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

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AND THE BLUE CROSS BLUE SHIELD ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF REVERSAL OF THE COURT OF APPEALS' SEVERABILITY JUDGMENT

ROGER G. WILSON
SENIOR VICE-PRESIDENT & GENERAL COUNSEL
BLUE CROSS BLUE SHIELD ASSOCIATION
225 N. Michigan Ave.
Chicago, IL 60601
(312) 297-6000

Counsel for Blue Cross Blue Shield Association

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

Counsel for America's Health Insurance Plans

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

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INTEREST OF AMICI CURIAE[1]

America's Health Insurance Plans ("AHIP") is the national trade association that represents companies providing health insurance coverage to more than 200 million Americans. AHIP has over fifty years of experience in the health insurance industry (as AHIP and its predecessors). Its members offer a wide range of insurance options to consumers, employers of all sizes, and governmental purchasers nationwide. As a result, AHIP's members have extensive experience working with hospitals, physicians, pharmaceutical and device companies, and other health care stakeholders to ensure that patients have access to needed treatments and medical services. That gives AHIP extensive first-hand and historical knowledge about the Nation's health care and health insurance systems and a unique understanding of how those systems work.

The Blue Cross and Blue Shield Association ("Blue Cross Blue Shield") is a non-profit association of 38 independent, community-based, and locally operated health insurance companies. Those companies collectively provide healthcare coverage for nearly 99 million people—one out of three Americans—in every zip code in the United States, the District of Columbia, and Puerto Rico. Blue Cross and Blue Shield companies offer a variety of

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

insurance products to all segments of the population, including federal employees, large employer groups, small businesses, and individuals. As leaders in the healthcare community for more than 80 years, the Blue Cross and Blue Shield companies have a commitment to making healthcare work for all Americans and have an extensive knowledge of and experience with the health insurance marketplace.

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 and Blue Cross Blue Shield are filing this brief to share with the Court the uniquely comprehensive information that they and their members possess about how the health insurance market operates, the changes that will be made by the Act, and the consequences that would follow from decoupling the Act's minimum individual insurance coverage provision from certain insurance-market reforms.

AHIP and Blue Cross Blue Shield have each previously appeared as amicus curiae before this Court in other cases involving issues of particular importance to the health insurance industry. *See, e.g., Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (Blue Cross Blue Shield & AHIP; judicial review of benefit determinations by ERISA plan administrators); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (Blue Cross Blue Shield & AHIP; addressing whether an ERISA fiduciary may sue a

beneficiary for reimbursement of medical expenses paid by the ERISA plan when the beneficiary has recovered for its injuries from a third party); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (ERISA preemption of state-law claims against health maintenance organizations) (brief filed by AHIP's predecessor, AAHP-HIAA).

INTRODUCTION

1. This brief does not address the constitutionality of ACA's minimum individual insurance coverage provision, 26 U.S.C. § 5000A (Suppl. IV 2011). Nor does this brief address the Anti-Injunction Act, 28 U.S.C. § 2283 (1948), or Medicaid questions pending before this Court. Instead, this brief focuses exclusively on severability, in the event the Court reaches that question. With respect to that issue, AHIP's and Blue Cross Blue Shield's extensive, first-hand, and on-the-ground experience with health insurance markets, as well as their direct experience with earlier failed state efforts to implement certain insurance-market reforms without a minimum individual coverage mandate, allow them to bring a uniquely informed voice to this Court. The purpose of this brief is to share that perspective with the Court to help guide the proper legal analysis. This brief does not address any other constitutional, procedural, or severability questions that are outside AHIP's and Blue Cross Blue Shield's unique expertise in the health insurance market.

2. On March 30, 2010, Congress enacted 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"). ACA is a voluminous statute with a multitude of interlocking and interdependent provisions. Congress's stated intent was to increase the accessibility and affordability of health insurance and to reduce the frequency with which the cost of care for the uninsured is shifted to those who maintain health insurance. 42 U.S.C. § 18091(2)(B)-(G) (Suppl. IV 2011) (ACA § 1501(a)). While ACA addresses those issues through a variety of provisions, some of the Act's most significant reforms are aimed at the health insurance market.[2]

As most relevant to this brief, ACA's reforms of the insurance market include: (i) a "guaranteed issu[e]" provision that requires insurers to issue health care coverage to any individual who applies for it, 42 U.S.C. § 300gg-1 (PHSA § 2702, as amended by ACA § 1201(3)(A)); (ii) a prohibition on excluding preexisting medical conditions from coverage or imposing a waiting period before their coverage, 42 U.S.C. § 300gg-3 (PHSA § 2704, as added by ACA § 1201(2)(A)); (iii) a prohibition on the establishment of coverage eligibility rules that are based on health-status related factors, 42 U.S.C. § 300gg-4 (PHSA § 2705, as added by ACA § 1201(4)); and (iv) the required use of an adjusted "community rating" system that prevents health plans from setting premium prices based on an individual applicant's medical history and that sharply limits variations in

[2] The reforms relevant here were implemented through amendments and additions to the Public Health Service Act of 1944, 42 U.S.C. §§ 201 *et seq.* ("PHSA").

rates based on age, rating areas, or tobacco usage, *see* 42 U.S.C. § 300gg(a)(1) (PHSA § 2701, as added by ACA § 1201(4)). Those four reforms are referred to here collectively as "the insurance-market reforms." Congress packaged them together as a legislative mechanism for ensuring that all individuals have access to health insurance that is based on premium prices that are rated across a community of individuals rather than individual risk factors.[3]

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[3] Traditionally, health insurance in the United States is sold in three markets: individual consumers, small group, and large group. S. Rep. No. 89, 111th Cong., 1st Sess. 10 (2009). The guaranteed-issue requirement existed in the small group market prior to ACA, and limitations on preexisting condition exclusions and on coverage eligibility rules that discriminated based on health status previously existed in both the large and small group markets. *See* 42 U.S.C. § 300gg (2009) (limiting preexisting condition exclusions in the small and large group markets), amended and transferred to 42 U.S.C. § 300gg-3 by ACA § 1201(2)(A); 42 U.S.C. § 300gg-11 (2009) (guaranteeing issuance of coverage in the small group markets), redesignated as 42 U.S.C. § 300gg-1 by ACA § 1001(3), stricken by ACA § 1562(c)(8) (renumbered as ACA § 1563(c)(8) by ACA § 10107), amended and transferred to 42 U.S.C. § 300gg-1 by ACA § 1201(4); 42 U.S.C. § 300gg-1 (2009) (prohibiting coverage eligibility rules in the group markets based on certain health-status-related factors), stricken by ACA § 1201(3)(A) and transferred by ACA § 1201(3)(B) to end of new 42 U.S.C. § 300gg-4. Similar protections also applied pre-ACA in the individual market, but only to certain individuals exiting prior group coverage who (1) were no longer eligible for group coverage, (2) satisfied specified "creditable coverage" conditions, (3) exhausted all available COBRA and any similar state coverage programs, (4) were not eligible for coverage under any other government program, and (5) were not terminated from the immediately prior coverage based on nonpayment of premiums or fraud. There was no restriction on setting premium rates for such individuals based on health status or

In conjunction with its adoption of those insurance-market reforms, Congress also enacted a provision that requires every person, with limited exceptions, to maintain "minimum essential" health insurance coverage. 26 U.S.C. § 5000A. That provision is sometimes referred to as the "individual mandate."

In ACA, Congress found that, if the guaranteed-issue requirement and the prohibitions on preexisting-condition exclusions and health-status-related eligibility determinations were implemented without the minimum individual coverage mandate, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I). Congress further found that the individual coverage requirement would help to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.* Congress thus concluded that the minimum individual coverage provision 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." *Id.*

SUMMARY OF THE ARGUMENT

The central flaw in the Eleventh Circuit's holding that the minimum individual coverage provision is

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age. *See* 42 U.S.C. § 300gg-41(a), (b), (f). Those protections that preexisted ACA are not at issue in this brief.

completely severable from the balance of ACA is that the court largely confined its analysis to the narrow question of whether ACA could structurally be operative or enacted as a law without the minimum individual coverage provision. This Court, however, has held that severability turns on whether the remaining portions of the law "will function in a manner consistent with the intent of Congress" without the minimum individual coverage provision. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis omitted). Indeed, it is this Court's duty, in executing a judgment of unconstitutionality (should one arise), to undertake a full severability analysis that determines which provisions are so dependent on the mandate that, to leave them in place, would violate congressional intent and would, in effect, judicially create a statute that Congress would not have enacted.

Congress adopted its insurance-market reforms—guaranteed issue, prohibitions on preexisting condition exclusions or waiting periods, ban on coverage eligibility rules based on health-related factors, and the adjusted community rating system—together with the mandate as a package deal. The statutory text and legislative record establish that Congress would not have intended those insurance-market reforms to operate on their own, without the vital counterbalance of the minimum individual coverage mandate there to prevent the skyrocketing premiums that would otherwise arise due to crippling adverse-selection and cost-shifting problems.

Indeed, the Congress that enacted ACA had already seen the failed consequences of state efforts

to impose similar guaranteed issue, preexisting condition, health-status discrimination, and adjusted community rating reforms in the insurance market without a minimum individual insurance coverage mandate. Congress knew that, with such reforms, those who are most at risk of incurring substantial health costs pour into the insurance market once coverage is guaranteed and rates and exclusions are uncoupled from their individual health risk. At the same time, healthy individuals largely stay out, preferring to wait and purchase insurance only if and when the need arises.

In the absence of an individual coverage requirement, those reforms would dramatically skew the insurance pool by eliminating the price incentives for young and healthy people to purchase coverage, leading to a higher-cost mix of individuals in the insurance pool. This, in turn, would further increase premium prices, driving still more healthy individuals out of the insurance market. The result would be a "marketwide adverse-selection death spiral" that would thwart rather than advance Congress's goal of expanding affordable health care.[4]

The antidote to such market-crippling adverse-selection and cost-shifting problems, Congress determined, was the imposition of a mandate that all individuals have insurance. In Congress's judgment, the requirement that individuals maintain a base level of health insurance would ensure a workable

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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).

insurance system with a stable and balanced insurance-risk pool and without the adverse-selection and cost-shifting problems that would otherwise arise if insurance could be easily purchased only when needed. Indeed, Congress expressly found that the minimum individual coverage provision is "essential" to making its insurance-market reforms work. 42 U.S.C. § 18091(2)(I).

Congress's express finding of an "essential" link between the minimum individual coverage provision and the insurance-market reforms, combined with Congress's awareness of the States' distressing experiences with mandate-less insurance reforms, together demonstrate that Congress did not intend to implement those reforms without the mandate. Congress instead legislatively calibrated a package of insurance-market reforms that interlocked with the minimum individual coverage mandate to counterbalance the adverse-selection problems and spiraling premiums that such reforms, operating alone, had been shown to cause.

Were the mandate to be invalidated, those interdependent legislative provisions would be torn apart and the "essential" counterbalance stripped away, leaving the insurance-market reforms incapable by themselves of functioning as Congress intended. In fact, without a minimum individual coverage mandate to prevent the congressionally acknowledged adverse-selection and cost-shifting problems, those insurance-market reforms would confound Congress's legislative aims by causing premium prices to rise dramatically, thereby driving insurance products and consumers out of the

marketplace. In other words, the insurance-market reforms without the minimum individual coverage provision would be an edifice without a foundation, delivering the opposite of what Congress intended by ensuring that there would not be "affordable care" under the Affordable Care Act.

ARGUMENT

ACA'S INSURANCE-MARKET REFORMS CANNOT FUNCTION AS CONGRESS INTENDED WITHOUT THE MINIMUM INDIVIDUAL COVERAGE PROVISION AND THUS ARE INSEVERABLE FROM THE MANDATE

A. The Critical Severability Inquiry Is Whether Congress Intended ACA's Insurance-Market Reforms To Function Without The Minimum Individual Coverage Provision That Congress Deemed "Essential" To Their Operation

"[A] decision to declare an Act of Congress unconstitutional 'is the gravest and most delicate duty that this Court is called on to perform.'" *Rust v. Sullivan*, 500 U.S. 173, 191 (1991) (quoting *Blodgett v. Holden*, 275 U.S. 142, 148 (1927) (opinion of Holmes, J.)). When, in executing that constitutional duty, the Court determines that only a portion of a statute is unconstitutional, the Court must decide whether to invalidate the statute in its entirety, the unconstitutional provision alone, or the unconstitutional provision and those provisions that

Congress intended to work in inextricable conjunction with the unconstitutional provision.

Because the enactment of legislation is constitutionally confined to the Legislative Branch, basic separation-of-powers principles require that, when implementing a judgment of unconstitutionality, this Court not leave standing a law that would "'circumvent the intent of the legislature,'" *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329-330 (2006), or that Congress "'would not pass * * * independently,'" *Allen v. City of Louisiana*, 103 U.S. 80, 84 (1880).

Accordingly, if "different clauses of an act are so dependent upon each other that it is evident the legislature would not have enacted one of them without the other," *Huntington v. Worthen*, 120 U.S. 97, 102 (1887), then it is this Court's "duty" to strike down those provisions in conjunction with the invalidated provision, just as much as it is the Court's "'duty * * * to maintain the act in so far as it is valid,'" *Regan v. Time, Inc.*, 468 U.S. 641, 652-653 (1984). In either circumstance, severability analysis implements this Court's constitutional judgment in a manner that fully respects the constitutional assignment of legislative power to the Congress and "give[s] effect to what appears to have been the intent of the legislature." *Allen*, 103 U.S. at 84.

This Court's test for determining severability is "well-established" and reflects the Court's duty to implement its constitutional judgment consistent with those separation-of-powers principles: If Congress "'would not have enacted those provisions

which are within its power, independently of that which is not,'" then the provisions are inseverable and, if one is invalidated, the dependent provisions must be stricken too. *Alaska Airlines,* 480 U.S. at 684. That inquiry entails more than the abstract question of whether the remaining portions of a statute could operate or be enacted as law, *see id.*, which was the main focus of the court of appeals' analysis, No. 11-398, Pet. App. 172a-186a. Rather, the critical inquiry "is whether the statute," stripped of the unconstitutional provision, would "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 490 U.S. at 685 (emphasis omitted).

"[T]he touchstone" for severability analysis, therefore, "is legislative intent." *Ayotte*, 546 U.S. at 330. That intent, moreover, must be assessed not from the vantage point of Congress's original desire to enact the entire law, but what Congress's view would have been "*in light of [the] holding*" invalidating a portion of the law. *United States v. Booker*, 543 U.S. 220, 265 (2005).

Accordingly, if this Court were to invalidate the minimum individual coverage provision that Congress deemed "essential" to the insurance-market reforms, 42 U.S.C. § 18091(2)(I), the Court will have to determine whether the statute could "function" as Congress would have intended, *Alaska Airlines*, 490 U.S. at 685, "'had it known'" that the mandate's counterbalance would be stricken out of the law, *Denver Area Educ. Telecomms. Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996) (plurality opinion); *see Alaska Airlines*, 490 U.S. at 685 (unconstitutional provision cannot be severed if "the statute created in

its absence is legislation that Congress would not have enacted").

Furthermore, because ACA is "a highly complex statute" with "interrelated provisions," the Court "cannot assume that Congress, if faced with the statute's invalidity" in "key" respects, would have preferred that those "interrelated provisions," once disunited, continue to operate alone. *Booker*, 543 U.S. at 248. The Court instead must determine whether Congress "link[ed] specifically the operation" of the minimum individual coverage provision and its insurance-market reforms, or whether Congress instead would have intended for the reforms to "stand on their own, independent of" an invalidated mandate. *Alaska Airlines*, 480 U.S. at 688-689.[5]

ACA's text, structure, and legislative record establish that Congress enacted the minimum individual coverage mandate and its insurance-market reforms as a package deal, that those reforms cannot function as Congress intended without the mandate, and that, in fact, the continued operation of those reforms without the mandate would thwart Congress's central purpose of guaranteeing broad access to *affordable* health care.

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[5] While the presence of a severability clause "creates a presumption that Congress did not intend the validity of the statute in question to depend on the validity of the constitutionally offensive provision," the absence of a severability clause in ACA does not create any countervailing presumption. *Alaska Airlines*, 480 U.S. at 686.

B. ACA's Plain Text Establishes That The Minimum Individual Coverage Provision Is "Essential" To And Thus Inseverable From The Guaranteed Issue, Preexisting Conditions, Health-Status Discrimination, And Adjusted Community Rating Reforms

1. The Mandate and the Insurance-Market Reforms Are Textually Linked

ACA's plain text ties the minimum individual coverage provision and the insurance-market reforms tightly together. Congress expressly found that the minimum individual coverage 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(2)(I) (emphasis added). Congress textually extended that same finding to ACA's prohibition on discrimination based on other health-status-related factors. *See Id*. (citing PHSA § 2705's (42 U.S.C. § 300gg-4) prohibition on health-status discrimination).

That congressional judgment that the mandate is "essential" to guarantee the issuance of insurance to all who apply without regard to health condition, 42 U.S.C. § 18091(2)(I), necessarily subsumed the adjusted community rating system reform, 42 U.S.C. § 300gg(a)(1), as well. The adjusted community rating requirement, which prohibits rates from varying based on health status and limits variations based on age, is a mechanism for spreading risk

across a broad, demographically diverse insurance pool and enforcing cross-subsidization by which low-risk individuals (generally young and healthy) collectively pay more and high-risk individuals (generally older and sicker) collectively pay less. Such pooling ensures that the highest cost individuals can purchase health insurance at an affordable premium.

That community rating cross-subsidization is indispensable to making the "guaranteed issue" of insurance and the bar on preexisting condition exclusions and eligibility rules based on health status work. Without a balanced risk pool of sick and healthy alike, premiums would skyrocket because only those who needed coverage would purchase it, while the younger and healthier individuals would postpone purchasing insurance until a health crisis arose. Accordingly, Congress's finding that the mandate is "essential to creating effective health insurance markets" in which insurance is "guaranteed issue" without regard to health status, 42 U.S.C. § 18091(2)(I), necessarily also applies to the adjusted community rating requirement and its inherent dependence on the diverse insurance pool created by the individual coverage mandate.[6]

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[6] Of course, the affordability of health insurance, even with a mandate, is subject to additional factors such as the nature of the benefit package required and the rising cost of care. The point here is that, without community rather than individual-condition based ratings, Congress's effort to make affordable health insurance universally available would have stopped at the starting gate.

Congress's express statutory judgment in Section 18091(2)(I) thus provides the specific legislative linkage that makes the insurance-market reforms—guaranteed issue, preexisting condition prohibitions, health-status discrimination, and adjusted community rating—"'so mutually connected with and dependent on'" the minimum individual coverage provisions "'as to warrant a belief that the legislature intended them as a whole,'" and "if all could not be carried into effect, the legislature would not pass the residue independently[.]" *Allen*, 103 U.S. at 84. When Congress enacts a statutory scheme designed to be "upheld by two legs at once," that itself "suggests the improbability that Congress would have assented to a code supported by only one." *Carter v. Carter Coal Co.*, 298 U.S. 238, 314 (1936). Such "manifest" expressions of statutory "interdependence" by Congress require joint treatment in severability analysis. *Id.* at 315; *see also Booker*, 543 U.S. at 260 ("critical cross-references" between two provisions of a statute requires that both provisions be stricken from the statute).[7]

This case, in fact, is the flipside of *Tilton v. Richardson*, 403 U.S. 672 (1971), in which this Court

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[7] *Carter* was decided at a time when this Court generally applied a presumption of inseverability, 298 U.S. at 312, which this Court has since rejected, *see Alaska Airlines*, 480 U.S. at 686. Because the law at issue in *Carter* contained a severability clause, however, that case was decided under a presumption "of separability," which could be overcome only by "'the clear probability that the invalid part being eliminated the Legislature would not have been satisfied with what remains,'" *Carter*, 298 U.S. at 312, and thus the analysis fully comported with current severability analysis.

held that an invalidated provision was fully severable because "nothing in the statute or its objectives intimat[ed] that Congress considered" the unconstitutional provision to be "essential" to the statutory program, *id.* at 684. Congress, of course, not only intimated, but actually found precisely the opposite here, determining that the mandate is "essential" to the intended operation of the guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating reforms in the insurance market. *Cf. Alaska Airlines*, 480 U.S. at 688 (finding full severability where "Congress did not link specifically the operation" of two statutory provisions).

2. Congress's Linkage Accords with the Legislature's Knowledge of Marketplace Realities

Congress's decision to textually weave the mandate and its insurance-market reforms together reflects its knowledge and understanding of the practical interconnection of those measures in creating a viable market for universal insurance.

The insurance market is particularly susceptible to the economic phenomenon of "adverse selection" and its companion problem of cost shifting.[8] Adverse selection occurs because individuals with higher anticipated health care costs—generally less healthy and older individuals—are more likely than healthy and younger people to enter an insurance market.

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[8] *See* Kathryn Linehan, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 4 (June 4, 2009).

Health insurance is particularly prone to adverse selection because individuals know more about their own health than insurers do, creating incentives for people at low risk of significant health care needs and expenses to postpone purchasing coverage until they suffer from an illness or expect to need medical treatment.

Such adverse selection significantly increases the costs for all participants in the insurance market. 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 dominate the pool. *See* Linda Blumberg & John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* 2 (Jan. 2008). Moreover, it takes little disproportionality in the insurance pool to shift health care costs dramatically. Estimates are that just 5% of the population accounts for almost 50% of all health care costs, and the top 1% accounts for 20% of all health costs. At the same time, half of the population accounts for just 3% of health care spending. *See* Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, Research in Action, Issue 19, Agency for Healthcare Research and Quality, Publication No. 06-0060 (June 2006).[9]

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[9] *See also* Kaiser Family Foundation, *Health Care Costs: A Primer*, at 5 (Mar. 2009); National Inst. for Health Care Mgmt., *Understanding U.S. Health Care Spending*, at 1, 4 (NIHCM Foundation Data Brief July 2011).

The resulting increased cost of insurance makes it even more unlikely that healthy people will 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. *See* Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report* 3-4 (Apr. 2009). When those "free riders," *id.* at 4, require medical care, hospitals and other providers charge those who do have coverage higher prices to compensate for lost costs. Those higher prices, in turn, translate into increased health insurance premiums. Those with insurance are ultimately hit with a "hidden tax" estimated at $368 annually for a single person and over $1,017 for a family to pay for that uncompensated care. Families USA, *Hidden Health Tax: Americans Pay a Premium*, at 6-7 (May 2009) (citing 2008 analysis of private actuarial consulting firm); *see also* Wulsin, Jr. & Dougherty, *supra*, at 3-4 (hidden tax ranges from two to ten percent of private premiums).[10]

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[10] Adverse selection and the resultant cost shifting are of particular concern in the individual market because employers do not subsidize the cost of coverage, as they typically do in the large and small group markets. The group markets are composed of employees formed for purposes other than obtaining insurance, and the subsidy offered by employers results in high participation rates, including by healthy workers, such that the demographic and health status mix in a given pool tends to track the workforce as a whole. But in the individual market, where insureds pay the full premium with no employer subsidy, consumers are naturally more price-sensitive and more likely to wait to purchase insurance until they expect to need medical care. *See* AHIP, *Small Group Health Insurance in 2008:*

Prior to ACA, insurance companies were able to combat those problems of adverse selection and cost shifting by employing the actuarial mechanism of underwriting to set premium rates. That process allowed them to manage risk and hold down costs for their existing enrollees by assessing each applicant's health and age and then making an actuarial judgment about the amount and types of medical services that he or she would likely need. Based on that determination, the insurer might exclude coverage for an applicant's known preexisting conditions, impose a waiting period for coverage (which can prevent the belated or selectively timed purchase of insurance), adjust the applicant's premium to account for the risk, or deny coverage altogether. *See* Linehan, *supra*, at 4-6. By regulating risk, those underwriting practices also allowed insurers to offer lower premiums to younger and healthier people, thereby reducing the disincentives to purchasing insurance and attracting them into the insurance pool. *Id.*

ACA's insurance-market reform provisions eliminate many of those risk-management tools. For example, the guaranteed issue provision requires insurers to issue health care coverage to all individuals who are able to pay the premium. 42 U.S.C. § 300gg–1. The adjusted community rating system prohibits insurers from pricing policies according to an applicant's health status and sharply limits age-based variations. 42 U.S.C. § 300gg. In

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A Comprehensive Survey of Premiums, Product Choices, and Benefits 4 (Mar. 2009).

addition, insurers will no longer be permitted to exclude preexisting conditions from coverage, 42 U.S.C. § 300gg–3, or to base coverage eligibility on an applicant's health status, medical condition, or related factors, 42 U.S.C. § 300gg–4.

The effect of those reforms is to alter fundamentally the insurance business and, in particular, the mechanisms employed for spreading risk and keeping premiums affordable. First, prohibiting reliance on the traditional tools of underwriting would make participation in the insurance market more attractive for older and less healthy individuals with higher expected health care costs, thereby increasing the pressure on premiums, which in turn renders the insurance market less attractive for younger and healthier persons who have lower expected costs and are highly price sensitive. The attraction of a disproportionate share of high-risk individuals into the insurance pool will raise average costs, resulting in higher premiums for everyone. That deep imbalance in the pool of insurance customers can create a "marketwide adverse-selection death spiral" in the individual insurance market. Monheit, *supra*, at 169.

Second and relatedly, Congress recognized that, were the insurance-market reforms to be implemented without the mandate, healthy and younger individuals would have every incentive to take a "wait-and-see" approach, postponing the "purchase [of] health insurance until they needed care," 42 U.S.C. § 18091(2)(I)—the equivalent of "'insuring the building already on fire,'" *Federal Ins. Co. v. Raytheon Co.*, 426 F.3d 491, 499 (1st Cir. 2005).

Since health plans could neither exclude applicants from coverage based on preexisting conditions or other health-related factors, nor increase premiums based on health status, it would often be an entirely rational economic decision for healthy and low-risk individuals to forgo obtaining insurance coverage until their medical circumstances changed.

At the same time, guaranteed issue and community rating provide every incentive for the most unhealthy or medically risky individuals to flood the market because initial premiums could not be increased to reflect their individual medical risk. As a result, the insurance pool would skew dramatically toward individuals with higher health care costs, in turn driving up the cost of insurance– the polar opposite of Congress's intent in enacting the "Affordable" Care Act. *See* Uwe E., *The Case for Mandating Health Insurance*, N.Y. Times (Oct. 23, 2009, 7:06 AM), http://economix.blogs.nytimes.com/2009/10/23/the-case-for-mandating-health-insurance/.

Congress enacted the minimum individual coverage mandate as an antidote to those otherwise economically crippling adverse-selection and cost-shifting problems. *See* 42 U.S.C. § 18091(2)(I). Congress specifically found that, "[b]y significantly increasing health insurance coverage," the mandate requirement would help to "minimize * * * adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.*; *see* S. Rep. No. 89, 111th Cong., 1st Sess. 5 (2009) ("To ensure the insurance market reforms function properly, the [Act]

would create a personal responsibility requirement for health care coverage[.]").[11]

Congress also was informed that "guaranteed issue, community rating, and limits on pre-existing condition exclusions and waiting periods *will only be successful if there is an individual mandate to balance the risk in the insured population*." *Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Committee on Finance*, 110th Cong., 2d. Sess. 3 (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (emphasis added); *see also* Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals, Ch. 2, at 27 (Dec. 2008) (noting that "mandate[s] would increase insurance coverage by making it more costly for individuals to be uninsured and for employers not to offer coverage to their employees").

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[11] The court of appeals described the mandate as "toothless" and thus entirely severable because the amount of the penalty is relatively low and the statute limits enforcement of the penalty provision. No. 11-398, Pet. App. 151a-152a, 183a. However, this Court's operating "presumption of law [is] that * * * citizens obey the law," not that they disregard it in the absence of draconian penalties. *United States v. Norton*, 97 U.S. 164, 168 (1877). In any event, the strength of the penalty needed to enforce mandated behavior in any statute is a quintessentially legislative policy judgment. It has no bearing on the separate legal question of whether Congress, had it known that the mandate would be invalidated, would have wanted the insurance-market reforms to stand on their own, without *any* statutory mechanism (of any strength) for countering the known adverse-selection and cost-shifting problems.

Finally, the vital interconnectedness of the minimum individual coverage mandate and the insurance-market reforms was reconfirmed by the Congressional Budget Office, which advised shortly after the law's passage that, implementation of those market reforms without the minimum individual coverage provision would increase premiums for new policies by approximately 15% to 20% because of the adverse-selection problem that would result. *See* Congressional Budget Office, Effects of Eliminating the Individual Mandate to Obtain Health Insurance at 2 (June 16, 2010). About 16 million additional people would remain uninsured in 2019 (39 million rather than 23 million) without the mandate, according to that report. *Id.*[12]

Those reasons are why Congress determined that the minimum individual coverage 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(2)(I) (emphasis added). Given the known economically and programmatically damaging consequences of guaranteeing the issuance of insurance without regard to individual health status or the timing of the insurance application,

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[12] Because of adverse selection, that missing 16 million individuals is likely to include healthier and younger individuals, underscoring that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market. Over time, that would substantially reduce access to affordable coverage, the opposite of what Congress sought to achieve by enacting ACA.

Congress would not have wanted its insurance-market reforms to "stand on their own," *Alaska*, 480 U.S. at 689, without the mandate present to temper the severe adverse-selection and cost-shifting problems. Quite the opposite, ACA's text documents that Congress considered the minimum individual coverage provision and its insurance-market reforms "not like a collection of bricks, some of which may be taken away without disturbing the others, but rather * * * like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole." *Carter*, 298 U.S. at 315-316.

C. Congress Knew That States' Efforts To Implement Similar Market Reforms Without A Mandate Had Not Worked

1. Congress Was Aware of Failed State Reform Efforts

To determine whether a law can "function in a manner consistent with * * * the original legislative bargain," this Court considers not only the text and structure of the law, but also the experiential backdrop against which Congress legislated. *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted); *see id.* at 691-696 (considering legislative history in determining severability); *see also Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010) (considering statute's "historical context" in determining severability). Here, that history is one of severely compromised or failed legislative efforts to implement market reforms

without an adequate mandate of minimum individual insurance coverage.

In the 1990s, a number of States enacted individual market reforms, including guaranteed issue and various community rating requirements, without a minimum individual coverage requirement. The result in each State was a general destabilization of individual markets, increases in premiums, and declining 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, 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, *id.* at 4-7, and coverage rates plummeted as a result, dropping from an enrollment of 102,000 to 54,000 between 1994 and 2000. *See* U.S. Census Bureau, Historical Health Insurance Tables, Table HI-6 (1987—2005), *available at* http://www.census.gov/hhes/www/hlthins/data/historical/original.html. 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." Maine Bureau of Insurance, *supra*, at 10.

In Kentucky, adverse selection similarly contributed to significant destabilization of the individual market. Within two years of Kentucky's enactment of comprehensive insurance market reforms in 1994—including guaranteed issue and modified community rating requirements—more than forty insurers ended their participation in Kentucky's individual market, with only two insurers remaining to sell new policies in the individual market. Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Politics, Policy & Law 152 (2000).[13] Responding to the collapse of the individual market and fearing that many residents across the State no longer had coverage options, Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. Health Politics, Policy & Law 175, 194 (2000), the Kentucky legislature began repealing the insurance reforms in 1997, eventually eliminating many of the reforms' core provisions, including guaranteed issue and modified community rating. *See* Kirk, *supra*, at 152, 158; Nancy C. Turnbull, *et al.*, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Short Case Studies of Six States* 7 (Feb. 2005) ("The 1998 reforms were meant to attract

[13] Approximately 23 of these insurers were holding more than 100 individual policies but stopped selling new coverage when the reforms were enacted. Holding only a few or no policies, the rest of the insurers left Kentucky's individual market altogether. *See* Kirk, *supra*, at 152.

carriers back into the market and reduce rates for the healthy enrollees of existing carriers.").

The deterioration of the insurance market likewise led the New Hampshire legislature eventually to repeal its reforms of the individual health insurance market. In 1994, New Hampshire enacted reforms that included guaranteed issue, modified community rating, and limits on preexisting condition exclusions. *See* Alexander K. Feldvebel & David Sky, *A Regulator's Perspective on Other States' Experiences*, 25 J. Health Politics, Policy & Law 197, 198 (2000). Between 1994 and 2000, the number of carriers participating in the individual market dropped from twelve to two, and the two insurers that remained offered individual policies at higher prices. *Id*. at 197, 199. In 1997, the New Hampshire Insurance Department characterized those market changes as a "market-wide antiselection spiral." 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) (citing New Hampshire Insurance Department, *An Analysis of the Nongroup Market with Recommendations for Change* (Oct. 27, 1997)). In 2001, the New Hampshire legislature repealed the guaranteed issue requirement and allowed insurers once again to use medical underwriting for policies sold in the individual market. National Ass'n of Health Underwriters, *Analysis of State-Level Health Insurance Market Reforms* 11-12 (Oct. 2005).

Similarly, volatility in the individual market prompted the State of Washington to repeal the individual market reforms it had passed in 1993.

The 1993 reforms included a guaranteed issue provision, a phased-in community rating requirement, and limits on preexisting condition exclusions. *See* Kirk, *supra*, at 133, 136-137. 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, at A21. Over that same period, enrollment in Washington's individual market fell by 25 percent, *id.*, and the market retracted from having 19 private health insurers in 1993 to only three by 1999, Roger Stark, *Overview of the Individual Health Insurance Market in Washington State*, Washington Policy Center (Jan. 2011) at 1.

By September 1999, there were only two insurers offering individual health insurance, both of which announced their intention to stop selling individual policies in Washington because the reforms rendered it unviable for them to continue offering affordable coverage to consumers. Stark, *supra*, at 1 (explaining that by 1999 "the individual market had essentially collapsed"); *see* Press Release, Office of Governor Gary Locke, "Locke signs bill to revive individual health insurance market" (Mar. 23, 2000), *available at* http://www.digitalarchives.wa.gov/GovernorLocke/press/press-view.asp?pressRelease=283&newsType=1 ("The governor noted that he signed the law at a time when individuals in 36 of 39 counties cannot buy individual policies at any price."); *see also* Conrad F. Meier, *Universal Health Insurance in Washington State: A Grim Prognosis for All of Us*, Medical Sentinel (Mar./Apr. 2000).

Starkly demonstrating the problem of adverse selection, "Washington state also became a magnet for patients from around the country who had serious and expensive medical conditions because they knew they could get immediate health insurance coverage." Doug Ericksen and Roger Stark, *What Washington, D.C. Could Learn from Washington State Health Care Reform*, Washington Policy Center (July 2010). Additionally, many people took advantage of the system by, for example, changing from a low-cost health insurance plan with a high deductible to a high-coverage plan with a low deductible when they needed major medical treatment, and then changing back or dropping their coverage altogether after receiving the treatment. *Id.*; *see* Bill Richards, *Perils of Pioneering: Health-Care Reform In State of Washington Riles Nearly Everyone*, Wall St. J., Apr. 4, 1996, at A1 (describing cancellation letter insurer received from a Washington woman who praised the policy's maternity benefits and "would be sure to come back and get another [policy] if she got pregnant again").

As a result of the near "collapse" of the individual insurance market, the Washington legislature repealed the market reforms in 2001, and subsequently enacted legislation designed 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).

Finally, in 1996, the Massachusetts legislature passed reforms, including guaranteed issue of certain

benefit packages, a prohibition on preexisting condition exclusions and waiting periods, and a modified community rating system. Kirk, *supra*, at 161; *see also* Turnbull, *supra*, at 11. After those reforms were implemented, premiums rose and coverage rates fell, with enrollment in the individual market declining from approximately 135,000 people in 1996 to just over 55,000 in 2000. Turnbull, *supra*, at 13; *see also* Kirk, *supra*, at 167-68.

In 2000, the Massachusetts legislature began modifying those provisions, Turnbull, *supra*, at 13, culminating with the passage of a comprehensive health reform bill in 2006. S.K. Long, *On the Road to Universal Coverage: Impact of Reform In Massachusetts At One Year*, 27 Health Affairs w270, w270 (June 3, 2008). The 2006 reform package maintained some of the measures passed a decade earlier, including guaranteed issue and modified community rating, but added numerous new requirements, including a minimum individual coverage mandate that required every qualifying Massachusetts resident over the age of 18 to purchase health insurance. J.E. McDonough, *et al.*, *Massachusetts Health Reform Implementation: Major Progress and Future Challenges*, 27 Health Affairs w285, w291 (June 3, 2008).

Other States that enacted market reforms without an individual mandate in the 1990s experienced similar destabilization. *See* Monheit, *supra*, at 168 (as of 2004, New Jersey individual market was "heading for collapse"); Paul Howard, *Building a Market-Based Health-Insurance Exchange in New York*, Manhattan Institute for Policy

Research at 6-7 (Apr. 2011) (noting that "New York has one of the most expensive individual and small-group insurance markets in the country, largely as a result of its 1992 community-rating/open-enrollment" law, and explaining that regulatory policies like community rating "[o]ver time * * * can lead to a 'death spiral,' where the risk pool—and the market—collapses entirely (as it has in New York)"); Mark A. Hall, *An Evaluation of Vermont's Reform Law*, 25 J. Health Politics, Policy & Law 101 (2000) (Vermont); Elliott K. Wicks, *The Individual Market in Vermont: Problems and Possible Solutions* 15 (Dec. 2006) (reporting that the individual health insurance market in Vermont "seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing") (prepared for Vermont Department of Banking, Insurance, Securities and Health Care Administration); Susan Besio, *Vermont Health Care Reform: Five-Year Implementation Plan* 3, 10 (Dec. 1, 2006) ("[T]he Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation."); *see also* Les Masterson, *Indiana Program Shows Health Reform Without Individual Mandate Is Costly*, HealthLeaders Media (Sept. 9, 2009); Rob Damler, *Experience Under The Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured*, Milliman Health Reform Briefing Paper (Aug. 2009).

Congress enacted ACA and its minimum individual coverage provision against that backdrop of severely compromised and failed state efforts at

mandate-less market reforms, and it aimed to inoculate its insurance-market reforms against the same adverse-selection and cost-shifting problems that had plagued the States by requiring a minimum level of individual insurance coverage. Indeed, Congress was expressly advised of the market disruptions that occurred with State reform efforts and the ensuing lesson that the minimum individual coverage mandate is "a critical linchpin * * * to the overall effort to reform the health care market and bring associated costs under control." 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (statement of Rep. Miller); *see, e.g., Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Committee on Finance*, 110th Cong., 2d. Sess. 3 (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (noting that the absence of a minimum individual coverage mandate in Washington state during the mid-1990s effort to reform insurance markets "rapidly led to a classic adverse risk spiral in the marketplace").

Accordingly, when Congress labeled the mandate "essential" to the implementation of its insurance-market reforms, 42 U.S.C. § 18091(2)(I), that judgment was based on its knowledge that state efforts to implement similar insurance market reforms without the economic counterbalance of a minimum individual coverage requirement had not worked. Congress specifically found both that, "if there were no [minimum individual coverage mandate] requirement, many individuals would wait to purchase health insurance until they needed care," and that the mandate would help to "minimize this

adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.*

In other words, Congress's 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(2)(I), means exactly what it says. It embodies Congress's judgment that the minimum individual coverage provision and the insurance-market reforms regarding guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating are inseparable components of a unified legislative design that, for severability purposes, must rise or fall together. Indeed, implementation of ACA's market reforms in the absence of the minimum coverage provision would thwart Congress's central goal of increasing the availability of affordable health care coverage.

2. The Court of Appeals Failed to Focus on How Congress Intended the Mandate and Reforms to Function Together

The Eleventh Circuit reached a contrary result, holding that the mandate is entirely severable from the balance of ACA. Pet. App. 5a, 172a-186a. But the court was able to do so only because its analysis focused on whether a statute with insurance reforms but without a mandate could be operative or enacted as law. Of course it could. Many States passed such

laws. But Congress knew that, without a mandate, they had produced disastrous results.

The relevant question for severability purposes, however, is whether the Congress that looked at those State experiences and labeled the mandate "essential" to the proper functioning of its insurance-market reforms would have intended, if the mandate were stricken, to replicate on a national level the profound adverse selection and cost-shifting problems that had afflicted State reform efforts. *See*, *e.g.*, *Booker*, 543 U.S. at 265. The court of appeals, in other words, failed to ask the right question about Congress's intended functioning of the law and, in so doing, never came to grips with the implications of Congress's knowledge of state reform efforts, and the proven, substantial risk of profound economic displacement and a "market-wide antiselection spiral" that the reforms would cause in the absence of a mandate.[14]

Tellingly, the federal government has agreed in previous briefing that the minimum individual coverage provision is not severable from ACA's guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions. *See, e.g.*, No. 11-398, U.S. Pet. at 25 ("Indeed, no party to this case has suggested that the guaranteed-issue and community-rating requirements could function effectively without the minimum coverage provision."); Nos. 11-393, 11-400,

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[14] 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).

U.S. Brief in Response at 10-11 (similar); Br. of United States, *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir. Apr. 1, 2011) at 59 (recognizing "that the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions").[15]

Those insurance-market reforms not only cannot function as Congress intended if enforced without a minimum coverage mandate, but in fact would thwart congressional intent if left to operate alone. The Eleventh Circuit cited no case, and amici are aware of none, where severability was found in the face of such a plain textual linkage, express findings, extensive evidence of the catastrophic consequences of leaving just half of a legislated package intact, and the Executive Branch's judgment that specified

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[15] The Government's briefs consistently use the term "guaranteed issue" as an umbrella term encompassing not only the guarantee of insurance for all qualified applicants, but also the prohibitions on preexisting-condition exclusions and other health-status discrimination in coverage eligibility. *See* No. 11-398, U.S. Pet. at 4 (describing fact that Act "will bar insurers from refusing coverage because of a pre-existing medical condition" as the "guaranteed-issue" provision, and citing to both 42 U.S.C. § 300gg-1, the guaranteed issue provision, and 42 U.S.C. § 300gg-3, the provision barring preexisting condition exclusions); Nos. 11-393, 11-400, U.S. Resp. Br. 4 (same), 10, 31-32 (arguing that, without the individual mandate, "the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available," citing to Congress's finding in 42 U.S.C. § 18091(2)(I) that the prohibitions on preexisting condition exclusions (PHSA § 2704, 42 U.S.C. § 300gg-3) and other health status discrimination in coverage eligibility (PHSA § 2705, 42 U.S.C. § 300gg-4), standing alone, would lead to adverse selection).

provisions are inextricably bound together. This case should not be the first to cast aside such powerful evidence that the specified statutory provisions would not function as Congress intended, and indeed that severing the interconnected provisions within the statute would likely do significant harm.

* * * * *

Should this Court strike the mandate and have to address the severability question, then this Court must determine whether "different clauses of [the] act are so dependent upon" the minimum individual coverage mandate "that it is evident the legislature would not have enacted one of them without the other," *Huntington v. Worthen*, 120 U.S. 97, 102 (1887), and whether those additional provisions could, standing alone, "function in a manner consistent with the intent of Congress," *Alaska Airlines*, 490 U.S. at 685 (emphasis omitted). In undertaking that analysis, this brief addresses only the insurance-market reform provisions with which AHIP, Blue Cross Blue Shield, and their members have direct experience both generally and in particular with respect to reform efforts at the state level. Based on that expertise, at a minimum, the insurance-market reforms implemented by ACA cannot function as Congress intended without the individual coverage requirement and, in fact, would likely impede Congress's goal of ensuring affordable universal health care if left to operate on their own. Those market reforms include the guaranteed issue provision (42 U.S.C. § 300gg-1), the provisions prohibiting waiting periods, preexisting condition exclusions, and other health status discrimination

(42 U.S.C. §§ 300gg-3, 300gg-4), and the adjusted community rating provision (42 U.S.C. § 300gg(a)). The insurance-market reforms are thus inseverable from the minimum individual coverage provision and would have to be stricken from ACA if the individual coverage requirement were to be invalidated.

CONCLUSION

For the foregoing reasons, if this Court invalidates the minimum individual coverage provision, 26 U.S.C. § 5000A, the court of appeals' severability judgment should be reversed and, with respect to the minimum individual coverage mandate's operation, this Court should sever, along with Section 5000A, ACA's guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions.

Respectfully submitted.

Roger G. Wilson
Senior Vice-President
& General Counsel
BLUE CROSS BLUE SHIELD
ASSOCIATION
225 N. Michigan Ave.
Chicago, IL 60601
(312) 297-6000

Counsel for Blue Cross Blue Shield Association

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

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

Counsel for America's Health Insurance Plans

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