Nos. 11-393 & 11-400

In the Supreme Court of the United States

NAT'L FED. OF INDEP. BUSINESS, ET AL.,
Petitioners,
v.
KATHLEEN SEBELIUS, ET AL.,
Respondents.

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
U.S. DEPT. OF HEALTH & HUMAN SVCS., ET AL.
Respondents.

On Writs of Certiorari to the U.S. Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* TEXAS PUBLIC POLICY FOUNDATION AND CATO INSTITUTE SUPPORTING PETITIONERS ON SEVERABILITY

Richard Epstein
800 N. Mich. Ave, #3502
Chicago, IL 60611
(773) 450-4476
richard.epstein@nyu.edu

Ilya Shapiro
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(202) 842-0200
ishapiro@cato.org

Mario Loyola
Counsel of Record
Josiah Neeley
TEXAS PUBLIC POLICY FOUNDATION
900 Congress Ave.,
Suite 400
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

QUESTION PRESENTED

Whether the individual mandate of the Patient Protection and Affordable Care Act is severable from Titles I and II if that mandate is found unconstitutional.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases

Statutes

Other Materials

INTEREST OF *AMICI CURIAE*[1]

The Texas Public Policy Foundation is a nonprofit public policy organization based in Austin, Texas. TPPF's mission is to defend liberty, personal responsibility, free enterprise, and limited government in Texas and across the nation. TPPF's Center for Tenth Amendment Studies was established to pursue the restoration of the Constitution's limits on the federal government, which are necessary for the protection of liberty.

Established in 1977, the Cato Institute is a nonpartisan public policy research foundation dedicated to advancing the principles of individual liberty, free markets, and limited government. Cato's Center for Constitutional Studies was established in 1989 to help restore the principles of limited constitutional government that are the foundation of liberty. Toward those ends, Cato publishes books, studies, and the annual *Cato Supreme Court Review*, conducts conferences, and files *amicus* briefs.

Various provisions of the Patient Protection and Affordable Care Act impede state sovereignty and individual liberty, limiting states' ability to chart their own course on matters relating to health care. Holding the entire Act unconstitutional would thus vindicate *Amici Curiae*'s missions. The severability issue also concerns *Amici Curiae* because it

---

[1] Pursuant to this Court's Rule 37.2(a), *amici* state that all parties have lodged blanket consents. Pursuant to Rule 37.6, *amici* state that no part of this brief was authored by any party's counsel, and that no person or entity other than *amici* funded its preparation or submission.

implicates the scope of judicial review and will clarify how judges are to apply statutes suffering from constitutional defects.

SUMMARY OF ARGUMENT

When a federal court finds unconstitutional only one part of a congressional act, it generally sustains the remainder, severing only the invalid part. But in doing so courts must remain faithful to Congress's intent in shaping the legislation. The basic principle of severability is thus subject to an important limitation: This Court, out of respect for the dignity of a coequal branch of the government, must avoid creating a law that Congress never adopted.

On March 23, 2010, 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, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively, "PPACA" or "the Act") was enacted into law. [2] Title I of the Act Deals with Quality, Affordable Health Care for All Americans. Title II addresses the role of public programs, and sets out a detailed program for expanded access to Medicaid. Section 1501 of Title I contains a mandate that individuals purchase health insurance or pay a tax penalty (the "individual mandate"). Many parties, including parties in this case, immediately challenged the constitutionality of the individual mandate and the manifold impositions that the expanded Medicaid programs impose on the states.

---

[2] Citations herein are to the "consolidated print" of the Act, P.L. 111-148 as amended by P.L. 111-149.

The District Court below held both that the individual mandate was unconstitutional and that it could not be severed from the rest of the Act, *Florida v. HHS*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011). The Court of Appeals agreed that the individual mandate is unconstitutional, but reversed the District Court's ruling on severability, and upheld the remainder of the Act. *Florida v. HHS*, 648 F.3d 1235 (11th Cir. 2011).

Amici Curiae take no position on whether the entire statute should be struck down if the individual mandate is found unconstitutional. The Court of Appeals was right to find that some portions of the Act are so independent from the provisions which depend on the mandate (Titles I and II) that they could survive *independent* constitutional challenge.[3] But the District Court was surely correct to decide that the individual mandate is so interwoven with Titles I and II that none of them could stand. The individual mandate was essential to the Act's scheme for achieving near-universal health care coverage at an acceptable cost. In its core provisions, the Act was designed to make health care more affordable and accessible. Whether the Act would have achieved those goals at an acceptable cost with the individual mandate is open to doubt. But the Act certainly will not achieve those goals once that provision is stripped from the Act; nor, without that provision, will the Act operate in anything like the manner intended by Congress.

---

[3] See, *e.g.*, The Biologics Price Competition and Innovation Act of 2009, Title VII, Subtitle A of the Act, 124 Stat. 119, 804-821 (2010), codified in various sections of Titles 21, 35, and 42 ("BPCIA").

Severing the individual mandate from its related provisions in Titles I and II will produce new comprehensive health care legislation that Congress did not enact and would never have enacted. Virtually all of the health insurance reforms in Title I either strengthen the conditions for an "adverse selection spiral" (healthy people exiting the health insurance risk pool as premiums rise) or will not function as intended in conditions of adverse selection. The purpose of the individual mandate was to prevent such adverse selection, which had led to the failure of many state health care reform efforts.

The individual mandate is scarcely less tied into the provisions in Titles I and II related to Medicaid expansion and insurance premium subsidies. Those provisions were designed to work in tandem with the individual mandate to reduce the number of uninsured. But without the mandate, the reduction in the number of uninsured will be much smaller than projected under current law; the federal budget will be strained by larger-than-forecast premium support subsidies because the subsidies increase as premiums increase; and the insurance market for those not eligible for subsidies will be particularly subject to adverse selection. Hence the congressional objective of achieving affordable and accessible health care at an acceptable cost will be defeated by eliminating the mandate from the unified scheme of Medicaid, premium support, and individual mandate that was designed to achieve those objectives. The Court cannot repair a broken system, but must leave that task to Congress.

ARGUMENT

I. THE COURT CANNOT CREATE A NEW LAW THAT CONGRESS NEVER ENACTED

A. Severability Law Began with *Marbury v. Madison* and Involves a Two-Prong Test

In *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803), this Court struck down a single invalid clause of the lengthy Judiciary Act of 1789, which created the federal judiciary. *Id.* at 176. No other provision of the Judiciary Act depended on or was affected by the invalid clause, which was minor and entirely separate from the overall legislative scheme. Accordingly, the Court allowed the rest of the law to stand. Nearly two centuries later, the principles which guided the Court's decision in *Marbury v. Madison* are still in force.

In *Alaska Airlines v. Brock,* 480 U.S. 678 (1987), the Court considered the Airline Deregulation Act of 1978. That act provided certain benefits to airline workers laid off as a result of deregulation, including granting these workers right of first refusal on new airline job openings. It empowered the Secretary of Labor to issue implementing regulations, subject to a unicameral legislative veto of the type that had recently been struck down in *INS v. Chadha*, 462 U.S. 919 (1983). After concluding that the legislative veto was unconstitutional, this Court turned to the question of severability. This Court began by noting that when "an act of Congress contains unobjectionable provisions *separable* from those found to be unconstitutional, it is the duty of this court to so declare and to maintain the act *in so far as it is*

valid." 480 U.S. at 684 (*quoting Regan v. Time, Inc.*, 468 U.S. 641, 642 (1981) (*quoting El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909)) (emphasis added).

The Court then offered a concise articulation of its traditional two-prong severability test: "'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.'" *Id.* (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976) (per curiam) (in turn quoting *Champlin Refining Co. v. Corporation Comm'n of Oklahoma*, 286 U.S. 210, 234 (1932)) (emphasis added).

1. Is the remainder "fully operative as a law?"

Most instructively the Court clarified the phrase "fully operative as a law" in this fashion:

> Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently. *See*, *e.g.*, *Hill v. Wallace*, 259 U.S. 44, 70-72 (1922) (holding the Future Trading Act nonseverable because the valid and invalid provisions were so intertwined that the Court would have to rewrite the law to allow it to stand)."

Id. This Court's explicit reference to *Hill* is crucial to the dispute over the individual mandate in its relation to both Title I and Title II. When unconstitutional and constitutional provisions are "so interwoven" "that they cannot be separated,"

Hill, 259 U.S. at 70, the provisions remaining after excision are not "operative" notwithstanding that they may have *some* legal effect on their own.[4]

If the effect of excising one provision is to upset Congress's intended balance, then the court has created a new "law" out of whole cloth—one that no Congress ever passed and no President ever signed. Such a remainder would not be a "valid" law. Even a severability clause "in no way alters the rule that in order hold one part of a statute unconstitutional and

---

[4] *Champlin's* shorthand phrase "fully operative as a law," cited in *Alaska Airlines* and subsequent cases, requires more than that the provision have *some* legal effect. This is clear from an examination of the authorities cited in *Champlin*. *See*, *Connolly v. Union Sewer Pipe Co*., 184 U.S. 540, 565 (1902) ("if an obnoxious section is of such import that the other sections without it would cause results not contemplated or desired by the legislature, then the entire statute must be held inoperative"); *Pollock v. Farmers' Loan and Trust Co.*, 158 U.S. 601, 635 (1895) (law may be held partly "inoperative" only "where the parts are so distinctly separable that each can stand alone, and where the court is able to see, and to declare, that the intention of the legislature was that the part pronounced valid should be enforceable, even though the other part should fail. To hold otherwise would be to substitute, for the law intended by the legislature, one they may never have been willing by itself to enact"); *Regan v. Farmer's Loan & Trust Co.*, 154 U.S. 362, 395-96 (1894) (invalid provisions "may fail, and still the great body of the statute have operative force, and the force contemplated by the legislature in its enactment"); and *Field v. Clark*, 143 U.S. 649, 695-96 (1892) ("These different parts of the act, in respect to their operation, have no legal connection whatever with each other. […]While, in a general sense, both may be said to be parts of a system, neither the words nor the general scope of the act justifies the belief that Congress intended they should operate as a whole, and not separately for the purpose of accomplishing the objects for which they were respectively designed").

uphold another part as separable, they must not be mutually dependent upon one another." *Carter v. Carter Coal*, 298 U.S. 238, 313 (1936) (striking down mutually dependent price-fixing and labor regulations of a law). This is because even a severability clause "does not give the court power to amend the act." *Hill*, 259 U.S. at 71.

Champlin's shorthand phrase "fully operative as a law," 286 U.S. at 234, thus highlights a vital constitutional element that may be wholly determined within the four corners of the act. The post-excision remainder must operate in a way that is consistent with the evident congressional design for those remaining provisions. Any provisions that are "dependent, conditional, or connected" with an invalid provision must fall along with it. *Allen v. City of Louisiana*, 103 U.S. 80, 84 (1881) (quoting *Warren v. Mayor of Charlestown*, 68 Mass. (2 Gray) 84, 99 (1854). Otherwise, the court will have created a new legal creature that does not meet the minimum constitutional requirements for a bill to become law. The cases cited as authority in *Champlin* clearly suggest that the post-excision remainder must not merely "operate," but they must "operate" as Congress intended.[5]

---

[5] A valuable new commentary, Kenneth A. Klukowski, *Severability Doctrine: How Much of a Statute Should Federal Courts Invalidate?* 16 Tex. Rev. L. & Pol. 1 (2011), places the interdependence inquiry with the second step, which asks whether Congress would have passed the remainder of the law without the invalid provision. In this reading of the test, the first step looks only to the basic functionality of the post-excision remainder, and might be satisfied if the remainder has *some* legal effect. But that on its own would tell us nothing about what Congress intended, which has been the deciding

Applying this standard, the Court noted the peculiar status of legislative vetoes; by definition, if the veto is never exercised, the rest of the law will operate as Congress intended. *Id.* Similarly, in *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138 (2010), this Court found that tenure restrictions on an accounting oversight board were severable from the remainder of the act, which both preserved presidential appointment power and left the board "fully responsible" to both the oversight commission and to the president, just as Congress intended.

2. Would Congress have enacted the remainder?

Taking up the second part of the traditional severability standard, this Court in *Alaska Airlines* stated, "The final test, for legislative vetoes as for other provisions, is the traditional one: the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." 480 U.S. at 685. In applying this severability prong , this Court examined text and historical context to see whether Congress would have achieved the same legislative bargain without the excised provision. *Id.*

This Court noted that the obligations imposed on the Secretary of Labor in dealing with displaced workers were "obviously designed merely to

---

factor for this Court, as the cases cited in *Champlin* make clear. The second part of the severability test should instead focus on whether the text and historical context of the law make it evident that Congress would have reached the same legislative bargain without the excised provisions.

facilitate" the law's substantive provisions, and were thus "ancillary, "subsidiary," and "relatively insignificant." *Id.* at 688. It was apparent at every stage of the legislative process that such regulations were subordinate to the law's central mission, which was to soften the impact of deregulation on airline industry labor. *See generally id.* at 691-97.

In *Free Enterprise,* this Court gave further clarity on the second severability step. It held that the tenure restrictions on an accounting oversight board created by a comprehensive financial law were severable from the board itself because "nothing in the statute's text or historical context makes it evident that Congress, faced with the limitations imposed by the Constitution, would have preferred no Board at all to a Board whose members are removable at will." *Id.* at 3162 (internal quotations omitted). This Court concluded that the board provisions and related tenure restrictions were independent and separable; Congress would have reached the same legislative bargain even without the tenure restrictions, and would have retained the provisions which created the board.

B. The Eleventh Circuit Erred in Its Severability Analysis

In denying the intimate connection between the individual mandate and Titles I and II, the Court of Appeals misread this Court's decisions. The court moreover failed to understand the interrelation among the Act's key provisions, particularly among the individual mandate and those provisions with which it is most deeply interwoven: guaranteed

issue and the prohibition on preexisting conditions exclusions.

The Court of Appeals first alluded to the finding in Section 1501(a)(2)(I) of the Act, which explains why those two insurance reforms would create an incurable problem of adverse selection without the individual mandate. 648 F.3d at 1332.

The feared scenario runs as follows. As a result of guaranteed issue, and with no reason to fear exclusion for preexisting conditions, healthy people would wait until they are sick to get coverage, thus diminishing the pool of insured and driving up premiums for those who retain their coverage. Those higher premiums in turn drive more healthy people out of coverage. As the reduction in the number of insured and rising premiums start to become mutually reinforcing, the insurance industry faces what health care analysts call the "adverse selection death-spiral." Jonathan Gruber, *Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer with Higher Premiums*, Center for American Progress (April 8, 2010), http://www.americanprogress.org/issues/2010/04/pdf/individual_mandate.pdf. Accordingly, as the Court of Appeals noted, Congress explicitly found that the 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." 648 F.3d at 1323 n. 138 (quoting Sec. 1501(a)(2)(I) of the Act).[6]

---

[6] There is a consensus among policy experts that the individual mandate is "a central pillar of health reform. Without the

After thus plainly laying out the vital dependency between the insurance reforms (including "improved health insurance products") and the individual mandate, the Court of Appeals then concluded: "Our severability concern is not over whether the two reforms can 'fully operate as a law.' They can. Rather, our severability concern is only whether 'it is evident' that Congress 'would not have enacted' the two insurance reforms without the individual mandate." 648 F.3d at 1324 (quoting *Alaska Airlines*, 480 U.S. at 684).

But, as the Court's prior decisions show, *see supra* Part I.A.1, the operative test is never whether the remainder may have *some* legal effect, standing alone, for that would be true in all cases. Nobody disputes that the Act's insurance reforms will have *some* legal effect without the mandate; that "indicate[s] little about the intent of Congress regarding severability." *Alaska Airlines*, 480 U.S. at 685. But it will be an effect Congress never intended, and Courts must not "frustrate[] the intent of the elected representatives of the people."

---

individual mandate, the entire structure of reform would fail." Jonathan Gruber, *supra* Part I.B. The consensus crosses the political spectrum. *See*, *e.g.*, Paul Krugman, *Do the Right Thing*, N.Y. Times, January 22, 2010, A31; Michael D. Tanner, *Bad Medicine: A Guide to the Real Costs and Consequences of the New Health Care Law*, Cato Institute (February 14, 2011), http://www.cato.org/pub_display.php?pub_id=11961;Ezra Klein, *The Importance of The Individual Mandate*, Wonkblog (Dec. 16, 2009 3:23 PM), http://voices.washingtonpost.com/ezra-klein/2009/12/draft_1.html; Janet Trautwein, *Why We Need A Strong Individual Mandate*, Wall Street Journal, (Nov. 10, 2009),http://online.wsj.com/article/SB10001424052748704402404574574525923255957640.html.

Regan, 468 U.S. at 652. The courts cannot, by judicial fiat, create a new law that no Congress ever enacted and no president ever signed.

The Court of Appeals also erred in applying the second inquiry of the severability analysis—whether Congress would have adopted the related remainder without the individual mandate. It stated 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." *Florida v. HHS*, 648 F.3d at 1324. But the key findings for the individual mandate *do* contain critical cross-references to the related health insurance reforms, and they explicitly state that the implementation of the provisions referred to *is* dependent on the mandate. Section 1501(a)(2)(I) of the Act specifically refers to the health insurance reforms in Sections 2704 and 2705 of the Public Health Services Act, 42 U.S.C. §§ 300gg et seq., as well as to "improved health insurance products," a reference to the myriad of insurance reforms in Title I. That finding stresses that "if there were no requirement, many individuals would wait to purchase health insurance until they need care." Section 1501(a)(2)(I). Striking down the mandate while sustaining the provisions that Congress designed to be vitally dependent on it thus defeats the unified purpose of the law.

The Court of Appeals sought to defend that rash conclusion by noting that "a basic objective of the Act is to make health insurance accessible and thereby to reduce the number of uninsured persons." 648 F.3d at 1324-25. The court then concluded,

"Undoubtedly, these [health insurance] reforms seek to achieve those objectives. All other things being equal, then, a version of the Act that contains these two reforms would hew more closely to Congress's likely intent than one that lacks them." Id. at 1325. This conclusion is manifest error. The question is not whether a court or some independent policy maker could view the preexisting conditions and guaranteed issue provisions as freestanding provisions unrelated to the mandate. The question is whether Congress so thought. On that the answer is unequivocal. As Congress was at pains to explain, Sec. 1501(a)(2)(I) of the Act, the insurance reforms would not achieve their objective and would not operate as intended without the mandate.

The court compounded its initial error by citing numerous other provisions "that also serve to reduce the number of the uninsured," including the health insurance reforms themselves! 648 F.3d at 1325. In so doing it substituted its judgment about the interrelation of these provisions for Congress's assertion that they were part of a single plan. Unlike in *Alaska Airlines*, both the text and historical context of the Act make clear that the individual mandate was essential to the legislative bargain.

The lower court correctly points out that some parts of the Act bear little relation to the individual mandate, compared with the insurance reforms.[7] In this brief *Amici Curiae* take no position on the parts of the Act that fall outside Titles I and II. The focus

[7] *See, e.g.,* BGCIA, *supra* n. 3.

of this brief rather is to illuminate for the Court just how deeply and inextricably interwoven Titles I and II are with the individual mandate. As a detailed examination of those provisions shows, Congress presupposed that they would stand or fall together, given that the individual mandate is necessary for the health insurance reforms to operate as intended, and that it is designed to work *in tandem* with Medicaid and premium support to make health care more accessible and affordable.

II. THE INDIVIDUAL MANDATE IS OPERATIVELY INSEPARABLE FROM TITLES I AND II OF THE ACT

The core of the Act is in its first two titles, which provide for a sweeping program of health insurance reforms, state-based insurance exchanges, and expanded Medicaid and premium support benefits. Titles I and II are primarily responsible for projections that the law will dramatically decrease the number of uninsured. Subsequent titles of the Act are generally ancillary to the first two titles.

Virtually all the provisions in Titles I and II were designed to depend upon or dovetail with the individual mandate. Without the mandate they will have an operation and effect entirely different than what Congress intended—in many cases, the opposite of what Congress intended.

At the time the Act was signed into law, the Congressional Budget Office estimated that without the Act, by 2019 the United States would have 55 million uninsured persons out of a total nonelderly population of 282 million, and estimated that the Act would reduce the number of uninsured by 33

million by 2019. CBO, *Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 20101 (P.L. 111-152)* (March, 2011), http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf. CBO subsequently estimated that, stripped of the mandate, the Act would reduce the number of uninsured by only about 16 million. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

In other words, CBO estimated that, with the mandate, the Act would reduce the number of uninsured by about two-thirds, but without it, by only about one-third. Hence, at the time the Act passed, Congress could have expected that stripping the mandate would reduce the overall impact of the Act on the uninsured population by half. Some economists estimate that without the mandate, reductions in the number of uninsured will be far lower. *See*, *e.g.*, Gruber, *supra* Part I.B.

Stripped of the mandate, the Act would also cause a dramatic rise in premiums. According to one estimate, individual insurance premiums could rise 40 percent higher without the mandate. *Id.* And, as explained *infra* Part II.A, premiums would rise for group plans as well.

A. Provisions with an Operative Dependency on the Individual Mandate

Title I of the Act consists mainly of health insurance reforms that, without the mandate, will

create, or exacerbate, an adverse-selection spiral, and increase fiscal pressure on the government as a result of premium-support subsidies. Virtually all of these provisions take effect in 2014, coincident with the individual mandate.

1. "Guaranteed Issue"

Prior to the Act, *group* health insurance plans (about 90 percent of the insurance market) were subject to a guaranteed-issue requirement[8] under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 1936 ("HIPAA"). In order to forestall the expected adverse selection spiral, HIPAA allowed exclusions for pre-existing conditions, up to 12 months generally. Because allowing insurance companies to exclude unhealthy people from the rolls helps to avert an adverse selection spiral, this scheme allowed HIPAA to avoid having to impose an individual mandate.

The Act supplants the HIPAA scheme. Effective 2014, Sections 1201(4) and 1202(2)(A) of the Act provide for guaranteed issue *and* a prohibition on pre-existing conditions exclusions in all cases, respectively. Because the ban applies to group insurance plans under HIPAA in addition to the individual market, it creates an incentive for many of those who are *already covered* under employer-provided group insurance to drop insurance and wait until they get sick to buy health insurance. Consequently, under the Act adverse selection pressure affects the whole nonelderly population, including those who are already insured under

[8] HIPAA imposed no such limitation on individual plans (approximately the remaining 10 percent).

employer-provided group insurance; hence the need for a broad insurance mandate.

CBO estimates that as a result of eliminating the health care mandate, 16 million more people will be uninsured than under the Act in its original form:

> That increase in the number of people who are uninsured relative to current law would be the net result of about 4-5 million fewer individuals with employer-sponsored coverage, about 5 million fewer people with coverage obtained in the individual market (including individual policies purchased in the exchange or directly from insurers in the non-group market), and about 6-7 million fewer individuals with Medicaid or CHIP coverage.

CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, *supra* Part II.

One immediate effect of so many millions of healthy people dropping coverage will be to raise the per-unit costs of insuring those who remain in the pool. The price rise could be as high as 40 percent or higher. Gruber, *supra* Part II.B. Nobody can say with certainty, however, because rising premiums will accelerate the shrinking population of healthy people and vice versa, until the adverse selection spiral rests at some new equilibrium. After many of the state reform efforts, that equilibrium was reached only when virtually all insurers had left the individual market. *See*, *infra* Part III.B.

There is nothing in the record that suggests the individual mandate could have done the yeoman work that is intended for it. Indeed, the experience of state reform efforts suggests that neither the

preexisting conditions exclusions prohibited by the Act nor even the individual mandate is entirely effective in preventing an adverse selection spiral as a result of guaranteed issue and similar insurance reforms. *See infra* Part III.B. The adverse selection could still take place with the mandate on the books. But this Court's task in a severability context is limited to the interrelation of the provisions in question, not the separate question of whether the Act can make good on its extravagant promises. To Congress, the health insurance reforms and the individual mandate were irretrievably interwoven. They are inseparable.

2. "Community Rating" compression

Effective in 2014, Section 1201(4) of the Act limits insurers to an age-based variation in premiums of no more than three to one. Because the eldest non-Medicare- eligible adults consume about five times more health care than youngest adults, the effect of this provision is to compress age-related premium variations, lowering premiums for the elderly and raising premiums for the young. Edmund Haislmaier, *Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets*, Heritage Foundation (Jan 20, 2011), http://thf_media.s3.amazonaws.com/2011/pdf/wm3111.pdf.

According to Haislmaier, *id.,* a three-to-one compression in age-related premiums variations would increase premiums for those aged 18 to 24 by 45 percent and those aged 15 to 29 by 35 percent, while reducing premiums for those aged 55-59 by 12 percent and those aged 60 to 64 by 13 percent.

Because the adverse selection spiral results from healthy (and typically, younger) people waiting until they get sick to get health insurance, the Act's age rating compression provisions, which artificially raise insurance premiums for that very population, will dramatically add to adverse selection pressures.

3. Provisions that increase the cost of insurance

Most of the Act's insurance product reforms tend to increase the cost of insurance. Because upward pressure on prices is one of the basic drivers of the adverse selection spiral, anything that increases such upward pressure will aggravate the adverse selection spiral. Absent the individual mandate, this will affect particularly those who are not eligible for premium support; and with respect to those who are, the government will feel the fiscal brunt of increased premium support. Still other reforms will increase the number of uninsured outright.

a. Prohibition on annual limits

Effective 2014, Section 1001(5) of the Act prohibits insurers from imposing "annual limits on the dollar value of benefits for any participant or beneficiary." This provision will eliminate many of the limited-benefit and health-reimbursement arrangements currently offered by employers with disproportionately low-wage workforces. The Act is designed to accommodate low-wage workers through Medicaid and premium-support provisions. Without the mandate, however, Congress believed that many of these currently insured would become uninsured. Because these individuals tend to be working-age and healthier, the relative proportion of healthy

people in the insured risk pool would diminish, artificially aggravating adverse selection pressures.

b. Comprehensive coverage requirement

Section 1302(a) of the Act requires the Secretary of HHS to establish minimum "Essential Health Benefit" standards, to include specified elements typically associated with comprehensive coverage. Given the statutory minimum requirements, those plans are likely to increase average premiums in both the group and individual markets.

c. Limitation on cost-sharing

Section 1302(c) of the Act imposes cost-sharing restrictions on group health plans. Individuals currently enrolled in plans with cost-sharing provisions beyond those maxima will see their cost-sharing reduced and premiums correspondingly increased. Reduced cost-sharing will also encourage greater use of health services, which will further drive up premiums.

d. Preventive care coverage requirement

In addition to the coverage required by the "Essential Health Benefit" provisions, the Act requires group and individual plans to provide preventive services without enrollee cost sharing. *See*, *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 (July 19, 2010). The effect will be to increase premiums through the shifting of cost-sharing to the insurers,

and to encourage increased overuse of preventive care services, which will also increase premiums.

B. Provisions Designed to Dovetail with the Individual Mandate

The Act's combination of individual mandate, Medicaid benefits, and sliding scale insurance premium support creates four general income brackets. The lowest is eligible for Medicaid and exempt from the mandate; the next highest is both eligible for Medicaid and subject to the mandate; the next is eligible for a sliding scale subsidy and subject to the mandate; and the highest is eligible for no benefit and is subject to the mandate.

The individual mandate thus operates in tandem with the Act's Medicaid expansion and sliding-scale premium support to increase access and affordability across income categories. Eliminating the mandate will dramatically skew this coverage, resulting in the concentration of large numbers of uninsured in particular income categories. Without the mandate, the Act's Medicaid and premium support provisions will fail to accomplish Congress's purpose of comprehensively expanding access and affordability of health care for all Americans.

1. Insurance exchanges

The Act provides for state-based exchanges where individuals will be able to purchase individual health insurance. The Act's premium support provisions in turn subsidize the purchase of insurance within the exchanges.

According to CBO estimates, most of the increase in the uninsured population that will result from

elimination of the mandate will come among those who are eligible for subsidies (from 133 percent FPL to 400 percent FPL) and among those who are ineligible for the subsidies (above 400 percent FPL). *Explaining Health Care Reform: Questions about Health Insurance Subsidies,* Kaiser Family Foundation (April, 2010), http://www.kff.org/healthreform/upload/7962-02.pdf. The individual market for both populations will be organized under the exchanges. As the experience of state reform efforts shows, *see infra* III.B, guaranteed issue, community rating, and similar reforms pose grave risks to the individual market even with a robust individual mandate, and Congress knew from the states' experience that the risks could be catastrophic without the mandate.

In most of the states where health insurance reforms similar to those in the Act were attempted without an individual mandate, the individual health insurance industry virtually disappeared in just a few years as a result of adverse selection. *See infra* Part III.B. The Act's complex provisions related to state exchanges would certainly be pointless with the individual insurance industry in danger of collapse.

Moreover, if the individual mandate is struck down along with its most intimately related provisions, e.g., the ban on preexisting conditions exclusions, underwriting criteria based on health status would come back into the insurance application process, making the "pricing" mechanism of the exchange highly notional, and thereby defeating the purpose of the exchange from the consumer's point of view. Bradley Herring, *An*

Economic Perspective on the Individual Mandate's Severability from the ACA, The New England Journal of Medicine (March 10, 2011) http://www.nejm.org/doi/full/10.1056/NEJMpv1101519. A proper understanding of how the exchanges work in relation to other aspects of Titles I and II of the Act reveals that the legislative bargain which produced PPACA's central regulatory scheme was highly interwoven.

2. Medicaid expansion and premium subsidies

The Medicaid expansion and premium support provisions of the Act are designed to work in tandem with the individual mandate to spread health insurance coverage across income categories. According to CBO, the number of uninsured will drop by only one-third without the individual mandate, as opposed to the projected two-thirds with the individual mandate. The increase in the number of uninsured without the mandate would include 5 million fewer people with coverage obtained in the individual market, and 6-7 million fewer people eligible for Medicaid or CHIP. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, *supra* Part II.

Adverse selection could dramatically increase the numbers of uninsured beyond CBO estimates, however, particularly for those in the individual market who are not eligible for subsidies (above 400 percent FPL). In many of the states that adopted guaranteed issue and community rating provisions, the market for such individuals was virtually wiped out in just a few years after adoption of the reforms.

See, infra III.B. But as CBO projections make clear, even among those eligible for subsidies and Medicaid or CHIP, millions will decline to enroll in coverage absent the mandate. The result—an uncertain fiscal impact, millions more without health insurance, and rising premiums—will upend the careful balance that Congress sought to achieve through its combination of Medicaid expansion, premium support, and individual mandate.

3. Reduced funding for safety-net hospitals

Federal law ensures emergency room care for low-income individuals. This requirement affects hospitals in low-income areas disproportionately. Federal law has long provided for supplemental payments to these "disproportionate share hospitals" (DSHs) under the Medicaid and Medicare programs. Because the Act was expected to reduce the number of uninsured by two-thirds, it accordingly reduces the funds available for DSH payments. Without the individual mandate, the reduction in the number of uninsured will be far lower (a third, or even less), CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance, supra* Part II, thus putting DSHs in financial jeopardy.

In sum it is evident from this close examination of the Act, which barely passed Congress, that it would have not been able to make it through without inclusion of the individual mandate. So long as the test for severability requires this Court strike down provisions that Congress has linked to the

passage of the independent mandate, Title I and Title II should be struck down.

III. THE TEXT AND HISTORICAL CONTEXT OF THE ACT MAKE IT EVIDENT THAT CONGRESS WOULD NOT HAVE PASSED THE ACT WITHOUT THE INDIVIDUAL MANDATE

A. The Act's Text Shows that Congress Would Not Have Passed the Legislation without the Individual Mandate

Title I contains all of the key health insurance reforms: guaranteed issue, prohibition of preexisting conditions exclusions, enhanced benefits, state-based exchanges, premium subsidies, and the individual and employer mandates. Considered as a comprehensive legislative bargain, it is obvious that individual and employer mandates had no other purpose than to spread the costs of the preceding benefits among a large risk pool, and thereby avoid the consequence the benefits were sure to have on their own, namely that of an adverse selection spiral. The mandates are designed to implement the insurance reforms, and are as textually essential to each other as the regulations and related tax penalty in *Hill*, 259 U.S. at 44 (1922).

B. The Historical Context of State-Based Health Reform Efforts Shows that Guaranteed Issue and Community Rating Reforms Would Lead to Adverse Selection without An Individual Mandate

Before Congress took up health care reform in 2009, a handful of states had experimented with

major health insurance reforms including guaranteed issue and some form of community rating compression, focused on the individual insurance market.[9] These reform efforts generally had disastrous effects: States experienced adverse selection spirals, with increased numbers of uninsured, large premium increases, and insurers exiting the individual market. *See*, Conrad F. Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*, The Council for Affordable Health Insurance and The Heartland Institute (2005), http://www.cahi.org/cahi_contents/resources/pdf/destroyinginsmrkts05.pdf. This "historical context" explains why Congress would never have passed the Act without the individual mandate.

In each of these cases, state law generally permitted exclusions for preexisting conditions in the individual market. As the experience of HIPAA showed in the group market, allowing such exclusions could significantly attenuate the adverse selection problem. These state level experiments offer a particularly telling aspect of the historical context for the Act, which prohibits such exclusions altogether, thereby increasing the pressure for adverse selection, and leaving little alternative to an individual mandate beyond wholesale subsidies of health insurance.

---

[9] Before the Act, the employer-provided group insurance market was largely regulated by federal law—HIPAA and ERISA. That left only the individual insurance market open to state regulation.

New Hampshire and Kentucky both adopted guaranteed issue and community ratings reforms in 1994. N.H. Rev. Stat. Ann. §420-G, P.L. 1994 c. 294; Ky. Rev. Stat. Ann. §304.17A, P.L. 1994 c. 512. In both states, adverse selection set in in the individual market almost immediately. *See* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, pp. 5-6, 20 Milliman (July 10, 2007), http://alankatz.files.wordpress.com/2007/09/-milliman-study-on-gi-20070912.pdf. In New Hampshire both reforms were repealed in 2002, replaced by a high-risk pool for the commercially uninsurable. *Id.* at 20. In Kentucky, more than 40 insurers left the individual market within just two years, leaving just two insurers (one of them state-run) offering individual insurance; the state repealed the guaranteed issue and community ratings reforms in 1998 and declared a moratorium on mandated benefits in 2004. *Id.* at 5-6.

Similarly, individual insurance market guaranteed issue and community rating reforms were adopted in Vermont (1992), Washington (1993), and New Jersey (1992), with the same result: an adverse selection spiral, increased numbers of uninsured, skyrocketing premiums, and the virtual disappearance of the individual market. Title 8 V.S.A. §4080b (1992), 1991 Adj. Sess. No. 160 (Vermont); RCW 48.43, L. 1993 c. 492 (Washington); NJ ST §17B:27A, P.L. 1992 c. 161 (New Jersey); *see generally*, Wachenheim & Leida, *supra*, pp. 25-27, 36-43. In 1999, Washington significantly weakened its guaranteed issue provision by allowing insurers to exclude the sickest 8 percent of the population,

who were instead offered a high risk pool. *Id.* at 42. In Vermont, deductibles were allowed to increase dramatically from $50 prior to reform; by 2006 the lowest indemnity deductible available in Vermont was $3,500. *Id.* at 37. In New Jersey, a 2003 reform allowed insurers to offer minimal benefit plans with similarly high deductibles, which tempted insurers back into the individual market.

Similar guaranteed issue and community rating reforms were adopted in New York (1993), and Maine (1993) with the same results as elsewhere. 11 NYCRR Parts 360-62, NY INS §3231, P.L. 1992 (New York); Me. Rev. Stat. Ann. Tit. 24-A §2736-C, P.L. 1993 c. 477 (Vermont). Adverse selection set in immediately, driving most insurers out of the individual insurance market and dramatically driving up premiums. Wachenheim & Leida, *supra*, pp. 10-14, 31-35. In response Maine adopted a state-based health insurance program (the Dirigo Health Reform Act of 2003) which in turn was repealed in June 2011. In Maine, New Jersey, and New York a losing struggle against the unintended consequences of their reform efforts was overtaken by the Act's passage.

The individual mandate grew out of the experience of Massachusetts, which adopted its guaranteed issue and community rating reforms in 1996. Mass. Gen. Laws. Ann. Ch. 176M §§ 2 and 4, P.L. 1996 c. 203. Adverse selection set in, shrinking the size of the individual insurance market as elsewhere. Wachenheim & Leida, *supra*, pp. 15-16. In 2006, the state adopted a major series of reforms that included an individual mandate, a state exchange for individual insurance plans, and several

high-deductible, limited-benefit options to entice healthy individuals back into the insurance pools. *Id.* at 16. The mandate's initial success in initially arresting and reversing the adverse selection spiral provided what Congress could only have thought was vital information when it took up health reform in 2009 and 2010, namely that an individual mandate was an effective way to counteract the adverse selection spiral that, if history was any guide, would inevitably result from guaranteed issue and community rating provision—particularly with a prohibition on preexisting conditions exclusions.

Given this historical context, it is simply not believable that Congress had any intention of repeating the costly mistakes of the states, by adopting even more sweeping health insurance reforms without the balancing of an individual mandate.

C. At Every Point in the Legislative Process, Congress Gave the Individual Mandate the Highest Priority and Would Not Have Passed the Act without It

Shortly after the 2008 election, Senator Max Baucus released a white paper, *Call to Action: Health Reform 2009*, laying out the broad outlines of what would form the basis of the Act. Among six principles laid out in the Baucus paper was "Individual Responsibility," requiring all individuals to maintain health insurance coverage: "Once affordable, high-quality, and meaningful health insurance options are available to all Americans, it will be each individual's responsibility to have

coverage. This step is necessary to make the entire health care system function properly." *Id*. at 13.

In the summer of 2009, the Senate Finance Committee held hearings on various aspects of health care reform. From the beginning, these hearings discussed the importance of a mandate as a means of making other elements of the health care reform package work as intended. *See*, *e.g.*, *The President's Fiscal Year 2010 Health Care Proposals: Hearing Before the S. Committee on Finance*, 111th Cong. (2009).

On September 16, 2009, Senator Baucus released his Chairman's Mark of the Finance Committee health care reform bill, titled "The America's Healthy Future Act." The Chairman's Mark included an individual mandate. Several opponents of the bill objected to the inclusion of an individual mandate in the law, citing concerns over the provision's constitutionality as well as other concerns.

Several attempts were made during the Committee markup to strip or dilute the mandate provision. Senator Orin Hatch offered an amendment to eliminate the individual mandate altogether. This was tabled. Senator Charles Grassley offered an amendment that would have allowed states to opt out of the mandate requirement. This was rejected 10-14. Senator Bunning offered an amendment allowing individuals to opt out of the mandate upon request. This was defeated 9-14. An amendment by Senator Hatch to stay implementation of the individual mandate until judicial review of its constitutionality

was ruled non-germane by a vote of 7-9. Finally, Senator Mike Crapo offered an amendment that would have exempted individuals making less than $200,000 a year and families making less than $250,000 a year from the mandate requirement. This was defeated 11-12. *See*, *Markup on Health Care Overhall: S. Committee on Finance*, 111th Cong. (2009).

Through votes in its principal committee of jurisdiction, the Senate thus repeatedly expressed the priority it placed on the individual mandate. Throughout, Senator Baucus vigorously defended the necessity of the individual mandate. For example, in response to Senator Jim Bunning's amendment allowing individuals to opt out of the mandate upon request, the Chairman stated, "I'd say it's a mortally wounding amendment because it basically says no more personal – or no shared responsibility for individuals . . . individuals will opt themselves out and that's going to undermine this whole system here. It clearly is going to undermine the system. The system won't work if this amendment passes." *Markup on Health Care Overhall, Part 3: S. Committee on Finance*, 111th Cong. (2009). Likewise, in response to Senator Crapo's amendment, Senator Baucus declared: "This is a killer amendment. This is an amendment which guts and kills health reform." *Markup on Health Care Overhaul, Part 7: S. Committee on Finance*, 111th Cong. (2009).

Senator Jeff Bingaman likewise noted that "it would seem to me that if you took away the requirement for–of an individual mandate you'd have–the expectation would have to be that a lot

fewer people would wind up getting coverage . . . the ultimate effect of this would be that – would be that in states that took this option [that is, that opted out of the individual mandate] you would have to expect insurance premiums to be higher than in states that did not." *Markup on Health Care Overhall, Part 3: S. Committee on Finance*, 111th Cong. (2009).

On October 13, the bill was favorably reported out of Committee by a vote of 14-9. Thereafter, the individual mandate was discussed and debated extensively on the floor of the Senate prior to passage. As in committee, during discussion of the bill Senators repeatedly noted the importance of the mandate as a cost saving measure necessary to offset other aspects of the bill. *See*, *e.g.*, Cong Rec. S10447 (daily ed. Oct. 15, 2009) (statement of Senator Lamar Alexander) ("[O]ne does not have to be an actuary to figure this out. If the individual mandate is weaker, premiums will go up."); S10448 (daily ed. Oct. 15, 2009) (statement of Senator Alexander) ("We want to read the bill and know what it costs . . . . If it weakens the individual mandate; if it says young people can't buy inexpensive policies anymore; if it says millions of us have to buy government-approved, richer policies instead of policies with high deductibles; and if it imposes $955 billion of taxes that will be passed on, raising our premiums; if it raises our premiums instead of lowering our premiums, then why are we doing this?"); S11897 (daily ed. Nov. 20, 2009) (statement of Senator Tom Coburn) ("Then we have the insurance mandate. What is wrong? If, in fact, you have a preexisting illness, you don't get insured.

That is wrong. We need to fix that."); S10002 (daily ed. Oct 1., 2009) (statement of Senator Alexander) ("Coverage for all is also an essential element of health care reform and I believe an enforceable and effective individual mandate, combined with guaranteed insurance of insurance, is the best way to accomplish this goal. The individual mandate must provide effective incentives to help prevent adverse selection that could occur if the mandate is too weak."); S13577 (daily ed. Dec. 20, 2009) (statement of Senator Coburn) ("One of the big 'shall also's' that I do not think will ever hold scrutiny before the Supreme Court is, you shall buy an insurance policy. That doesn't fit anywhere in the Constitution that I read. If you do the legal research on it, as my staff lawyers from the Judiciary Committee have done, it is highly unlikely that will ever hold up. So the whole premise of a large portion of the taxes collected in this bill will be out the window. It will also change, through adverse selection, all of the insurance premiums in the country because, if you do not have an individual mandate making people buy insurance, the costs relative to the illness and the age, even though we have compressed the ratios, will rise exorbitantly.")

On Christmas Eve 2009, the health care bill, now HR 3590, passed the Senate on a vote of 60-39. H.R. 3590 111th Cong (2009). A previously passed House version also included an individual mandate in the form of a surtax on all individuals not maintaining health insurance coverage. H.R. 3200, 111th Cong. (2009). The House then took up the Senate-passed version, and again repeated reference was made to

the individual mandate. Comments by California Rep. George Miller are perhaps most telling:

> The bill contains an individual mandate to either obtain health insurance or pay a penalty . . . Without an individual mandate, individuals could wait to purchase health insurance until they are sick – thereby driving up insurance costs and undermining the bill's efforts to bring health care costs and costs to the broader economy under control. This requirement spreads risk to ensure lower costs for everyone, prevents adverse selection, helps end overpayment by the government and other consumers for the uninsured, and makes health care reform overall sustainable.

156 Cong Rec. H1882 (daily ed. March 21, 2010) (statement of Rep. Miller).

On March 21, 2010, the bill, including the individual mandate, passed the House on a very narrow vote of 219-212.

CONCLUSION

For the foregoing reasons, if this Court rules the individual mandate unconstitutional, it should rule that the mandate is not severable from Titles I and II, and strike them down with the mandate.

Respectfully submitted,

Richard Epstein
800 N. Michigan Avenue
Apartment #3502
Chicago, IL 60611
richard.epstein@nyu.edu
(773) 450-4476

Ilya Shapiro
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(202) 842-0200
ishapiro@cato.org

Mario Loyola
Counsel of Record
Josiah Neeley
TEXAS PUBLIC POLICY FOUNDATION
900 Congress Ave., Suite 400
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

Counsel for Amici Curiae

January 5, 2012