No. 11-393 and No. 11-400

In The
Supreme Court of the United States

National Federation of Independent Business, *et al.*,
Petitioners,
v.
Kathleen Sebelius,
Secretary of Health and Human Services, *et al.*,
Respondents

State of Florida, *et al.,*
Petitioners,
v.
Department of Health and Human Services, *et al.*,
Respondents

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

BRIEF AMICI CURIAE OF DAVID R. RIEMER AND COMMUNITY ADVOCATES IN SUPPORT OF THE COURT-APPOINTED AMICUS CURIAE ON THE SEVERABILITY QUESTION

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INTEREST OF THE AMICI CURIAE

David R. Riemer and Community Advocates join in this brief in support of the Court-appointed *amicus curiae* in No. 11-393 (National Federation of Independent Business, *et al.* v. Kathleen Sebelius, Secretary of Health and Human Services, *et al.*) and No. 11-400 (State of Florida, *et al.* v Department of Health and Human Services, *et al.*) with respect to the severability question.[1]

Community Advocates (CA), founded in 1976, provides basic needs and advocacy services each year to tens of thousands of low-income, at-risk individuals and families in the Milwaukee area. The organization's services include health insurance advocacy. Every year, CA helps impoverished and uninsured Milwaukeeans to enroll in Wisconsin's Medicaid program and assists those ineligible for the program to find alternative ways of obtaining medical care.

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[1] No counsel for any party authored this brief in whole or in part. Neither counsel for any party, nor any party, made a monetary contribution intended to fund the preparation or submission of this brief.

David Riemer, Senior Fellow at the Community Advocates Public Policy Institute, is a health policy expert who has worked for over 35 years to create state and federal policies that expand health care coverage to low-income workers and control health care costs.[2]

In the 1970s, Riemer drafted Wisconsin's first Medicaid rule during the Administration of former Wisconsin Governor Patrick Lucey. He also worked on drug regulation and mental health policy reform for the U.S. Senate Subcommittee on Health and Scientific Research, chaired by the late Senator Edward Kennedy. Returning to Wisconsin in the 1980s, he helped to draft legislation that converted the state employee health plan into a large and long-lasting health insurance exchange.

While serving in the 1990s as budget director and administration director for Milwaukee Mayor John Norquist, Riemer teamed up with the Administration of former Wisconsin Governor Tommy Thompson to design the state's BadgerCare

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[2] *See generally* http://ca-ppi.org (providing additional information on David Riemer and the Community Advocates Public Policy Institute).

program. BadgerCare weaves together the portion of Medicaid that serves the poorest uninsured children and custodial parents with the State Children's Health Insurance Program (SCHIP) to greatly expand coverage for low-income families.

In 2003, as State Budget Director for former Wisconsin Governor Jim Doyle, Riemer worked to further improve the state employee health plan's exchange mechanism. From 2004 through 2007, as head of the Wisconsin Health Project, he coordinated the development of bi-partisan legislation to create a comprehensive state health insurance plan, which was folded into a bill passed by the Wisconsin State Senate.

In 2008, Riemer joined CA to lead its Public Policy Institute (PPI), and is now a Senior Fellow. Drawing on CA's experience in directly assisting poor people, and seeking to create for the poor and non-poor alike a rational system of comprehensive and affordable health insurance, Riemer and CA have worked to bring about policy changes at the state and national level. Their goal has been to persuade policy-makers to enact laws that expand health insurance coverage to the low-income

uninsured population, control health insurance costs, and improve the quality of health care. Much of Riemer's and CA's work has focused on the ACA.

Specifically, Riemer and CA have played a major role in Wisconsin, and a significant role nationally, in advocating for (1) the expansion of BadgerCare coverage to low-income non-custodial parents (both in advance of and pursuant to the ACA's extension of Medicaid to this group), and (2) the adoption of federal and state policies for the insurance exchanges created by the ACA that will enable them to be effective in covering uninsured individuals between 133% and 400% of the Federal Poverty Level (FPL), assisting small employers to obtain affordable coverage for their employees, and holding down health insurance costs while improving health care quality.[3]

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[3] *See*, *e.g.,* David R. Riemer and Alain Enthoven, *The Only Public Health Plan We Need,* New York Times (June 24, 2009), http://www.nytimes.com/2009/06/25/opinion/25enthoven.html; David R. Riemer, *Prescription for a Health Insurance Compromise*, Committee for Economic Development (Sept. 24, 2009), http://www.ced.org/commentary/65-commentary/ 378-prescription-for-a-health-insurance-compromise-forget-the-public-option-and-co-ops-rewire—the-exchange.

Advancing these positions on the uninsured and exchanges, Riemer served in 2010 and 2011 on the Wisconsin Legislative Council Special Committee on Health Care Reform Implementation, as well as on the National Association of Social Insurance (NASI) Study Panel on Health Insurance Exchanges. In 2011, CA launched the Project for Health Insurance Exchange Education (PHIXE) to provide technical support to state policy-makers to design exchanges that are effective in controlling costs.

The low-income, uninsured individuals and families that CA serves, and on whose behalf Riemer and CA work, will benefit greatly if, should the Court strike down the ACA's minimum coverage provision, the Court upholds the rest of the law.

If the ACA (except for the minimum coverage provision) is found to be constitutional, thousands of CA's low-income clients who are now uninsured will gain health insurance coverage. Those whose incomes fall below 133% of FPL will be able to enroll in an expanded Medicaid program. Those above 133% of FPL will be able to take advantage of the ACA's generous sliding-scale tax credit and use the

new health insurance exchange to purchase individual policies from competing private insurers.

Upholding the ACA as a whole also will benefit CA's low-income clients—as well as the small employers that many of them work for—by creating a health insurance exchange that offers individuals and small firms a much wider range of health insurance choices. Other ACA provisions that will particularly help CA's low-income clients, if the law as a whole is upheld, include eliminating pre-existing medical conditions to deny coverage; letting parents keep their older children on their health insurance policies; expanding the Medicare prescription drug benefit; and preserving a long list of programs and policies that aim to control health care costs.

In short, the ACA is about much more than the minimum coverage requirement. If the Court should stretch the invalidation of that provision to strike down the entire legislation, thousands of CA's low-income clients—along with tens of thousands of Wisconsinites, millions of Americans, and the nation's small employers—will be needlessly harmed.

SUMMARY OF THE ARGUMENT

If the Court strikes down the ACA's minimum coverage requirement, that provision can be excised and the balance of the ACA allowed to stand.

Ample and independent evidence supports the conclusion that, even in the absence of the minimum coverage provision, the ACA's major policy goals will be accomplished and the basic structure of the law will successfully function.

One of the ACA's key goals is to greatly reduce the number of uninsured Americans. Regardless of the fate of the minimum coverage provision, the ACA will move the nation a long way towards achieving this goal.

According to two separate independent studies, one prepared by the Congressional Budget Office and another recently released by the Lewin Group, the number of uninsured Americans will decline *even if the minimum coverage provision is struck down* by between 10 million and 23 million. This large reduction in the uninsured population is due to a combination of: (1) the expansion of Medicaid to

all low-income persons below 133% of the Federal Poverty Level (FPL), and (2) the provision of substantial subsidies to low-to-moderate income persons between 133% and 400% of FPL.

A second key goal of the ACA is to offer uninsured individuals above 133% of FPL and small employers a wide choice of health insurance options at an affordable range of premiums. Regardless of what happens to the minimum coverage provision, the ACA also will be able to achieve this goal.

The law's health insurance exchange mechanism will remain in place. The law's requirement that health insurance companies—whether they market through the exchange or not—must present individuals and small employers with health insurance plans that are easier to compare also will remain intact. And the law's prohibition against using "pre-existing medical conditions" to deny coverage or increase premiums, as well as its provision that allows parents to keep their children up to age 26 on their insurance plans, can continue to apply.

Finally, the third key goal of the ACA is to control costs. No matter what happens to the

minimum coverage provision, the law's provisions that seek to achieve this—especially the creation of health insurance exchanges, and reforms of the Medicare payment system—will remain in place.

It would be disingenuous to maintain that striking down the minimum coverage provision will not hamper the goals and weaken the structure of the ACA. But to hamper is not to undermine. To weaken is not to destroy. Severing the minimum coverage provision will still allow the ACA to achieve the greater part of its goals and maintain its core structure. Under this Court's standards for severability, if the minimum coverage provision is struck down, the remainder of the ACA should stand.

ARGUMENT

I. IF THE COURT STRIKES DOWN THE MINIMUM COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT (ACA), THAT PROVISION CAN BE SEVERED WITHOUT UNDERMINING THE ACA'S BASIC GOALS AND STRUCTURE.

A. The Primary Policy Goal of the Minimum Coverage Requirement—Greatly Reducing the Number of Uninsured Americans—Will Be Accomplished Even If the Provision is Struck Down.

One of the ACA's basic goals—and the primary goal of the minimum coverage requirement—is to bring about a very large reduction in the number of uninsured Americans. Whatever the fate of minimum coverage provision, the ACA will continue to make major progress towards achieving that objective.

Striking down the minimum coverage provision will not diminish the law's expansion of Medicaid in every state to all persons below 133% of

the Federal Poverty Level (FPL).[4] Nor will removing the minimum coverage provision disturb the sliding-scale subsidies offered to individuals between 133% and 400% of FPL if they opt to use their state's American Health Benefits Exchange to purchase an "essential health benefits package" from a "qualified health care plan."[5, 6] Together, the ACA's Medicaid expansion and tax subsidies will induce millions of currently uninsured Americans to obtain health insurance coverage.

Several studies by highly regarded, independent organizations confirm that, even if the

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[4] Patient Protection and Affordable Care Act Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271-79 (2010) (as amended) (citing the Patient Protection and Affordable Care Act since the Affordable Care Act has not yet been fully codifiedin the United States Code).

[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401.

[6] Striking down the ACA's penalty provisions would also not affect the law's that expand the scope of health insurance coverage by increasing the benefits that both uninsured and insured Americans receive, such as requiring both Medicaid as well as all plans sold in the individual and small group markets to provide at least "essential health benefits" and requiring Part D of federal Medicare program to expand level of insurance coverage for prescription drugs (by shrinking the so-called "donut hole"). Patient Protection and Affordable Care Act, § 1101.

ACA's minimum coverage requirement[7] were removed from the law, there would still be a very large reduction in the number of uninsured Americans.[8] The Congressional Budget Office (CBO), just a few weeks after the ACA was enacted, estimated that if the ACA were upheld in its entirely, it would shrink the number of nonelderly uninsured Americans from 49 million in 2010[9] to 23 million in 2019.[10] If the law's minimum coverage requirement were excised, however, the CBO estimated that the number of uninsured would decline from 49 million in 2010 to 39 million in 2019.[11] Thus, compared to a 26 million person

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[7] The studies refer to the minimum coverage requirement as the "individual mandate."

[8] The studies differ in methodology. They also range in the magnitude of their estimates of the reduction in the size of the nation's uninsured population. What they all agree on is that—penalties or not—the Act will result in millions of uninsured Americans' gaining insurance coverage.

[9] Carmen DeNavas-Walt *et al.*, U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, 26 tbl.8 (Sept. 2011), http://www.census.gov/prod/ 2011pubs/p60-239 pdf.

[10] Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_ Individual_ Mandate_06_16.pdf.

[11] *Id.*

decrease in the uninsured population, amounting to more than a 50% reduction, CBO estimated that the ACA *even without the minimum coverage requirement* will drive down the number of uninsured Americans by 10 million people, a substantial 20% reduction.[12]

Another comprehensive analysis of this issue, published by the Lewin Group just a few days before the Court granted *certiorari* in these cases, concluded the ACA will dramatically reduce the number of uninsured, from a pre-ACA estimated level of 51.6 million, whether the minimum coverage

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[12] Two other analyses have reached similar conclusions. Professor Jonathan Gruber of the Massachusetts Institute of Technology estimated that, while preserving the ACA's minimum coverage requirement would reduce the number of uninsured by 32 million or 65%, even in the absence of the minimum coverage provision the ACA would reduce the uninsured by approximately eight million or 16%. *See* Jonathan Gruber, *Health Care Reform Without the Individual Mandate,* Center for American Progress, 2 (Feb. 2011). http://www.americanprogress.org/issues/2011/02/gruber_mandate.html. An Urban Institute study estimated that preserving the ACA's minimum coverage requirement would reduce the number of uninsured by 24 million or 48%, while removing the minimum coverage provision would cause a reduction in the uninsured population of between 8 million and 10.5 million, or 16-21%. *See* Matthew Buettgens & Caitlin Carroll, Urban Institute, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care,* 5 (Jan. 2012). http://www.urban.org/publications/ 412480.html.

requirement stays or goes.[13] The Lewin study concluded that, if the minimum coverage provision remains, the number of uninsured will drop to 20.7 million.[14] The Lewin study then calculated that, even if the minimum coverage provision were struck down, the ACA will still drive down the number of

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[13] *See* DeNavas-Walt, *supra* note 9, that estimates the number of *non-elderly* uninsured in 2010 at 49.1 million, calculates the *total* number of uninsured Americans in 2010 to be 49.9 million. This is consistent with The Lewin Group's estimate that the total number of uninsured "before the act" is 51.6 million.

[14] John F. Sheils & Randall Haught, *Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted*, 30 Health Affairs, (Nov. 2011) at 6 (citing Exhibit 2), http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0709.full.html. The analysis assumes that the ACA is fully implemented in 2011. The Lewin Group simulated the effect of the ACA using its Health Benefits Simulation Model. The model draws on "data from the [federal] Agency for Healthcare Research and Quality's Medical Expenditure's Panel Survey, data from the Kaiser Foundation's annual survey of employer health plans, and the most recent health spending and coverage date available from federal sources" to "simulate employers' decisions to offer coverage and to identify families that appear to be eligible for Medicaid and the premium subsidy programs based on their income." The model also simulates "changes in premiums and coverage resulting from reforms of the insurance markets" and "employers' decisions to either discontinue or start offering coverage, depending on the financial incentives they face under the Affordable Care Act." *See id.* at 3-4.

uninsured to 28.5 million.[15] In other words, compared to a 30.9 million person or 60% reduction in the uninsured population if the minimum coverage requirement stays in place, the ACA *even without the minimum coverage provision* will lower the number of uninsured Americans by 23.1 million, a huge 45% reduction.

It is thus beyond dispute that millions—perhaps tens of millions—of uninsured Americans will gain coverage under the ACA even if the Court strikes down the law's minimum coverage requirement. The experts' analyses vary primarily on the magnitude.

But whichever analysis turns out to be closest to the mark, there should be no doubt that, even absent a minimum coverage requirement, several key ACA provisions will combine to make major progress towards achieving the law's fundamental coverage goal. The law's (1) expansion of Medicaid eligibility to everyone below 133% of FPL, (2) offer of sliding-scale tax credits to individuals between 133% and 400% of FPL, and (3) removal of current

[15] *Id.* at 6 (citing Exhibit 2).

barriers such as the denial of insurance coverage to people with pre-existing medical conditions, ensure that result.

B. The Other Major Goals of the ACA Will Also Be Achieved, and the Law's Structure Will Stand, Regardless of Whether the Minimum Coverage Requirement Is Upheld.

The fate of the ACA's minimum coverage requirement will have no effect on most of the other provisions of the law.

Whether the requirement is upheld or not, the law's expansion of Medicaid coverage will take place.

The deletion of the minimum coverage provision will also have only a limited impact on the ACA's new mechanism for providing individuals and small employers with a substantial expansion of affordable health insurance options—the individual exchange[16] and the small employer exchange.[17]

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[16] Formally known as the American Health Benefits Exchange. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b), 124 Stat. 119, 173-74 (2010).

The Lewin Group analysis explains why the exchanges will still be able to provide large numbers of uninsured Americans with affordable coverage, despite worries about a so-called "death spiral":

> Many policy analysts fear that eliminating the individual health insurance mandate and penalty from the Affordable Care Act of 2010 would lead to a "premium spiral," in which healthy people would drop coverage, premiums would soar, and the number of people with coverage would plummet. However, there are other provisions of the law that would greatly mitigate this effect. For example, the subsidies provided in the law to help people purchase coverage through health insurance exchanges would restrain a premium spiral by absorbing much of the impact of premium increases.[18]

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[17] Formally known as the Small Employer Health Options Program (or SHOP Exchange). Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b)(1)(B).

[18] *See* John F. Sheils & Randall Haught, *supra* note 14 at 1.

The Lewin study concludes: "Neither our simulations nor the available research demonstrates that the mandate is necessarily a 'linchpin' of the Affordable Care Act . . . ."[19]

Finally, whether the minimum coverage requirement survives or not, many other ACA provisions that aim to lower health care costs—including new initiatives designed to promote preventive and primary care, as well as important reforms of the Medicare payment system[20]—also will be able to go into effect.

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[19] *See* John F. Sheils & Randall Haught, *supra* note 14 at 7.

[20] *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4106, 124 Stat. 119, 559-60 (Medicaid coverage of evidence-based preventive services with no cost-sharing); Patient Protection and Affordable Care Act, § 2713 (prevention and wellness requirements for all new group and individual plans to provide first dollar coverage for certain preventive services); Patient Protection and Affordable Care Act, Title III; Patient Protection and Affordable Care Act, §§ 4103, 4104, 4105 (Medicare payment reforms, including the beginning of Medicare annual preventive and wellness visits and the waiver of all cost-sharing for preventive services); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022 (Accountable Care Organizations).

II. THE COURT'S RULINGS ON SEVERABILITY, AS APPLIED TO THE MINIMUM COVERAGE REQUIREMENT, LEAD TO ONLY ONE CONSTITUTIONAL OUTCOME — EVEN IF THE PROVISION IS STRUCK DOWN, THE REST OF THE ACA CAN BE UPHELD.

The three primary goals of the ACA are to (1) achieve a very large reduction in the number of uninsured Americans; (2) provide individuals and small employers with a substantial expansion of health insurance options; and (3) create new mechanisms for lowering health care costs.

Even if the Court strikes down the ACA provisions related to "minimum essential coverage," the law's remaining provisions and overall architecture will allow it to make enormous strides towards achieving these three fundamental purposes.

Independent experts have confirmed that, with or without the minimum coverage provision, the ACA will reduce the number of uninsured by millions—possibly tens of millions—of individuals.

The fate of the minimum coverage provision also will not alter the capacity of the law's new

health insurance exchanges to provide individuals and small employers with a substantial increase in health insurance choices, unimpeded by current underwriting practices that deny coverage to people with pre-existing medical conditions.

Finally, this Court's decision about the minimum coverage does not impinge on a long list of other ACA programs and policies that aim to control health care costs.

Reasonable people will continue to disagree for years about whether the ACA's minimum coverage provision provision, as well as the law as a whole, represent good public policy. There simply is no reasonable basis, however, upon which the Court could conclude that striking down that single provision makes it impossible for the ACA to fulfill its major policy goals. Nor is there a basis upon which the Court could find that invalidating the ACA's minimum coverage requirement will fundamentally destroy the law's structure.

Thus, if the Court should invalidate the ACA's minimum coverage provision, the Court's

long-established tests for severability[21] require that the provision should be surgically excised and the rest of the law can stand.

Respectfully submitted,

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[21] *See, e.g., Regan v. Time, Inc.,* 468 U.S. 641, 653 (1984) (presumption in favor of severability), *Ayotte v. Planned Parenthood*, 546 U.S. 320, 329 (2006) (normal rule is partial invalidation), and *Free Enterprise Fund v. Public Company Accounting Oversight Board,* 561 U.S. __ , 130 S. Ct. 3138, 3161-3162 (2010) (portions of law that are fully operative and capable of functioning independently must be sustained unless it is evident that legislature would not have enacted).