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, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

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

REPLY BRIEF FOR THE RESPONDENTS
(Severability)

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

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Because the minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act)[1] is a constitu-

[1] Amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

tional exercise of Congress's powers, this Court need not consider any issue of severability in this case. If the Court does have occasion to address severability, however, it should decline to invalidate as inseverable the many provisions of the Act that do not apply to petitioners, much less to take the extraordinary step of nullifying the entire statute. If the Court does address severability, it should find only the guaranteed-issue and community-rating provisions inseverable and allow the rest of the Act to stand.

I. THE SEVERABILITY OF MOST PROVISIONS OF THE ACT MAY NOT BE CONSIDERED IN THIS CASE

The government demonstrated in its opening brief (at 14-25) that, with the limited exception of state petitioners' meritless inseverability contention regarding the Act's expansion of Medicaid eligibility, petitioners' severability arguments are not properly presented in this case. In addition to statutory bars to review relevant to many parts of the Act and general limitations on the scope of equitable relief, see *id.* at 14-16 & nn.8 & 9, 23, courts have "no business" addressing the severability of provisions that "burden only" parties absent from the litigation. *Printz* v. *United States*, 521 U.S. 898, 935 (1997) (declining "to speculate regarding the rights and obligations of parties not before the Court").

A. The Court-appointed amicus curiae contends that the Court may address the purported inseverability of the remaining provisions of the Act that do not apply to petitioners (including guaranteed issue and community rating) because severability involves "the proper scope of equitable relief for the constitutional violation that the plaintiffs have already established." Br. 20. Amicus's premise that severability is a form of "relief" is correct, but amicus draws

the wrong conclusion from that premise.[2] The Court has "insisted * * * that 'a plaintiff must demonstrate standing separately for each form of relief sought.'" *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 352 (2006) (quoting *Friends of the Earth, Inc.* v. *Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000)). Indeed, it was the *dissenters* in *City of Los Angeles* v. *Lyons*, 461 U.S. 95 (1983), who submitted that, once a plaintiff's standing to assert a claim is established, "his requests for particular forms of relief [do not] raise any additional issues concerning his standing." *Id.* at 114 (Marshall, J., dissenting). The majority, however, squarely rejected that position, holding that a plaintiff who unquestionably had standing to assert a constitutional violation and seek damages did not have standing to secure an injunction. *Id.* at 109.

Amicus is correct that a court "must examine how various remedies might affect the public interest" when exercising its equitable powers. Br. 20. The public interest requirement, however, does not expand the courts' equitable authority; it instead limits that authority. Courts must consider whether "the public interest would * * * be *disserved*" by an equitable remedy that might otherwise be warranted. *Monsanto Co.* v. *Geertson Seed Farms*, 130 S. Ct. 2743, 2756 (2010) (emphasis added) (citation omitted); see, *e.g.*, *Winter* v. *NRDC*, 555 U.S. 7, 24, 26, 32-33 (2008). The obligation to consider the public interest when crafting an equitable remedy does not justify expanding relief beyond what is necessary to redress the injury to the plaintiff actually before the court. Cf. *United States* v. *National Treasury Employees Union*, 513 U.S. 454, 478

[2] Amicus does not mention the statutes that would preclude invalidation of a number of provisions, such as the Act's tax and Medicare provisions, on inseverability or any other grounds. Gov't Br. 14-15 nn.8 & 9.

(1995). In *Lyons*, for example, the Court recognized that there was a public interest in stopping "certain practices of law enforcement officers [that] are unconstitutional," but it nonetheless held that a "federal court * * * is not the proper forum to press such claims unless the requirements for entry and the prerequisites for injunctive relief are satisfied." 461 U.S. at 111-112.

B. While amicus maintains that the Court has authority to invalidate as inseverable provisions of the Act that do not apply to petitioners, amicus acknowledges that "the Court is not *required* to decide the severability issues that petitioners raise." Br. 22. Amicus also agrees that any severability questions left undecided by the Court could be addressed in subsequent litigation by parties with an actual stake in their continuing validity. *Id.* at 23 n.5; see Gov't Br. 21-22.[3] Amicus nonetheless maintains that the Court should address petitioners' inseverability claims in this case in the event it invalidates the minimum coverage provision. Br. 23.

Amicus observes that declining to address petitioners' inseverability arguments in this case would delay resolution of the status of the remainder of the Act. Br. 23. But any period of uncertainty would presumably be quite brief, and amicus does not address the countervailing costs associated with premature adjudication. This Court has emphasized the importance of having legal questions "resolved * * * in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Massachu-*

[3] In a hypothetical situation in which Congress "included an express inseverability clause" in a statute (Court-Appointed Amicus Br. 21 n.4), such follow-on litigation would be quickly completed, or might not even be necessary in the first place, because the Executive could choose not to enforce the remaining provisions of such a statute in light of Congress's express instructions on the question.

setts v. *EPA*, 549 U.S. 497, 517 (2007) (quoting *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 581 (1992) (Kennedy, J., concurring in part and concurring in the judgment)). The Court "depends for illumination" on "concrete adverseness" to "sharpen[] the presentation of issues." *Ibid.* (quoting *Baker* v. *Carr*, 369 U.S. 186, 204 (1962)). Such concrete adverseness is wholly lacking here with respect to nearly the entire Act. Gov't Br. 18-19. Petitioners have not even offered a reason why they are so vigorously seeking invalidation of the myriad provisions of the Act that do not apply to them (or that *benefit* their members or citizens, see *id.* at 19), much less established any cognizable harm flowing from those provisions.[4] The absence of a properly adversarial presentation more than offsets any momentary benefit that would be gained by deciding severability issues in the wholly abstract context of this case.[5]

II. IF THE COURT REACHES THE QUESTION, IT SHOULD HOLD THAT THE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION EXCEPT FOR THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS THAT TAKE EFFECT IN 2014

If the Court does address severability questions in this case, it should reject petitioners' contention that the entire Act must be invalidated, as the Court-appointed amicus

[4] Any attempt by petitioners to establish injury from other provisions of the Act for the first time in this Court would come too late. Cf. *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 495 n.* (2009).

[5] While state petitioners do have a concrete interest in the expansion of Medicaid eligibility, the Court is not required to address that issue if it agrees with individual petitioners that the minimum coverage provision is unconstitutional. Gov't Br. 24-25. In any event, the claim that the expansion is inseverable from the minimum coverage provision lacks merit. *Id.* at 34-35; Court-Appointed Amicus Br. 48-50; California Amicus Br. 16-17; see also Gov't Medicaid Br. 52-53.

persuasively demonstrates. Br. 48-52. The Court should, however, reject amicus's contention that the Act's guaranteed-issue and community-rating provisions are severable from the minimum coverage provision. *Id.* at 24-47.

A. As the Court-appointed amicus explains, "[i]t is a striking use of judicial power for a federal court to declare that perfectly valid provisions of a law passed by Congress are void and unenforceable." Br. 8. "Before taking such action, therefore, the Court should have clear evidence that Congress, faced with the unconstitutionality of one part of a statute, would have wanted some or all of the remaining parts struck down as well." *Ibid.* As the government demonstrated in its opening brief (at 28-44), petitioners have failed to satisfy this standard with respect to virtually the entire Act (much of which is already in effect). "Compared to the guaranteed issue and community rating requirements, the remainder of the Act has far less connection to the minimum coverage provision—in many instances, none whatsoever." Court-Appointed Amicus Br. 48. Indeed, "petitioners have made little attempt to demonstrate that the Act in general, or specific provisions in particular, cannot function in an effective manner without the minimum coverage provision alone." *Ibid.*

Many of the Act's provisions, like the minimum coverage provision, are intended to expand access to affordable health care. That common purpose is a reason to find the provisions severable, not to invalidate them. See *United States* v. *Booker*, 543 U.S. 220, 258-259 (2005) (Courts should preserve provisions that are "consistent with Congress' basic objectives in enacting the statute."); *New York* v. *United States*, 505 U.S. 144, 186 (1992) ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to

achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated."); see also *Leavitt* v. *Jane L.*, 518 U.S. 137, 143-144 (1996) (per curiam) ("The relevant question * * * is not whether the legislature would prefer (A+B) to B, because by reason of the invalidation of A that choice is no longer available. The relevant question is whether the legislature would prefer not to have B if it could not have A as well."). Among the provisions that are severable for this basic reason are the expansion of Medicaid eligibility, see note 5, *supra*; the employer responsibility provision and small-business tax credits, Court-Appointed Amicus Br. 50-51; Gov't Br. 35; the health-insurance exchanges, Gov't Br. 36-37; California Amicus Br. 14-16; the premium tax credits, Gov't Br. 36; and the Act's insurance reforms beyond guaranteed issue and community rating, *id.* at 38-40.

In addition, there is no basis for invalidating as inseverable provisions of the Act "that have no apparent connection at all, let alone an inextricably close connection, to the minimum coverage provision." Court-Appointed Amicus Br. 51-52; see Gov't Br. 30-31. Congress surely would not have intended such stand-alone provisions, passed as part of a large omnibus bill, to fall in the event the minimum coverage provision were invalidated.[6]

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[6] See California Amicus Br. 9-10 & n.3 (noting that many parts of the Act "were originally introduced as entirely separate bills that did not even conceive of the minimum coverage provision"); National Indian Health Bd. Amicus Br. 4-5 (Affordable Care Act's amendments to the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, "were developed over a period of ten years in a separate legislative process from the ACA" and "are not connected to or dependent on the application of minimum coverage"); American Pub. Health Ass'n Amicus Br. 19-24 (discussing "stand-alone" measures in the Act intended to "guide public health research and infrastructure development"); AARP Amicus Br. 15-24 (describing series of Medicare reforms in the Act,

B. The Court-appointed amicus is correct that Congress's decision to extend to the individual insurance market guaranteed-issue and community-rating protections like those that previously applied only in the group markets, see Gov't Minimum Coverage Br. 5-6, 28-29, is a central component of the Act's effort to remove barriers to access and make coverage more affordable. Br. 25-28; American Ass'n of People with Disabilities Minimum Coverage Amicus Br. 26-32. Contrary to amicus's submission, however, there is clear evidence that Congress would *not* have wanted those provisions to stand without the minimum coverage provision.

Amicus is also correct that the provisions were "meant to work together." Br. 25. In fact, Congress viewed the minimum coverage provision as essential to the success of guaranteed issue and community rating, and it understood that, without a minimum coverage provision, those measures would increase insurance costs and reduce access to coverage—the opposite of what Congress intended in enacting the Affordable Care Act. Those most familiar with the workings of the insurance industry have informed the Court that they hold the same view. See America's Health Ins. Plans (AHIP) Amicus Br. 4, 11 (health insurers with "extensive, first-hand, and on-the-ground experience with health insurance markets" explain that guaranteed issue and community rating without minimum coverage provision

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including elimination of the Medicare prescription drug benefit "donut hole" that was the "culmination of extensive efforts by Congress" over a number of years); Joella Swann Amicus Br. 15 (noting that the Act includes "an entirely discrete" provision amending a provision of the Black Lung Benefits Act, 30 U.S.C. 901 *et seq.*, governing eligibility for survivor benefits, see Gov't Br. 31); 11-398 Pet. App. 174a (discussing provision in the Act "establishing reasonable break times for nursing mothers").

would "deliver[] the opposite of what Congress intended by ensuring that there would not be 'affordable care' under the Affordable Care Act"); American Acad. of Actuaries Amicus Br. 3-4 ("In the Academy's view, a decision invalidating the individual-mandate provision, while leaving in place the 'guaranteed-issue' and 'community-rating' provisions, would have adverse effects on the affordability and accessibility of health insurance in the United States.") (footnote omitted).

1. Congress's findings expressly make the connection between the minimum coverage provision on the one hand and guaranteed issue and community rating on the other. Congress found that, without a minimum coverage provision, "many individuals" in a guaranteed-issue/community-rating market "would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I);[7] see Gov't Br. 45 n.21. Congress further found that the minimum coverage provision would "minimize" such adverse selection and was therefore "*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.A. 18091(a)(2)(I) (emphasis added). Given that Congress viewed the minimum coverage provision as "essential" to the success of a reformed individual insurance market with guaranteed issue and community rating, it would not have wanted those provisions to stand without that "essential" supporting component. Gov't Br. 45-47.

The Court-appointed amicus describes this inseverability argument based on Congress's findings as "perfectly reasonable." Br. 31. Amicus observes, however, that "the

[7] Unless otherwise noted, all citations hereinafter to the United States Code refer to Supp. IV 2010, and all citations to the United States Code Annotated refer to Supp. 2011.

findings were not addressed to the issue of severability" but instead were included "to show the close relationship between the minimum coverage provision and interstate commerce," and thereby to underscore the constitutionality of the provision. *Id.* at 31-32. Amicus is correct that Congress made these findings in order explicitly to demonstrate the constitutionality of the minimum coverage provision. Amicus is also correct to note (*id.* at 32-33) that the question of Article I power is not the same as the question of severability. A provision may be a valid means to make a broader regulation of interstate commerce effective even if the broader scheme without the provision would not defeat Congress's overall goals.

In this case, however, it is evident that Congress's finding on the "essential" connection between the provisions, 42 U.S.C.A. 18091(a)(2)(I), "though directed at the antecedent constitutional question, can also be read to answer the severability question." Court-Appointed Amicus Br. 33. This is so because the finding rested on evidence showing that, unless paired with a minimum coverage provision, the guaranteed-issue and community-rating provisions would actually undercut Congress's goals because they would cause premiums to rise and coverage to decline. See pp. 10-18, *infra*. As both a logical and practical matter, therefore, Congress's finding on the "essential" role of the minimum coverage provision in effectuating the guaranteed-issue and community-rating provisions effectively serves as an inseverability clause—albeit one limited to only those two provisions, given that Congress did not find the minimum coverage provision to be "essential" to any other part of the Act.

2. Congress's express findings on the essential nature of the minimum coverage provision to guaranteed issue and community rating were based on strong empirical evidence

in the legislative record. During proceedings leading to enactment of the Affordable Care Act, Congress was warned that it should not adopt guaranteed-issue and community-rating insurance reforms unless it paired them with a minimum coverage provision to combat adverse selection. In particular, Uwe E. Reinhardt, one of the country's foremost health-care economists, told Congress that "[i]t is well known that community-rating and guaranteed issue coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." Uwe E. Reinhardt, Princeton Univ., *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 11 (Mar. 17, 2009); see pp. 14-16, *infra* (discussing testimony of National Association of Insurance Commissioners).[8]

a. Amicus does not dispute that guaranteed issue and community rating, in isolation from the other reforms in the Act, would seriously exacerbate the problem of adverse selection in the individual insurance market. Indeed, amicus acknowledges that the Congressional Budget Office (CBO)

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[8] See also, *e.g.*, *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways & Means*, 111th Cong., 1st Sess. 9 (2009) (*House Hearing*) (statement of Uwe E. Reinhardt) ("[I]f you put those two mandates on the [insurance] industry," *i.e.*, guaranteed issue and community rating, "you must also mandate the individual to be insured or the market will blow up, as it has in New Jersey" and other States.); *id.* at 117 (statement of Phil Caper, M.D., and Joe Lendvai) ("[W]hen Maine enacted legislation some years ago requiring insurers to accept anybody who applied (guaranteed issue) and charge all policyholders in the same class the same premiums (community rating), most health insurers withdrew from the state.").

> noted just what petitioners and the United States assert: that changes like guaranteed issue and community rating, viewed by themselves, "would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care."

Br. 36 (quoting CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19 (Nov. 30, 2009) (*Insurance Premiums*)). CBO concluded that, absent other changes to the insurance market, "people who are older and more likely to use medical care would be more likely to enroll in nongroup plans," and that this adverse selection "would tend to increase premiums in the exchanges relative to nongroup premiums under current law." *Ibid.*

As amicus notes (Br. 36), CBO cited "several" provisions of the version of the Affordable Care Act it had reviewed that "would tend to mitigate that adverse selection." *Insurance Premiums* 19. Most notably, CBO concluded that the bill's minimum coverage provision "would * * * encourage a broad range of people to take up coverage in the exchanges" and thus mitigate adverse selection. *Id.* at 20. CBO also cited other provisions of the legislation that would mitigate adverse selection. For example, CBO noted that the bill would establish an annual open enrollment period for new individual policies sold in exchanges, which would reduce opportunities for healthy people to wait until illness struck before enrolling. *Id.* at 19. CBO also concluded that the substantial premium tax-credit subsidies available in the exchanges would encourage enrollment of a broad range of individuals. *Id.* at 19-20.

But CBO did not assess the relative importance of these provisions in mitigating adverse selection. Nor did it suggest that open enrollment periods and tax credits, by themselves, would be sufficient to mitigate adverse selection in the absence of a minimum coverage provision.[9] Nonetheless, amicus hypothesizes that annual enrollment periods and premium subsidies would in fact be sufficient. From that hypothesis, amicus further posits that Congress would have thought the same, thus intending guaranteed issue and community rating to survive if the minimum coverage provision were held unconstitutional. Br. 36-39. Amicus is incorrect.

As an initial matter, severability is a question of congressional intent, not post-enactment economic modeling. Amicus is correct that "predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence." Br. 34. That principle, however, cuts in favor of finding the guaranteed-issue and community-rating provisions inseverable. Congress's findings (with ample empirical support) reflect its determination, based on a legislative prediction it is uniquely qualified to make, *Turner Broad.*

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[9] Moreover, CBO's analysis was based on an earlier version of the legislation that capped the shared responsibility payment at $750 per adult and $375 per child. See *Insurance Premiums* 20; see also *id.* at 1 (noting that analysis was of a proposal introduced by Senator Reid on November 18, 2009). The minimum coverage provision was later revised to cap the penalty for many individuals at approximately the price of obtaining insurance. Compare 26 U.S.C. 5000A(c), with 155 Cong. Rec. S11,607, S11,642 (daily ed. Nov. 19, 2009) (minimum coverage provision in earlier version of the legislation analyzed by CBO). That decision to link the penalty to the price of insurance will result in increased economic incentives to obtain coverage, making the minimum coverage provision as enacted even more effective in mitigating adverse selection than the version analyzed by CBO would have been.

Sys., Inc. v. *FCC*, 520 U.S. 180, 195-196 (1997), that the minimum coverage provision was "essential" to the success of the guaranteed-issue and community-rating reforms. It made no comparable finding for annual enrollment periods or premium tax credits.

In any event, amicus is mistaken in suggesting that Congress would have viewed annual enrollment periods and tax credits as sufficient to mitigate adverse selection by themselves. Amicus is correct that, if enrollment periods are limited, uninsured persons who "choose to forego enrollment during the specified period * * * must bear the risk of illness suffered prior to the next enrollment period." Br. 36. But that incentive to obtain insurance will be far less powerful than the incentive the uninsured now have to do so. Under current law, insurers in the individual market can deny coverage to uninsured adults outright or charge unaffordable premiums based on medical conditions. Despite those risks, millions of people postpone the purchase of insurance in the individual market. There is every reason to think that such adverse selection would increase if, instead of facing the risks of permanent denial of coverage and unaffordable premiums, uninsured individuals merely faced the risk of having to wait until the next enrollment period to obtain coverage.

Amicus is likewise mistaken in positing that Congress would have believed that the Act's premium tax credits would sufficiently mitigate adverse selection without a minimum coverage provision. In fact, Congress understood that premium tax credits were necessary, but not sufficient, to protect individual insurance markets operating under guaranteed-issue and community-rating rules. The National Association of Insurance Commissioners (NAIC), "offer[ing] the experience and expertise of the states," specifically warned Congress that "[s]tate regulators [could]

support" national guaranteed-issue reforms only "to the extent they [were] coupled with an effective and enforceable individual purchase mandate *and* appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussions on Comprehensive Health Care Reform: Hearings Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503, 504 (2009) (*Roundtable*) (statement of Sandy Praeger, Kansas Commissioner of Insurance, on behalf of NAIC) (emphasis added).[10] NAIC noted that, by themselves, "subsidies or incentives could ameliorate some of the selection issues," but emphasized that "as costs continue to rise and premiums increase, the effectiveness of such inducements could erode." *Id.* at 504. Congress's recognition of NAIC's technical expertise is expressly reflected in various provisions giving the group a formal role in the Act's implementation,[11] so there is every reason to believe that Congress, in light of NAIC's warning, did not intend guaranteed issue and community rating to

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[10] See *Roundtable* 74 (statement of Commissioner Praeger) ("[W]e have a great opportunity here to, I think, get rid of one of the most oner[o]us aspects of the current system, and that is rating based on health. The people who need health insurance are sometimes absolutely just priced out, especially in the individual market. But you cannot do that without requiring that everybody have coverage, otherwise you will just wait until you are sick and then buy the coverage. That is where we do need rules set at the national level so that all of the States are functioning under the same system.") (paragraph break omitted).

[11] Among other things, Congress directed the Secretary of Health and Human Services to consult NAIC in formulating community-rating rules, 42 U.S.C. 300gg(a)(3), and in establishing transitional reinsurance programs to mitigate adverse selection during the transition to a guaranteed-issue/community-rating individual insurance market, see 42 U.S.C.A. 18061(b)(1) and (3)(B)(iii). See also, *e.g.*, 42 U.S.C. 300gg-15, 300gg-18(c), 300gg-19(b)(1); 42 U.S.C.A. 18031(c)(1)(F), 18041(a)(2), 18053(a)(1).

stand if the minimum coverage provision were held unconstitutional.

NAIC's recommendation was consistent with CBO's findings on the connection between reductions in premiums through tax credits and increases in participation rates in the individual insurance market. When CBO examined the impact of premium tax credits in isolation, it concluded that a 50% reduction in premiums would lead no more than 20% of the uninsured to obtain coverage, and that the figure could be as low as 4%. *CBO's Health Insurance Simulation Model: A Technical Description* 21 (Oct. 2007). CBO further found that, even if tax credits were to reduce premiums by 70%, the rate of participation in the individual market would still be less than 40%. *Id.* at 22 fig.2. Accordingly, while the Act's premium tax credits (and cost-sharing reductions) are generous, Gov't Minimum Coverage Br. 10-11, Congress understood that it was necessary to pair them with the minimum coverage provision in order to adequately mitigate adverse selection.

The pre-Act experience in Massachusetts confirmed that premium subsidies alone would not prevent adverse selection in the individual market. Amicus is mistaken to suggest that "no State providing for guaranteed issue and community rating bolstered its insurance reforms with subsidies of the particular type and magnitude contemplated by the federal Act." Br. 42. Massachusetts made heavily subsidized insurance available to residents with incomes below 300% of the federal poverty level for nearly a year before that State's minimum coverage provision took effect. Amitabh Chandra et al., *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 New Eng. J. Med. 293 (2011). In Massachusetts, subsidies for eligible individuals are even more generous than those that will be available under the Affordable Care Act. *Id.* at 294, 295.

Nonetheless, the Massachusetts enrollees who signed up for coverage before the state tax penalty took effect (but while the state subsidies were available) were nearly four years older on average than those who signed up after the tax penalty was fully implemented. *Id.* at 294. They were almost 50% more likely to have a chronic illness. *Ibid.* And their health-care costs were about 45% higher than those who signed up after the tax penalty was fully in effect. *Ibid.* In other words, subsidies paired with a minimum coverage provision proved significantly more successful in combating adverse selection in Massachusetts than did subsidies alone.

b. Amicus recognizes (Br. 40-41) that CBO has projected that adverse selection would increase premiums in the individual market by 15%-20% relative to current law if the Act were implemented without the minimum coverage provision. Amicus also acknowledges that another study found that "premiums for individual polices would rise by 27 percent" if the minimum coverage provision were invalidated but guaranteed issue and community rating remained. Br. 41 (citing Jonathan Gruber, *Health Reform Without the Individual Mandate: Replacing the Individual Mandate Would Significantly Erode Coverage Gains and Raise Premiums for Health Care Consumers* 2 (Feb. 2011)).[12]

[12] The two additional studies cited by amicus do not provide substantial support for the position amicus advances. The lower Urban Institute estimates that amicus cites (Br. 38) assumed "robust enrollment in subsidized coverage." Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care* 2 (Jan. 2012). By contrast, when it modeled the expected premium increase if the take-up of subsidized coverage were low, it concluded that premiums for policies sold through the exchanges would rise by 25%. *Id.* at 6, tbl. 4. The Urban Institute also cautioned that "[t]here is a genuine risk that initial low exchange enrollment could

Amicus suggests that these predictions of significant premium increases (and resulting decline in participation) in the individual market "fall short of demonstrating that the health insurance market will be so negatively impacted that Congress would plainly prefer a return to a market without guaranteed issue and community rating." Br. 41. But Congress's goal was to make coverage more accessible and affordable, not to strike a balance at some particular level of "negative[] impact[]." *Ibid.* The individual insurance market is already plagued by high premiums and low participation, and there is no reason to conclude that Congress would have wanted to implement measures that would cause that market to deteriorate further.

c. As the government explained in its opening brief (at 47-50), a number of States attempted to implement guaranteed issue and community rating without a minimum coverage provision, and each encountered increased premiums, decreased participation, and general destabilization of the market for individual insurance. Amicus states (Br. 44) that four of the seven States that enacted guaranteed-issue and community-rating requirements without a minimum coverage provision (Maine, New Jersey, New York, and Vermont) did not repeal those requirements or enact a minimum coverage provision. But the experience of these States hardly supports the conclusion that guaranteed issue

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start an adverse selection cycle," and concluded that "the nongroup exchange may not be viable in some states without an individual mandate." *Id.* at 8. The Lewin Group study that amicus cites (Br. 40) acknowledged that its findings differed from those of other analysts and also noted that, if "consumers are about one-third less risk averse than in our analysis, premiums increase by 18 percent and 9.3 million people lose coverage." John F. Sheils & Randall Haught, *Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted*, Health Affairs, Nov. 2011, at 1, 2, 6-7.

and community rating can function effectively, or even avoid making matters worse, in the absence of a minimum coverage provision.

As an initial matter, it is not the case that all the States amicus identifies have adhered to their original guaranteed-issue and community-rating requirements. Most insurers pulled out of Maine after it adopted its insurance reforms, *House Hearing* 117, and that State recently relaxed community-rating requirements, permitting greater variation in premiums by age and geographic location. 2011 Me. Laws 114-116 (amending Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2) (Supp. 2011)). In 2008, New Jersey likewise relaxed its community-rating rules to allow premium variation by age. 2008 N.J. Laws 561-562 (Ch. 38, § 9 ("Modified community rating")) (amending N.J. Stat. Ann. § 17B:27A-2 (West Supp. 2011)). In 2006, Vermont established a health-care reform commission to provide "needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 if less than 96 percent of Vermonters have health insurance by 2010." 2006 Vt. Acts & Resolves 478 (Vt. Stat. Ann. tit. 2, § 902(a)(3)(D) (2010) (repealed 2011)). That effort by Vermont and other possible market reform efforts in the three other States amicus identifies were overtaken by enactment of the Affordable Care Act. Indeed, in 2011 Vermont enacted a statute providing that the State will seek a waiver of certain provisions of the Affordable Care Act in 2017 in order to implement a single-payer health-insurance system for its residents. 2011 Vt. Acts & Resolves 242 (Pub. Act No. 48, § 2(a)); see Gov't Minimum Coverage Reply Br. 12 (discussing Affordable Care Act's state innovation waiver provision).

Equally to the point, amicus cites no positive discussion of those States' experiences in the record before Congress, and, in fact, what Congress heard about them was uni-

formly negative. See Gov't Br. 48-50 & n.22; AHIP Amicus Br. 34. Any comprehensive analyses of those States' experiences would hardly have led Congress to view them as models for the Nation. For example, "the prediction" that the individual insurance market in New York after enactment of guaranteed issue and community rating would "become essentially a widely dispersed high-risk pool * * *, in which enrollment [would] continue to shrink and rates [would] continue to rise faster than inflation, *has come to pass*." Peter Newell & Allen Baumgarten, *The Big Picture: Private and Public Health Insurance Markets in New York* 127 (2009) (emphasis added; internal quotation marks and footnote omitted); see Stephen T. Parente & Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured* i (2009) (Exec. Summary) ("[A]s a result of a significant increase in the cost of private-insurance coverage for individuals, the market for individual health insurance in New York has nearly disappeared, declining by 96 percent since 1994."); see also *id.* at 5. A 2004 study of New Jersey's Individual Health Coverage Program "point[ed] to a market that [was] heading for collapse." Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, Health Affairs, July/Aug. 2004, at 167, 167-168. "Enrollment * * * declined from a peak of 186,130 lives at the end of 1995 to 84,968 at the end of 2001. In addition, premiums * * * increased two- to threefold above their early levels." *Id.* at 168.[13] The fact is

[13] See also Susan Besio, Director, Health Care Reform Implementation, Vermont Agency of Admin., *Vermont Health Care Reform: 2007 Annual Update to 2006 Five-Year Implementation Plan* 10 (Feb. 2008) ("[T]he Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation."); Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed*

that those States that enacted guaranteed issue and community rating experienced harmful effects in the individual insurance market, with the only variable being how quickly and how drastically the market deteriorated. That experience amply supports Congress's judgment that the minimum coverage provision was essential to the Act's guaranteed-issue and community-rating reforms.

d. Finally, amicus argues (Br. 45-46) that, if the guaranteed-issue and community-rating provisions were not in place, the state-based health-insurance exchanges would be less effective in achieving the benefits of standardization. It is certainly true that the exchanges would function better with the guaranteed-issue and community-rating provisions that without them. Gov't Minimum Coverage Br. 31. Nonetheless, exchanges would still serve as central and transparent marketplaces that would reduce premium costs through increased competition and economies of scale even without those market reforms. Gov't Br. 37. Indeed, Utah operates an exchange without guaranteed-issue or community-rating rules. *Ibid.* Given Congress's express findings and the ample empirical evidence before it on the importance of a minimum coverage provision, there is little reason to believe that it would have wanted to preserve guaranteed issue and community rating without a minimum coverage provision (and thereby run the risk of creating an adverse selection spiral in the individual insurance market) solely because of their connection to enhanced functioning of the exchanges.

Issue and Community Rating Reforms on Individual Insurance Markets 12 (July 10, 2007) (Maine's insurance reforms "reduced availability of individual coverage * * * by driving almost all carriers out of the market [and] contributed to increases in premiums.").

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For the foregoing reasons and those stated in the government's opening brief, in the event the Court invalidates the minimum coverage provision, it should vacate the court of appeals' judgment addressing the severability of provisions of the Act that do not apply to petitioners or are subject to statutory bars to review. To the extent the Court reaches the issue of severability, it should reverse the portion of the judgment of the court of appeals finding the minimum coverage provision severable from the guaranteed-issue and community-rating provisions, but otherwise affirm the judgment of the court of appeals finding the minimum coverage provision severable from the remainder of the Act.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

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