot find affordable coverage. As a result she is in the ER once or twice a year; given care to stabilize her condition and released. Having no access to a doctor the cycle repeats itself resulting in high hospital bills when basic treatment would keep her healthier.

The present system also forces people like C into bankruptcy when they get needed care and cannot afford to pay for it. So some provisions of the ACA focus on hospital's 'charity care.' The present system does not provide enough primary care or prevention or wellness. The ACA addresses that problem, too.

The present system locks people in to jobs because of their coverage. B had a heart condition and was covered by her employer's insurance. She was offered another job at higher pay but could not take it because there was a 6-month pre-existing condition waiting period. The ACA addresses that problem through the insurance reforms as well as creating an Exchange. B's freedom in the job market was constrained by her health insurance.

While the Appellants argue that the Congress does not have the power under the Commerce Clause to create the 'mandate,' it appears that they are really complaining about their freedom to avoid their own responsibility. They argue that they should not be required to buy something they do not want even though their failure to contribute to the system means that millions of their fellow Americans remain uninsured. Personal responsibility means finding coverage for yourself and your family; not avoiding coverage and throwing the financial burden of your care onto others.

Abraham Lincoln said,

> We all declare for liberty; but in using the same word we do not all mean the same thing. With some the word liberty may mean for each man to do as he pleases with himself, and the product of his labor; while with others, the same word may mean for some men to do as they please with other men, and the product of other men's labor. Here are two, not only different, but incompatible things, called by the same name - liberty. And it follows that each of the things is, by the respective parties, called by two different and incompatible names - liberty and tyranny.[6]

In the health care debate there is a similar conflict. The 'liberty' of a healthy individual to opt out of the insurance market means that those who purchase insurance pay for their care. This drives the price of premiums up. Higher premiums mean more people who *would* buy insurance, cannot afford to. The cost of their care is also thrown on to the diminishing number who have insurance, spiraling premiums upward yet again. The liberty of others to buy coverage is limited by the liberty exercised by some to avoid buying insurance.

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[6] *The Collected Works of Abraham Lincoln* edited by Roy P. Basler, Volume VII, "Address at Sanitary Fair, Baltimore, Maryland" (April 18, 1864), p. 301-302.

This trend, coupled with the fact that health care costs are rising for other reasons, leads to higher and higher premiums; more and more un-insurance; and more people on government insurance and off of private coverage.

Our Declaration of Independence says "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.--That to secure these rights, Governments are instituted among Men. . ." The Preamble to the Constitution makes it clear that the role of government includes the promotion of the "general welfare."

The ACA frees Americans from the insurance model that is now failing to provide health care to significant segments of the population. Because that insurance model has become so fragmented the ACA has 'attacked' it with many tools. These tools could all stand alone.

Those tools are instruments of liberty for our clients, freeing BL, C, and B from the access to care problems they face.

Sections of ACA Already in Effect

Several provisions are already in effect. These provisions cannot be tied to the mandate since the mandate is not in effect until 2014. For example the requirement that each health insurer spend at least 80% of the premium dollars on actual health care

[85% for larger employers] is already in effect. No one is challenging its Constitutionality. Some commentators believe this is the most important provision in the ACA.[7] It is clearly not connected to the mandate.

Other provisions already in place include;

> Insurers can no longer deny children coverage because of a pre-existing condition;
>
> Individuals who meet certain criteria can purchase insurance from a 'pre-existing insurance plan' set up by the ACA and presently covering about 45,000 people;[8]
>
> Adult children can remain on their parent's group policy which has resulted in covering 2.5 million young adults;[9]
>
> Insurers who request premium increases now must, if the increase is 10% or more, post it

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[7] Others suggest that the Exchange or the Medicaid expansion are the most important.

[8] Announced by HHS at Herndon Alliance Annual meeting; January 21, 2012. This plan would not help BL because she would have to be uninsured for 6 months; a chance she cannot take.

[9] Announced by HHS at Herndon Alliance Annual meeting; January 21, 2012.

online and subject the increase request to public comment;[10]

Lifetime caps for health insurance are illegal;

Annual caps have been raised and made the subject of federal regulation;

Medicaid across the country was preserved last year because of the 'maintenance of effort' clause of the ACA;

Insurers can no longer charge co-pays for a wide range of preventive procedures resulting in greater use of those procedures and earlier detection of disease;[11]

Companies with early retirees who would lose their coverage have been provided subsidies to maintain the insurance for those early retirees, who are often being 'forced out' due to the economy;

Medicare recipients have seen Part D improved so that the 'doughnut hole' is closing and will be completely closed as of 2020 ;[12]

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[10] Five such requests are posted for Michigan as of early January, 2012. some insurers in other states have lowered their requests as a result of this provision.
[11] 30 million Medicare recipients benefited from this provision already. Announced at Herndon Alliance; January 21, 2012.
[12] 3 million Medicare recipients have benefited. HHS at Herndon; January 21, 2012.

Funds have been granted to expand the medical education system and graduate more primary care providers;

Planning for Exchanges has occurred in many states, including Michigan where SB 693 has passed the Senate and is awaiting action in the House;

Accountable Care Organizations and Medical or Health Homes are encouraged by the ACA and planning has begun to implement these provisions creating changes in the delivery of care;

Insurers can no longer rescind a policy due to the need for care;

Insurance documents have to be written in consumer friendly language;

Insurers must have an internal appeals process for denials.

These are all significant reforms affecting the daily lives of Michiganders. These reforms have the effect of increasing the pool; controlling premiums; transforming the delivery of care to focus more on primary or preventive care; increasing the number of providers; and protecting consumers.

None of these provisions depend upon the implementation of the mandate.

Indeed three provisions of the ACA have been substantially changed or totally abandoned. The number of FQHC's contemplated under the ACA was significantly reduced because of costs. The CLASS system – long term care insurance – was abandoned because the administration determined the program was not fiscally sound in the long term. A requirement of IRS reporting for small businesses was repealed.

The whole ACA did not fall apart because of the failure of these provisions even though they were important to the passage of the Act. FQHC's care for the uninsured and provide them a medical home – lowering the cost of that care. CLASS would have provided resources to care for high-cost people with severe disabilities in the future. And the small business reporting would have provided some funding.

Proportion vs. Political Hyperbole

The mandate was correctly described by the Eleventh Circuit when it found the mandate is not such a crucial part of the ACA as to require any of the ACA to be struck down with the mandate. Indeed, Medicaid expansion; the Exchanges; and MLR reforms are probably the most important parts of the ACA.

District Court Analysis was Flawed

The District Court found that an analysis of Congressional intent was needed. That Court analogized the ACA to a 'finely crafted watch' which,

absent the mandate, would not operate as 'Congress intended.' *Florida et al. v. Kathleen Sibelius, et al.,* 780 F. Supp. 2d 1256, 1304 (N.D. Fla. 2011).

Yet three other provisions have already been dropped. Perhaps the watch was not so finely crafted after all. The court writes, "Although many of the remaining provisions, as just noted, can most likely function independently of the individual mandate, there is nothing to indicate that they can do so in the manner intended by Congress."
Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1304 (ND Fla, January 31,2011)

This constricted analysis was rightly rejected by the 11th Circuit. After all, there are 535 Members of Congress. Determining how even a single member felt the ACA would function, or how a particular provision would function, at the time of voting on the ACA, is the sort of mind reading that courts avoid.

The fact is that many of the provisions of the ACA can clearly function independently. To assume that Members of Congress did not realize that is erroneous.

The District Court went on to point out that the Government had acknowledged that the Mandate was crucial to and connected with the insurance reforms. Indeed, this connection is included in the ACA itself.

> [I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care . . . The [individual mandate] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

Act § 1501(a)(2)(I)

As an *Amicus* we do not accept the Government's throwing insurance reform under the mandate 'bus.' Section 1502(a)(2)(I) makes it clear that the mandate attempts to insure that people do not wait to purchase coverage until they are ill. The mandate is not the only way to accomplish this and Congress knew that at the time. Congress also rejected the 'public option' as a way to encourage purchasing coverage. Since the mandate can be replaced, it is 'evident' that the mandate can be severed.

The test for severability is:

> First, we try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people. . . . Second, mindful that our constitutional mandate and

> institutional competence are limited, we restrain ourselves from rewriting [a] law to conform it to constitutional requirements even as we strive to salvage it . . . Third, the touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.

Ayotte v. Planned Parenthood of Northern New England, 546 U.S. 321, 329-30, 126 S. Ct. 961, 163 L. Ed. 2d 812 (2006)

The 'finely crafted watch' analogy is absent from this test. Perhaps courts realize that to expect any collective body to create a 'finely crafted' instrument is unrealistic.

The court writes in conclusion:

> In sum, notwithstanding the fact that many of the provisions in the Act can stand independently without the individual mandate (as a technical and practical matter), it is reasonably "evident," as I have discussed above, that the individual mandate was an essential and indispensable part of the health reform efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently. I must conclude that the individual mandate

> and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit. The individual mandate cannot be severed.

Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1305 (N.D. Fla. 2011).

In fact Congress did not intend the whole ACA to depend on the mandate. Else it would have said so in § 1501(a)(2)(I). Instead Congress explicitly limits the mandate to being 'essential' only to the insurance reforms. The court has to pile an inference on its ruling saying that the 'insurance reforms' are essential to the rest of the ACA when there is absolutely no indication from Congress to that effect.

In fact, the mandate is not 'essential' to the insurance reforms. It is simply one tool that Congress chose. In fact, as Judge Vinson acknowledged;

> . . . it should be emphasized that while the individual mandate was clearly "necessary and essential" to the Act as drafted, it is not "necessary and essential" to health care reform in general. It is undisputed that there are various other (Constitutional) ways to accomplish what Congress wanted to do.

Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1305 at fn 30 (N.D. Fla. 2011)

A list of possibilities includes the way Medicare part B works, automatically enrolling people in coverage and allowing them to 'opt out' if they preferred not to buy the insurance. Medicare Part D operates with a voluntary enrollment but a penalty if the person delays enrolling. Other ideas are to conduct a public education and outreach campaign; provide broad access to personalized assistance for health coverage enrollment; impose a tax to pay for uncompensated care; condition the receipt of certain government services upon proof of health insurance coverage; use health insurance agents and brokers differently; or require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings. Combining one of these ideas with an Exchange has been raised as a possibility by Rep. Ryan and Sen. Wyden, among others. To assume Congress was unaware of alternatives disrespects the legislative process. Indeed, the mandate is not essential. It may have been the best possible alternative given the political 'log rolling', but it is not 'evident' that if it fails Congress would want the rest of the ACA to be struck down.

> 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.

Alaska Airlines Inc v. Brock, 480 US 678, 684 (1987)

There is no constitutional challenge to any other part of the ACA, save Medicaid. The rest of the ACA is 'fully operative.' Severing the mandate may have a negative effect on premiums, but it does not negate the law.

Eleventh Circuit Analysis

In the 11th Circuit Judges Dubina and Hull rejected Judge Vinson's analysis. The court begins by noting that Congress found there were about 50 million uninsured people and $43 Billion in uncompensated care which leads to cost shifting.

> The findings state that this cost-shifting scenario increases family premiums on average by $1,000 per year. *Id.* § 18091(a)(2)(F). Although not in the findings, the data show the cost-shifting increases individual premiums on average by $368–410 per year. The cost-shifting represents roughly 8% of average premiums. In its findings, Congress also points out that national health care in 2009 was approximately $2.5 trillion, or 17.6% of the national economy.10 *Id.* § 18091(a)(2)(B).

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1244-5 (11th Cir. 2011)

The size of the health care sector in our economy argues that the mandate must be severed. Can anyone seriously argue that regulating and

reforming a sector that is larger than most other nation's economies entirely depends on one section of one act?

The Eleventh Circuit also noted that Congress eliminated underwriting costs to the tune of $90 Billion because the ACA requires insurers to accept all applicants. The cost of the insurance reforms supposedly connected to the 'mandate' are adequately funded by these underwriting savings. 42 U.S.C. § 300gg-1(a).

> . . . the Act employs five main tools: (1) comprehensive insurance industry reforms which alter private insurers' underwriting practices, guarantee issuance of coverage, overhaul their health insurance products, and restrict their premium pricing structure; (2) creation of state-run "Health Benefit Exchanges" as new marketplaces through which individuals, families, and small employers, now pooled together, can competitively purchase the new insurance products and obtain federal tax credits and subsidies to do so; (3) a mandate that individuals must purchase and continuously maintain health insurance or pay annual penalties; (4) penalties on private employers who do not offer at least some type of health plan to their

> employees; and (5) the expansion of Medicaid eligibility and subsidies.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1246 (11th Cir. 2011)

The court goes on to note that most Americans already have insurance that satisfies the 'mandate.' ESI, Medicaid, and Medicare recipients all meet the criteria of the mandate. The court writes:

> The government's assertion that the individual mandate is "essential" to Congress's broader economic regulation is further undermined by components of the Act itself. In *Raich*, [*Gonzales v. Raich*, 545 U.S. 1, 22, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005)] Congress devised a "closed regulatory system," *id.* at 13, 125 S. Ct. at 2203, designed to eliminate *all* interstate marijuana traffic. Here, by contrast, Congress itself carved out eight broad exemptions and exceptions to the individual mandate (and its penalty) that impair its scope and functionality. *See* 26 U.S.C. § 5000A(d)–(e). Even if the individual mandate remained intact, the "adverse selection" problem identified by Congress would persist not only with respect to these eight broad exemptions, but also with respect to *those healthy persons who choose to pay the mandate penalty*. Those who pay the penalty one year

> instead of purchasing insurance may still get sick the next year and *then* decide to purchase insurance, for which they could not be denied.
>
> Additionally, Congress has hamstrung its own efforts to ensure compliance with the mandate by opting for toothless enforcement mechanisms. Eschewing the IRS's traditional enforcement tools, the Act waives all criminal penalties for noncompliance and prevents the IRS from using liens or levies to collect the penalty. *Id.* § 5000A(g)(2). Thus, to the extent the uninsureds' ability to delay insurance purchases would leave a "gaping hole" in Congress's efforts to reform the insurance market, Congress has seen fit to bore the hole itself.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1311 (11th Cir. 2011)

We agree with the Eleventh Circuit's analysis.

> . . . the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1322 (11th Cir. 2011)

. . . .

> It is also telling that none of the insurance reforms, including even guaranteed issue and coverage of preexisting conditions, contain any cross reference to the individual mandate or make their implementation dependent on the mandate's continued existence. *See United States v. Booker*, 543 U.S. 220, 260,125 S. Ct. 738, 765 (2005) (stating that 18 U.S.C. § 3742(e) "contains critical cross-references to the (now-excised) § 3553(b)(1) and consequently must be severed and excised for similar reasons"); *Alaska Airlines*, 480 U.S. at 688–89, 107 S. Ct. at 1482 ("Congress did not link specifically the operation of the first-hire provisions to the issuance of regulations."). Indeed, § 300gg-3's prohibition on preexisting condition exclusions was implemented in 2010 with respect to enrollees under 19, despite the individual mandate not taking effect until 2014.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1324 (11th Cir. 2011)

. . . .

> "[T]he remedial question we must ask" is "which alternative adheres more closely to Congress' original objective" in passing the Act: (1) the Act without the individual mandate but otherwise

> intact; or (2) the Act without the individual mandate and also without these two insurance reforms. *See Booker*, 543 U.S. at 263, 125 S. Ct. at 766–67.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1324 (11th Cir. 2011)

If the mandate falls, the American public should not be denied insurance due to pre-existing conditions. The public should not be 'punished' for Congress's error. Congress did not intend for the insurance reforms to fail just because a particular part of the ACA falls.

The court went further with its analysis.

> First, the Act retains many other provisions that help to accomplish some of the same objectives as the individual mandate. *See Booker*, 543 U.S. at 264, 125 S. Ct. at 767 ("The system remaining after excision, while lacking the mandatory features that Congress enacted, retains other features that help to further these objectives."); *New York v. United States*, 505 U.S. at 186, 112 S. Ct. at 2434 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions

operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated."). For example, Congress included other provisions in the Act, apart from and independent of the individual mandate, that also serve to reduce the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage. These include: (1) the extensive health insurance reforms; (2) the new Exchanges; (3) federal premium tax credits, 26 U.S.C. § 36B; (4) federal cost-sharing subsidies, 42 U.S.C. § 18071; (5) the requirement that Exchanges establish an Internet website to provide consumers with information on insurers' plans, *id.* § 18031(d)(4)(D); (6) the requirement that employers offer insurance or pay a penalty, 26 U.S.C. § 4980H; and (7) the requirement that certain large employers automatically enroll new and current employees in an employer sponsored plan unless the employee opts out, 29 U.S.C. § 218A, just to name a few.

. .

Second, the individual mandate has a comparatively limited field of operation vis-à-vis the number of the uninsured. In *Alaska Airlines*, the Supreme Court

found that the unconstitutional legislative veto provision of the Airline Deregulation Act (permitting Congress to veto the Labor Secretary's implementing regulations) was severable because, among other things, the statute left "little of substance to be subject to a veto." 480 U.S. at 687, 107 S. Ct. at 1481. The Supreme Court noted the "ancillary nature" of the Labor Secretary's obligations and the "limited substantive discretion" afforded the Secretary.140 *Id.* at 688, 107 S. Ct. at 1482. Thus, the limited field of operation of an unconstitutional statutory provision furnishes evidence that Congress likely would have enacted the statute without it. *Cf. Booker*, 543 U.S. at 249, 125 S. Ct. at 759 (considering whether "the scheme that Congress created" would be "so transform[ed] . . . that Congress likely would not have intended the Act as so modified to stand").

Here, as explained above, the operation of the individual mandate is limited by its three exemptions, its five exceptions to the penalty, and its stripping the IRS of tax liens, interests, or penalties and leaving virtually no enforcement mechanism. Even with the mandate, a healthy individual can pay a penalty

> and wait until becoming sick to purchase insurance.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325 (11th Cir. 2011)

> . . .
>
> The multiple features of the individual mandate all serve to weaken the mandate's practical influence on the two insurance product reforms. They also weaken our ability to say that Congress considered the individual mandate's existence to be a *sine qua non* for passage of these two reforms. There is tension, at least, in the proposition that a mandate engineered to be so porous and toothless is such a linchpin of the Act's insurance product reforms that they were clearly not intended to exist in its absence.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325-6 (11th Cir. 2011)

Finally the Eleventh Circuit makes the astute observation that a Congressional finding that one section of an Act is 'essential' to the operation of another, " . . . is separate, and very different, from the constitutional analysis." *Florida et al. v. Kathleen Sibelius, et al.*, 648 F.3d 1235, 1326 (11th Cir. 2011)

> The congressional language respecting Congress's constitutional authority does

not govern, and is not particularly relevant to, the different question of severability (which focuses on whether Congress would have enacted the Act's *other insurance market reforms* without the individual mandate). An example makes the point. Section 18091(a)(2)(H) of the same congressional findings provides:

> Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, *et seq.*), the Public Health Service Act (42 U.S.C. 201, *et seq.*), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market. 42 U.S.C. § 8091(a)(2)(H). By its text, § 18091(a)(2)(H) states that the individual mandate is essential to "this larger regulation of economic activity"—that is, "regulating health insurance," which it does through ERISA and the Public Health Service Act. If applied to severability, this would mean that Congress intended the individual mandate to be "essential" to, and thus inseverable from, ERISA (enacted in 1974) and the entire Public Health Service Act (or at least all parts of those

> statutes that regulate health insurance). This is an absurd result for which no party argues.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325 (11th Cir. 2011)

We think the Eleventh Circuit is correct when it writes:

> These congressional findings do not address the one question that is relevant to our severability analysis: whether Congress would not have enacted the two reforms *but for* the individual mandate. Just because the invalidation of the individual mandate may render these provisions *less desirable*, it does not ineluctably follow that Congress would find the two reforms *so* undesirable without the mandate as to prefer not enacting them at all. The fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable. This is particularly true here because the reforms of health insurance help consumers who need it the most. In light of all these factors, we are not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.

> . . .
> And where it is not evident Congress would not have enacted a constitutional provision without one that is unconstitutional, we must allow any further—and perhaps even necessary—alterations of the Act to be rendered by Congress as part of that branch's legislative and political prerogative. *See Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1326 - 7 (11th Cir. 2011)

At footnote 142 the court notes;

> . . .that the same congressional findings also state—not once, but six times—that the individual mandate operates "*together with the other provisions of this Act*" to reduce the number of the uninsured, lower health insurance premiums, improve financial security for families, minimize adverse selection, and reduce administrative costs. *See* 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J) (emphasis added). Congress itself states that *all* the provisions of the Act operate together to achieve its goals. On this reasoning, the entire Act would be invalidated along with the individual mandate. As discussed above, this conclusion is invalid.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, fn 142 (11th Cir. 2011)

The District Court found the whole act invalid. That was an indefensible result reached by no other court. The District Court fell prey to the hyperbolic and angry political atmosphere that suggested the 'mandate' – rather than being a toothless law – was a serious abridgment of our freedoms.

> Even though the government, in arguing for the individual mandate's constitutionality, states that the individual mandate cannot be severed from the Act's guaranteed issue and community rating provisions because the individual mandate "is integral to those sections that . . . provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions." Whether a statutory provision is "integral" or "essential" to other provisions for Commerce Clause analytical purposes is a question distinct from severability. And in any event, the touchstone of severability analysis is legislative intent, not arguments made during litigation.
> *Florida et al. v. Kathleen Sibelius, et al.*, 648 F.3d 1235, fn 143 (11th Cir. 2011)

Health Care as a Human Right

A distinguishing feature of health care legislation is that health care is a human right. The right to broccoli is not a human right.

Nation after nation has decided to treat health care as a human right. Even the reconstituted Iraq, while under American control, in *Article 14 of its interim Constitution of 2004 says, "*The individual has the right to security, education, health care, and social security."

Similar provisions are found in the constitutions of many other nations. In the *Universal Declaration of Human Rights, Article 25* states;

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Some in Congress voted for the ACA because it recognized for the first time that health care is a right for all Americans,not just the elderly, children and disabled. It is that internationally recognized right, a right that is increasingly recognized by the American voting public, that makes this legislation

distinguishable from all other legislation under the commerce clause.

Everyone needs health care at some time. The portal to receive that care is insurance coverage. The provisions of the ACA work together to fulfill our human right to adequate and affordable health care. But the 'mandate' is only one part of that Act. The remainder of the ACA also implements our human right to health care.

Conclusion

For the reasons stated herein *Amici* ask the court to affirm the Eleventh Circuit's holding on severability.

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