NOS. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.,

v.

KATHLEEN SEBELIUS, ET AL.

STATE OF FLORIDA, ET AL.,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

BRIEF FOR PRIVATE PETITIONERS ON SEVERABILITY

KAREN R. HARNED
NFIB SMALL BUSINESS LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV. LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

QUESTION PRESENTED

Congress effected a sweeping and comprehensive restructuring of the Nation's health-insurance markets in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 109 (collectively, the "Act" or "ACA"). In No. 11-398, this Court is reviewing whether Congress exceeded its Article I authority when it enacted the ACA's mandate that virtually every individual American obtain health insurance. 26 U.S.C.A. § 5000A(a). Here, the question presented is:

Whether the remainder of the Act must be invalidated in whole or in part because it cannot be severed from the individual mandate.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Three private individuals or organizations were Plaintiffs-Appellees below and are Petitioners in No. 11-393 and Respondents (by rule) in No. 11-400: National Federation of Independent Business ("NFIB"); Kaj Ahlburg; and Mary Brown. NFIB is a nonprofit mutual benefit corporation that promotes and protects the rights of its members to own, operate, and grow their businesses across the fifty States and the District of Columbia. NFIB is not a publicly traded corporation, issues no stock, and has no parent corporation. There is no publicly held corporation with more than a 10% ownership stake in NFIB.

26 States, by and through their Attorneys General or Governors, were Plaintiffs-Appellees/Cross-Appellants below and are Petitioners in No. 11-400 and Respondents (by rule) in No. 11-393: Alabama; Alaska; Arizona; Colorado; Florida; Georgia; Idaho; Indiana; Iowa; Kansas; Louisiana; Maine; Michigan; Mississippi; Nebraska; Nevada; North Dakota; Ohio; Pennsylvania; South Carolina; South Dakota; Texas; Utah; Washington; Wisconsin; and Wyoming.

Six federal officers or agencies were Defendants-Appellants/Cross-Appellees below and are Respondents in Nos. 11-393 & 11-400: Kathleen Sebelius, in her official capacity as Secretary of Health and Human Services; Timothy F. Geithner, in his official capacity as Secretary of the Treasury; Hilda L. Solis, in her official capacity as Secretary of Labor; and the United States Departments of Health and Human Services, of the Treasury, and of Labor.

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BRIEF FOR PRIVATE PETITIONERS

Private Petitioners respectfully submit this brief arguing that the individual mandate is not severable from the remainder of the Act.[1]

OPINIONS BELOW

The opinion of the court of appeals (Pet.App. 1a-273a) is reported at 648 F.3d 1235. The summary-judgment opinion of the district court (Pet.App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's motion-to-dismiss opinion (Pet.App. 394a-475a) is reported at 716 F. Supp. 2d 1120.

JURISDICTION

The Eleventh Circuit entered judgment on August 12, 2011. The petitions for writs of certiorari were filed on September 27 and 28, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The appendix hereto reproduces selected provisions from the Act.

STATEMENT OF THE CASE

The Act reflects an intricate deal that emerged from one of the most hard-fought and narrowly decided legislative battles in recent memory. It produced a "comprehensive and complex regulatory scheme" (Pet.App. 22a) that proponents claimed would achieve near-universal health-insurance coverage and reduce health-insurance costs—without increasing the federal budget deficit.

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[1] To avoid confusion, all "Pet.App." citations reference the appendix to the Government's certiorari petition in No. 11-398. "RE" citations reference the Eleventh Circuit Record Excerpts.

A. The Act's Passage

1. Origins Of The Act

Comprehensive change of the Nation's system of health insurance was a central issue in the 2008 Democratic presidential primary, with each major candidate outlining proposals to achieve near-universal coverage while lowering costs. *See, e.g.*, Michael Cooper, *It Was Clinton vs. Obama on Health Care*, N.Y. TIMES, Nov. 16, 2007, at A30. Then-Senator Hillary Clinton was the first to propose a mandate that every individual purchase health insurance—a proposal that then-Senator Barack Obama sharply criticized. *Id.* Clinton responded that universal coverage would be impossible absent an individual mandate. *Id.*

After taking office, President Obama's position on an insurance mandate changed. The shift began after the insurance industry's two main trade associations offered to support comprehensive regulation on the condition that any bill contain "an enforceable mandate for individual coverage." Robert Pear, *Health Insurers Offer to Accept All Applicants, On Condition*, N.Y. TIMES, Nov. 20, 2008, at A30. This offer led to planning sessions between congressional leaders and major healthcare stakeholders, at which the centrality of the mandate became clear. *See, e.g.*, Robert Pear, *Health Care Industry in Talks to Shape Policy*, N.Y. TIMES, Feb. 20, 2009, at A16. In the face of this pressure, the President signaled a willingness to depart from his campaign pronouncements. Robert Pear, *Obama Open to Mandate That People Own Coverage*, N.Y. TIMES, June 3, 2009, at A17. Likewise, the chairs of critical congressional committees agreed "to plow

ahead on the assumptions that individuals would be required to carry insurance" and "that most employers would be required to help pay for it." Robert Pear, *Team Effort In the House To Overhaul Health Care*, N.Y. TIMES, Mar. 18, 2009, at A12.

2. Goals Of The Legislative Effort

For proponents of change, any legislation had to serve two fundamental goals: (1) ensuring nearly universal coverage, in particular by prohibiting what were described as discriminatory and abusive practices by insurance companies, such as the refusal to insure sick individuals and the pricing of insurance based on individual actuarial risk; and (2) reducing the overall cost of health insurance.

The President made clear throughout the process that his core goal was to expand coverage, especially by eliminating the putative insurer abuses. As he explained in his 2010 State of the Union address:

> I took on health care because of the stories I've heard from Americans with preexisting conditions whose lives depend on getting coverage; patients who've been denied coverage; families—even those with insurance—who are just one illness away from financial ruin. …
>
> The approach we've taken would protect every American from the worst practices of the insurance industry. It would give small businesses and uninsured Americans a chance to choose an affordable health care plan in a competitive market.[2]

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[2] http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address.

Legislators echoed the sentiment. *E.g.*, 155 Cong. Rec. S13295, 13306 (daily ed. Dec. 16, 2009) (Sen. Johnson) ("This legislation … puts an end to insurance industry abuses that have denied coverage to hard-working Americans ….").

Equally "driving" the legislative effort, though, was the fact that costs were "exploding." Robert Pear, *Obama's Health Plan, Ambitious in Any Economy, Is Tougher In This One*, N.Y. TIMES, Mar. 2, 2009, at A14 (quoting Melody C. Barnes, director of the President's Domestic Policy Council). Once again, President Obama was emphatic:

> Then there's the problem of rising cost. … [This is why] so many employers–especially small businesses—are forcing their employees to pay more for insurance, or are dropping their coverage entirely ….
>
> The plan I'm announcing tonight …will slow the growth of health care costs for our families, our businesses, and our government. It's a plan that asks everyone to take responsibility for meeting this challenge—not just government, not just insurance companies, but everybody including employers and individuals.

Remarks by the President to a Joint Session of Congress on Health Care, Sept. 9, 2009 ("*Remarks to Congress*").[3]

Then-Speaker Pelosi, and countless other legislators, echoed this refrain:

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[3] http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/

> We all know that the present … health insurance system in our country is unsustainable. We simply cannot afford it. … The best action that we can take on behalf of America's family budgets and on behalf of the Federal budget is to pass health care reform.

156 Cong. Rec. H1891, 1896 (daily ed. Mar. 21, 2010); *see also, e.g.*, 156 Cong. Rec. S1923, 1931 (daily ed. Mar. 24, 2010) (Sen. Levin) ("At its heart, this bill … aim[s] to tackle the central problems of our health care system—rising costs and the insecurity many Americans rightly feel about the lack of dependability of their insurance.").

3. Critical Constraints

Despite the urgency with which the President and congressional leaders pushed forward, they faced many obstacles to obtaining the necessary votes.

Significant disagreements, even among proponents of comprehensive legislation, left little room for workable compromise. For example, many supported a strong "public option," *i.e.*, a government-run insurer, which was said to "remove the profit motive as an obstacle to medical care";[4] others argued that the "public option" would produce inefficient and unfair competition with the private sector; and still others offered compromise solutions involving more limited public plans. *See* Robert Pear, *Schumer Points to a Middle Ground on Government-Run Health Insurance*, N.Y. TIMES, May

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[4] David M. Herszenhorn, *Public Option Keeps Toehold in Senate Deal on Health Bill*, N.Y. TIMES, Dec. 9, 2009, http://www.nytimes.com/2009/12/10/health/policy/10health.html?scp=32&sq=health+care+public+option&st=nyt.

5, 2009, at A20. Many legislators were concerned about imposing the onerous taxes that would be necessary to fund an expansion in health-insurance coverage. *See* David M. Herszenhorn, *Democrats Are at Odds on Financing Health Care*, N.Y. TIMES, July 10, 2009, at A14.

Moreover, the Act had no hope of passing if it was scored by the Congressional Budget Office ("CBO") as increasing the federal deficit. President Obama was emphatic that "[h]ealth care reform must not add to our deficits over the next 10 years—it must be at least deficit neutral." Letter from President Obama to Senators Kennedy and Baucus (June 3, 2009).[5] The President bluntly warned: "I will not sign a plan that adds one dime to our deficits—either now or in the future." *Remarks to Congress*, *supra*. The Senate Majority Leader agreed that any bill had to not only "lower the cost of staying healthy" but also "reduce the national debt."[6] And key, centrist Senators likewise insisted on this constraint. *See, e.g.*, Robert Pear & David M. Herszenhorn, *Democrats Are Considering Additional Tax on Insurers*, N.Y. TIMES, Oct. 9, 2009, at A19 ("[W]e all set goals and we really, really, really worked hard to stay within those goals of making sure that it was deficit-neutral." (quoting Sen. Lincoln)); *Nelson: Bill Must Be Deficit Neutral*, ORLANDO SENTINEL, Oct. 2, 2009, at A18.

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[5] http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus.

[6] Press Conference of Sen. Harry Reid at 0:29-0:34, Dec. 19, 2009, *available at* http://reid.senate.gov/newsroom/121909_finalbill.cfm.

4. Early Versions Of The Act

The Act's first precursor was released by the House Ways and Means Committee. The draft bill:

- Required that insurance companies provide insurance on a "guaranteed-issue" basis, *i.e.*, that they provide coverage for all consumers, regardless of any pre-existing health conditions. H.R.__ [Discussion Draft], §§ 111-112 (June 19, 2009).[7]
- Required "community-rated" premiums—*i.e.*, premiums reflecting average costs in a particular region, but (with limited exceptions) not individual characteristics reflecting actuarial risk. *Id.* § 113.
- Provided that "[i]n the case of any individual who does not [maintain insurance] at any time during the taxable year, there is hereby imposed a tax." *Id.* § 401.

This draft was subject to intense negotiations, and sharp disagreements led to three different committee versions.[8] Ultimately, the House passed, by a vote of 220 to 215, a version that retained the guaranteed-issue and community-rating provisions, and imposed a tax on individuals without insurance (but not a direct mandate to buy it). H.R. 3962, 111th Cong. §§ 211-213, 501 (Nov. 7, 2009). The bill also included a severability clause, providing that if any provision were held to be unconstitutional, the rest of the bill would remain in effect. *Id.* § 255.

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[7] http://waysandmeans.house.gov/media/pdf/111/hrdraft.pdf.

[8] David M. Herszenhorn & Robert Pear, *House Health Care Bill Criticized as Panel Votes for Public Plan*, N.Y. TIMES, July 31, 2009, at A11.

The initial bill reported from committee in the Senate, like the House bill, imposed guaranteed-issue and community-rating rules on insurers. Affordable Health Choices Act § 101, S. 1679, 111th Cong. (as reported by Sen. Comm. on Health, Educ., Labor, and Pensions Sept. 17, 2009). In contrast to the House bill, however, the Senate bill did not apply a tax if an individual was uninsured. Rather, to comport with the President's campaign pledge not to raise taxes on families earning under $250,000 per year, it instead imposed a direct legal requirement that "[e]very individual shall ensure that such individual … is covered under qualifying coverage at all times during the taxable year." *Id.* § 161; *see also* Adam Nagourney & David M. Herszenhorn, *Republicans Call Health Legislation a Tax Increase*, N.Y. TIMES, Oct. 2, 2009, at A22.

Following intense negotiation among the congressional leadership, a final Senate bill was introduced. S. Amend. No. 2786 to H.R. 3590, 111th Cong. (introduced Nov. 19, 2009). This version included guaranteed-issue and community-rating rules, like each of its predecessors, and it also imposed an individual insurance mandate, with compliance enforced by "payment of [a] penalty." *Id.* §§ 1201, 1501. Notably, however, the Senate amendment deleted the severability clause that had been included in the House bill. Following further amendments, exactly sixty Senators—just enough under Senate rules, Sen. R. XXII—ended debate on the bill on December 23, 2009; and with the same sixty votes, the Senate passed the bill the next day.[9]

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[9] Bill Summary and Status, H.R. 3590, *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@@X.

5. Final Passage And Reconciliation

Just a few weeks later, Scott Brown won a special election to fill a Senate seat previously occupied by Paul Kirk, who had voted for the Senate bill. A central plank in Brown's campaign was that he had "vowed to oppose" the bill. Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010, at A1. Thus, when he was sworn in, there were no longer sixty supportive Senators, so a filibuster could not be avoided on any future votes.

This was critical, because no single bill had yet been enacted by both houses of Congress, as required by the Constitution. Ordinarily, different House and Senate versions of a bill are reconciled by a conference committee into a final bill, which each house then must pass. But, in this case, any bill remotely resembling the one passed by the Senate in December 2009 was sure to be filibustered in the reconstituted Senate. Accordingly, the House had no choice, if it wanted such a bill, but to pass it in the *exact* form in which it had passed the Senate.

The only way for Congress then to make any changes was to amend the bill through a procedure known as budget reconciliation. By statute, budget reconciliation bills may be debated in the Senate for only twenty hours, 2 U.S.C. § 641(e)(2), which makes filibusters impossible. However, such bills may include only provisions that have direct budgetary impacts. *Id.* § 644(b)(1)(A). Congress was thus precluded from making any *non-budgetary* amendments to the Senate bill.

With no other option, the House adopted a rule providing for all-or-nothing consideration of the Senate bill without amendments, *see* H.R. Res. 1203,

111th Cong. (2010), and passed the Senate bill (the Patient Protection and Affordable Care Act) by a final vote of 219 to 212. The House and Senate then passed, by simple majority vote, the Health Care and Education Reconciliation Act of 2010, a reconciliation bill that adopted certain budgetary amendments. David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle over Health*, N.Y. TIMES, Mar. 26, 2010, at A17.

B. Operation Of The Act

The Act operates through nine titles (as amended by a tenth). Its heart, contained in Title I, expands insurance coverage by simultaneously requiring insurers to provide broad coverage to all comers and imposing on individuals and employers a "shared responsibility" to buy it. Title I also assists individuals in satisfying the mandate by subsidizing their purchase of insurance through newly created "Health Benefit Exchanges." Title II fills remaining gaps in coverage, by expanding Medicaid and other public insurance programs. Titles III through VIII aim to increase the availability of various services and the efficiency of health-insurance coverage—*e.g.*, by increasing preventative-care coverage, reducing fraud and abuse in public insurance, and expanding prescription-drug coverage. Finally, Title IX imposes various revenue-raising measures to "offset" the spending measures in the Act.

1. Insurance Regulations

The Act comprehensively regulates various aspects of health insurance. Specifically, Congress banned "discrimination based on health status," by requiring insurance companies to provide "guaranteed-issue" coverage and charge "community-

rated" premiums. 42 U.S.C.A. §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4. Relatedly, Congress limited insurers' ability to restrict the scope and duration of covered services. Insurers thus may not: refuse to pay for certain services, such as "preventative health services," *id.* §§ 300gg-6(a), 300gg-13; impose annual or lifetime limits on coverage, *id.* § 300gg-11; rescind coverage absent fraud, *id.* § 300gg-12; impose "unreasonable" premium increases, *id.* § 300gg-4(a)(1); or require more than a maximum level of "cost sharing" (*e.g.*, deductibles) from insured individuals, *id.* § 18022(c)(3)(A). *See* Pet.App. 26a-31a (describing the Act's restrictions on insurance).

The Act thus effectively requires insurers to offer health insurance to any individual, no matter how sick, and to cover limitless amounts of healthcare for the life of the insured, at average rates that ignore actuarial risk. These measures serve the Act's goal of expanding health-insurance coverage and curbing "discriminatory" insurance practices; but by themselves, they severely undermine the Act's other principal goal of reducing health-insurance costs. *See* 42 U.S.C.A. § 18091(a)(2)(I). As the Eleventh Circuit noted, according to the CBO, by "requir[ing] private insurers … to cover the unhealthy," but forbidding them from "pric[ing] that coverage [based] on actuarial risks," the Act's insurance regulations will raise insurance costs in the individual market by *27 to 30%*. Pet.App. 126a n.107, 129a n.114.[10]

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[10] Citing CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009) ("CBO, *Premiums*"), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.).

2. Individual Mandate

To counteract the cost-increasing effect of the Act's insurance regulations, Congress heeded the insurance industry's lobbying to impose a mandate for individuals to purchase insurance coverage.[11]

The mandate provides:

> An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

26 U.S.C.A. § 5000A(a). This legal "requirement" to obtain health insurance is enforced by a monetary "penalty" for each month of non-compliance. *Id.* § 5000A(b).

The mandate was intended to counteract the inflationary effects of the Act's insurance regulations in two distinct ways. *First*, and most significantly, the mandate directly subsidizes insurance companies by forcing healthy individuals to buy extensive coverage on economically disadvantageous terms, namely, at the same price as unhealthy persons. *Second*, Congress believed the mandate, along with other provisions of the Act, would reduce the costs imposed on doctors, patients, and insurers as a result of uncompensated care.

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[11] *See, e.g.*, Addressing Insurance Market Reform: Hearing Before the S. Comm. on Health, Education, Labor & Pensions, 111th Cong. (2009) (submission of Ronald A. Williams, Chairman & CEO, Aetna, Inc.) ("Since 2005, we at Aetna have been speaking out in support of an individual coverage requirement ….").

a. The most significant effect of the mandate is to subsidize insurers, which will in turn hold down the premiums paid by individuals and families. By forcing "millions of new customers [in]to the health insurance market," the mandate increases the number of customers for insurers. 42 U.S.C.A. § 18091(a)(2)(C). As Senator Franken explained in justifying the insurance regulations, "we are giving these companies a huge influx of new business." 156 Cong. Rec. S1821, 1862 (daily ed. Mar. 23, 2010). Moreover, this "huge influx" is highly profitable, because it consists of primarily *healthy* individuals, who have sensibly decided that comprehensive insurance is not financially worthwhile. The statutory findings expressly state that the mandate's "broaden[ing of] the health insurance risk pool to include healthy individuals … will lower health insurance premiums" and is therefore "essential to creating effective health insurance markets." 42 U.S.C.A. § 18091(a)(2)(I).

The mandate does not target, and was not needed to capture, the sick or the poor. Regardless of the mandate, unhealthy individuals will voluntarily purchase insurance at favorable rates, under the guaranteed-issue and community-rating provisions.[12] And impoverished individuals will generally be covered either by the Act's subsidies for participation in health-insurance exchanges or by the expanded Medicaid program. *See infra* at 19-22. Accordingly, the mandate targets healthy individuals who could

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[12] CBO, *Premiums*, 19 ("[I]n the absence of [the mandate], people who are older and more likely to use medical care would be more likely to enroll in nongroup plans" than "people who are younger and expect to use less medical care.").

afford insurance but believe, given their infrequent healthcare needs, that its cost is not warranted, particularly given the 30% increase in premiums caused by the Act's insurance regulations.[13]

Conscripting these individuals into the insurance market will greatly reduce the average payouts required from insurance companies. That is why the mandate *lowers* prices for voluntary insurance customers, inverting the normal economic axiom that increased demand *increases* prices. Specifically, the mandate is supposed to lower premiums in the non-group market by *15-20%*, offsetting roughly two-thirds of the increase caused by the Act's insurance regulations.[14] Based on CBO estimates, this subsidy is worth between $28 and $39 billion in 2016 alone.[15] As the Eleventh Circuit noted, Congress used this subsidy "to mitigate [the Act's] regulatory costs on private insurers." Pet.App. 129a.[16]

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[13] CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010) ("CBO, *Effects*"), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf ("[T]he elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people.").

[14] CBO, *Effects*, 2.

[15] The average premium in the non-group market in 2016 will be $5,800 after the reduction, which would mean the mandate lowered premiums by $1,024 to $1,450 for each of the 27 million voluntary participants. CBO, *Premiums*, 6; CBO, *Effects*, 2.

[16] Indeed, as the Government explained below, Congress believed that "the absence of a minimum coverage requirement [to offset] guaranteed-issue and community-rating requirements had undermined health care reform efforts in several states." Govt. Br. at 31 (11th Cir. Apr. 1, 2011).

In addition to reducing the average payouts by insurance companies, Congress also believed that the mandate protected insurers' incoming revenue stream, by preventing a type of "adverse selection" thought to be enabled by the Act's guaranteed-issue and community-rating rules. Namely, people now "would wait to purchase health insurance until they need[] care." 42 U.S.C.A. § 18091(a)(2)(I). Indeed, some proponents of the mandate claimed that this "adverse selection" phenomenon "tends to lead to a death spiral of individual insurance."[17] Rightly or wrongly, Congress thought the mandate "essential" to prevent such adverse selection. *Id.*[18]

b. In addition to directly subsidizing insurance companies by conscripting healthy individuals,

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[17] Statement of Uwe Reinhardt, Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong. 11 (Mar. 17, 2009).

[18] As the Eleventh Circuit explained, Congress' concerns about this kind of "adverse selection" are both highly implausible and completely speculative. One "cannot literally purchase insurance on the way to the hospital," because "the Act permits insurers to restrict enrollment to a specific open or special enrollment period," and it additionally allows waiting periods for general coverage eligibility. Pet.App. 178a n.139 (citing 42 U.S.C.A. §§ 300gg-1(b), 300gg-7). Thus, an individual hoping to game the Act's insurance regulations would have to gamble that, if he contracted some catastrophic illness, he would be able to wait until an open enrollment period (generally one month out of each year) and then wait an additional period for coverage to kick in. In this regard, neither Congress nor the CBO offered even a rough estimate, based on the States' experience or otherwise, of the extent to which people might delay purchasing insurance because of the availability of guaranteed-issue and community-rating rules.

Congress also thought the mandate would "lower health insurance premiums" by reducing the alleged premium increase of "over $1,000 a year" attributable to uncompensated care provided to the uninsured. 42 U.S.C.A. § 18091(a)(2)(F). Congress found that the uninsured "fail to pay the full cost of the services they consume" and instead "shift the costs of their uncompensated care—totaling $43 billion in 2008—to health care providers." Govt. Cert. Pet. 6 (citing 42 U.S.C.A. § 18091(a)(2)(A)). Congress believed that providers in turn "pass on the cost to private insurers," which "increases family premiums by on average over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F). Congress thus thought that, "[b]y significantly reducing the number of the uninsured, the [mandate] … will lower … premiums." *Id.*

In fact, the mandate will have virtually no impact on uncompensated care. As the Eleventh Circuit explained, the data on which Congress relied for its $43 billion estimate of uncompensated care show that the vast majority of this sum is attributable to people *not* affected by the mandate. First, $15 billion is attributable to people who will become eligible for Medicaid under the Act, and are therefore likely to obtain insurance without the mandate. Pet.App. 127a. Another $8.7 billion is provided to individuals with pre-existing conditions, who will buy coverage *voluntarily* under the new guaranteed-issue and community-rating regulations. *Id.* 127a-28a. An additional $8.1 billion is attributable to aliens not subject to the mandate. *Id.* 127a. And another $3.3 billion is caused by the failure of individuals *with insurance* to pay out-of-pocket expenses such as deductibles. *Id.* 128a. Thus,

the amount of uncompensated care even *potentially* attributable to individuals affected by the mandate is less than *$8 billion*, 0.33% of the $2.4 trillion healthcare market. *Id.*

Moreover, other data show that even this $8 billion figure is substantially overstated. As a threshold matter, many uninsured individuals obtain *no* healthcare in a given year, and most others actually pay in full. The uninsured on average obtain *no* uncompensated care from non-emergency providers and actually pay *more* for those services than the insured do.[19] As for emergency care, less than 20% of the full-year uninsured visit emergency rooms, which is the only place where federal law requires that the indigent receive limited "stabilizing" care.[20]

Thus, as detailed by *amicus curiae* in the court below, the voluntarily uninsured obtain, on average, only $854 in healthcare services per year.[21] And when it comes to *emergency-room care*, "the data show that the targets of the mandate consume only $56 per year on average in total emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to patients) and the more routine care administered there."[22] Given CBO estimates that the individual

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[19] Jonathan Gruber & David Rodriquez, *How Much Uncompensated Care Do Doctors Provide?*, 26 J. HEALTH ECON. 1151, 1159-61 (2007).

[20] CDC, *Health*, 337; 42 U.S.C. § 1395dd.

[21] *See* Amicus Curiae Economists Br. at 13-16 (11th Cir. May 11, 2011).

[22] *Id.*

mandate will cause 16 million people to buy insurance,[23] it will only affect people consuming about *$900 million* (16 million x $56) in emergency-room care, and an even smaller amount of *uncompensated* care. The full $900 million equals approximately 2% of Congress' inflated estimate of $43 billion in uncompensated care, and .038% of the $2.4 trillion healthcare market. In short, the mandate targets individuals who are *unlikely* to obtain healthcare at all and who mostly *pay* when they do.

In truth, Congress's professed concern with cost-shifting attributable to uncompensated care is somewhat ironic, given the extent to which the Act affirmatively requires cost-shifting in other respects. By any measure, uncompensated care attributable to those affected by the individual mandate is a small fraction of the $28 to $39 billion in costs that will be shifted from the new, healthier customers affected by the individual mandate to insurance companies and their voluntary, less-healthy customers.

In addition, even after 2014, the Act does not allow insurers to subject those who refuse to buy insurance to pre-existing condition bans or higher premiums. Moreover, the Act exempts millions of individuals from the penalty for violating the mandate, *see* 26 U.S.C.A. § 5000A(e), and the relatively modest penalties are not used to offset the costs of insuring those who purchase insurance only once ill. For all of these reasons, private insurance customers will continue to bear the cost of millions of people failing to buy insurance after 2014.

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[23] CBO, *Effects* 2.

Moreover, Medicaid pays substantially lower rates than private insurers.[24] On Congress' view that hospitals shift unrecovered costs to private insurers, such rates would likely shift costs to private insurance. Indeed, the Act exacerbates that cost-shifting by *expanding* Medicaid while *cutting* Medicaid reimbursements. Likewise, "[t]he current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent" to those receiving employer-based insurance, another amount far greater than any subsidy for uncompensated care provided to the voluntarily uninsured.[25]

3. Exchanges And Federal Subsidies

Title I of the Act also requires the creation of state "Health Benefit Exchanges" by January 1, 2014. 42 U.S.C.A. § 18031. These are marketplaces through which individuals (or small businesses) can purchase the mandated insurance.

To sell insurance on an exchange, an insurer must be certified as offering "qualified health plans," *id.* § 18031(d)(2)(B)(I), which must pay for certain "essential health benefits," *id.* § 18021(a)(1)(B). These include a wide range of services including substance-abuse treatment, behavioral health treatment, prescription drugs, rehabilitative services, and preventive services. *Id.* § 18022(b)(1). Insurers must limit "cost sharing" by insureds—*i.e.*, out-of-pocket costs like deductibles. *Id.* § 18022(c).

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[24] CBO, *Key Issues in Analyzing Major Health Insurance Proposals*, at 114-15 (Dec. 2008), http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

[25] *Id.* at XVII.

Insurers also must calibrate their plans to pay for a specific percentage of the healthcare costs for all enrollees: A "bronze" plan must pay for 60% of the healthcare costs obtained by enrollees, a "silver" plan must pay 70%, a "gold" plan 80%, and a "platinum" plan 90%. *Id.* § 18022(d)(1). Insurers may offer the option of a "catastrophic plan," which provides no benefits until a certain level of out-of-pocket costs is met, but only to individuals who are under 30 or exempt based on economic hardship from the penalty for violating the mandate. *Id.* § 18022(e).

The Act provides extensive subsidies for low-income individuals to participate in exchanges. 26 U.S.C.A. § 36B; 42 U.S.C.A. § 18071. Specifically, tax credits are available for individuals who purchase health insurance through an exchange and have income between 100% and 400% of poverty levels. 26 U.S.C.A. § 36B(a), (b), (c)(1). The credits are tied to the lesser of (i) the actual premiums paid by the individual on a plan purchased on an exchange, or (ii) the community-rated premiums for the second-cheapest "silver" plan offered through an exchange for the geographic "rating area" where the individual resides. *Id.* §§ 36B(b)(2), (b)(3)(C).

The CBO has predicted that, by 2019, 24 million people will be insured through exchanges, and 20 million of them will receive federal subsidies of, on average, $6,460 per person.[26] That amounts to an annual federal subsidy of almost $13 billion.

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[26] CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 19 (Mar. 30, 2011) ("CBO, *Analysis*"), http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCare Legislation.pdf.

4. Employer "Responsibility" Assessment

Subtitle F of Title I imposes "Shared Responsibility for Health Care," not just on individuals subject to the mandate, but on employers as well. Immediately after creating the mandate requiring "Individual Responsibility" for insurance in Part I, Subtitle F creates "Employer Responsibilities" in Part II. In contrast to the individual mandate, employers' "responsibility" does not include a direct legal requirement to offer insurance to their employees. Instead, it consists of an exaction that is triggered if at least one employee of an employer with at least 50 full-time employees obtains a federal subsidy to purchase health insurance on an exchange, whether because (a) the employer fails to offer "minimum essential coverage" in an employer-sponsored plan, 26 U.S.C.A. § 4980H(a), or (b) the employer offers "minimum essential coverage," but it is unaffordable or does not cover the same level of benefits as a "bronze" plan on an exchange, *id.* § 4980H(b). *See also* Pet.App. 45a-47a.

5. Expansion Of Medicaid

In keeping with the Act's theme of "shared responsibility," Title II compels the States to expand Medicaid coverage for many individuals who would likely not be able to obtain other insurance. Starting in 2014, states must offer Medicaid to adults under age 65 with incomes up to 133% of federal poverty levels. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII). States must likewise offer Medicaid to all children whose families earn up to 133% of federal poverty levels. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 2(C). As the Eleventh Circuit explained, "[t]his is a significant change, because previously the Medicaid Act did not

set a baseline income level [and] many states currently do not provide Medicaid to childless adults and cover parents only at much lower income levels." Pet.App. 49a.

6. Revenue-Raising And Deficit-Neutrality "Offset" Measures

To ensure a CBO score of deficit-neutrality, the Act includes various tax increases and spending cuts necessary to fund the subsidies, Medicaid expansion, and other expenditures in the Act. As the Federal Government itself explained below, "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending … was offset by other revenue-raising and cost-saving provisions." RE 1024.

Title IX adopts a series of new healthcare-related taxes and fees expressly described as "Revenue Offset Provisions," which fall, *inter alia*, on individuals, employers, insurance companies, pharmaceutical companies, and manufacturers of medical devices. *E.g.*, 26 U.S.C.A. §§ 1401(b)(2), 1411, 3101(b)(2) (imposing additional Medicare taxes on high-income taxpayers); *id.* § 4980I (taxing so-called "Cadillac" plans); *id.* §§ 106(f), 125(i), 220(d)(2)(A), 223(d)(2)(A) (restricting ability to pay for healthcare with pre-tax dollars); *id.* § 213(a) (limiting itemized deduction for medical expenses); *id.* § 139A (eliminating deduction for employers who provide prescription-drug coverage for retirees); ACA §§ 9008-9010 (various fees).

The Act also cuts various payments under public programs such as Medicare. For example, it reduces "disproportionate share hospital payments," which are special payments to hospitals that provide a disproportionate share of uncompensated care. 42

U.S.C.A. §§ 1396r–4(f)(7), 1395ww(r). According to the President, this was a "common-sense change[]" because "if more Americans are insured, we can cut payments that help hospitals treat patients without health insurance." Sheryl Gay Stolberg & Robert Pear, *Health Plan May Mean Payment Cuts*, N.Y. TIMES, June 14, 2009, at A20.

7. Miscellaneous Additions

The Act also includes hundreds of measures ostensibly aimed at improving the quality, efficiency, and availability of healthcare. Many of these operate through public programs like Medicare. *E.g.*, ACA §§ 2501, 2503 (adjusting reimbursement formulas for prescription drugs); *id.* § 3401 (adjusting payments for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers according to productivity); 42 U.S.C.A. § 1395ww(q) (reducing Medicare payments to hospitals with specified percentages of preventable readmissions); *id.* § 1395ww(p) (reducing Medicare payments for hospital-acquired conditions).

Other measures involve direct federal spending. *E.g.*, 42 U.S.C.A. § 1315a (creating Center for Medicare and Medicaid Innovation to study more efficient payment methods for public programs); *id.* § 300hh–31 (establishing grants for epidemiology laboratories); *id.* § 1320e (establishing "Patient-Centered Outcomes Research Institute" to research effectiveness of various medical treatments).

And yet other provisions impose direct requirements on employers or individuals. *E.g.*, 29 U.S.C.A. § 207(r)(1) (requiring employers to provide reasonable break times for nursing mothers); 21 U.S.C.A. § 343(q)(5)(H) (requiring chain restaurants

to "disclose in a clear and conspicuous manner" the nutritional content of standard menu items).

Many provisions of the Act, though not directly related to the individual mandate or the insurance regulations, were added as *quid pro quo* measures needed to secure the votes of specific legislators. For example, legislators such as Congressman Bart Stupak and Senator Ben Nelson insisted that the bill clearly prohibit the use of federal funds to pay for abortions. *See* ACA § 1303; David D. Kirkpatrick, *Abortion Fight Adds to Debate on Health Care*, N.Y. TIMES, Sept. 29, 2009, at A1. Other provisions in the Act were, even more explicitly, included to benefit individual legislators. For example, § 10323 of the Act extends Medicare coverage to "individuals exposed to environmental health hazards" in an area "subject to an emergency declaration made as of June 17, 2009." In fact, this "cryptic, mysterious" provision, demanded by Montana Senator Max Baucus, refers specifically to "people exposed to asbestos from a vermiculite mine in Libby, Montana." Robert Pear, *Buried in Health Bill, Very Specific Beneficiaries*, N.Y. TIMES, Dec. 21, 2009, at A1. Likewise, § 2006 increases Medicaid payments to certain "states recovering from a major disaster." In fact, this would give hundreds of millions of dollars to a single state, Louisiana, and was inserted at the behest of wavering Louisiana Senator Mary Landrieu. Brian Montopoli, *Tallying the Health Care Bill's Giveaways*, CBS NEWS, Dec. 21, 2009.[27]

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[27] http://www.cbsnews.com/8301-503544_162-6006838-503544.html.

Still other provisions were not identified as part of specific *quid pro quos*, but provide suspiciously targeted benefits. For example, § 10502 of the Act grants $100 million to an unnamed "health care facility" affiliated with a health center at a public university in a state where there is only one public medical and dental school. *Buried in Health Bill, Very Specific Beneficiaries*, *supra* ("Senators and their aides … were not sure who would qualify for this money … [but] a new school in Scranton, Pa., was a likely candidate."); *see also Tallying the Health Care Bill's Giveaways*, *supra* ("Also in the bill … is an item that increases Medicare payments to hospitals and doctors in states where half the counties are 'frontier counties' …. Montana, North Dakota, South Dakota, Utah and Wyoming.").

The Senate Majority Leader, one of the chief architects of the legislative deal, candidly admitted doubting "if there's a senator that doesn't have something in this bill that was important to them."[28]

C. Private Petitioners' Challenge

Private Petitioners NFIB, Ahlburg, and Brown, along with 26 States, brought this action challenging the ACA's facial validity. Pet.App. 2a. As relevant here, they argued that the individual mandate exceeds Congress' Article I authority and cannot be severed from the remainder of the Act. *Id.* 3a.

The district court granted summary judgment to the challengers. Holding the mandate to be unconstitutional and non-severable, the court

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[28] David Welna, *On Health Bill, Reid Proves The Ultimate Deal Maker*, NATIONAL PUBLIC RADIO, Dec. 23, 2009, http://www.npr.org/templates/story/story.php?storyId=121791736.

invalidated the Act in its entirety. *Id.* 362a-364a The Eleventh Circuit affirmed in part and reversed in part. In an opinion jointly authored by Chief Judge Dubina and Judge Hull, that court held the mandate unconstitutional, but concluded that it was severable from the remainder of the Act, including even the insurance regulations that the Government had *conceded* were non-severable. *Id.* 186a & n.144.

After the parties filed their certiorari petitions, Petitioner Brown, whose standing had been conceded by the Government in the Eleventh Circuit (*id.* 8a), filed a voluntary petition for bankruptcy. *See* Letter from G. Katsas to D. McNerney (Dec. 7, 2011). Private Petitioners do not believe that Brown's pending bankruptcy undermines her standing; to the contrary, her worsened financial state exacerbates the degree to which future costs from the mandate are "immediately and directly affect[ing]" her "financial strength[] and fiscal planning." *Clinton v. City of New York*, 524 U.S. 417, 431 (1998). Moreover, Brown's standing obviously does not affect the standing of Petitioners Ahlburg or NFIB, both of whom the courts below held had standing: Ahlburg is an unrelated individual, and NFIB has additional members who filed declarations materially indistinguishable from Brown's in support of NFIB's associational standing. *See* Pet.App. 8a-10a, 290a-293a, 439a; JA 151-56. Nevertheless, in an abundance of caution, on January 4, 2011, Private Petitioners, with the support of the Government and the State Petitioners, moved to add two of these additional NFIB members as formal parties, thereby eliminating any possible concerns. That motion is pending as of this filing.

SUMMARY OF ARGUMENT

Severability of an unconstitutional statute turns on congressional intent. By any fair measure, the text, structure, and operation of the ACA—not to mention its tortured path through the legislative process—make it evident that, without the individual mandate at its heart, no statute remotely resembling the Act would or could have been enacted. Once the mandate is invalidated, the entire Act must fall with it.

In constructing the ACA, Congress sought to restructure the health-insurance market to obtain near-universal coverage, bring down costs, and keep the federal deficit from growing. Ambitious goals, but Congress believed it had a magic bullet to achieve them—the individual mandate. By forcing healthy individuals to buy full-scale insurance at artificially inflated prices, the mandate handed an annual $30 billion subsidy to insurance companies. That subsidy allowed Congress to force the insurers, in turn, to sell coverage to the old and the sick at artificially low prices. The Federal Government could then provide limited assistance to those who could not afford even the premiums as reduced by the mandate's subsidy. Miscellaneous taxes and spending cuts could balance out this new spending and thus maintain deficit-neutrality. And, with individuals and insurance companies bearing such a substantial amount of the Act's costs, employers and States could be co-opted into filling some residual gaps—by, respectively, sponsoring affordable insurance for employees and expanding public-insurance programs like Medicaid.

Without the mandate, the remainder of the Act cannot operate as Congress intended. Absent the mandate's mammoth subsidy to insurance companies, the Act's insurance regulations would dramatically drive up premiums—reversing Congress' goal of reducing health-insurance costs. That is why Congress found the mandate "essential" to these provisions, and why the Government concedes that at least some of them cannot survive alone. But without the mandate *and* the new regulations prohibiting the insurance practices that Congress condemned as abusive and discriminatory, *none* of the Act's primary goals would be satisfied. These provisions are the heart of the Act, its central *raison d'etre*. To remove them would be to fundamentally alter the legislation; this Court has *never* used severability to effect such a major change to such a major part of such a major bill.

Moreover, without the mandate and insurance regulations, none of the Act's major planks would operate as intended by Congress. Federal subsidies would no longer be linked to community-rated premiums; instead, they would *pay* private insurance companies for the very "abusive" practices Congress intended to *forbid*. Other actors, like healthcare providers and the States, would bear burdens well beyond those intended, as elimination of the mandate and insurance regulations would destroy the bill's careful allocation of shared responsibility. And new taxes would reap revenue no longer being used to further the Act's primary goals. At best, the parts of the Act unaffected in operation by the foregoing measures would amount to a hodge-podge of minor, miscellaneous measures, many added only to secure passage of provisions no longer intact.

That is nothing like what Congress enacted, and it is not an Act that Congress would have enacted. The ACA was the fragile product of extensive legislative deal-making; to strip out its centerpiece would fundamentally alter the original legislative bargain. Particularly in light of the *deletion* of a severability clause from an earlier version of the bill, and the House's determination to consider the Act on an all-or-nothing basis, it is clear that Congress intended this unique legislative deal to rise or fall as a whole. Invalidation of the mandate therefore requires that the entire Act be stricken; this Court should leave to Congress the complex and political task of revisiting comprehensive health-insurance reform.

ARGUMENT

I. UNCONSTITUTIONAL PROVISIONS MAY BE SEVERED ONLY WHERE CONSISTENT WITH CONGRESSIONAL INTENT

When a court invalidates part of a statute, it faces the question of what happens to the rest. Can the stricken provision be severed, so that the remainder of the statute survives? Or would severance—the slicing of legislation into a new, judicial creation—be an inappropriate intrusion into the lawmaking process? The answer, as this Court has explained, depends on legislative intent: whether Congress would have enacted the bill absent the stricken provision, or whether omission of that provision would have scuttled legislative bargains or undermined statutory objectives. If the latter is true, judicial revision through severance is improper, particularly where it entails complex line-drawing that is best left to the legislature.

Severability questions invariably raise serious separation-of-powers issues. By severing invalid provisions, courts may save Congress from having to go back to the drawing board. On the other hand, severance creates a law that Congress never enacted, and risks having it operate differently than intended—*e.g.*, by preserving a *quid* enacted only because of the now-invalidated *quo*. Such partial invalidation of integrated statutes thus may produce a serious invasion of the legislative domain. To respect the distinct legislative and judicial roles, severability analysis must recognize the separation-of-powers concerns on *both* sides of the calculus.

A. An Unconstitutional Provision Cannot Be Severed If The Remainder Of The Act Would Not Operate As Congress Intended, And So Would Not Have Been Enacted On Its Own

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) ("[T]he touchstone for any decision about remedy is legislative intent."). The ultimate question is whether Congress "would have been satisfied with what remained" after the unconstitutional provisions were removed. *Champlin Rfg. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 235 (1932). Courts should avoid "nullify[ing] more of a legislature's work than is necessary," *Ayotte*, 546 U.S. at 330, but it would likewise be improper for judges to "substitute, for the law intended by the legislature, one they may never have been willing by itself to enact," *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895).

If "the balance of the legislation is incapable of functioning independently," then certainly "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987). But even if the remainder of the act could stand alone from an operational perspective, the question remains whether "it is evident that the Legislature would not have enacted those provisions independently of that which is invalid." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) ("*FEF*"). Thus, "[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

To determine whether the rest of the legislation would operate in the "manner" intended by Congress, courts look to various objective factors, including: "the nature" of the stricken provision, *Alaska Airlines*, 480 U.S. at 685; its role "in the original legislative bargain," *id.*; the "historical context" of the legislation, *FEF*, 130 S. Ct. at 3162; the economic connection between the invalidated provision and the remainder of the statute, *Carter v. Carter Coal Co.*, 298 U.S. 238, 314-15 (1936); and the impact of that provision on the "dominant aim of the whole statute," *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935). If these considerations show that Congress "would not have been satisfied with what remains" after invalidation of the unconstitutional provision, then severance is improper. *Williams v. Standard Oil Co.*, 278 U.S. 235, 242 (1929).

In undertaking the analysis, courts consider clauses that expressly address severability—text that apprises the judiciary whether Congress intends the statute's provisions to survive, and to operate independently of, any one that may be invalid. Thus, inclusion of a severability clause "gives rise to a presumption that Congress did not intend the validity of the Act as a whole, or of any part of the Act, to depend upon whether" a particular provision "was invalid." *INS v. Chadha*, 462 U.S. 919, 932 (1983). But the absence of a severability clause is treated simply as silence, creating no presumption at all, neither "against severability," *Alaska Airlines*, 480 U.S. at 686, nor for it, *see* Br. of Amici Curiae Family Research Council et al. at 4-14 (Nos. 11-393 & 11-400). If, however, a severability clause was specifically *removed* from a law during the legislative process, that "does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all." *Gubiensio-Ortiz v. Kanahele*, 857 F.2d 1245, 1267 (9th Cir. 1988) (Kozinski, J.); *accord United States v. Croxford*, 324 F. Supp. 2d 1230, 1245 (D. Utah 2004) (Cassell, J.); *see also Russello v. United States*, 464 U.S. 16, 23-24 (1983) (drawing inference of congressional intent from fact that Congress included text "in an earlier version of a bill but delete[d] it prior to enactment").

B. Severability Analysis Must Account For The Separation-Of-Powers Dangers Inherent In Both Potential Courses of Action

This Court has observed that the refusal to sever unconstitutional provisions "frustrat[es] the intent of the elected representatives of the people." *Regan v.*

Time, Inc., 468 U.S. 641, 652 (1984) (plurality opinion). Accordingly, courts should "act cautiously" and "refrain from invalidating more of the statute than is necessary." *Id.* Conversely, however, if the Court does sever part of a statute, the necessary result is a new law that was never enacted by the political branches through the required means of bicameral passage and presentment to the President, *Chadha*, 462 U.S. at 951-59. Judicial creation of such new laws poses obvious dangers of intrusion into legislative function: "This would, to some extent, substitute the judicial for the legislative department of the [G]overnment," and in substance "make a new law, not … enforce an old one." *United States v. Reese*, 92 U.S. 214, 221 (1876). Indeed such partial invalidation "may call for a 'far more serious invasion of the legislative domain' than [the Court] ought to undertake," especially "where linedrawing [would be] inherently complex." *Ayotte*, 546 U.S. at 330 (quoting *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479, n.26 (1996)).

The Court has therefore repeatedly held it improper to rewrite a statute to solve constitutional flaws. To "dissect an unconstitutional measure and reframe a valid one," by "inserting limitations it does not contain," would be "legislative work beyond the power and function of the court." *Hill v. Wallace*, 259 U.S. 44, 70 (1922); *see also FEF*, 130 S. Ct. at 3162 (courts lack "editorial discretion" to "blue-pencil" statute). Given the "many different possible ways the legislature might respond" to the law's defects, courts should let *Congress* "rewrite those provisions." *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

Partial judicial deletion of an enacted statute can pose similar problems of judicial usurpation. As this Court noted in holding that Congress cannot authorize the President to delete parts of an enacted statute, selective deletion impermissibly amends an enacted law: "In both legal and practical effect, the President has amended two Acts of Congress by repealing a portion of each." *Clinton*, 524 U.S. at 438; *cf. Hill*, 259 U.S. at 71 (reiterating that severability "does not give the court power to amend the act"). Moreover, partial judicial "repeal" leaves in its wake a never-enacted law based on judicial speculation about counter-factual congressional desires. Particularly when Congress has omitted a severability clause—the traditional method of informing courts how it wants the judiciary to respond if part of a law is held unconstitutional—there is a grave danger that excising only part of the integrated whole will be based on mere guesswork, which may result in judicial creation of a law that Congress would not have enacted.

Indeed, such selective judicial deletion is virtually indistinguishable from improper judicial revision where the "line-drawing is inherently complex," *Ayotte*, 546 U.S. at 330. This is especially true here because, as discussed below and as even the Government concedes, *some* constitutional parts of the Act *must* be excised once the mandate is invalidated. When some constitutional parts of a law must be severed, judicial selection of *which* parts of Congress' permissible handiwork will remain is akin to judicial rewriting. *Selectively* deleting the remaining parts of the statute entails the same "blue pencil[ing]" as judicial rewriting. In both cases, the Court is not performing the straightforward judicial

function of striking unconstitutional statutory provisions, but also the quasi-legislative function of deciding which lawful provisions will survive, based on guesswork about which subset of the constitutional residue best serves Congress' policy goals.

Finally, these worries of judicial intrusion on legislative prerogative are particularly acute when the invalidated provision is part of a comprehensive, heavily negotiated package. Where legislation is born of compromise, severing an invalid provision threatens improperly to strip one side of the deal of its benefits in the "original legislative bargain." *Alaska Airlines*, 480 U.S. at 685. *See, e.g.*, *Carter*, 298 U.S. at 316 (refusing to sever provisions that are "conditions, considerations, or compensations" for one another); *Allen v. Louisiana*, 103 U.S. 80, 84 (1881) (same); *see also Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 561-62 (2001) (Scalia, J., dissenting) (courts have "no authority" to "eliminate a significant *quid pro quo* of the legislative compromise"). It is no answer to say that Congress can simply repeal the remainder, given the inertial forces that check the legislative process. Imagine, for example, a law including some provisions demanded by each house of Congress, together reflecting a *quid pro quo*. If a court were to invalidate only one set of these, the result would be a law that never would have been enacted yet is unlikely to be repealed. Further, in a comprehensive legislative package, removal of any provision could impact the severability of every *other* provision, making the task all the more difficult and all the less appropriate for the judiciary.

The lesson is that this Court, "mindful that [its] constitutional mandate and institutional competence are limited," *Ayotte*, 546 U.S. at 329, must be equally skeptical of severing either too much *or too little* of a law. At least absent a severability clause, severing a key provision from a hard-fought legislative deal should be viewed with special skepticism.

II. THE ACT'S INSURANCE REGULATIONS OPERATE IN TANDEM WITH, AND SO MUST FALL WITH, THE INDIVIDUAL MANDATE

The Act expressly states that the mandate is "essential to creating effective health insurance markets" because it was necessary to "lower health insurance premiums" that would be increased by the guaranteed-issue and community-rating provisions. 42 U.S.C.A. § 18091(a)(2)(I). That statutory finding—expressly linking the intended operation of the guaranteed-issue and community-rating provisions to the mandate—should be dispositive for severability purposes. But, in any event, further examination of the interrelationship of these provisions eliminates any conceivable doubt.

Even the Government agrees that the individual mandate is inextricably linked to the guaranteed-issue and community-rating requirements. The mandate was intended to be a direct subsidy to insurance companies, as compensation for requiring them (in the guaranteed-issue provision) to insure against "risks" that have already come to pass and forbidding them (in the community-rating provision) from using actuarially sound insurance premiums. The mandate thus works to counteract the powerful inflationary impacts of these other provisions, which would otherwise make premiums in the individual

insurance market prohibitively expensive, thereby frustrating Congress' goal of affordable health insurance. And Congress further viewed the mandate as necessary to prevent "adverse selection" to "game" the new insurance rules, which proponents warned would spark a "death spiral" in insurance.

The guaranteed-issue and community-rating requirements thus cannot operate without the mandate in the manner intended by Congress. Rather, "their associated force—not one or the other but both combined—was deemed by Congress to be necessary to achieve the end sought." *Carter*, 298 U.S. at 314. To strike the mandate alone would impermissibly eliminate a central *quid pro quo* of the Act. If the mandate falls, the guaranteed-issue and community-rating regulations must therefore fall with it, as the Government itself has conceded.

A. Congress Intended The Individual Mandate To Offset The New Burdens Imposed On Insurers By The Act's Insurance Regulations

The Act's guaranteed-issue and community-rating rules, both found in Subtitle C of Title I, prohibit the related "discriminatory" practices of denying coverage for a pre-existing condition or charging higher premiums to people who will require greater health-care expenditures because of risky conditions or habits. *Supra* at 10-11.

As Congress recognized, the unavoidable result of these measures would be a dramatic rise in premiums. The CBO estimated that they would cause a 30% increase in individual premiums. *Supra* at 11. Congress also believed that, because insurance companies would now be prohibited from "discriminating" against sick people, "many

individuals would wait to purchase health insurance until they needed care." If the prediction of this type of "adverse selection" were accurate, it would reduce insurers' revenues, and thus force them to increase the premiums charged to their diminishing number of customers. *Supra* at 15.

Congress was equally explicit that the individual mandate was its solution to these dual problems created by the guaranteed-issue and community-rating provisions. As the statutory findings expressly state, Congress believed the mandate was "essential" to mitigating increased premiums from these effects, and thus to "creating effective health insurance markets." 42 U.S.C.A. § 18091(a)(2)(I). This was so for two reasons.

First, the individual mandate's principal purpose and effect was to greatly offset the estimated 30% increase in premiums attributable to guaranteed-issue and community-rating. Specifically, the mandate was supposed to lower insurance premiums by 15-20%, or $28 to $39 billion annually, thus reducing nearly two-thirds of the premium increases caused by these insurance regulations. *Supra* at 14. It would do so by, in Congress' words, "add[ing] millions of new consumers to the health insurance market," 42 U.S.C.A. § 18091(a)(2), primarily healthy individuals whose premium payments far outweigh any reasonably foreseeable healthcare expenditures. This is why Congress emphasized that the individual mandate's "broaden[ing] [of] the health insurance risk pool to include *healthy* individuals" would "lower health insurance premiums." *Id.* (emphasis added).

A statute expected to increase premiums by some 30% would not have been acceptable to Congress, as it would have materially undermined the Act's stated goal of reducing costs to achieve "affordable care." The guaranteed-issue and community-rating rules would still dramatically drive up premiums, but without any countervailing effect. Absent the mandate, then, these insurance regulations plainly would not "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. They are legislation that Congress "never [would] have been willing by itself to enact." *Pollock*, 158 U.S. at 636. Nor could Congress have, without the vital support of the insurance industry, which found the insurance requirements palatable only as tempered by the mandate. *See supra* at 2, 12.

In short, the mandate is so closely tied to these provisions that its invalidation spells their demise. In concluding otherwise, the Eleventh Circuit simply failed to consider the adverse effect on premiums—and thus on the Act's express purposes—that the insurance regulations would have, if unmitigated by the mandate. *See* Pet.App. 180a-85a.

Second, Congress expressly stated its belief that the individual mandate was "essential" to eliminate the "adverse selection" enabled by guaranteed-issue and community-rating. 42 U.S.C.A. § 18091(a)(2)(I). To be sure, as the Eleventh Circuit explained, Congress greatly exaggerated this problem. *See supra* at 15, n18. Nevertheless, second-guessing Congress' judgments about how the individual mandate will actually operate should play no role in severability analysis. For severability, the question is whether *Congress* "would … have been satisfied

with what remains" after the unconstitutional provision is invalidated, *Williams*, 278 U.S. at 242, not whether Congress *should* have been satisfied had it better understood the effect of its law.

In sum, because Congress thought the individual mandate was "essential" to cure dramatic premium increases and market distortions caused by the guaranteed-issue and community-ratings provisions, those provisions cannot, without the mandate, "function in the manner" Congress intended.

B. The Act's Guaranteed-Issue And Community-Rating Provisions Are Indistinguishable From Its Other, Related Insurance Regulations

The Government has acknowledged that the mandate cannot be severed from the guaranteed-issue and community-rating provisions. Govt. Cert. Resp. 31-33 & n.13. But these provisions cannot be singled out from the Act's restrictions on health-insurance products. *All* of these regulations, which appear together in Sections 1001 and 1201 of Title I of the Act, also must fall with the mandate—and for the same reasons.

In addition to precluding insurers from setting premiums based on individualized factors, and from refusing to cover pre-existing conditions, the Act imposes closely related restrictions on insurance products. Many are designed to combat the *same* assertedly abusive or unfair insurance practices addressed by the guaranteed-issue and community-rating rules. For example, the Act forbids insurers to set limits on coverage, to exceed certain levels of cost-sharing, to refuse to cover various services, or to freely rescind or decline to renew coverage. *Supra* at

10-11. Like the guaranteed-issue and community-rating provisions, all of these are designed to protect health-insurance consumers—particularly unhealthy consumers most in need of open-ended, permanent coverage—from insurance practices that make coverage inadequate, expensive, or unavailable. By forcing insurers to offer policies on economically unfavorable terms, all of these provisions would drive up premiums. The individual mandate would offset many of those increased costs. The insurance regulations, together, thus comprise a package of restrictions that work in unison and are offset by the mandate. Absent the mandate, the *entire* set of insurance regulations must be invalidated.

The Government's position, that this Court can strike the guaranteed-issue and community-rating provisions, but nonetheless retain the other insurance regulations, seems to rest on a policy determination that eliminating the former provisions, but no others, would sufficiently relax the burdens on insurance companies to make up for invalidation of the mandate's subsidy. But that is precisely the type of responsive policy choice reserved to Congress. *See, e.g.*, *Randall*, 548 U.S. at 262. For example, Congress could just as easily have decided to remedy the problem by retaining guaranteed-issue and community-rating but doing without the prohibition on coverage limits. For this Court to choose *which* of the Act's insurance regulations to strike, in an effort to offset the effects of invalidating the mandate, would amount to nothing less than unauthorized "blue pencil[ing]" of the Act, *FEF*, 130 S. Ct. at 3162.

III. WITHOUT THE MANDATE AND INSURANCE REGULATIONS AT ITS HEART, THE ACT WOULD NOT OPERATE AS CONGRESS INTENDED

It is one thing to strike, from a major law, a minor or ancillary provision only tangentially related to its overarching purposes. But it is another thing entirely to displace a primary pillar of the legislative structure. When legislation is constructed around certain foundational provisions, striking them will almost inevitably topple the edifice as a whole.

The Act's pillars are the insurance regulations and the individual mandate. Indeed, the Act's full name is the *Patient Protection* and *Affordable Care* Act. By forcing insurance companies to forever extend equally priced coverage to all comers, the Act "protects patients" from market practices thought to be discriminatory. By forcing unwilling Americans to purchase insurance, the law subsidizes everyone else's premiums, ensuring "affordable care." These provisions are the heart of the legislation, and the foundation of the statute. None of the Act's other provisions can survive their excision; Congress would hardly have reached the same destination had it proceeded from an entirely different starting point.

Moreover, without the mandate and insurance regulations, the Act's other principal features would operate in dramatically different ways, shifting costs in unforeseen directions and allocating benefits and burdens inconsistent with the congressional scheme. Some of these provisions could perhaps continue to "function" without the mandate and insurance regulations, but not "in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

A. The Mandate And Insurance Regulations Are So Central To The Act's Principal Objectives That The Entire Act Must Be Invalidated

1. In determining whether partial invalidation would produce "legislation that Congress would not have enacted," *Alaska Airlines*, 480 U.S. at 685, courts consider "the nature" of the stricken provision; its role "in the original legislative bargain," *id.*; and the "historical context" of the legislation, *FEF*, 130 S. Ct. at 3162. These considerations establish a basic divide between run-of-the-mill provisions and legislative centerpieces. A statutory provision will likely be severable if it played only a minor role in the legislative debate; or if its effects are relatively small in the grand scheme; or if it simply added an additional frill to an otherwise-coherent regime. Conversely, if a provision was especially contentious; or if it constituted a core element of the legislation; or if it was a principal means of securing the law's objects, severing it would likely be improper.

The caselaw bears out this distinction. For example, in *Alaska Airlines*, the record showed that Congress had "paid scant attention" to the unconstitutional provision of the statute at issue, while it had regarded another provision as "an important feature." 480 U.S. at 691. During floor debate, "neither supporters nor opponents of the bill ever mentioned" the unconstitutional provision; it was, in fact, mentioned but once "during the entire deliberation on the Act"—and even then, only in general terms. *Id.* at 691-96. Faced with this history, the Court could not conclude that Congress "would have failed to enact" the law "if the [invalid provision] had not been included." *Id.* at 697.

Similarly, in *Reagan v. Farmers' Loan & Trust Co.*, 154 U.S. 362 (1894), the invalidation of a provision giving conclusive effect to railroad rates set by an agency did not require striking the entire statute, which created the agency and gave it regulatory authority. Rather, "creation of a commission, with power to establish rules for the operation of railroads and to regulate rates, was the *prime object* of the legislation," and that object could be "*fully accomplished*" regardless of "whether the rates shall be conclusive or simply *prima facie* evidence." *Id.* at 395-96 (emphases added); *see also United States v. Jackson*, 390 U.S. 570, 586-91 (1968) (invalidating death-penalty provision but severing it from criminal prohibition, as "elimination [of death penalty] in no way alters the substantive reach of the statute and leaves completely unchanged its basic operation").

By contrast, in *Mille Lacs Band*, the Court considered an executive order that (i) directed certain Indians to remove from territories they had ceded to the United States; and (ii) stripped those Indians of their treaty rights to hunt and fish on those lands. 526 U.S. at 179. After invalidating the former aspect of the order, the Court held it was not severable from the latter. Applying the "severability standard for statutes," the Court concluded that the order had "to stand or fall as a whole," because it "embodied a single, coherent policy," and removal of the Indians from the lands was its "predominant purpose." *Id.* at 191. Although the other portion of the order admittedly "perform[ed] an integral function in this policy," it could not survive on its own after the primary function of the executive order had been so undermined. *Id.* at 192.

The severability principles applied in *Mille Lacs Band* have been settled for decades. For example, in *Alton*, the invalidation of central features of a compulsory pension scheme required the entire statute to be scrapped, because the unconstitutional provisions "so affect[ed] the dominant aim of the whole statute as to carry it down with them." 295 U.S. at 361-62. Likewise, in *Williams*, this Court invalidated the substantive provisions of price-fixing legislation, 278 U.S. at 239-41, and then held that the law's other provisions could not stand alone because they were "mere appendants in aid of the [statute's] main purpose" or "mere aids to their effective execution." *Id.* at 243-44. Although the new agency designated to fix prices could, in theory, still collect data, issue permits, and collect fees, it would have been "unreasonable to suppose" that the legislature would have wanted these mechanisms to keep operating once the most basic function of the law had been disabled. *Id.* at 244.

These cases make clear that severance is improper when the stricken provision is the heart of the legislative scheme—the principal effort toward its predominant purpose. In that context, it cannot fairly be surmised that Congress would have pushed ahead unperturbed, making no changes to the bill once its hallmark was stripped out. In such cases, the residue simply could not function in the manner that Congress intended. And it is not enough that Congress might have enacted "*some* form" of legislation without the invalid provision; severance is permissible only if Congress would have enacted "the same [provisions] currently found in the Act." *Alaska Airlines*, 480 U.S. at 685 n.7.

2. The individual mandate, together with the insurance reforms, are the heart of the ACA, as demonstrated by their crucial significance in achieving its objectives and their central role in the legislative debate. The ACA cannot survive the elimination of these critically important provisions.

The overriding goals of the Act were to reduce premiums and the number of uninsured, without raising the deficit. *Supra* at 2-6; 42 U.S.C.A. § 18091(a)(2)(F). It is no surprise, then, that both the mandate and the insurance regulations appear in the Act's first title. These were considered indispensable to meeting the Act's core objectives. To expand coverage, the insurance regulations force insurers to provide coverage to the unhealthy on terms economically *unfavorable* to insurers. To keep premiums down, the mandate forces healthy people to buy insurance on terms economically *favorable* to insurers. And Congress thereby avoided the need to use direct spending to subsidize insurance companies (as well as the concomitant need to adopt a politically unpopular tax). The insurance regulations fundamentally transform the way health insurance may be sold in this country, and the mandate is expected to force some 16 million new consumers into the insurance market. By any fair measure, these provisions are the Act's centerpiece, and embody its "predominant purposes" or "dominant aims." Accordingly, once they are invalidated, the rest of the Act must fall. This is true even if its other parts can operate independently: Hunting and fishing rights in *Mille Lacs Band*, for example, could have been stripped independent of tribal removal, but because the latter was the "predominant purpose" of the executive order, its invalidity doomed the whole.

Further confirming this point, the mandate and insurance regulations were the clear focus of the debate surrounding the Act's negotiation and enactment. The President's 2010 State of the Union address, delivered while the Act was being debated in Congress, highlighted his desire to "protect every American from the worst practices of the insurance industry"—through the insurance regulations—and to give "uninsured Americans a chance to choose an *affordable* health care plan in a competitive market"—through the mandate. *Supra* at 3. Legislators emphasized that the insurance reforms would rein in practices condemned as odious and discriminatory. *Supra* at 4. Indeed, a major voting bloc was committed to going still further—through a public option designed to entirely eliminate the "profit motive" in insurance—but settled for the insurance regulations as a necessary compromise. *See supra* at 5-6. And numerous legislators highlighted how the mandate, together with guaranteed-issue and community-rating, would decrease the number of uninsured individuals in the country. *Supra* at 4-5; 42 U.S.C.A. § 18091(a)(2)(C) (finding that mandate "will increase the number and share of Americans who are insured"). What matters is not the accuracy of these claims, but that the Act is largely premised on them.

The contrast to *Alaska Airlines*—where the invalid provision had been referenced only a single time during extensive debate, 480 U.S. at 691—could not be starker. Congress' sustained attention to the mandate and insurance reforms reflects their singular importance to the overall legislative bargain.

B. Invalidating Only The Mandate And Insurance Regulations Would Disturb The Allocation Of "Shared Responsibility" Intended By Congress

Analysis of the Act's other notable provisions reinforces that the mandate and insurance regulations were its foundational premises. Without them, the operation of the Act's other features would be significantly undermined. And, if an unconstitutional provision "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." *Connolly v. Union Sewer Pipe Co.*, 184 U.S. 540, 565 (1902).

Most obviously, elimination of the mandate and insurance regulations would displace Congress' effort to allocate the costs of the Nation's health insurance. President Obama argued that "[i]mproving our health care system only works if everybody does their part." *Remarks to Congress*, *supra*. "Shared Responsibility for Health Care" (ACA Title I, Subtitle F) is thus the Act's theme; Congress sought to distribute the costs of near-universal coverage across individuals, employers, insurers, participants in the healthcare industry, States, and the Federal Government itself. As explained below, without the mandate and insurance regulations, individuals and insurers will be freed of the major burdens that the Act imposed on them—and other stakeholders will, to a degree not intended, be left to pick up the slack.

Pollock is instructive as to the implications of those redistributive impacts. In that case, this Court invalidated a general income tax as applied to income from real or personal property. 158 U.S. at

637. Then, it held that the tax could not survive subject to those exclusions, because revenues from property "formed a vital part of the scheme," and striking it "would leave the burden of the tax to be borne by professions, trades, employments, or vocations." *Id.* at 636-37. Eliminating the invalid provisions thus would shift tax burdens "in a direction which could not have been contemplated." *Id.* at 637. "[W]hat was intended as a tax on capital would remain in substance a tax on occupations and labor," and the scheme, "considered as a whole," was not intended to function as such. *Id.*

Here, striking only the mandate and insurance regulations would similarly disturb the allocation of costs and shared responsibility under the Act.

1. Title I of the Act includes not only the mandate and insurance regulations, but also subsidies to help individuals with lower incomes to buy insurance. The subsidies grant refundable tax credits tied to the lesser of (i) the premiums paid by those individuals, or (ii) the community-rated cost of the second-cheapest "silver" plan for the individual's geographic "rating area." *Supra* at 19-20.

If, per the Eleventh Circuit, this Court were to sever only the mandate, the anticipated cost to the Government would skyrocket. As explained above, in that circumstance, premiums in the individual market would rise by some 30%. *Supra* at 11. And, because the subsidies are calculated based on actual premium costs, the Government would be on the hook for these costs. Congress intended for the Government to subsidize premiums, but on the assumption that they would be relatively low, given the mandate's subsidy.

Even if the insurance regulations are properly invalidated along with the mandate, the subsidies would not operate as intended. The subsidy amounts are effectively capped by the community-rated premiums for the applicable geographic "rating area," *see* 26 U.S.C.A. § 36B(b)(3)(C); 42 U.S.C.A. § 300gg(a)(2), which of course exist only by virtue of the insurance regulations. And if that now-inoperative cap were simply set aside, and the subsidies calculated by reference only to actual premiums paid, the effects would be unacceptable: Absent the insurance regulations, insurers would return to the individualized pricing that Congress found discriminatory, with higher premiums for the elderly and those with pre-existing conditions. Yet the Government, paying subsidies tied to actual premiums, would simply be footing the bill for *private insurers* to charge these *unrestricted* prices. Rather than *ban* the insurer practices that Congress condemned, the Act would actually *pay for them* with federal money. The Congress that enacted the ACA could not possibly have intended that result.

Nor would Congress have been willing to pay the whole bill for universal coverage. Congress required healthy people, through the mandate, to provide an annual $30 billion subsidy to defray premiums for the sick—Congress simply could not afford, and never intended, for the Government to pay the entire amount. Moreover, if the Federal Government really wanted to shoulder the entire cost of healthcare for Americans who cannot afford it, it would likely have done so through a public program like Medicaid—not by simply accepting, and paying, "discriminatory" prices charged by private insurance companies.

2. A cousin to the individual mandate, the employer "responsibility" assessment, encourages certain employers to sponsor health plans for their employees. Specifically, it imposes an exaction on covered employers if one of their employees obtains a federal subsidy to help pay for insurance purchased elsewhere. *Supra* at 21.

This assessment—labeled "shared responsibility for employers regarding health coverage," 26 U.S.C.A. § 4980H—was one plank of a multi-part effort to spread health-care costs across *multiple* actors. For that reason alone, it cannot stand once individuals, insurers, and the Federal Government are all let off the hook. *Pollock*, 158 U.S. at 636-37.

Further, the exaction is inextricably intertwined with the subsidies described above. Indeed, if those subsidies are invalidated, no employee will ever receive one—and so the employer exaction will never be triggered. The employer exaction is thus simply "incapable of functioning independently" of the subsidies. *Alaska Airlines*, 480 U.S. at 684.

3. The Act also creates new health-insurance "exchanges," marketplaces where individuals and small businesses can buy the Act's new insurance products. The Federal Government only subsidizes coverage purchased within an exchange, thus giving insurance companies a reason to sell there despite the distinct regulatory burdens imposed on plans offered through the exchanges. *Supra* at 19-20.

The exchanges cannot be severed from the provisions already addressed. Without the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are

subject to far greater restrictions. Premised on the mandate, the insurance regulations, and the subsidies, the insurance exchanges cannot operate as intended by Congress absent those provisions.

4. Another part of the Act requires that States substantially relax the eligibility criteria for Medicaid. *Supra* at 21-22. But, as the Government explained below, Congress intended for the additional Medicaid spending required of the States to be "offset" by other "cost-saving provisions." RE 1024. For example, Congress believed the insurance regulations would prevent individuals with pre-existing conditions from being driven onto Medicaid rolls, or into state-funded high-risk pools, by the uninsurable cost of their care. *See* RE 1023; 42 U.S.C.A. § 18091(a)(2)(G) (finding that "62 percent of all personal bankruptcies are caused in part by medical expenses"). Congress further believed the States would also, in light of the mandate and premium subsidies, save money on uncompensated care. *See* RE 1023. If the States need no longer worry about picking up the tab for uninsurable sick people (because private insurers will now be forced to), or for cost-shifting by the uninsured (because the mandate will force them to buy insurance), then they can devote more resources to the poor. Absent the mandate, insurance regulations, and subsidies, this premise would no longer be true, and the States would be forced to bear additional costs far greater than those intended by Congress.[29]

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[29] Of course, if the Medicaid expansion is independently unconstitutional, as the State Petitioners contend, then the severability analysis must take their invalidity as a given.

5. Another major component of the Act is a set of new taxes, most of which are found in Subtitle A of Title IX ("Revenue Offset Provisions"), and a set of spending cuts to public programs like Medicare.

Many of these affect insurance companies and healthcare providers but, like the insurance regulations, were offset by the substantial benefits conferred by the mandate. *Supra* at 22. Without the mandate's subsidy, these taxes and cuts would saddle insurance companies and providers with far greater net burdens than did the original legislative bargain. *See Pollock*, 158 U.S. at 636-37.

Moreover, these provisions satisfied (as the heading of the revenue Subtitle indicates) the Act's overriding political constraint—that it not add to the federal deficit. *Supra* at 6. Given the new *liabilities* adopted by the Government—notably, the subsidies for low-income Americans—Congress had to include new *revenues* to "offset" them. The Act's revenue-raising and spending cuts were thus premised on the funds being used to expand coverage and hold down the cost of health insurance.

But, as shown, the subsidies cannot survive without the mandate and insurance regulations. And there is no reason to think that Congress would have imposed this hodge-podge of taxes and cuts for its own sake, without furthering the twin goals of the Act. Accordingly, these "offset" provisions, too, must fall. *Williams*, 278 U.S. at 244 (holding "taxes" that were enacted to "defra[y] the expenses" of an invalid provision to be non-severable). Nor could this Court restore budget neutrality by "blue pencil[ing]" the Act, *FEF*, 130 S. Ct. at 3162, in determining which of the new taxes to strike. *Randall*, 548 U.S. at 262.

* * *

In sum, Congress designed the Act to spread the costs of expanded insurance coverage among individuals (the mandate), insurers (the insurance regulations), employers (the "responsibility" assessment), the Federal Government (the premium subsidies), the States (the Medicaid expansion), and other actors (the "offset" taxes and spending cuts). Eliminating the mandate and insurance reforms would have major ripple effects, twisting Congress' reticulated scheme of "shared responsibility" beyond repair. Accordingly, the Act must be invalidated *in toto*.

C. Retaining Only The Act's Miscellaneous Tag-Along Provisions Would Fundamentally Change The Statute That Congress Enacted

To be sure, the discussion above does not address *every* provision of the 2700-page Act. As the Eleventh Circuit observed, within the law's countless provisions can be identified various obscure measures that appear independent of its major planks. The Act, for example, requires employers to provide "reasonable break time for nursing mothers" and restores "funding for abstinence education." Pet.App. 174a-175a. For three reasons, however, the existence of these peripheral provisions does not affect the conclusion of wholesale non-severability.

First, the mandate cannot be severed from the Act's *major* components. As explained above, a law's central pillars cannot be removed without toppling the statute as a whole, and the mandate and insurance regulations together plainly qualify as such pillars. *Supra* Part III.A. *A fortiori*, so too does the combination of the mandate, insurance

regulations, subsidies, health exchanges, employer assessment, Medicaid expansion, and taxes. Once all of these are stricken, what is left would bear no resemblance to the statute Congress enacted.

Whereas severability analysis normally removes a small discrete part to preserve a larger coherent whole, the issue here is removing a large coherent whole to preserve small discrete parts. We are aware of no precedent that has allowed severance in remotely similar circumstances. And for good reason: It is inconceivable that Congress, trying to adopt a comprehensive solution to a perceived crisis, would "have been satisfied" with the menagerie of tag-along provisions that remain after a statute's pillars are removed. *Williams*, 278 U.S. at 242.

Second, if the severability analysis really must proceed provision-by-provision, courts would be faced with the impractical, unrealistic task of proceeding through the Act's "hundreds of new laws about hundreds of different areas of health insurance and health care," Pet.App. 21a, and evaluating each provision's relationship to the others and to the whole. There are simply too many provisions to engage in such granular inquiries, particularly because the severance of each provision could alter the calculus and call into question earlier decisions about other provisions. Once numerous, substantial pieces of the legislation cannot operate as intended, this Court should invalidate the whole statute.

Third, even if it were somehow practical to consider every provision on its own, the difficulty of analysis required would be far beyond the judicial ken. In an act this complex and interrelated, courts cannot confidently deem individual provisions to be

operationally independent. Once a number of major provisions are stricken, the only responsible course for a court—"mindful that [its] constitutional mandate and institutional competence are limited," *Ayotte*, 546 U.S. at 329—is to declare the entire Act non-severable, and let Congress handle rebuilding.

IV. THE ACT WOULD NOT, AND COULD NOT, HAVE BEEN ENACTED WITHOUT THE MANDATE AND INSURANCE REGULATIONS

Another way of framing the severability inquiry is to ask whether the valid portions would have been enacted independently of the invalid ones. *FEF*, 130 S. Ct. at 3161. Here, even apart from the centrality of the mandate and insurance regulations to the functioning of the whole, the unusual legislative proceedings further confirm that, absent those provisions, the Act would not have been enacted in anything even resembling its current form. The Act emerged only after extended, hard-fought, legislative negotiation. Every vote was crucial to its passage, and the vote-trading and log-rolling that developed as a result make this "sweeping and comprehensive Act" (Pet.App. 4a) an unusually unstable grand bargain. Moreover, the shift in the composition of the Senate that preceded the Act's final passage made it *certain* that the bill *could not* have passed without the mandate.

A. The Act Was A Grand Bargain, With Nearly Every Provision Crucial To Its Success

In an oft-cited analysis, Chief Justice Shaw of the Supreme Judicial Court of Massachusetts reasoned that, while "the same act of legislation may be unconstitutional in some of its provisions, and yet constitutional in others," the proposition "must be

taken with this limitation": If the parts "are so mutually connected with and dependent on each other, as *conditions, considerations or compensations* for each other," then the statute must fall as a whole. *Warren v. Charlestown*, 68 Mass. 84, 98-99 (1854) (emphasis added). This Court long ago adopted that test, directing courts to inquire whether, if "while the bill was pending in Congress a motion to strike out the [invalid] provisions had prevailed," Congress would still have enacted the bill. *Carter*, 298 U.S. at 313, 316; *see also Alaska Airlines*, 480 U.S. at 685 (considering role of invalid provision in "original legislative bargain"). Here, the nature of the debate that produced the bill, and the indications from its drafting history, confirm that the answer is "no."

1. The Act ultimately passed, in both the House and the Senate, by the closest of margins. In the Senate, every affirmative vote was necessary for passage, making every Senator in the majority a swing vote. And the uncertain outcome of the votes shaped negotiations over the bill throughout the legislative process. Dispositive blocs of votes demanded a wide-ranging set of provisions—from the Act's treatment of abortion to its exclusion of the so-called "public" option. Yet other votes were extended in exchange for particular, parochial benefits, such as a Medicaid subsidy for Louisiana; a pilot program for a group of people exposed to asbestos in Montana; and grants to particular, but unnamed, hospitals and universities in other states. *See supra* at 23-25.

This historical context provides strong additional evidence that, if "while the bill was pending in Congress a motion to strike out the [mandate and insurance reforms] had prevailed," *Carter*, 298 U.S.

at 313, the delicate compromises embodied in the Act would have blown up, and there is little chance that Congress would nonetheless have proceeded, unfazed, to enact the remainder of the law.

Separation-of-powers concerns about the judicial displacement of legislative bargains are especially grave in this context. Granted, every statute represents some compromise, but this Act's inherent "conditions, considerations [and] compensations," *Warren*, 68 Mass. at 98-99, are unusually complex and were unusually important to its passage. As the Senate Majority Leader acknowledged, there are more *quid pro quos* in this Act than anyone even knows. *See supra* at 25. For this Court to slice up the legislation in unforeseen, uncontemplated ways—invalidating *quids* and retaining *quos*, likely without even realizing it—would raise profound separation-of-powers concerns regarding the judicial creation of a statute so substantially different, politically as well as operationally, from the one that Congress enacted.

2. Textual confirmation that Congress intended the Act to operate as a package deal can be found in its drafting history—namely, *removal* of an express severability clause. If a law simply *omits* such a clause, its silence "does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686. But here, Congress *removed* a severability clause that *had* been included in an earlier iteration of the bill. H.R. 3962, § 255 (Oct. 29, 2009). While not dispositive, this fact "does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all." *Gubiensio-Ortiz*, 857 F.2d at 1267.

The Eleventh Circuit entirely discounted this drafting history, pointing out that "both the Senate and House legislative drafting manuals state that … severability clauses are unnecessary." Pet.App. 175a. That may have explained a failure to include a severability clause *at all*, but it hardly explains why Congress went to the effort of *deleting* a clause it had earlier found important enough to include. And, despite the drafting manuals, the very same Congress included—in its other showcase piece of complex legislation, enacted just weeks after the Act—an apparently "unnecessary" severability clause. *See* Dodd-Frank Wall Street Reform and Consumer Protection Act, § 3, Pub. L. No. 111-203 (2010). That fundamental difference between these two landmark statutes is highly probative of congressional intent.

B. Under Congress' Procedural Rules, The Act Could Not Have Been Enacted Without the Individual Mandate

In many cases, determining whether Congress would have enacted the legislation absent its invalid provision may be an "elusive" inquiry. *Chadha*, 462 U.S. at 932. Not so here. The unique procedures by which the Act was passed, following an unexpected change in the political composition of the Senate, provides the plainest evidence imaginable that this bill not only *would not*, but *could not* have been enacted without the mandate.

On December 24, 2009, the Senate passed a health-insurance reform bill with exactly the sixty votes needed to overcome a filibuster the day prior. *Supra* at 8. But when Senator Scott Brown, a staunch opponent of the legislative efforts, was

elected soon thereafter, the balance of power shifted, and the Act's proponents could no longer retain its fundamental structure and yet avoid a filibuster. *Supra* at 9. Accordingly, the House of Representatives had no choice but to pass the bill in the *exact* form in which it had already passed the Senate, since a *different* bill emerging from a bicameral conference committee, reconciling the two houses' versions, could not then pass in the Senate. To satisfy the Constitution's requirement that a bill pass both houses in the same form, the House was bound (if it wanted *any* bill remotely resembling the pending one) to pass the Senate's version—which included the mandate and insurance regulations. *Id.*

Thus, the *only* way for Congress to make changes to the bill as passed by the Senate was through the budget reconciliation process, but that process allowed only for *budgetary* provisions. *Id.* Congress therefore was precluded from making any *non-budgetary* amendments to the version of the Act passed by the Senate. In other words, the large parts of the Act that did not affect the budget—*i.e.*, everything aside from the Act's taxes, subsidies, and changes to public programs like Medicare—were unalterable, and thus *essential* to the Act's successful enactment. The point is further confirmed by the rule that the House adopted to govern its consideration of the Senate bill: It allowed for no amendments, requiring instead an all-or-nothing vote on the entire package. *See supra* at 9-10.

This history confirms that the Act, without the mandate or insurance regulations, could not have been enacted. The latter have no direct budgetary impact, and so any attempt to amend them out of the

Act through reconciliation would have failed. The whole statute is thus procedurally—not just operationally—intertwined with the mandate and insurance regulations. It therefore would be doubly inappropriate for this Court to substitute for the Act a law that Congress would not, and could not, have enacted.

CONCLUSION

This Court should hold that the ACA is entirely non-severable from the individual mandate and reverse in relevant part the judgment below.

Respectfully submitted,

KAREN R. HARNED
NFIB SMALL BUSINESS
LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV.
LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

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