Nos. 11-393, 11-398, and 11-400

In The
Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *ET AL.*,
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF HEALTH & HUMAN SERVICES, *ET AL.*

DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,
Petitioners,
v.
FLORIDA, *ET AL.*

FLORIDA, *ET AL.*,
Petitioners,
v.
DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*

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

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN PARTIAL SUPPORT OF CERTIORARI REVIEW

JOSEPH MILLER
JULIE SIMON MILLER
AMERICA'S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, DC 20004
(202) 778-3200

PATRICIA A. MILLETT
Counsel of Record
KEVIN R. AMER
AKIN, GUMP, STRAUSS, HAUER & FELD LLP
1333 New Hampshire Ave., N.W.
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

QUESTIONS PRESENTED

Amicus curiae, America's Health Insurance Plans, submits this brief in support of this Court's review of the following questions:

I. Whether Congress had the legislative power under Article I of the Constitution to enact the minimum individual insurance coverage mandate, 26 U.S.C. § 5000A, of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. [This is Question I in No. 11-398 and is Question III in No. 11-400.]

II. Whether, if the minimum individual insurance coverage mandate exceeds congressional power, the mandate is severable in whole or in part from the balance of the Act. [This is the only Question Presented in No. 11-393 and is Question III in No. 11-400.]

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INTEREST OF THE *AMICUS CURIAE*[1]

America's Health Insurance Plans ("AHIP") is a national trade association representing companies that provide health insurance coverage to more than 200 million Americans. Its members offer a wide range of insurance options to consumers, employers of all sizes, and governmental purchasers nationwide, providing AHIP with a unique understanding of how the Nation's health care and health insurance processes work.

[1] All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court. 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 or submission of this brief.

Health insurance plans are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA" or "Act"). AHIP therefore has a unique perspective on both the practical impact of the Act and the measures necessary to achieve compliance with its requirements. In addition, given its members' extensive experience working with affected parties throughout every sector of the health care system, AHIP is uniquely positioned to address the highly complex and interdependent nature of ACA's various provisions, including the relationship between the individual mandate and ACA's market reforms.

AHIP has previously appeared as *amicus curiae* before this Court in other cases involving issues of particular importance to the health insurance industry. *See, e.g., Health Care Service Corp. v. Pollitt*, *cert. granted*, 130 S. Ct. 396 (2009) (No. 09-38) (removability to federal court of suits under the Federal Employees Health Benefits Act), *cert. dismissed*, 130 S. Ct. 1574 (2010); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (judicial review of benefit determinations by ERISA plan administrators); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (ERISA preemption of state-law claims against health maintenance organizations) (brief filed as AAHP-HIAA).

SUMMARY OF THE ARGUMENT

The parties' certiorari briefs extensively address the legal questions surrounding the constitutionality

of ACA's individual mandate provision. AHIP therefore submits this brief to focus on two issues of utmost concern to AHIP and its members: (i) the urgency of this Court's consideration and resolution of that constitutional question this Term, and (ii) the vital importance of the Court obtaining full briefing on the severability question to ensure that, should the mandate be struck down, this Court can also comprehensively consider and resolve this Term the question of the mandate's severability from the balance of the Act and the scope of statutory invalidation.

At the root of this litigation are the individual mandate and its relationship to ACA's remaining provisions. Taken together, those provisions will fundamentally shift the way that health insurance is configured, financed, marketed, and sold, eliminating many of the risk management measures upon which insurers have relied for decades. The magnitude of those changes means that health plans must make and implement numerous critical decisions now to ensure their ability to comply as requirements come into effect in the coming years. Those comprehensive compliance efforts, however, are being conducted in a cloud of uncertainty about the durability of the monumental changes being made and the legal regime that will govern insurance plans going forward. Only a prompt and definitive ruling by this Court on the individual mandate's constitutionality can restore needed certainty to the health care market.

The widely divergent conclusions reached by the lower courts that have addressed the individual mandate's severability from the balance of the Act

have compounded the uncertainty under which health plans are laboring. The health insurance industry cannot meaningfully predict whether, if the mandate were to be struck down, its business operations should be reformulated to comply with an Act in which the mandate would be severed completely from the Act (as the Eleventh Circuit held), or partially severed (as two district courts have held), or is inseverable and the entire statute falls (as one district court has held).

Definitive resolution of these issues is a matter of vital importance to the health care industry. Since ACA's enactment, health plans have made extensive efforts to bring their businesses, products, and services into compliance with the Act's provisions as they have come into effect. But now, given the conflicting court decisions, they are confronted with four potential and very different regulatory scenarios under which they must be prepared to meet vital health insurance needs in short order: (i) under ACA; (ii) without ACA; (iii) in a world where there is no individual mandate, but the rest of ACA remains intact; and (iv) in a world in which the individual mandate is stricken from ACA along with some other, as-yet unknown subset of provisions. Each of those scenarios would present a vastly different set of obligations for health care plans. Thus, if the Court were to rule that the individual mandate is unconstitutional, the Court's fully considered analysis of the severability question this Term will be necessary to resolve the interconnectedness and workability of the remaining provisions.

As important as definitive resolution of the severability question is to the insurance industry, the

question is also complex. Severability analysis must take into account the background against which Congress legislated, which included substantial experiential evidence that decoupling the individual mandate from market reforms could destabilize the individual insurance market. As Congress was aware, each of the eight States that had enacted market reforms without a mandate experienced severe market disruptions in the form of higher premiums, lower enrollment, and a general failure to achieve the goals articulated by the state legislatures. To ensure that it has the benefit of the parties' full analysis of whether Congress would have enacted the market reforms and other provisions of ACA in the absence of an individual mandate, AHIP agrees with the United States that the Court should direct the parties to include focused briefing on the question of severability.

Accordingly, AHIP respectfully requests that the Court grant review of the single question presented in No. 11-393, the first question presented in No. 11-398, and the third question presented in No. 11-400.

ARGUMENT

I. A DEFINITIVE RULING BY THIS COURT IS URGENTLY NEEDED BECAUSE HEALTH PLANS ARE REQUIRED TO TAKE COMPLIANCE MEASURES AMID DEEP UNCERTAINTY ABOUT THE CONSTITUTIONALITY OF THE INDIVIDUAL MANDATE

ACA legislated a sweeping transformation of the health care market, requiring fundamental changes in the way health insurance is configured, financed,

marketed, and sold. The continuing uncertainty over which, if any, of the statute's requirements will ultimately be implemented is heavily straining the good-faith efforts of the member companies to prepare for compliance with ACA and its comprehensive overhaul of the insurance industry. As more and more resources and planning have been poured into rapidly cascading obligations, the legal landscape has grown increasingly unstable and unpredictable. A definitive resolution of the individual mandate's constitutionality thus is crucial to the ability of health plans to timely bring their operations and insurance products into compliance.

Beyond that, the health care market represents over 17% of the national economy. Stability in the governing legal regime and certainty as to whether ACA remains effective in whole or in part going forward thus is critical to the Nation's economic health and is urgently needed by not just the member companies, but also their individual customers, business clients, and state government regulators.

ACA provides for its manifold requirements to be implemented in accelerated stages. The initial provisions became effective within the first six months of enactment and include, *inter alia*, a requirement that health plans provide coverage for dependent adult children until age 26, 42 U.S.C. § 300gg–14(a), and a prohibition on the imposition of lifetime dollar limits for essential health benefits, *id.* § 300gg–11(a)(1)(A).

Additional provisions took effect in 2011, including a requirement that health plans provide rebates to consumers when the plans' medical loss

ratios fall below specified thresholds, 42 U.S.C. § 300gg–18(b), and the establishment of a federal and state review process for unreasonable premium increases, *id.* § 300gg–94(a)(1). Compliance with these requirements has necessitated substantial changes in health plans' existing business operations and involves significant ongoing costs.

While bringing themselves into compliance with those provisions already in effect, member companies also have had to prepare for the seismic changes that will occur with the ACA provisions that go into effect on January 1, 2014 and beyond. Among the most significant of those requirements are market reforms that will transform the way that insurance contracts are written, priced and sold, especially in the individual and small group markets. Those changes include "guaranteed issue" and "guaranteed renewability" provisions requiring insurers to issue and renew health care coverage for any individual who applies, 42 U.S.C. §§ 300gg–1, 300gg–2; a "community rating" system that prohibits health plans from adjusting premium prices based on an applicant's health status, and that sharply limits the degree to which premium rates can be varied on the basis of age and tobacco use, *id.* § 300gg(a)(1)(A); and a prohibition on exclusions from coverage on the basis of an applicant's preexisting conditions, *id.* § 300gg–3.

Collectively, those requirements will fundamentally change the existing health insurance market. They will also bring about a dramatic shift in the way health insurers account for and spread risk in the individual insurance market. Under the current system, insurers assess and control costs

through the use of underwriting mechanisms that take into account the risk factors and projected treatment needs of individual applicants. Those practices enable health plans to offer lower-priced premiums to younger and healthier individuals, which attract such individuals into the health insurance market and, in turn, create a broader coverage pool across which risk can be spread. *See* Part II.B.1, *infra*. By prohibiting those practices as of January 1, 2014, ACA is requiring health plans to undertake a wholesale and fundamental overhaul of their methods for offering insurance. The sheer magnitude of those changes is requiring an enormous degree of advance planning and resource commitment by health plans to ensure compliance by the statutory effective date.

What is more, the changes that member companies must make to their business operations are fundamental and far-reaching, making it virtually impossible for them to try to unscramble the egg after the fact should a final resolution of the constitutional question not be issued until 2013 or beyond. A scenario in which health plans must restructure every level of their business practices to achieve compliance and then, on the eve of implementation, throw the entire process into reverse, would impose crushing burdens on the insurance industry that would affect every level of the health care system nationwide.

Other health care stakeholders face similar challenges. Employers, for example, will be required by January 1, 2014 to meet a broad range of substantive and administrative obligations, including offering minimum essential coverage to all full-time

employees and their dependents, 26 U.S.C. § 4980H(a); automatically enrolling full-time employees in coverage, 29 U.S.C. § 218a; and providing detailed reports to the Department of Health and Human Services, 26 U.S.C. § 6056.

Within that same timeframe, the States must undertake the massive administrative task of establishing Health Insurance Exchanges to facilitate the purchase of insurance in both the individual and small group markets. 42 U.S.C. § 18031. With the implementation date just over two years away, these stakeholders must make critical budgetary, investment, and employment decisions now and in the near future to have any realistic hope of achieving compliance.

Unfortunately, those decisions are being made within an environment of significant uncertainty. Additionally, given the possibility that this Court might hold the individual mandate unconstitutional and inseverable, in whole or in part, the uncertainty extends to the future application and workability of the remaining interrelated provisions of ACA.

For the member companies, the effect of this ongoing uncertainty is particularly manifest in the action (or inaction) of their state governmental regulators. As of September 2011, fewer than half the States had taken steps to create a Health Insurance Exchange, *see* Henry J. Kaiser Family Foundation, Health Reform Source, http://healthreform.kff.org/the-states.aspx. For at least some States, that inaction is partly attributable to uncertainty over the outcome of this litigation and other challenges to the ACA. *See, e.g.*, Grant Schulte,

Heineman: Nebraska will wait for health care ruling, Associated Press, Oct. 3, 2011 ("Nebraska will not enact a health care exchange mandated by the federal health care overhaul until officials know for sure whether the measure is constitutional."); N.M. Senate Executive Message No. 53 (Apr. 8, 2011) (vetoing bill to implement exchange structure on ground that legislation was "premature" and noting that "challenges to specific components of the federal law have been brought in several federal and district courts and are ongoing").

All of this paralyzing uncertainty—among health plans, employers, government regulators, and others—underscores the vital need for a prompt and conclusive resolution of the constitutional challenge to the individual mandate. AHIP therefore respectfully urges the Court to grant review of that issue and to resolve it this Term.

II. THE COURT SHOULD OBTAIN BRIEFING ON AND, IF NECESSARY, CONCLUSIVELY RESOLVE THE QUESTION OF SEVERABILITY

ACA is a 2,700-page statute consisting of hundreds of interrelated requirements, making the question of severability one of enormous importance to the insurance industry. Any decision invalidating the individual mandate could have profound implications for the workability of many other requirements and for the member companies' practical ability to implement the law's obligations. In particular, the historic experience under State laws documents that the economic viability and sustainability of the market reforms—*e.g.*, the

guaranteed issue, community rating requirements, and preexisting condition provisions—can be materially affected by the existence (or not) of an individual mandate. Having witnessed what occurred in States that had enacted market reforms without an individual mandate, Congress legislated against a backdrop of powerful proof that decoupling the mandate from those other requirements would destabilize the insurance market throughout the Nation.

Accordingly, AHIP joins the United States' request (Consol. Response Br. 10-11) that, if the Court grants review on the underlying constitutional question, the Court also order supplemental briefing devoted to analysis of the severability question. That will ensure that, if the Court were to invalidate the mandate, the Court could in this same case conclusively and timely resolve the impact of that invalidation on the balance of ACA's provisions, rather than leave companies in a profound state of confusion and instability during the critically important months and years ahead.

A. The Severability Question Has Produced Sharply Different Court Rulings

Four courts have analyzed the severability question and have reached four different answers. Each of those courts determined that the severability analysis is governed by this Court's decision in *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987), but they divided sharply on the proper application of that test in ACA's unique context. *See generally* States' Petition for Certiorari at 29-33 (No. 11-400) (discussing the conflicting rulings).

The district court in *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010), found it "virtually impossible within the present record to determine whether Congress would have passed this bill" in the absence of the mandate, *id.* at 789, and accordingly severed only those provisions that "make specific reference to" the mandate, *id.* at 790.

Reaching a somewhat different conclusion, the court in *Goudy-Bachman v. United States Department of Health & Human Services*, No. 1:10-CV-763, — F. Supp. 2d —, 2011 WL 4072875 (M.D. Pa. Sept. 13, 2011), recently ruled that the guaranteed issue and preexisting condition provisions could not be severed from the individual mandate, but that all other provisions could remain in place, *id.* at *21.

In contrast, the district court in this case held that the individual mandate is "inextricably bound together in purpose" with the remaining provisions, and that the invalidation of the mandate therefore required striking down ACA in its entirety. U.S. Pet. App. 363a.

The Eleventh Circuit, however, reversed that holding, concluding that the strong "presumption of severability" dictated that all provisions of ACA other than the mandate should remain intact. U.S. Pet. App. 184a. Despite the United States' concession that the guaranteed issue and community rating provisions (including the ban on preexisting condition exclusions) would have to be severed with the mandate, the court of appeals determined that those provisions and the balance of the statute could be "'fully operative as a law,'" and on that basis ruled

that the mandate was fully severable. U.S. Pet. App. 174a. The court, however, did not address the further question, required by *Alaska Airlines*, of whether a mandate-free ACA would "function in a manner consistent with * * * the original legislative bargain," 480 U.S. at 685 (emphasis omitted), or whether Congress would "have been willing * * * to enact" the law without the mandate, *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (citation omitted).

In addition, the Eleventh Circuit relied on what it viewed as a "paucity" of modern precedents in which this Court determined that a constitutionally invalid provision of a law could not be severed from *any* portion of the law. U.S. Pet. App. 173a. That empirical observation, however, is not only mistaken, but also irrelevant because it says nothing about the proper outcome of this Court's severability analysis in any given case and, in particular, as applied to a statute as complex, interconnected, and painstakingly legislated as ACA.[2]

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[2] The Eleventh Circuit's observation overlooked two relatively recent decisions in which this Court held that a constitutionally invalid provision of a law could not be completely severed. In *Randall v. Sorrell*, 548 U.S. 230 (2006), this Court held that an unconstitutional Vermont campaign finance statute was not severable from other constitutionally valid contribution limits because severance would have required the Court "to write words into the statute," *id.* at 262. And in *United States v. Booker*, 543 U.S. 220 (2005), the Court held that the unconstitutional scheme of enhanced sentences under the federal Sentencing Guidelines could not be severed from the provisions of the statute that made the Guidelines mandatory and that called for *de novo* appellate review of departures by

That widespread divergence in the outcome of the courts' severability analyses, by itself, underscores the complexity of the severability question under ACA and thus the particularized need for this Court to order briefing devoted to the question.[3] The necessity of such cautious deliberation and focused briefing is amplified still further by the position of the United States (Consol. Response Br. 31) that the mandate is not entirely severable from ACA's market reforms (*i.e.*, the guaranteed issue and community rating provisions), and Congress's own finding that the mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," 42 U.S.C. § 18091(a)(2)(I).

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district courts, because both of those provisions necessarily depended on the existence of the Guidelines enhancement scheme, *id.* at 259-260.

[3] To be sure, this Court does not commonly consider conflicting district court decisions in its certiorari calculus. But in this case, the severability issue is automatically embedded in the constitutional question on which the circuits are in plain conflict. The conflicting lower courts decisions thus are relevant to the subsidiary question of whether the complexity of the severability analysis in this case merits focalized briefing.

B. Severability Analysis Must Be Undertaken Against the Backdrop, Well Known to Congress, of Prior, Failed Legislative Efforts to Enforce Market Reforms Without an Individual Mandate

1. ACA's Market Reforms Require an Individual Mandate to Prevent Economically Unviable Adverse Selection and Cost-Shifting

To determine whether a law can "function in a manner consistent with * * * the original legislative bargain," *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted), courts must consider the experiential backdrop against which Congress legislated. Here, that history of failed legislative efforts to implement market reforms without an adequate individual mandate should substantially inform the question whether Congress intended the guaranteed issue, preexisting condition, and community ratings provisions, along with the Act's other health insurance market reforms, to continue to operate if the individual mandate were invalidated.

By way of background, health insurance is generally sold in three markets: non-group (also known as the individual market), small group, and large group. Approximately 14 million Americans purchase health insurance on the individual market. Henry J. Kaiser Family Foundation, *The Uninsured, A Primer: Key Facts About Americans Without Health Insurance*, 31 (Dec. 2010).

Under the current system, the individual market is particularly susceptible to the economic phenomenon of "adverse selection" and the closely-

related problem of cost-shifting. *See* Kathryn Linehan, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 4 (June 4, 2009). Adverse selection occurs because individuals with higher anticipated health care costs—generally less healthy or older individuals—are more likely than healthy, younger people to enter an insurance market. Members of the latter group, for whom the risk of significant health care needs and expenses is more remote, are more likely as a consequence to wait to purchase coverage until they suffer from an illness or expect to need medical treatment.

Such adverse selection increases costs for all participants in the insurance pool. Because insurers generally set premiums according to the expected medical costs of those participating in a coverage pool, premiums increase for all participants when individuals with higher expected health care costs constitute a majority of the pool. Linda Blumberg & John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* 2 (Jan. 2008). The result is that healthy people become even less inclined to purchase coverage. Indeed, up to 20% of uninsured individuals have the financial means to obtain coverage but forgo it, relying instead on emergency care when they need medical treatment. Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report* 3-4 (Apr. 2009). Those costs, in turn, are shifted to the insured in the form of higher premiums. Such cost-shifting creates a "hidden tax" ranging from two to ten percent of private premiums. *Id.* at 4.

To combat those problems of adverse selection and cost-shifting, many States allow for premium

rates in the individual market to be set through the actuarial mechanism of underwriting. That process allows insurers to manage costs by assessing each applicant's health and making an actuarial judgment about the amount and types of medical services he or she is likely to need. Based on that determination, the insurer might exclude coverage for an applicant's known preexisting conditions, impose a waiting period, adjust the applicant's premium, or deny coverage altogether. *See* Linehan, *supra*, at 4-6. Those underwriting practices allow insurers to offer lower premiums to younger, healthier people, thereby reducing the incentives for such individuals to postpone obtaining coverage until they need medical treatment. *Ibid.*

ACA's market reform provisions eliminate many of those risk management tools. For example, the guaranteed issue and guaranteed renewability provisions require insurers to issue and renew health care coverage for all applicants and enrollees who are able to pay the premium. 42 U.S.C. §§ 300gg–1, 300gg–2. The community rating system prohibits insurers from pricing policies according to an applicant's health status. *Id.* § 300gg. And insurers will no longer be permitted to make exclusions on the basis of preexisting conditions, *id.* § 300gg–3; to base coverage eligibility on an applicant's health status, medical condition, or related factors, *id.* §§ 300gg–1, 300gg–4; or to establish a waiting period of more than 90 days, *id.* § 300gg–7.

The effect of those reforms is to alter fundamentally the insurance business and, in particular, the mechanisms employed for spreading risk and controlling premium prices. Without more,

prohibiting reliance on the traditional tools of underwriting would make participation in the individual insurance market more attractive for individuals with higher expected health care costs, thereby increasing the pressure on premiums, which in turn renders the insurance market less attractive for those with lower expected costs. That deep imbalance in the pool of insurance customers can create a "marketwide adverse-selection death spiral" in the individual insurance market.[4]

Congress enacted the individual mandate as a counterweight to those economically crippling adverse-selection and cost-shifting problems. The mandate ensures that the individual market includes larger, more representative participant pools across which insurers can viably spread risk. Were the market reforms to be implemented in the absence of the mandate, healthy individuals would have every incentive to take a "wait-and-see" approach to participation in the insurance market. Indeed, since health plans could neither exclude applicants based on preexisting conditions nor increase premiums based on health status, it would be an entirely rational economic decision for healthy and low-medical-risk individuals to forgo obtaining insurance coverage until their medical circumstances changed. At the same time, the most unhealthy or medically risky individuals would have every incentive to flood into the market. As a result, the risk pool would skew toward individuals with higher health care

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[4] Alan C. Monheit, *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in N.J.*, 23 Health Affairs 167, 169 (2004).

costs. *See* Uwe E. Reinhardt, *The Case for Mandating Health Insurance*, N.Y. Times, Oct. 23, 2009.

Congress, moreover, was fully aware of the adverse implications of adopting market reforms unaccompanied by an individual mandate. The Congressional Budget Office advised that, if the market reforms were to be implemented in the absence of the individual mandate, increased adverse selection in the individual market would increase premiums for new policies by approximately 15 to 20 percent. *See* Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010). Similarly, while ACA is projected to expand coverage to 32 million previously uninsured individuals, estimates are that only 8 million of the currently uninsured would obtain coverage if the statute contained no mandate. *See* Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, New Eng. J. Med. (Mar. 10, 2011). Empirical evidence thus strongly indicates that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market and, over time, would substantially reduce access to affordable coverage.

2. Congress Was Aware That States' Efforts to Implement Similar Market Reforms Without an Individual Mandate Had Largely Failed

Congress was not writing on a clean slate with ACA. Instead, Congress knew that, when individual

States had attempted to undertake similar insurance market reforms unaccompanied by an individual mandate, the result was substantial economic destabilization and spiraling health care costs. That background must be factored into any severability determination.

In the 1990s, eight States enacted market reforms, including guaranteed issue and community ratings requirements, without an individual mandate. The result in each State was a general destabilization of individual markets, increases in premiums, and declines in enrollment.

For example, Maine enacted guaranteed issue and modified community rating reforms for its individual market in 1993, allowing limited price variation only for age, occupation or industry, and geographic location. *See* B. Gorman, *et al.*, *Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance* 5 (May 30, 2007). According to the Maine Bureau of Insurance's report analyzing the ensuing problems in the individual insurance market, the "market for individual HMO coverage" as of January 2001 "appear[ed] to be in a death spiral." Maine Bureau of Insurance, *White Paper*: *Maine's Individual Health Insurance Market* 4 (Jan. 22, 2001). Premiums for indemnity coverage increased dramatically, and coverage rates plummeted as a result. *Ibid.* State regulators attributed those trends in part to the modified community rating requirement, which "result[ed] in the risk pool having a higher average age and therefore higher costs." *Id.* at 10.

New Jersey's reform efforts tell a similar story. In 1993, New Jersey implemented the Individual Health Coverage Program, which required guaranteed issue, guaranteed renewal, and pure community rating of individual health policies. *See* Alan C. Monheit, *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in N.J.*, 23 Health Affairs 167, 167 (2004). One study examining the impact of New Jersey's reforms found that, as of 2004, the individual market was "heading for collapse." *Id.* at 168. More than half of the enrollees had left the individual market between 1995 and 2001, and premiums had increased two or three times above their early levels. *Ibid.*

Faced with similar market disruptions after it enacted reforms, Washington succeeded in reversing some of the adverse trends by returning to a more carrier-friendly system. In 1993, Washington enacted comprehensive insurance market reforms, including a guaranteed issue provision, a phased-in community rating requirement, and limits on pre-existing condition exclusions. *See* Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Politics, Policy & Law 133, 136-137 (2000). In the ensuing three years, premiums in the individual market rose by as much as 78 percent. *See* Peter Suderman, *The Lesson of State Health-Care Reforms*, Wall St. J., Oct. 15, 2009. Over the same period, enrollment in Washington's individual market fell by 25 percent. *Ibid.*

As a result, the Washington legislature repealed the market reforms, and subsequently enacted legislation to encourage carriers to reenter

Washington's individual market. *See* Robert Wood Johnson Foundation, *Issue Brief: Recognizing Destabilization in the Individual Health Insurance Market* 4 (July 2010). Today, there are five insurance companies participating in the individual market, compared to the two that remained before the 1993 reforms were repealed. Roger Stark, *Overview of the Individual Health Insurance Market in Washington State* (Jan. 2011).[5]

All of that evidence underscores the very real likelihood that implementation of ACA's market reforms in the absence of the individual mandate would confound the legislation's central goal of increasing the availability of affordable health care coverage. Congress, moreover, enacted the individual mandate in conjunction with its market reforms because it was acutely aware of the widespread difficulties that had arisen from the efforts of States to implement similar insurance market reforms without the economic counterbalance of an individual mandate. *See* 42 U.S.C. § 18091(a)(2)(I) ("[I]f there were no [mandate] requirement, many individuals would wait to purchase health insurance until they

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[5] Other States that enacted market reforms in the 1990s experienced similar destabilization. *See* Kirk, *supra,* at 158, 167-168 (Kentucky and Massachusetts); Alexander K. Feldvebel & David Sky, *A Regulator's Perspective on Other States' Experiences*, 25 J. Health Politics, Policy & Law 197, 198-199 (2000) (New Hampshire); Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Policy & Law 71 (2000) (New York); Elliott K. Wicks, *The Individual Market in Vermont: Problems and Possible Solutions* (Dec. 2006) (prepared for Vermont Department of Banking, Insurance, Securities and Health Care Administration).

needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.").

In determining whether Congress would "have been willing * * * to enact," *Pollock*, 158 U.S. at 636, ACA without an individual mandate, the Eleventh Circuit's severability analysis failed to grapple with the implications of that experiential history and the proven, substantial risk of profound economic displacement and a "market-wide antiselection spiral."[6] Directing the parties to brief the severability issue, however, would give the Court the benefit of comprehensive analysis and consideration of all the pertinent factors in determining whether or not Congress would have enacted ACA's market reforms in the absence of the individual mandate provision.

C. Severability Is a Question of Surpassing Importance and Its Prompt Resolution Is of Paramount Importance to the Health Care Industry

Should this Court determine that the individual mandate exceeds congressional power (a question on which AHIP takes no position), then the instability and uncertainty surrounding the question of the mandate's severability and the scope of constitutional invalidation would be every bit as economically

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[6] David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16 J. Ins. Reg. 399, 401 (Summer 1998).

destabilizing and suffocating for business planning as the current uncertainty surrounding the legality of the mandate itself. The difference between developing measures to implement a mandate-less ACA (i) with market reforms intact, and (ii) without some or many of those market reforms is night and day.

AHIP's request that this Court order briefing focused on the severability question thus is an honest reflection of the imperative for the insurance industry that severability be resolved now, rather than remanded or even postponed until the next Term. Any delay would deprive businesses and consumers of desperately needed certainty about the profound changes in health care adopted by ACA until, in all likelihood, less than a year before the market reforms' effective date on January 1, 2014. *See* U.S. Consolidated Response Br. 10-11 (noting the "importance of severability issues in this case" and urging review). AHIP accordingly respectfully requests that this Court ensure that any resolution of the constitutional challenge to the individual mandate this Term offer a viable measure of certainty and closure to these debates, rather than perpetuate business instability and confusion for both member companies and their customers.

CONCLUSION

For the foregoing reasons, this Court should grant review of the single question presented in No. 11-393, the first question presented in No. 11-398, and the third question presented in No. 11-400.

Respectfully submitted.

Joseph Miller
Julie Simon Miller
AMERICA'S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, DC 20004
(202) 778-3200

Patricia A. Millett
Counsel of Record
Kevin R. Amer
AKIN, GUMP, STRAUSS, HAUER & FELD LLP
1333 New Hampshire Avenue, N.W.
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

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