Nos. 11-393 and 11-400

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.,
Petitioners,

v.

KATHLEEN SEBELIUS, ET AL.,
Respondents.

STATE OF FLORIDA, ET AL.,
Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE AMERICAN BENEFITS COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PARTIAL REVERSAL ON SEVERABILITY

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INTEREST OF THE *AMICUS CURIAE*

The American Benefits Council (the "Council") is a broad-based nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans.[1] The Council's approximately 350 members are primarily large U.S. employers that provide employee benefits to active and retired workers. The Council's membership also includes organizations that provide services to employers of all sizes regarding their employee benefit programs. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering more than 100 million Americans. The Council frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration.[2]

The Council was involved in extensive discussions with the Congressional leadership and the Administration during the legislative process leading to the enactment of the Patient Protection and Affordable Care Act of 2010,

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1. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no person other than *amicus* made a monetary contribution intended to fund the preparation and submission of this brief.

2. *See, e.g., Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan,* 555 U.S. 285 (2009); *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008); *Sereboff v. Mid Atl. Med. Servs., Inc.,* 547 U.S. 356 (2006); *Aetna Health Inc. v. Davila,* 542 U.S. 200 (2004); *Gen. Dynamics Land Sys., Inc. v. Cline,* 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003); *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002).

Pub. L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (the "ACA" or the "Act"). The Council submits this brief because that background and its general experience with the design and administration of health benefits give it a perspective that may be helpful to the Court in addressing the severability issues posed by the Eleventh Circuit's decision below.

SUMMARY OF ARGUMENT

Although the Council supported the need for reform of the health care system in Congress, this brief does not address any of the questions presented in the companion cases before this Court regarding the constitutionality of the ACA's individual mandate, ACA § 1501, the Anti-Injunction Act, 28 U.S.C. § 2283, or the Medicaid coercion issue based on *South Dakota v. Dole*, 483 U.S. 203 (1987). Rather, the sole question this brief addresses is what remedy should follow in the event that the individual mandate is held unconstitutional.

The Council disagrees with the Eleventh Circuit's holding that the individual mandate is completely severable from the rest of the ACA, because that court's ruling does not take adequate account of the overarching aims of the ACA or the mechanics of the law meant to meet those aims. The Council also disagrees with those parties and amici who argue that, if the individual mandate is invalidated, the Court should discard the balance of the ACA as well. Rather, a holding that a few discrete portions of the ACA are inseverable is required under the cautious severability standards of this Court's cases. The teachings and principles of such cases as *Ayotte v.*

Planned Parenthood of N. New England, 546 U.S. 320 (2006), and *United States v. Salerno*, 481 U.S. 739, 745 (1987) define a vital but necessarily restrained role for judicial invalidation of duly enacted legislation.

Under the test this Court has articulated for determining severability, *see, e.g.*, *Alaska Airlines v. Brock*, 480 U.S. 678, 685 (1987); *Carter v. Carter Coal Co.*, 298 U.S. 238, 312-5 (1936), the Council believes that most of the ACA is severable from the individual mandate. Nevertheless, the Council believes that two sets of provisions are so intimately connected with the individual mandate, and so dependent upon it to function in the manner Congress intended, that they must be held inseverable and, therefore, invalidated if the individual mandate is struck down.

First, the Council agrees with the United States and *amici* America's Health Insurance Plans and the Blue Cross Blue Shield Association (collectively, the "Health Insurance Industry") that the insurance market reforms that led to the enactment of the individual mandate (and without which it would not have been enacted or function properly) are so inextricably entwined with it as to be inseverable from an invalidated individual mandate. In view of the extensive briefing received by the Court in these cases, the Council largely relies on the brief submitted by the Health Insurance Industry in support of that argument. *See* Point II below.

Second, the Council contends that the employer mandate is also inseverable from the individual mandate, as the former could not function as Congress intended or advance the objectives for which it was enacted if the latter

were invalidated. The comprehensive and reticulated coverage scheme promulgated in Subtitle F would be disrupted in the absence of the individual mandate, skewing the shared responsibility paradigm upon which reform is built. *See* Point III below.

The Congressional record extensively documents Congress's objective of achieving near-universal health coverage through a system of shared responsibility. *See, e.g.*, Congressman Stark, co-sponsor of House Bill 3200, discussing issues prior to House vote on the ACA: "The bill guarantees health coverage to 96 percent of Americans. It's fully paid for. People who like their coverage indeed can keep it. It reforms health insurance regulation and *requires shared responsibility by individuals, businesses, and government*." 155 Cong. Rec. H12856 (daily ed. Nov. 7, 2009) (emphasis added).[3] Both the text

3. *See also* Senator Dodd, discussing issues prior to vote on HR 3200: "In the United States of America, we believe in shared risk and shared responsibility. Our bill, if signed into law, lowers costs for everyone by ensuring that everyone is insured. The bigger the pool, obviously the broader the risk and the lower the cost. In return, our bill asks individuals, employers, the Federal Government, all of us to share responsibility . . . ." 155 Cong. Rec. S7941 (daily ed. July 22, 2009); Congresswoman Pingree, discussing HR 3200: "The plan that has just been released has a shared responsibility from employers and individuals alike. It has real components to control costs." 155 Cong. Rec. H7132 (daily ed. June 23, 2009); Congresswoman Schwartz, co-sponsor of House Bill 3590 which became law: "We also think that this is a shared responsibility. I certainly do. This is something that we're asking individuals to take some responsibility, employers to take some responsibility, we're asking insurance companies, and many of them are stepping up to the plate saying, We can do this." 155 Cong. Rec. H6145 (daily ed. June 3, 2009).

and statutory structure of the employer mandate show in various ways that the employer mandate was not simply a free-standing add-on to a long list of provisions in the law, but inextricably entwined with the individual mandate, incapable of functioning as Congress intended in its absence.

ARGUMENT

I. SEVERABILITY TURNS ON WHETHER THE REMAINDER OF A STATUTE WOULD FUNCTION AS CONGRESS INTENDED ABSENT THE OFFENDING PROVISION

The touchstone of severability analysis is legislative intent. *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). Before severing an unconstitutional section or provision from a statute, a court must ask: "Would the legislature have preferred what is left of its statute to no statute at all?" *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006). Because the unconstitutionality of a part of an Act does not necessarily undercut the validity of its remaining provisions, the "normal rule" is "that partial, rather than facial, invalidation is the required course." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). However, only by examining the structure and aims of the law can a court discern what Congress would have chosen to do in the absence of the offending provision.

The threshold question is whether Congress directly addressed the question of severability in the statutory text

itself. When Congress includes a severability clause in a piece of legislation, a presumption arises that portions of the legislation are severable. Omission of such a clause, however, does not invoke the opposite presumption. *Alaska Airlines v. Brock*, 480 U.S. 678, 686 (1987) ("In the absence of a severability clause . . . Congress's silence is just that—silence."). Apart from such clauses, the Court has also looked to "structure and purpose" as primary indicators of legislative "severability intention." *Denver Area Educ. Telecomms. Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996).

Separately, Congressional intent concerning severability may be inferred from the ability of the remaining provisions of the statute to function on their own. A statute will be struck down in its entirety if, after the unconstitutional part is severed, the remainder is "incapable of functioning independently." *Alaska Airlines*, 480 U.S. at 684. Not only must a statute function after partial invalidation—it must do so in a "*manner* consistent with the intent of Congress." *Id*. at 685 (emphasis in original). That is, what remains must be "consistent with Congress's basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 259 (2005) (citing *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984)).

In the context of a "highly complex statute" with "interrelated provisions" that may affect one another in subtle ways—such as the ACA—the Court has expressed the need for caution before severing individual provisions. *See, e.g.*, *Booker*, 543 U.S. at 248. By contrast, in cases where the Court has endorsed severance, it has emphasized the discrete, limited effect of the portions held invalid. *See Denver Area Educ. Telecomms. Consortium*, 518 U.S. at 767-8. The more interrelated the various

provisions of a regulatory scheme, the more a holding of inseverability may be necessary because of their mutual "interdependence." *Carter v. Carter Coal Co.*, 298 U.S. at 315. As the Court has held, where severance would require it to "write words into the statute" on the one hand or to "leave gaping loop-holes" on the other, or to foresee "which of many different possible ways the legislature might respond to the constitutional objections" found, prudence counsels against severance. *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

II. THE INDIVIDUAL MANDATE CANNOT BE SEVERED FROM THE ACT'S PRINCIPAL MARKET REFORM PROVISIONS

For the reasons set forth by the Health Insurance Industry—and by the United States as respondent—the market reform provisions of the ACA are not severable from the minimum coverage requirement (the "individual mandate").

The insurance market reforms of the ACA (guaranteed issue, prohibitions on preexisting condition exclusions or waiting periods, ban on coverage eligibility rules based on health-related factors, and the adjusted community rating system) were enacted along with the individual mandate as a single package, and for a simple reason: Congress concluded, based on extensive evidence, much of it canvassed by the Health Insurance Industry *amicus* brief, that the desired insurance market reforms were unworkable without an individual mandate. That was the lesson gleaned from the experience of various states where market reforms without an individual mandate had been tried and failed.

The individual mandate was not enacted for its own abstract value, but in order to make workable the insurance market reforms that were the central goal, because all the evidence showed that they could not function successfully absent the broader market participation that the individual mandate would supply.

To avoid burdening the Court with repetitive briefing, the Council relies for this argument on the brief of the Health Insurance Industry.

III. THE INDIVIDUAL MANDATE CANNOT BE SEVERED FROM THE EMPLOYER MANDATE

Congress expressly stated in § 1501(a)(2)(D) of the ACA that the individual mandate "achieves near-universal coverage *by building upon* and strengthening the private employer-based health insurance system . . . ." (emphasis added). As such, the private employer-based health insurance system serves to support the individual mandate.

With that in mind, Congress crafted a comprehensive and reticulated coverage scheme based on the concept of shared responsibility, a concept that appears throughout the Congressional record.[4] The very structure of Subsection F of the ACA reveals Congress's intent that the employer mandate function to support the individual mandate by

4. *See, e.g.*, 155 Cong. Rec. H12856 (daily ed. Nov. 7, 2009) (statement of Rep. Stark); 155 Cong. Rec. S7941 (daily ed. July 22, 2009) (statement of Sen. Dodd); 155 Cong. Rec. H7132 (daily ed. June 23, 2009) (statement of Rep. Pingree); 155 Cong. Rec. H6145 (daily ed. June 3, 2009) (statement of Rep. Schwartz).

way of a shared responsibility model. Finally, the manner in which the employer responsibility provisions would malfunction in the absence of the individual mandate and related individual-market reforms is yet another indicator of Congress's intent that the employer responsibility provisions work with the individual mandate and related individual-market reforms, serving little function in their absence.

A. Overview Of The Employer Mandate

The Act's employer responsibility provisions (also referred to as the "employer mandate") are located in Part II of Subtitle F of the ACA, §§ 1511-1515, which sets forth a number of rules affecting employers, including notice, shared payment, and other coverage obligations. Taken together, these rules establish the structure meant to support the individual mandate vis-à-vis the private employer-provided health system.

1. Employer Payment Responsibility.

The core of the employer responsibility provisions under the ACA is an obligation for an employer to either (1) offer its full-time employees the ability to access minimum essential coverage under an eligible employer-sponsored plan or (2) make so-called shared responsibility payments to the federal government to the extent the employer elects (a) not to offer coverage at all or (b) to provide coverage deemed inadequate under the Act. ACA § 1513. For this purpose, "minimum essential coverage" is insurance coverage offered through a group health plan, a governmental plan, or any other plan or coverage offered in the small or large group market within a State.

ACA § 1501(b). It should be noted that it is ultimately the employees' responsibility to obtain minimum essential coverage. *Id.* In that respect, the employer responsibility provisions of the ACA are meant to support individual employees in their quest to fulfill their individual mandate under the ACA.

Failure to offer such coverage potentially subjects the employer to one of two tax penalties.

First, an employer that fails to offer *any* health insurance coverage is subject to a penalty if at least one full-time employee receives a federal premium tax credit or cost-sharing reduction and is covered under a public exchange plan. ACA § 1513. Put differently, so long as at least one full-time employee is required to turn to a state plan in order to meet his individual mandate obligation and receives a federal premium tax credit, the employer must pay the penalty. That penalty is $167 per month ($2,000 annually) multiplied by the number of full-time employees, minus the first thirty. Pub. L. No. 111-152, 124 Stat. 1029 § 1003.

Second, an employer fails to offer *adequate* coverage if the insurance it makes available does not satisfy either specified "minimum value" or "affordability" standards. Minimum value is defined as an insurance plan that is expected to pay 60% of covered medical expenses across a typical population, with the remaining 40% to be paid by the enrollees through the plan's cost-sharing requirements.[5] ACA § 1401(a). Affordability means that the

5. The Act refers to this metric as "actuarial value." ACA § 1302(d). Actuarial value consolidates a plan's various cost-sharing mechanisms, such as deductibles, coinsurance, and copayments,

cost of the coverage cannot exceed 9.5% of the employee's household income. *Id.*

Employers that do not offer adequate coverage are subject to a penalty of $250 per month ($3,000 annually) for each full-time employee who is forced to obtain insurance on the open market. In the language of the Act, any employee who receives a federal premium tax credit or cost-sharing reduction and who is covered under a public exchange plan in the course of meeting his or her individual mandate obligation triggers the employer penalty. The penalty for inadequate coverage, however, cannot exceed the penalty that would apply had the employer offered no coverage.[6]

The minimum value standard itself illustrates the inexorably entwined nature of the individual mandate and the employer mandate, as the requisite level of coverage (60%) assumes that an employee's health care expenses will be borne partly by the employer-provided plan and partly by the employee himself (through co-pays, deductibles, or other individual arrangements). Also, the 60% standard under the employer responsibility provisions is equivalent to the actuarial value of a "bronze" plan that will be offered through the state exchanges. A bronze-level plan represents "minimum essential coverage," which satisfies a consumer's requirements under the individual mandate.

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into a single measure that allows consumers to evaluate the plan's overall financial protection.

6. Because the shared payment penalty formula for the failure to provide adequate coverage uses a figure of $3,000, whereas the formula for failing to provide any coverage uses a figure of $2,000, absent this rule, an employer who provides coverage deemed inadequate could conceivably pay more in shared payment penalties than an employer who provides no coverage.

2. Other Employer Responsibilities.

The employer mandate places other obligations on employers. An employer with over 200 full-time employees is required to enroll its full-time employees automatically in coverage offered under the employer's health plan, if any. ACA § 1511. All employers are required to provide to each of their employees at the time of hiring (or with respect to current employees, not later than March 1, 2013) written notice informing the employee of the existence of a state exchange, including a description of the services provided by such state exchange (the "notice" requirement). ACA § 1512. If the employer's group health plan fails to provide coverage that meets the minimum value and affordability standards, the notice must also state that the employee may be eligible for a premium tax credit and a cost sharing payment if the employee purchases coverage through the exchange. *Id.*

Additionally, employers with more than 50 full-time employees or those who otherwise offer coverage to their employees must report certain aspects of the coverage to the federal government (the "reporting" requirement) as well as notice to employees regarding the same. ACA § 1514. Finally, an employer may make coverage offered under a state exchange available for purchase by its employees through the employer's cafeteria plan.[7] ACA § 1515.

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7. A "cafeteria plan" is generally an employer-provided plan under which an employee may contribute a portion of his pretax income towards the purchase of various benefits offered under the plan's menu, such as medical insurance and life insurance. 26 U.S.C. § 125.

B. The Structure Of The Statute Evidences Congress's Intent To Implement A Comprehensive Coverage Scheme Premised On Shared Responsibility.

The text and structure of Subtitle F demonstrate that Congress intended both the individual and employer responsibility provisions of the ACA to operate as one comprehensive coverage scheme, built upon a foundation of shared responsibility between employees and employers.

Subtitle F is called "Shared Responsibility for Health Care." Its two parts, which appear side by side, are titled "Individual Responsibility," §§ 1501-02, and "Employer Responsibilities," §§ 1511-15. That structure plainly reflects the Congressional understanding that the two sets of provisions were meant to operate hand in hand. *See Carter v. Carter Coal Co.,* 298 U.S. 238, 314 (1936) (concluding that provisions of a comparably complex statute were inseverable).

Indeed, the very text of the employer mandate is built on, and cross-references, definitions that are crucial to the individual mandate. The basic responsibility expressed in the individual mandate is for a person to maintain "minimum essential coverage" for himself as well as for his dependents. ACA § 1501(b). Significantly, that term is defined within the individual responsibility provisions of the Act and is the foundation term for many of the Act's employer responsibility provisions. *See, e.g.,* ACA § 1513(a) (assessing shared payment penalty against employer who fails to provide its full-time employees an opportunity to enroll in "minimum essential coverage" offered under an "eligible employer sponsored plan") (citing ACA

§ 1501(b)); ACA § 1513(a) (assessing shared payment penalty against employer who fails to provide affordable or minimum value "minimum essential coverage" to its employees through an "eligible employer sponsored plan") (citing ACA § 1501(b)); ACA § 1513(a) (assessing penalty against employers who require an extended waiting period to enroll in "minimum essential coverage" through its "eligible employer sponsored plan") (citing ACA § 1501(b)); ACA § 1514(a) (requiring employers with 50 or more full-time employees to file an annual return with the federal government containing, among other information, a certification as to whether the employer provides "minimum essential coverage" to its employees through an "eligible employer sponsored plan") (citing ACA § 1501(b)).[8]

As *Carter* instructs, "[t]he statutory mandate for a code upheld by two legs at once suggests the improbability that Congress would have assented to a code supported by only one." 298 U.S. at 314. Subtitle F sets forth the two legs Congress intended to serve as the basis for affording an employee the opportunity to satisfy the individual mandate vis-à-vis the private employer-provided health insurance system; namely, Part I, "Individual Responsibility," §§ 1501-02, and Part II, "Employer Responsibilities" §§ 1511-15. The structure of Subtitle F thus suggests that Congress would not have assented to the removal of the individual mandate without also removing the employer responsibility provisions.

8. ACA § 1514(a) acknowledges that much of the information required to be reported under this section is also required to be reported under ACA § 1501(b), which is housed within the individual responsibility provision of the Act, and permits the oversight agency to adopt rules consolidating the reporting requirements.

C. The Employer Responsibility Provisions Of The Act Would Not Function As Congress Intended In The Absence Of The Individual Responsibility And Individual-Market Reform Provisions Of The ACA.

If the individual mandate and its associated insurance market reforms were invalidated, the employer responsibility provisions of the ACA would not serve their stated purpose or function in the manner that was intended by Congress. *Alaska Airlines*, 480 U.S. at 684. The reason is straightforward: the employer responsibility provisions serve as a base to support the individual mandate through the private employer-provided insurance market. As such, Congressional intent in implementing the employer responsibility provisions of the ACA would be frustrated without the individual mandate and related individual-market reforms because the employer responsibility provisions would lose their purpose. Indeed, the manner in which the employer responsibility provisions would function (or malfunction) in the absence of the individual mandate and related individual-market reforms demonstrates this result.

1. Operation of the Shared Payment Penalties.

As mentioned above, the ACA assesses a shared payment penalty against an employer who does not provide any coverage to its employees. That penalty is triggered if at least one full-time employee receives federally subsidized coverage under a state exchange. As with the other employer responsibility provisions

under the Act, this formula makes sense under a system of universal coverage under the state exchanges, but not otherwise. That is, it can be assumed that a large number of employees who are not covered under an employer-provided plan will receive subsidized coverage under a state exchange, particularly in certain industries.[9] As such, the rule assesses a penalty calculated over the employer's entire employee base (less 30) in order to assure that the employer meets its shared responsibility under the Act.

However, a large number of employees would no longer be eligible for federally subsidized coverage under the state exchanges in a system that lacked the individual mandate and related individual-market reforms because the market reforms make it possible for individuals to obtain coverage who otherwise could not.[10] Moreover,

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9. *See* Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population*, Emp. Benefit Res. Inst. No. 362 at 15 (Sept. 2011). "Workers employed in agriculture, forestry, fishing, mining and construction were disproportionately more likely to be uninsured in 2010."

10. In a series of reports examining the impact full repeal of the ACA would have on congressional districts and large metropolitan areas, the House Committee on Energy and Commerce highlighted the fact that removal of market reforms could affect large numbers of individuals, particularly those with preexisting conditions, who currently lack insurance coverage and who would lose the ability to obtain coverage in individual markets. Each of the thirty metro area reports includes the projected number of residents (in thousands) who fit into this group. Letter from Rep. Henry A. Waxman, Ranking Member of the House

absent the individual mandate, it may be assumed that there will be a certain number of employees who leave the system by choice. One result of striking the individual mandate and its related individual-market reforms, then, is that the federal government would pay considerably less in federal subsidies through the state exchanges due to there being fewer employees in the system. In the absence of the individual mandate, the employer responsibility provisions of the ACA would continue to assess a penalty against employers as though state-based coverage was being fully utilized by employees, even though a number of employees would be precluded from such coverage due to the absence of the individual-market reforms and others would opt out of the system by choice.

The point of the penalty is to require the employer to offset costs to the federal government for premium subsidies it provides to qualified individuals who obtain coverage in a health insurance exchange rather than through an employer-sponsored health plan.[11] It was not

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Comm. on Energy and Commerce, and Rep. Frank Pallone, to the House of Representatives (Jan. 18, 2011), *available at* http://democrats.energycommerce.house.gov/index. php?q=news/impact-of-repealing-health-care-reform.

11. According to Douglas E. Elmendorf, Director of the Congressional Budget Office: "[Federal] costs will be partly offset by higher revenues . . . from four sources: an increase in net revenues from the excise tax on high-premium insurance plans, totaling $87 billion; penalty payments by uninsured individuals, increasing revenues by $34 billion; penalty payments by employers, increasing revenues by $81 billion; and other budgetary effects, mostly on tax revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from

part of Congress's intention to direct employers to pay a "shared responsibility" payment and, thus, reimburse the federal government with respect to individuals who cannot receive the intended federal subsidy that was an integral part of the intended arrangement.

The same is true of the other shared payment penalty assessed against an employer who offers inadequate coverage. This penalty is only triggered with respect to employees who receive federally-subsidized coverage through a state exchange. In the absence of the individual responsibility and individual-market reform provisions, however, it is almost a certainty that those employees who were uninsurable in the individual market prior to passage of the ACA (because of poor health or pre-existing conditions) would once again find themselves unable to obtain coverage in the individual market by way of the state exchanges.

Consequently, the only penalties employers would pay if they provide coverage that failed to meet the minimum affordability and value standards would be in regard to the very employees who were already capable of obtaining their own insurance. Thus, absent the individual mandate and related individual-market reforms, Congress's overall coverage scheme would leave to the sideline those whom Congress most wanted to incorporate into the system,

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changes in employment-based health insurance coverage, which will decrease deficits by $113 billion." *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Testimony Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 112th Cong. 18 (2011)

while assisting individuals who already receive its benefits.[12]

As explained in *Alaska Airlines*, the test for severability is not whether the statute would continue to function in some fashion absent the offending provision, but whether the remaining provisions would function in the manner that Congress intended. 480 U.S. at 685. Judged by that standard, the penalty provision for failure to meet the ACA's minimum value and affordability standards would no longer work as Congress intended in the absence of the individual mandate and individual market reforms.

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12. The Congressional Record extensively documents Congress's focus on the group of people who would otherwise be unable to obtain affordable insurance or any insurance at all without market reforms. *See, e.g.*, Senator Rockefeller discussing the focus of one of the initial health care bills introduced, portions of which were eventually included in ACA: "Unfortunately, preexisting condition exclusions are often a barrier for individuals seeking access to comprehensive health insurance coverage." 155 Cong. Rec. S3183 (daily ed. Mar. 17, 2009) (statement of Sen. Rockefeller); Senator Kerry discussing the purpose of ACA: "People who are criticizing this bill ought to take a look at what it does . . . . This bill will prohibit companies from denying insurance to people because they have a preexisting condition . . . . Uninsured Americans with a pre-existing condition can have access to an immediate insurance program and help them avoid medical bankruptcy." 155 Cong. Rec. S13449-50 (daily ed. Dec. 18, 2009) (statement of Sen. Kerry); "We are against preexisting conditions, making sure that any child doesn't get denied coverage because of a preexisting condition." 155 Cong. Rec. H1438 (daily ed. Mar. 15, 2010) (statement of Congressman T. Ryan).

In sum, Congress would not have sought to impose the shared payment penalties if it could not create the intended benefits for the uninsured or difficult-to-insure among the American workforce and their families. Accordingly, that mandate should rise or fall along with the individual mandate and the corresponding market reforms.

2. Operation of Other Shared Employer Responsibilities.

Although an employer is required to offer its employees "an opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan," it is the employees who are ultimately responsible to secure minimum essential health coverage. *See, e.g.*, ACA § 1513(a); § 1501(b). The employer responsibility provisions are meant to assist employees in meeting the individual mandate under the Act. If the individual mandate were invalidated, many aspects of the employer responsibilities would become unnecessary, or even counter-productive.

For example, the notice provisions would serve little purpose in the absence of the individual mandate. These notice requirements are meant to arm an employee with the relevant information necessary to make an informed choice between electing coverage under his employer-sponsored plan or through a state exchange. But as discussed above, absent the individual mandate and related individual-market reforms, many employees would not have an actual choice between types of plans; indeed, they might not be eligible for either. Nor would those uninsurable employees be eligible for a premium tax credit and a cost sharing payment by the federal

government. As such, requiring employers to provide such a notice would be pointless. Indeed, it might actually be counter-productive, as it would likely confuse and mislead employees into assuming they have eligibility when they do not.

Similarly, § 1514 of the ACA requires employers to report to the federal government, among other information, whether it offers a plan that meets minimum essential coverage. The employer must also report to the federal government regarding each employee who is eligible for coverage under its employer-sponsored plan, and provide a notice to these employees regarding the information being reported to the government. *Id*. These rules would lose their purpose absent the individual mandate because there would be no requirement that an individual acquire minimum essential coverage at all. It would be an odd result to continue to require an employer to report whether it provides its employees the opportunity to enroll in minimum essential coverage under a system where employees are no longer required to obtain such coverage. Moreover, it would be too burdensome and intrusive to continue to require an employer to forward the names and other information regarding its employees to the federal government after that information loses its value to the government.

In the end, the reporting requirements under § 1514 lose their purpose absent the individual mandate. This loss of purpose is another indication that Congress intended the individual mandate and the employer responsibility provisions of the ACA to function as a unitary coverage scheme meant to operate within the private employer-provided insurance system.

Striking the individual mandate would undercut another feature of the employer mandate. The ACA specifically authorizes employers to meet their obligations through the offering of a cafeteria plan. § 1515. This option is important because it provides a mechanism for employees to purchase group health coverage on a pretax basis by way of payroll reduction. Under governing tax law, employer-sponsored cafeteria plans may not discriminate in favor of highly compensated employees ("HCEs"). 26 U.S.C. § 125.

In a system of universal availability of exchange-based coverage, the discrimination issue is largely irrelevant, because all employees will be eligible to participate in and benefit under the cafeteria plan. But, in a system where many employees will not qualify for coverage—*i.e.*, a system absent the individual mandate and related individual-market reforms—discrimination testing is back on the table. The inability of individuals to obtain insurance through the exchange, and therefore participate in the cafeteria plan, could result in discrimination in violation of 26 U.S.C. § 125. Any such discrimination would be caused by the uninsurability of employees as opposed to any action taken by the employer in implementing its cafeteria plan.

However, employers have no way of identifying which of their employees will or will not be eligible for state exchange-coverage in the absence of the individual mandate and related individual-market reforms and, thus, eligible to participate in the employer-sponsored cafeteria plan. Employers will not know whether their employees are or are not insurable through the state exchanges. This uncertainty will likely cause reluctance by employers to

utilize a cafeteria plan strategy, because there will be a lack of certainty as to the tax consequences of such strategy. This result is yet another indication of the entwined nature of the individual mandate, the individual-market reforms, and the employer responsibility provisions of the ACA.

These are but a few examples, in addition to the shared payment penalty examples above, demonstrating the widening impact that elimination of the individual mandate and related individual market reforms would create with respect to the functioning of the employer responsibility provisions of the ACA and its ability to serve the underlying goals of the statute. Surely other unforeseeable consequences would result from the excision of the individual mandate and related individual market reforms from the Act unless the employer mandate were also invalidated. Inasmuch as the Court cannot possibly foresee every consequence, and is not in a position to determine how Congress would have wanted to address such unexpected developments arising from striking the individual mandate, prudence counsels against severing the employer responsibility provisions from the individual mandate provisions of the ACA. *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

CONCLUSION

For the foregoing reasons, if the Court invalidates the individual mandate, the Eleventh Circuit's severability judgment should be vacated, and both the ACA's market reform provisions (concerning guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions) and the employer mandate should be invalidated as well.

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