Nos. 19-840, 19-1019

In the
Supreme Court of the United States

CALIFORNIA, ET AL., *Petitioners*,

v.

TEXAS, ET AL., *Respondents.*

TEXAS, ET AL., *Petitioners*,

v.

CALIFORNIA, ET AL., *Respondents.*

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

BRIEF FOR RESPONDENTS-CROSS PETITIONERS NEILL HURLEY AND JOHN NANTZ

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QUESTIONS PRESENTED

In 2010, Congress commanded almost every American to buy "minimum essential [health-insurance] coverage." Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, §1501(b). In 2012, this Court held that "[t]he Federal Government does not have the power to order people to buy health insurance." *NFIB v. Sebelius*, 567 U.S. 519, 575 (2012) (Roberts, C.J.); *id.* at 657 (joint dissent). The Court upheld the law only because that mandate was attached to a revenue-producing penalty and thus could "reasonably be characterized as a tax." *Id.* at 574.

In 2017, Congress eliminated that tax. But it left undisturbed both the mandate itself and the ACA's inseverability clause—that is, the sections of the statute that declare the mandate "essential" to the ACA's operation. 42 U.S.C. §18091(2)(I). The questions presented are:

1. Whether at least one respondent has standing to challenge the constitutionality of Congress's ongoing command that Americans buy health insurance.

2. Whether Congress may command Americans to purchase health insurance other than as a trigger for a revenue-producing tax.

3. Whether, in light of Congress's decision in 2017 to eliminate any revenue-producing tax yet leave intact both the command and the inseverability clause, any provisions of the ACA remain operative.

4. Whether the district court properly declared the ACA invalid in its entirety and unenforceable anywhere.

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INTRODUCTION

The Affordable Care Act commands nearly all Americans to buy health insurance. 26 U.S.C. §5000A(a). Almost ten years ago, this Court construed that command as a valid exercise of Congress's taxing power because the Act yielded the "essential" feature of any tax: it raised at least some revenue for the federal government. *NFIB v. Sebelius*, 567 U.S. 519, 564 (2012). Without that saving feature, the Court held, the mandate would have exceeded Congress's powers under the Commerce Clause and the Necessary and Proper Clause. *See id.* at 549-61 (Roberts, C.J.); *id.* at 649-61 (joint dissent).

The Act now lacks that saving feature. In 2017, Congress set the penalty for failure to comply with the mandate at $0. But it left the mandate in place. Under a straightforward application of *NFIB*, that makes the mandate unconstitutional—even if no member of Congress expected that outcome. "[T]he limits of the drafters' imagination supply no reason to ignore the law's demands." *Bostock v. Clayton Cty.*, — S. Ct. —, 2020 WL 3146686, at *3 (2020).

So too for what follows from that straightforward application of *NFIB*. The "express terms" of the ACA make clear that Congress never would have passed the Act without the individual mandate. *Id.* Under this Court's severability cases, that makes the mandate inseverable. So the entire ACA must fall—

any "extratextual considerations" about politics or pandemics notwithstanding. *Id.* "[N]one of th[o]se contentions … allow" the Court, or anyone else, "to ignore the law as it is." *Id.* at 9.

STATEMENT OF THE CASE

A. Background

1. After President Obama took office in 2009, he and Congress set out "to build [the] future" of the American health-care system. *Remarks by the President to a Joint Session of Congress on Health Care*, Sept. 9, 2009, https://bit.ly/2Y2M1xC. The President proposed specific federal legislative reforms: Forbid insurance companies to "deny you coverage because of a preexisting condition." *Id.* Create new government "insurance exchange[s]" where people could shop for coverage, with "tax credits" available for those "who still can't afford the lower-priced insurance available in the exchange." *Id.* Stop "individuals who can afford coverage" from "gam[ing] the system" by "requir[ing]" people "to carry basic health insurance." *Id.* And do it all without "add[ing] one dime to our deficits—either now or in the future." *Id.*

Congress had not previously tried those reforms, but seven states had. *See NFIB v. Sebelius*, 567 U.S. 519, 597 (2012) (Ginsburg, J.). In the 1990s, states from Maine to Washington imposed "guaranteed issue" laws, which require insurers to sell health insurance to anyone regardless of preexisting health conditions. Those states also required insurers to price their policies without considering whether an

applicant had a preexisting condition, a pricing practice called "community rating." *See id.*

Combined, those two laws let persons with preexisting conditions (who thus consume more health-care services) buy insurance at the same price as healthy consumers (who consume less). But that "impose[d] massive new costs on insurers, who [we]re required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage." *Id.* at 548 (Roberts, C.J.). Those laws also created "an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage." *Id.* Those economic realities forced insurers "to increase premiums" because, "more and more, it was the sick rather than the healthy who were buying insurance." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). "And that consequence fed back into the first: As the cost of insurance rose, even more people waited until they became ill to buy it." *Id.* at 2485-86.

So it went across the board. "All seven states suffered from skyrocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers." *NFIB*, 567 U.S. at 597-98 (Ginsburg, J.). In Washington, for example, "premiums rose by 78 percent and the number of people enrolled fell by 25 percent" in the three years after it adopted guaranteed-issue and community-rating rules. *King*, 135 S. Ct. at 2486. Three years after that, "17 of the State's 19 private insurers had left the market, and

the remaining two had announced their intention to do so." *Id.*

Massachusetts alone avoided those disastrous outcomes. That's because it adopted "two more reforms" *beyond* guaranteed-issue and community-rating: It "required individuals to buy insurance or pay a penalty, and it gave tax credits to certain individuals to ensure that they could afford the insurance they were required to buy." *Id.* Massachusetts's mandate to buy insurance thus "cracked the adverse selection problem" by "ensur[ing] that insurers would not be left with only the sick as customers." *NFIB*, 567 U.S. at 598-99 (Ginsburg, J.).

In short, the states' "long history of failed health insurance reform," *King*, 135 S. Ct. at 2485, left no doubt: "Imposition of community-rated premiums and guaranteed issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with … a mandate on individual[s] to be insured." *NFIB*, 567 U.S. at 597 (Ginsburg, J.) (emphasis omitted) (quoting Hearings before the House Ways and Means Committee, 111th Cong., 1st Sess., 10, 13 (2009) (statement of Uwe Reinhardt)).

2. Based on those unmistakable lessons, Congress "followed Massachusetts' lead," *id.* at 599, when it passed the Patient Protection and Affordable Care Act, 124 Stat. 119, on a party-line vote. The Act contains nine titles as amended by a tenth.

Title I "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health

insurance market." *King*, 135 S. Ct. at 2485. Three of those "key reforms," *id.* at 2486, form the Act's beating heart: (1) the guaranteed-issue and community-rating provisions, 42 U.S.C. §§300gg-1(a), 300gg; (2) the individual mandate, 26 U.S.C. §5000A(a), necessary to stave off the "inexorabl[e] … market … extinction" the first two provisions would otherwise cause, *NFIB*, 567 U.S. at 597 (Ginsburg, J.) (internal quotation marks omitted); and (3) "refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line" to make insurance more affordable, *King*, 135 S. Ct. at 2487 (citing 26 U.S.C. §36B).

Congress housed the individual mandate in a code section separate from the guaranteed-issue and community-rating provisions. *See* 26 U.S.C. §5000A. Entitled "Requirement to maintain minimum essential coverage," §5000A consists of seven subsections; the first five of those are relevant here:

- Subsection 5000A(a) contains the mandate. It commands that "[a]n applicable individual shall … ensure that the individual … is covered under minimum essential coverage."
- Subsection 5000A(b), entitled "Shared responsibility payment," "impose[s] on the taxpayer a penalty" for "fail[ing] to meet the requirement of subsection (a)."
- Subsection 5000A(c) specifies a formula for calculating the "amount of the penalty" imposed by subsection (b).

- Subsection 5000A(d) exempts certain people from subsection (a)'s *mandate*.
- Subsection 5000A(e) exempts *other* people from subsection (b)'s *penalty* if they fail to comply with subsection (a)'s mandate.

Elsewhere in the ACA, Congress enacted text that calls the mandate "essential" to the ACA three times. 42 U.S.C. §§18091(2)(H), (2)(I), (2)(J). The mandate's "absence," Congress said, "would undercut Federal regulation of the health insurance market," *id.* §18091(2)(H), and prevent "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.* §18091(2)(I). In six other places, the statutory text confirms that the mandate works "together with the other provisions of this Act" as an integrated whole to achieve Congress's goals. 42 U.S.C. §§18091(2)(C), (2)(E), (2)(F), (2)(G), (2)(I), (2)(J).

The Act's eight other titles build on Title I's coverage-broadening provisions for the individual market. Title II expands Medicaid and other public-insurance programs. Titles III through VIII outline specific features and efficiencies Congress intended those coverages to provide. And Title IX contains the revenue-raising provisions to pay for it all.

3. Not everyone celebrated the Act's passage. In its immediate wake, no fewer than five lawsuits challenged its constitutionality or the legality of rules implementing it. Some of those cases made their way to this Court; of those, two are relevant here.

In the first, the Court resolved claims that the individual mandate exceeded Congress's enumerated powers. *NFIB v. Sebelius*, 567 U.S. 519 (2012). Five Members of the Court agreed with the plaintiffs that "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance," *id.* at 562 (Roberts, C.J.), and that read this way, the mandate exceeds Congress's powers under the Commerce Clause and the Necessary and Proper Clause, *see id.* at 549-62; *id.* at 649-61 (joint dissent). Those five Justices saw "no reason to depart from" 200 years of precedent confirming that "[t]he Framers gave Congress the power to *regulate* commerce, not to *compel* it." *Id.* at 555 (Roberts, C.J.).

In the Chief Justice's view, that conclusion required the Court then to consider whether it was "fairly possible" to read the individual mandate as a permissible exercise of Congress's taxing power. *Id.* at 574 (Roberts, C.J.). Four other Members of the Court agreed with the Chief Justice that such a reading was "fairly possible," *id.*, because the Act "yield[ed] the essential feature of any tax: It produces at least some revenue for the Government," *id.* at 564. Based on that fact, the Court "adopt[ed]" that "saving construction" and upheld §5000A "because it can reasonably be read as a tax." *Id.* at 575.

Though the Court split 5-4 on the merits, its Members agreed unanimously that the individual mandate constitutes the ACA's indispensable core. The Chief Justice called the individual mandate "Congress's solution to the[] problems" arising from the guaranteed-issue and community-rating

provisions. *Id.* at 548. Justice Ginsburg, joined by Justices Breyer, Sotomayor, and Kagan, said "guaranteed issue and community rating would work as intended" only "[w]hen complemented by an insurance mandate." *Id.* at 619. And the joint dissent concluded that the entire Act crumbles without the individual mandate. *See id.* at 697-707.

And in *King v. Burwell*, the Court rejected a challenge to an IRS rule that subsidized insurance policies purchased on federally run health-care exchanges. 135 S. Ct. 2480 (2015). To support its holding, the Court emphasized how "closely intertwined" Congress made the individual mandate, the guaranteed-issue and community-rating provisions, and the tax credits: "Congress found that the guaranteed issue and community rating requirements *would not work without* the coverage requirement. §18091(2)(I). And the coverage requirement *would not work without* the tax credits." *Id.* at 2487 (emphasis added); *see also id.* at 2494 (stating that the guaranteed-issue and community-rating requirements "only work when combined with the coverage requirement and the tax credits").

4. "Major initiatives practically guarantee" "unexpected consequences." *Bostock v. Clayton Cty.*, — S. Ct. —, 2020 WL 3146686, at *3 (June 15, 2020). The ACA's unexpected consequences are more severe than most.

Consider first how it has increased premiums for individual plans. From 2013 to 2017, the average monthly premium in the 39 states using healthcare.gov more than doubled, jumping from $232

to $476. Dep't of Health & Human Servs., Office of the Assistant Sec'y for Planning and Evaluation, *Individual Market Premium Changes: 2013-2017* at 1 (May 23, 2017), https://bit.ly/3h9CFJ9. In some states—Alabama, Alaska, Oklahoma—premiums more than *tripled* during that period. *See id.* at 4. A McKinsey & Company study for HHS concluded that in some of the healthcare.gov states, the guaranteed-issue and community-rating provisions and related risk factors caused between 41 percent and 76 percent of those premium hikes. U.S. Sens. Ron Johnson & Michael S. Lee, *Dear Colleague Letter* (July 19, 2017), https://bit.ly/3h84n8X.

The premiums for employer-sponsored plans—the way more than 153 million Americans get health insurance—spiked as well. *See* Kaiser Family Foundation, *Employer Health Benefits: 2019 Annual Survey* 7 (2019), https://bit.ly/3cHwLeF. Last year, the average family premium in an employer plan was $20,576, a 54 percent jump from 2009. *Id.* at 38. On average, workers pay $6,015 of that amount. *Id.* at 6. Between 2008 and 2018, premiums for employer-sponsored plans grew "twice as fast as workers' earnings (26%) and three times as fast as inflation (17%)." Kaiser Family Foundation, *Premiums for Employer-Sponsored Family Health Coverage Rise 5% to Average $19,616; Single Premiums Rise 3% to $6,896* (Oct. 3, 2018), https://bit.ly/2Up0jY8.

And premiums constitute just part of an insured's health-care expenses. Deductibles—"the amount that an enrollee must pay toward the cost of in-network covered services before the plan will start paying for

most types of care"—are another major part. Kaiser Family Foundation, *Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2020* (Dec. 9, 2019), https://bit.ly/37dIQHm. This year, the average deductible for a bronze plan with combined medical and prescription-drug deductibles is $6,506. *Id.* at Fig. 2. For a bronze plan with separate medical and prescription-drug deductibles, the average deductible is $4,683. *Id.* at Fig. 3. That means a family with a high-deductible bronze plan pays on average between $10,395 and $12,218 out of pocket every year in combined premiums and deductibles before coverage kicks in. A substantial number of working-age Americans pay those costs: "the share of Americans under 65 enrolled in high-deductible plans" jumped from 33.9 percent in 2013 to 43.7 percent in 2017. John Tozzi & Zachary Tracer, *Sky-High Deductibles Broke the U.S. Health Insurance System*, Bloomberg (June 26, 2018), https://bloom.bg/37dQVfa.

Americans dissatisfied with those costs have few options for seeking other coverage. Almost no meaningful competition exists on the exchanges. In 2013, the year before the Act took effect, "395 insurers sold coverage in the individual market across all states and the District of Columbia." Edmund F. Haislmaier, *2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink*, Heritage Foundation 1 (Jan. 25, 2018), https://herit.ag/3cKqkYg. Just 181 insurers did so in 2018. *Id.* "That makes the 2018 exchanges as a whole 54 percent less competitive than the individual market was before" the Act took effect. *Id.* The

situation looks just as bleak on a county level: 51.3 percent of all counties in the Nation have only one insurer selling policies on an exchange, and nearly 82 percent of counties have only one or two sellers. *Id.* at 4. "Just 7 percent of counties have four or more." *Id.*

Affording a plan is one thing; actually getting care under it is another. People who buy plans on exchanges have faced dire reductions in the quantity and quality of available care. By 2018, 73 percent of the exchange market consisted of restrictive plans that "often have comparatively fewer providers in their network and across specialties." Avalere, *Plans with More Restrictive Networks Comprise 73% of Exchange Market* (Nov. 2017), https://bit.ly/2UndB7J.

5. The ACA's partisan history and sundry shortfalls have long made it a political target. In the first eight years after the ACA became law, Congress passed more than 30 bills amending it. Annie L. Mach & Janet Kinzer, Cong. Research Serv., *Legislative Actions to Modify the Affordable Care Act in the 111th-115th Congresses* 5-15 (June 27, 2018), https://bit.ly/2XHyk8i. More than 60 other similar bills passed just one house of Congress, including four in the House of Representatives that would have repealed the ACA entirely. *See id.* at 17-21.

One of those enacted amendments prompted this lawsuit. In 2017, Congress passed the Tax Cuts and Jobs Act, which "eliminat[ed]" the operative parts of 26 U.S.C. §5000A(c) by changing the tax penalty to "[z]ero percent" and "$0." Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054, 2092, §11081 (2017) (capitalization altered). Just as important,

however, is what the TCJA did *not* do: It didn't repeal the individual mandate in 26 U.S.C. §5000A(a) or the statutory findings in 42 U.S.C. §18091(2). Those provisions remain unchanged.

B. Proceedings Below

1. Neill Hurley and John Nantz, the individual plaintiffs here, have lived the ACA's shortfalls. Nantz pays $266.56 monthly in insurance premiums for a policy with a $6,500 annual deductible and a "limited network of providers." JA72. His plan limits him "to using the health care providers within the network"; it "provides no out-of-network benefits." *Id.*

Hurley has a bronze plan that covers his family of four for $1,081.70 per month. JA76. His plan's annual deductible is $6,000 per person or $12,000 for his family as a whole. *Id.* That means he pays up to $24,980.40 out of pocket every year for both premiums plus deductibles. *Id.* He switched to a bronze plan in 2018 because renewing his prior gold plan would have caused his monthly premiums to jump from $1,071.50 in 2017 to $1,594.84 in 2018, an increase he could not afford. *Id.*

Both plans, however, fail to cover all the doctors that Hurley's family used to see under his prior employer-sponsored plan. *Id.* So when he enrolled in an exchange plan to comply with the ACA's mandate, he picked a plan that would cover his kids' pediatrician but would require his family to find a new family practice physician, ENT specialist, dermatologist, urgent care facility, and urologist. JA76-77. His new specialists "are not of the same

quality" as the ones on his prior non-ACA plan. JA77. Worse yet, they "have limited the number of appointments available to patients with ACA plans, which delays [his family's] ability to timely access health care." *Id.*

Despite those problems, Hurley and Nantz continue to purchase ACA-compliant policies because they "value compliance" with their "legal obligations," including the mandate's command to buy minimum essential coverage. JA73-74, 77.

2. After the TCJA amended §5000A(c), Hurley and Nantz joined with Texas and 17 other states as plaintiffs challenging the individual mandate's constitutionality. JA29-70. California, fifteen other states, and the District of Columbia intervened as defendants.

The District Court granted partial summary judgment to Plaintiffs, holding that the post-TCJA individual mandate exceeds Congress's power under the Commerce Clause and the Necessary and Proper Clause. PA163a-231a.[1] Hurley and Nantz have standing to challenge the individual mandate, it concluded, because they "are the object of the Individual Mandate. It requires them to purchase and maintain certain health-insurance coverage." PA182a. With standing established, the District Court held that because the TCJA changed the amount of §5000A(b)'s shared responsibility payment to zero, §5000A "no longer" bears "the essential feature of any

[1] All "PA" citations are to the petition appendix in *California v. Texas*, No. 19-840.

tax"—it fails to raise revenue for the government. PA194a. "So long as the shared-responsibility payment is zero, the saving construction articulated in *NFIB* is inapplicable and the Individual Mandate cannot be upheld under Congress's Tax Power." PA195a. And it "continues to be unsustainable under Congress's Interstate Commerce Power." PA204a. Finally, the District Court held that the "Individual Mandate is inseverable from the entire ACA." PA205a.

3. By a 2-1 vote, a panel of the Fifth Circuit affirmed the District Court's judgment on the merits. The majority agreed that Hurley and Nantz have Article III standing to challenge the mandate because they "are the objects of the individual mandate" and "have purchased insurance in order to comply with that mandate." JA397. The "undisputed" record evidence, *id.*—which "[t]he intervenor-defendant states … did not challenge," JA398—led the District Court to "expressly f[i]nd that Hurley and Nantz bought health insurance because they are obligated to, and" the majority "defer[red] to that factual finding," *id.*

The majority also agreed that the post-TCJA individual mandate is unconstitutional. *See* JA414-26. That conclusion follows, the majority said, from a straightforward application of *NFIB*'s holdings:

- The Chief Justice and the joint dissent formed a majority for the conclusion that when given its "most straightforward reading" as a "command[] … to purchase insurance," "the individual mandate is not constitutional under

either the Interstate Commerce Clause or the Necessary and Proper Clause." JA415 (quoting *NFIB*, 567 U.S. at 562 (Roberts, C.J.)).

- Based on that holding, the Chief Justice considered whether, "as an exercise in constitutional avoidance, the mandate could be read not as a command but as an *option* to purchase insurance or pay a tax." JA417.
- The Chief Justice, joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan, concluded that "it was 'fairly possible' to read the individual mandate" "together with the shared responsibility payment" as "a legitimate exercise of Congress' taxing power for four reasons." JA417-18. Foremost among them: "the shared responsibility payment 'produce[d] at least some revenue for the Government.'" JA418 (quoting *NFIB*, 567 U.S. at 564).

The TCJA's setting the shared responsibility payment to zero thus meant "the provision's saving construction is no longer available." JA419. Without a monetary penalty, the shared responsibility payment "no longer yields the 'essential feature of any tax' because it does not produce 'at least some revenue for the Government.'" *Id.* (quoting *NFIB*, 567 U.S. at 564). That makes it "no longer fairly possible to save the mandate's constitutionality under Congress' taxing power." JA420 (cleaned up). Instead, it requires giving the mandate its "'most straightforward' reading"—as "a command to purchase insurance." *Id.* (quoting *NFIB*, 567 U.S. at 562). And "[u]nder that reading, the individual mandate is unconstitutional because,

under *NFIB*, it finds no constitutional footing in either the Interstate Commerce Clause or the Necessary and Proper Clause." *Id.*

But the majority vacated the District Court's judgment that the mandate is not severable from the ACA and remanded with instructions for the District Court to redo its severability analysis. *See* JA427-48. In particular, the majority tasked the District Court with "consider[ing]" the federal government's contention first raised at oral argument "that relief in this case should be tailored to enjoin enforcement of the ACA in only the plaintiff states—and not just that, but that the declaratory judgment should only reach ACA provisions that injure the plaintiffs." JA446.

4. Judge King dissented. She would have held that the Individual and State Plaintiffs lack standing, JA455-67; that the individual mandate remains a constitutional exercise of Congress's taxing power despite producing no revenue, JA467-74; and that even if the individual mandate were unconstitutional, it is severable from the ACA, JA474-88.

SUMMARY OF ARGUMENT

I. Hurley and Nantz have Article III standing to challenge the individual mandate. The mandate states that Hurley and Nantz "shall" buy health insurance—a mandatory command governing their conduct now. That makes Hurley and Nantz objects of a regulation requiring them to spend money every month they otherwise would not. Those economic harms constitute a quintessential Article III injury,

and a judgment that the mandate violates the Commerce Clause would eliminate that injury.

II. After the Tax Cuts and Jobs Act of 2017, the individual mandate is unconstitutional. The Court upheld 26 U.S.C. §5000A in *NFIB v. Sebelius* only after concluding it was fairly possible to read that section as an exercise of Congress's taxing power. And that saving construction was fairly possible only because §5000A produced "at least some revenue for the Government"—the "essential feature of any tax."

The TCJA eliminated that feature. Amended §5000A(c) now sets at $0 the amount of §5000A(b)'s penalty for noncompliance with §5000A(a)'s mandate. The result? Section 5000A now raises *no* revenue for the government. All that's left is a command to buy insurance. And *NFIB* already held that neither the Commerce Clause nor the Necessary and Proper Clause gives Congress power to decide what Americans buy or when we buy it.

III. The ACA's text and structure, as enacted in 2010 and as they remain after the TCJA, leave no doubt: Congress would not have enacted the ACA without the individual mandate. A section of the United States Code states nearly a dozen times in at least three different ways that the individual mandate is essential to the ACA's proper functioning and works together with the Act's other provisions to accomplish its goals. Indeed, every Member of the Court to consider the ACA in *NFIB v. Sebelius* and *King v. Burwell* recognized that the mandate, the community-rating and guaranteed-issue provisions, and the tax credits form an integrated whole. As a result,

stripping only the mandate from the ACA will produce a statute foreign in form and function to what Congress passed. That amounts to rewriting the law, not saving it. The mandate is not severable; the entire ACA must fall.

ARGUMENT

I. Hurley and Nantz have Article III standing to challenge the individual mandate.

Few constitutional tests are more settled than the three elements of Article III standing: A "plaintiff must have suffered (1) an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016). And the Court's precedent has long established that when a plaintiff is "the object of the [government] action" he challenges, "there is ordinarily little question that the action … has caused him injury, and that a judgment preventing … the action will redress it." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561-62 (1992). That well-settled principle confirms that Hurley and Nantz are proper plaintiffs to challenge the individual mandate.

A. The individual mandate causes Hurley and Nantz an actual injury redressable by a judgment enjoining the mandate.

1. Hurley and Nantz are "object[s]" of the individual mandate. It commands that an "applicable individual shall … ensure that the individual … is

covered under minimum essential coverage." 26 U.S.C. §5000A(a). Hurley and Nantz fall within the Act's definition of "applicable individual" because neither has a "[r]eligious exemption," is unlawfully present in the United States, or is incarcerated. *Id.* §§5000A(d)(1)-(4). Each is therefore subject to §5000A(a)'s command to buy health insurance. *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) (recognizing that "shall" is "mandatory" and "normally creates an obligation impervious to judicial discretion"). Under *Lujan*, that alone establishes Hurley's and Nantz's standing.

Even if more were needed, Hurley and Nantz proffered unrebutted testimony of their injuries. Nantz has "been enrolled in an ACA-mandated plan since 2014," and he is currently "enrolled in [his] plan because [he is] required by the ACA to do so." JA72. Hurley likewise maintains insurance because he is "obligated to comply with the Affordable Care Act's individual mandate." JA77. The mandate also imposed "additional costs" and "burden[s]" on their "business[es]" by diverting resources away from them. JA77, *see also* JA73. Those economic harms constitute a "quintessential injury upon which to base standing." JA399; *see Clinton v. New York*, 524 U.S. 417, 432-33 (1998) (holding that a "likelihood of economic injury" is sufficient "to establish standing under our precedents"); *Sierra Club v. Morton*, 405 U.S. 727, 733 (1972) (explaining that "palpable economic injuries

have long been recognized as sufficient to lay the basis for standing").

"Causation and redressability 'flow naturally' from this concrete, particularized injury." JA400. Subsection 5000A(a)'s command causes the harm: Hurley and Nantz bought their minimum essential coverage plans to comply with it. JA73-74, 77. And a judgment declaring the mandate unconstitutional would free them from that obligation.

2. Petitioners' responses to this straightforward conclusion all flow from the same incorrect premise. They contend that because the TCJA amended §5000A(c) to eliminate §5000A(b)'s monetary penalty for noncompliance with §5000A(a)'s mandate, the mandate is not in force. But "the fact that no penalties are imposed … is not material" because "[s]ubtle influences may be just as effective as the threat or use of formal sanctions to hold people in line," *United States v. Nat'l Ass'n of Real Estate Bds.*, 339 U.S. 485, 489 (1950), particularly when "the highest legislative body of the nation" sounds the command, *Keegan v. United States*, 325 U.S. 478, 497 (1945) (Black, J., concurring).

The Congressional Budget Office recognized as much when it predicted in 2008 that "many individuals … would comply with a mandate, even in the absence of penalties, because they believe in abiding by the nation's laws." Cong. Budget Office, Key Issues in Analyzing Major Health Insurance Proposals 53 (Dec. 2008). That has largely turned out to be true. In fact, last year the Office of the Actuary in the Centers for Medicare and Medicaid Services

projected that the TCJA would cause only a "small reduction in the participation rate amongst employed individuals who were offered coverage by their employer." Ctrs. for Medicare & Medicaid Servs., *Projections of National Health Expenditures & Health Insurance Enrollment: Methodology & Model Specification* 30 (Feb. 2019), https://bit.ly/2ZH3Swl. That office also projected that only two million other individuals would stop purchasing their individual policies by 2021. *Id.* at 31. CMS recently confirmed that, in 2019, the number of people enrolling in health insurance through the exchanges remained unchanged from 2018. Ctrs. for Medicare & Medicaid Servs., *Health Insurance Exchanges 2020 Open Enrollment Report* 1, 3 (Apr. 1, 2020), https://tinyurl.com/y7tycsf4. A quarter of those were also new to the exchanges through which they enrolled. *Id.* at 1. And CMS's actuary now estimates that setting the penalty to $0 reduced private insurance rolls in 2019 by just 0.3%. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditure Projections 2019-2028: Forecast Summary* 1, 3, https://go.cms.gov/2M5FIU9.

The ACA's text confirms Congress understood all this. Congress exempted some people from the mandate itself, *see* 26 U.S.C. §5000A(d), but exempted others from only the penalty, *id.* §5000A(e). "Why would Congress exempt individuals from a mandate that is not mandatory? To ask is to answer." PA203a.

3. It should be no surprise, then, that *NFIB* implicitly rejected Petitioners' theory that plaintiffs have standing to challenge the mandate only if they

are subject to the penalty. The plaintiffs in *NFIB* challenged the mandate the day Congress passed the ACA in 2010. *NFIB*, 567 U.S. at 539-40. But the mandate and penalty did not take effect until 2014. 26 U.S.C. §5000A(a). And some people subject to the mandate were exempt from the penalty. *Id.* §5000A(e). For example, Congress exempted those with incomes below a certain threshold. *Id.* Thus no court could know in 2010 (or 2012) whether any of the individual plaintiffs would be subject to the penalty in 2014.

The Court grappled with this potential standing problem in *NFIB* and resolved the plaintiffs' challenge to the mandate anyway. Lower courts had explicitly addressed whether various plaintiffs had standing to challenge the mandate. *See, e.g., Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1243 (11th Cir. 2011); *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 535 (6th Cir. 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253, 266-68 (4th Cir. 2011). The parties' briefing before this Court flagged the issue. *See, e.g.*, Br. of United States*, Dep't of Health & Human Servs. v. Florida*, No. 11-398, 16-17 n.5 (Jan 2012). Indeed, in 2012 the Solicitor General conceded that individuals had standing to challenge the mandate despite not knowing whether any of them would need to pay the penalty in 2014. *Id.* The specific issue even came up during oral argument. *See* Tr. of Oral Arg. 68-69, *Dep't of Health & Human Servs. v. Florida*, No. 11-398 (Mar. 26, 2012). Given the Court's duty to assure itself of jurisdiction, *Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83,

93-102 (1998), that should be the end of the matter. Hurley and Nantz have standing to challenge the mandate regardless of the penalty amount.

B. "Imminent" injury theories are inapplicable here.

All that explains why "[n]o party initially challenged Plaintiffs' standing" in this case until "*amici* raised the issue." PA181. The two arguments that Petitioners continue to press since then both fail.

First, Petitioners argue that Hurley and Nantz lack standing because they face "no threat of prosecution." House Br. 23-25; Cal. Br. 18-19. That "pre-enforcement" principle, however, does not apply here. Hurley and Nantz do not allege "an Article III injury" based on "the *threatened* enforcement" of the mandate. *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 152, 158-59 (2014) (emphasis added). Rather, Hurley's and Nantz's undisputed evidence establishes an *actual* harm from the mandate's *current* command. *Lujan*, 504 U.S. at 560. They must buy insurance *now*—just as they have for the last five years. 26 U.S.C. §5000A(a). In short, this "is not a pre-enforcement challenge because [Hurley and Nantz] have already incurred a financial injury." PA28a-29a.

Second, Petitioners contend that Hurley's and Nantz's injuries are "self-inflicted" because the mandate is a tax that "imposes no obligation to make that purchase." House Br. 20-22. As a result, Petitioners continue, Hurley and Nantz "could have declined to purchase insurance without violating the

Act." *Id.* (citing *Clapper v. Amnesty Int'l USA*, 568 U.S. 398 (2013)); *see also* Cal. Br. 19-20.

The Fifth Circuit correctly rejected this argument "because it conflates the merits of the case with" standing. PA30a. The "threshold inquiry into standing in no way depends on the merits of the [plaintiffs'] contention that particular conduct is illegal." *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990). Whether the mandate still can be read as a "tax hike on certain taxpayers who do not have health insurance" (and thus remains constitutional under *NFIB*) or is now a "command to buy insurance" (and thus unconstitutional under *NFIB*) is the very merits question this case raises. *NFIB*, 567 U.S. at 562-63 (Roberts, C.J.). Hurley and Nantz contend that the mandate is the latter and that it harms them. That suffices to establish standing.

Petitioners' contrary view would have the Court "skip ahead to the merits to determine whether §5000A(a) is non-binding and therefore constitutional and then revert to the standing analysis to use its merits determination to conclude there was no standing to reach the merits in the first place." PA31a-32a. Their request contravenes "two centuries of jurisprudence affirming the necessity of determining jurisdiction before proceeding to the merits." *Steel Co.*, 523 U.S. at 98.[2]

Nor do Hurley's and Nantz's injuries resemble the type of "self-inflicted" injuries that *Clapper* held fail to

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[2] Even if this were the rare case where standing and the merits "come intertwined," *Bolivarian Republic of Venezuela v.*

establish standing. House Br. 20-22. The plaintiffs in *Clapper* claimed an "imminent" injury rather than an "actual" one: the potential that "their communications with their foreign contacts will be intercepted … *at some point in the future*." 568 U.S. at 410-11 (emphasis added). The Court rejected that "highly speculative fear" as a basis for standing. *Id.* at 410. Then the Court also rejected the plaintiffs' attempt to "repackage[]" their "first failed theory of standing." *Id.* at 416. Their "alternative argument" asserted that they were "suffering ongoing injuries" consisting of "tak[ing] costly and burdensome measures to protect the confidentiality of their communications." *Id.* at 415. That argument failed for the same reason as their first standing theory—parties "cannot manufacture standing merely by inflicting harm on themselves based on their fears of *hypothetical future harm* that is not certainly impending." *Id.* at 416 (emphasis added).

Clapper recognizes that when a future harm is not sufficiently "imminent" to establish standing, a plaintiff cannot change that reality and create standing by taking steps to avoid the speculative future harm. To find otherwise would allow "an enterprising plaintiff … to secure a lower standard for Article III standing simply by making an expenditure based" on a potential future injury. *Id.* Because Hurley and Nantz are objects of §5000A(a)'s command

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Helmerich & Payne Int'l Drilling Co., 137, S. Ct. 1312, 1319 (2017), that would not change the Court's analysis. It still "must inevitably decide … the merits issues." *Id.*

to purchase health insurance *now*, *Clapper* is inapposite.[3]

II. The individual mandate is unconstitutional.

The Fifth Circuit majority and dissent both recognized that "this case begins and ought to end" with *NFIB*. JA418; *see* JA450. Hurley and Nantz agree. *NFIB* upheld the individual mandate only after concluding it was "fairly possible" to read §5000A as a tax. The TCJA's amendment to §5000A(c) destroyed the grounds for that saving construction. The mandate can no longer be saved; it is unconstitutional.

A. The TCJA eliminated the basis for *NFIB*'s saving construction, leaving only an unconstitutional command to buy insurance.

Five Justices agreed in *NFIB* that the mandate "compels individuals to *become* active in commerce by purchasing a product." 567 U.S. at 552 (Roberts, C.J.); *id.* at 650 (joint dissent) ("Congress provide[d] that (nearly) all citizens must buy an insurance contract.").

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[3] *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020), does not change that conclusion. The plaintiffs lacked standing there "for a simple, commonsense reason: They have received all of their vested pension benefits so far, and they are legally entitled to receive the same monthly payments for the rest of their lives." *Id.* at 1622. Whether they won or lost "would not change the plaintiffs' monthly pension benefits." *Id.* But a win for Hurley and Nantz *would* end their financial harms; if the mandate is unconstitutional, the law could no longer command them to make unwanted monthly insurance payments.

Those same five Justices also agreed that Congress lacks power under the Commerce Clause and the Necessary and Proper Clause to command Americans to buy health insurance. *Id.* at 558 (Roberts, C.J.) ("The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to 'regulate Commerce.'"); *id.* at 657 (joint dissent) (explaining that the Commerce Clause "does not empower the Government to say when and what we will buy").

In the Chief Justice's view, that conclusion made it "necessary" to consider "the Government's alternative reading of the statute—that it only imposes a tax on those without insurance." *Id.* at 562 (Roberts, C.J.). Though the Court held that §5000A could not be read as a tax for purposes of the Anti-Injunction Act, *id.* at 543-46, such an interpretation was "fairly possible" for constitutional purposes, *id.* at 574. But that was true only because the penalty "looks like a tax in many respects." *Id.* at 563. The penalty was "paid into the Treasury by 'taxpayers' when they file their tax returns"; the amount owed was "determined by such familiar factors as taxable income, number of dependents, and joint filing status"; and "[t]he requirement to pay [was] found in the Internal Revenue Code and enforced by the IRS, which … collect[ed] it 'in the same manner as taxes.'" *Id.* All of this meant §5000A "yield[ed] the *essential* feature of any tax: it produce[d] at least some revenue for the Government." *Id.* at 564 (citing *United States*

v. Kahriger, 345 U.S. 22, 28 n.4 (1953)) (emphasis added). That reading was not the most "natural[]," but it was "reasonabl[e]" given the Court's "duty to construe a statute to save it, if fairly possible." *Id.* at 574.

The TCJA "eliminate[d]" the basis for *NFIB*'s saving construction. Pub. L. No. 115-97, 131 Stat. 2054, 2092, §11081 (capitalization altered). Now that §5000A(c) sets §5000A(b)'s penalty to zero, the Act no longer contains "the essential feature of any tax" because it no longer "produc[es] … some revenue." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see also Kahriger*, 345 U.S. at 28 (explaining that a provision that "produces revenue" was a central distinguishing factor between a valid tax and provisions the Court found to be penalties). Nor does the Act retain any ancillary attributes of a tax, such as specifying various amounts owed based on "familiar factors." *NFIB*, 567 U.S. at 563.

Because the "critical attributes [of a tax] are now missing from the shared responsibility payment, it is … no longer 'fairly possible' to save the mandate's constitutionality under Congress' taxing power." JA420. The mandate's "most straightforward reading" is now its only plausible reading: "[I]t commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562 (Roberts, C.J.). And the Court has already held, *id.* at 572, that this command violates the Constitution, *id.* at 548-61 (Roberts, C.J.); *id.* at 649-60 (joint dissent).

B. The individual mandate cannot be saved on any other grounds.

1. None of Petitioners' responses meaningfully grapples with *NFIB*'s straightforward application here. Petitioners defend the mandate primarily by arguing that the TCJA did not change the Court's view that §5000A "gave individuals a lawful choice" between purchasing health insurance or paying a tax. House Br. 14. That ignores *NFIB*'s analysis. It is the "imposition of a tax [that] leaves an individual with a lawful choice to do or not do a certain act." *NFIB*, 567 U.S. at 574. And five Justices were able to construe §5000A as a tax only because it raised revenue—the "essential feature of any tax." *Id.* at 564. If there is no tax to pay—and now there is not—there can be no "lawful choice" between compliance and paying a tax. *Id.* at 574 ("Congress's authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more.").

For those same reasons, Petitioners cannot save the mandate by characterizing the penalty as a now-dormant tax. Cal. Br. 32-34; House Br. 37-38. Accepting Petitioners' invitation to do so "would … puzzlingly allow Congress to prohibit conduct that exceeds its commerce power through a two-step process of first taxing it and then eliminating the tax while retaining the prohibition." JA422 (cleaned up).

California's claim (at 34) that Congress "routinely adopts taxes with delayed start dates or temporarily suspends the collection of certain taxes" is similarly of no moment. California cites no example where, as

here, Congress commanded action and taxed the failure to comply, much less an example where Congress suspended the tax but left the command in place. The medical-device tax that California relies on bears no resemblance to §5000A. *See* 26 U.S.C. §4191(a) (2010) ("There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.").

The House also asserts (at 37) that the Court can uphold the mandate as "necessary and proper to the exercise of Congress's power to lay and collect taxes." But the Necessary and Proper Clause is no independent fount of power; it is available only as an "exercise[] of authority derivative of, and in service to, a granted power." *NFIB*, 567 U.S. at 560 (Roberts, C.J.); *see also Kinsella v. U.S. ex rel. Singleton*, 361 U.S. 234, 247 (1960) ("[T]he Necessary and Proper Clause is 'but merely a declaration, for the removal of all uncertainty, that the means of carrying into execution those (powers) otherwise granted are included in the grant."). The House does not argue here, as it did below, that §5000A can be saved as necessary and proper to the commerce power. *See* Br. of House of Representatives, *Texas v. California*, No. 19-10011, at 37-38 (5th Cir. Mar. 25, 2019). And because §5000A can no longer be construed as a tax, leaving the "architecture" of the penalty in place cannot be "necessary and proper" to the taxing power. Indeed, as the House acknowledges (at 37), the Necessary and Proper Clause would be a refuge, if at all, only "if the Court concludes that Section 5000A …

[is] not a command." The mandate is a command. *See supra* at 18-21.

2. Petitioners also (1) read Respondents to argue that Congress implicitly overturned *NFIB*'s interpretation of the ACA, and (2) urge the Court to apply its precedents rejecting such arguments. House Br. 17-18; Cal. Br. 26-28; *see, e.g.*, *Ankenbrandt v. Richards*, 504 U.S. 689, 700-01 (1992); *TC Heartland LLC v. Kraft Foods Grp. Brands LLC*, 137 S. Ct. 1514, 1520 (2017); *Kimble v. Marvel Entertainment, LLC*, 576 U.S. 446 (2015). Those cases do not apply here because Petitioners mischaracterize Respondents' arguments.

To start, Hurley and Nantz do not ask the Court to overrule *NFIB*. *Compare Kimble*, 576 U.S. at 2406 ("The sole question presented here is whether we should overrule *Brulotte*."). Precisely the opposite: They ask the Court to apply *NFIB* by its own terms.

Beyond that, Hurley and Nantz do not claim that Congress altered *NFIB*'s prior interpretation of the mandate through technical changes, *Ankenbrandt*, 504 U.S. at 700-01, or by amending a different statute, *TC Heartland*, 137 S. Ct. at 1420. Contrary to the House's suggestion (at 15-16), *NFIB* specifically relied on §5000A(c) to conclude that the statute could be read as a tax. 567 U.S. at 563. Subsection 5000A(c) set the amount of revenue that §5000A(b)'s penalty generated. And the TCJA fundamentally changed §5000A(c); it now precludes the government from collecting *any* revenue. *Supra* at 27-28.

That Congress knew of *NFIB* and still made "an informed legislative choice" to change §5000A(c) actually cuts against Petitioners. *Boumediene v. Bush*, 553 U.S. 723, 738 (2008); *see* House Br. 18. When Congress amends a statute after this Court has interpreted it in a way to "avoid constitutional difficulties," the Court cannot bypass the "difficult constitutional question" again. *Boumediene*, 553 U.S. at 738. It must instead "proceed to its own independent judgment" on it. *Id.*

The House's (at 17) and California's (at 28-29) cherry-picked statements from individual members of Congress fare no better. "[E]xcerpts from committee hearings and scattered floor statements by individual lawmakers" are "the sort of stuff" this Court has "called 'among the least illuminating forms of legislative history.'" *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652, 1661 (2017).

Even if individual legislators' statements were relevant, debates on the TCJA contain ample statements—some from the same congressmen that Petitioners cite—confirming that Congress was leaving the mandate in place and repealing only the penalty, the very foundation of *NFIB*'s saving construction. *See, e.g.*, 163 Cong. Rec. S7655 (Dec. 1, 2017) (Sen. Toomey) ("We don't actually repeal the mandate, but we eliminate that tax penalty."); 163 Cong. Rec. S7370 (Nov. 29, 2017) (Sen. Hatch) (explaining that Congress was "repealing the individual mandate tax"); *Id.* (Sen. Barrasso) (explaining that the TCJA "wipes out" the ACA's "tax penalty").

In any event, it does not matter that some members of Congress "might not have anticipated their work would lead to this particular result." *Bostock*, 2020 WL3146686, at *3. "Only the written word is the law." *Id.* And "the limits of the drafters' imagination supply no reason to ignore the law's demands." *Id.*

3. The House pivots (at 35-36) from the taxing power to contend, alternatively, that the mandate is now a "non-binding" expression of Congress's preferences valid under its unenumerated "inherent authority." *See also* Cal. Br. 32 (arguing that §5000A is merely "an expression of national policy or words of encouragement" for "Americans to purchase health insurance"). But "[i]f no enumerated power authorizes Congress to pass a certain law, that law may not be enacted." *NFIB*, 567 U.S. at 535 (Roberts, C.J.). What's more, §5000A(a)'s plain text commands that an individual "shall" purchase health insurance. The term "shall" is "mandatory" and "creates an obligation impervious to judicial discretion." *Lexecon Inc.*, 523 U.S. at 35.

California recognizes (at 30) that "shall" is normally a command. Yet it contends that "legal writers sometimes use 'shall' to mean 'should.'" *See also* House Br. 35-36. Just a few months ago, however, the Court reiterated—when interpreting the ACA—that "[u]nlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement." *Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1320 (2020). When "Congress distinguishes between 'may' and 'shall,' it is generally

clear that 'shall' imposes a mandatory duty." *Id.* (cleaned up). And the ACA differentiates between "shall" and "may" in this manner, *see id.* (collecting provisions), including in §5000A itself, *see* 26 U.S.C. §5000A(d)(2)(A)(ii)(I) ("[T]he term 'medical health services' does not include … other services as the Secretary of Health and Human Services *may* provide in implementing section 1311(d)(4)(H)." (emphasis added)). Subsection 5000A(a) imposes a mandatory command.

On this point, California's reliance on *New York v. United States*, 505 U.S. 144 (1992), is misplaced. "The 'shall' in that case was contained in an introductory provision" that "could not impose upon the operative provisions of the Act a mandate that they did not contain." *NFIB*, 567 U.S. at 663-64 (joint dissent). California's reliance (at 31) on *King* fares no better. There, Congress used "shall" in conjunction with other parts of the statute that explicitly "gives the States 'flexibility' by allowing them to 'elect' whether they want to establish an Exchange." *King*, 135 S. Ct. at 2489 (quoting 42 U.S.C. §18041(b)). "If a State chooses not to do so, [another section] provides that the Secretary 'shall … establish and operate *such Exchange* within the States.'" *Id.* (quoting 42 U.S.C. §18041(c)(1)). No provisions in the ACA similarly work in concert with §5000A(a) to undermine the presumption that "shall" imposes a mandatory duty.

III. The individual mandate is not severable from the ACA.

Because the individual mandate violates the Constitution, the Court must consider whether the ACA can survive without it. Under well-established precedent, it cannot: the entire Act must fall.

A. Severability is a question of statutory construction that turns on Congress's intent.

An unconstitutional provision in a statute "dooms the remainder of the Act" if it is "evident that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018) (cleaned up); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) ("[T]he Court must ask: Would the legislature have preferred what is left of its statute to no statute at all?"). That's "a question of statutory construction and of legislative intent." *Carter v. Carter Coal Co.*, 298 U.S. 238, 313 (1936); *see also Williams v. Standard Oil Co.*, 278 U.S. 235, 241 (1929) ("The question is one of interpretation and of legislative intent … .").

Like all questions of statutory interpretation, severability analysis begins with "the statute's text," *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010), including its "structure," *Alaska Airlines v. Brock*, 480 U.S. 678, 687 (1987). The structural inquiry examines whether the unconstitutional provision is "inextricably

connected" with the statute's other provisions, *Booker v. United States*, 543 U.S. 220, 250 (2005), or is "so interwoven" with them "that they cannot be separated," *Hill v. Wallace*, 259 U.S. 44, 70 (1922), or whether all the provisions "constitute a unitary system," *Electric Bond & Share Co. v. SEC*, 303 U.S. 419, 438 (1938), or are "mutually dependent on each other" and "plainly meant to operate together and not separately," *Carter Coal*, 298 U.S. at 313-14.

When a statute's text and structure show that an unconstitutional provision "cannot be removed without fatal consequences to the whole," *id.* at 316, a court cannot sever that provision. For in those circumstances, even if the remaining provisions operate in some coherent way, *Alaska Airlines*, 480 U.S. at 684, no court can confidently say that the remaining "statute will function in a *manner* consistent with the intent of Congress," *id.* at 685.

Separation of powers concerns animate these interpretive questions. And those concerns cut both ways. On one hand, the Court "prefer[s] … to sever [an unconstitutional statute's] problematic portions while leaving the remainder intact," *Ayotte*, 546 U.S. at 328-29, since "a ruling of unconstitutionality frustrates the intent of the elected representatives of the people," *id.* at 329 (cleaned up); *see also Free Enterprise Fund*, 561 U.S. at 508 ("the 'normal rule' is 'that partial, rather than facial, invalidation is the required course'" (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)).

On the other hand, because the Court's "constitutional mandate and institutional competence

are limited," it "restrain[s]" itself "from 'rewrit[ing] … law to conform it to constitutional requirements' even as" it "strive[s] to salvage" the law. *Ayotte*, 546 U.S. at 329. "[M]aking distinctions in a murky constitutional context, or where line-drawing is inherently complex, may call for a 'far more serious invasion of the legislative domain' than" the Court "ought to undertake." *Id.* at 330 (quoting *United States v. Treasury Employees*, 513 U.S. 454, 479, n.26 (1995)). So the Court refuses to sever a statute when doing so "would be to make a new law, not to enforce an old one." *Hill*, 259 U.S. at 71 (internal quotation marks omitted). That "is no part of" this Court's "duty." *Id.*; *see also Free Enterprise Fund*, 561 U.S. at 510 ("editorial freedom … belongs to the Legislature, not the Judiciary").

Put simply, "automatic or too cursory severance of statutory provisions risks rewriting a statute and giving it an effect altogether different from that sought by the measure viewed as a whole." *NFIB*, 567 U.S. at 692 (joint dissent) (cleaned up). If that happens, judges become legislators, imposing on the Nation a "new statutory regime, consisting of policies, risks, and duties that Congress did not enact." *Id.*

B. Under those interpretive rules, the individual mandate is not severable from the ACA.

"Congress would not have enacted" the ACA "independently of" the individual mandate. *Murphy*, 138 S. Ct. at 1482 (cleaned up). The mandate is thus not severable.

1. The 2010 Congress never would have passed the ACA without the individual mandate.

Begin with the ACA's text. It leaves no doubt: "To the Congress that adopted" the ACA, *Murphy*, 138 S. Ct. at 1483, omitting the individual mandate was a non-starter.

Congress designed the Act to create "near-universal coverage." 42 U.S.C. §18091(2)(D). And Congress made clear that the individual mandate was indispensable to accomplishing that goal. The ACA's text calls the mandate "essential" three times. *Id.* §§18091(2)(H), (2)(I), (2)(J). The text further confirms that the lack of an individual mandate would "undercut Federal regulation of the health insurance market." *Id.* §18091(2)(H). And six different times the ACA's text says the individual mandate must work "together with the other provisions of this Act" as an integrated whole to accomplish Congress's goals. *Id.* §§18091(2)(C), (2)(E), (2)(F), (2)(G), (2)(I), (2)(J).

Section 18091 should end the inquiry. That text, which "ma[de] it through the constitutional processes of bicameralism and presentment," *Murphy*, 138 S. Ct. at 1487 (Thomas, J., concurring), says nearly a dozen times in three different ways that the individual mandate is indispensable to the Act. Congress could not have more clearly stated that those provisions are "plainly meant to operate together and not separately," *Carter Coal*, 298 U.S. at 314, thereby overcoming any "presumption … in favor of severability," *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality).

If there were still any doubt, the Act's drafting history should lay it to rest. An early draft of the bill contained a severability clause, but Congress deliberately cut that from the final version it enacted. *See* H.R. 3962, 111th Cong., 1st Sess. §255 (Oct. 29, 2009). "Where Congress includes limiting language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the limitation was not intended." *Russello v. United States*, 464 U.S. 16, 23-24 (1983); *see also Arizona v. California*, 373 U.S. 546, 580-81 (1963) (finding that because an earlier version of a bill contained language that was later stricken, Congress did not intend that language to survive).

The ACA's structure only buttresses what its text makes plain. The mandate, the guaranteed-issue and community-rating provisions, and the tax subsidies "constitute a unitary system," *Electric Bond & Share Co.*, 303 U.S. at 438, designed to accomplish the ACA's ambitious goals of broadening coverage while reducing costs. That conclusion flows so readily from the Act's text and structure that every Member of the *NFIB* and *King* courts said so. *See NFIB*, 567 U.S. at 547-48 (Roberts, C.J.) ("The individual mandate was Congress's solution to the[] problems" arising from "the guaranteed-issue and community-rating reforms."); *id.* at 619 (Ginsburg, J.) ("Without the individual mandate, Congress learned, guaranteed-issue and community-rating requirements would trigger an adverse-selection death spiral in the health-insurance market"); *id.* at 696-706 (joint dissent) (explaining that the individual mandate was

inseverable from the ACA); *King*, 135 S. Ct. at 2487 ("As noted, Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement. And the coverage requirement would not work without the tax credits.") (citation omitted)).

The Court's unanimous view of the individual mandate's text and structure in *NFIB* and *King* is confirmed by legislative history. Mounds of undisputed evidence before Congress showed that Massachusetts alone had accomplished the goal of universal coverage; every other state to try it had failed miserably. *Supra* at 2-4. Congress knew that the ACA could not duplicate Massachusetts's success without duplicating its mandate. Hence §5000A(a) became the ACA's centerpiece.

All this compels the conclusion that Congress "would not have enacted" the ACA in 2010 "independently of" the individual mandate. *Murphy*, 138 S. Ct. at 1482 (cleaned up). That makes the mandate nonseverable unless the TCJA's changes to §5000A(c) undermine that conclusion. As shown below, they do not.

2. The 2017 Congress's changes to §5000A(c) did not alter the individual mandate's text or its indispensable role in the ACA.

Petitioners ask the Court to look at "[w]hat Congress *actually did* in passing the 2017 amendment" to determine whether the mandate is severable. House Br. 40; Cal. Br. 36-37. Hurley and

Nantz agree that the Court should do so. Petitioners just misapply that inquiry.

a. Start again with the text. The TCJA did *not* "render[]" "Section 5000A … inoperative." House Br. 40. To understand why, recall that §5000A contains multiple subsections:

- Subsection (a), which contains the individual mandate.
- Subsection (b), which imposes a "shared responsibility payment" on those who "fail to meet the requirement of subsection (a)."
- Subsection (c), which specifies how to calculate the "amount of the penalty" imposed in subsection (b).

The TCJA amended only one part of §5000A. It changed §5000A(c)'s formula by setting the penalty to zero. No doubt that amendment affected §5000A(b)'s shared responsibility payment. But just as clearly, the TCJA did *not* amend §5000A(a)'s *predicate* command that each applicable individual "shall … ensure" he or she has "minimum essential coverage."

The upshot? After the TCJA, the only provision in §5000A that could be said to have "no practical effect" (House Br. 42) is §5000A(b). Subsection 5000A(a)'s command, in contrast, remains fully operative. Petitioners' contrary arguments simply cannot be reconciled with §5000A's post-TCJA text and structure.

Carefully read, the House's brief implicitly acknowledges as much. It contends "that Congress's

whole objective was to *effectively* repeal Section 5000A(a) while leaving the rest of the Act intact." House Br. 41 (emphasis added). Beware the adverb. To *effectively* repeal a provision is not to *actually* repeal it. And Congress knows the difference—it *actually* repealed §5000A(c)'s formula but *not* §5000A(a)'s mandate.

Consider also other text the TCJA left unchanged. The TCJA's amendments to §5000A(c) did not amend or delete the statutory text in §18091 calling the individual mandate "essential" to the ACA three times. Nor did they amend or delete the statutory text in §18091 stating that the individual mandate must work "together with the other provisions of this Act" as an integrated whole to accomplish Congress's goals. Because the 2017 Congress left those provisions untouched, it follows that the 2017 Congress viewed the mandate to be as essential to the ACA as the 2010 Congress did.

To escape the clear import of Congress's leaving §18091 untouched, the House contends (at 44) that by setting the penalty to zero, the TCJA made Congress's host of unrepealed findings "legally" irrelevant. According to the House, statutory "[f]indings have no operative legal effect," so the 2017 Congress "had no need to repeal" them. *Id.*

But the House cites only *Yazoo v. Mississippi Valley R.R. Co. v. Thomas*, 132 U.S. 174 (1889), for that assertion. *See* House Br. 44. The dispute in *Yazoo* centered on the statute's preamble, which was "no part of the act" and "cannot … control the words of the act." *Id.* at 188. Here, §18091 is a separate substantive

provision that cleared the Constitution's bicameralism and presentment requirements; its text is *squarely* "part of the act." *Id.*

For its part, California suggests (at 41-42) that Congress passed §18091 only to justify its exercise of the Commerce Clause power. No doubt that was one reason Congress enacted and the President signed §18091. But California cites no case from this Court holding that a duly enacted statute cannot establish Congress's views as to *both* a statute's constitutional footing *and* its indispensable role in the broader statutory scheme. California's related suggestion (at 42) that *NFIB* "rendered the findings irrelevant" fails for a similar reason. To be sure, that text no longer reflects a proper view of Congress's Commerce Clause power. But its continuing presence shows Congress still views §18091 as accurately stating the mandate's indispensable place in the ACA's post-TCJA statutory scheme.

b. Because the TCJA didn't amend or delete §5000A(a)'s mandate itself or §18091, Petitioners' argument must be that the TCJA repealed both provisions by implication. But "[t]he cardinal rule is that repeals by implication are not favored." *Posadas v. Nat'l City Bank of N.Y.*, 296 U.S. 497, 503 (1936). This Court finds implied repeals only when "provisions in the two acts are in irreconcilable conflict" or "if the later act covers the whole subject of the earlier one and is clearly intended as a substitute." *Id.* Neither condition exists here.

Taking them in reverse order, the House acknowledges (at 39) that the TCJA "amend[ed]" only

"a single sentence in Section 5000A." While that alteration triggered important consequences for the mandate's constitutionality under *NFIB*, that single change to §5000A(c) cannot fairly be read to "cover[] the whole subject of" the ACA, of §5000A(a)'s individual mandate, or of §18091. *Posadas*, 296 U.S. at 503. Put differently, the TCJA changed two terms in the 900-plus-page ACA—neither one in §5000A(a) or §18091. If that suffices to show Congress "clearly intended" the TCJA to be "a substitute" for §5000A(a) or §18091, *id.*, the implied-repeal doctrine no longer has meaningful bounds.

Nor does amended §5000A(c) irreconcilably conflict with §5000A(a)'s individual mandate or with §18091. In fact, they do not conflict at all. The mandate persists even after the shared responsibility payment is gone—a result that accords precisely with the 2010 Congress's design making the mandate and the penalty two different sections serving two different purposes. *See, e.g.*, §5000A(d) (exempting certain people from the mandate); §5000A(e) (exempting other people from the penalty).

c. Because what the 2017 Congress "*actually did*" was leave the individual mandate and §18091 in place, Petitioners strive to chart other severability paths around that binding text. None succeeds.

First, the House (at 43) marginalizes the mandate, reiterating its view that the mandate is "toothless." But as discussed, *supra* at 33-34, *Maine Community Health Options* forecloses this argument; §5000A(a) "impose[s] an obligation" by "its mandatory language: 'shall.'" 140 S. Ct. at 1320. And other parts

of §5000A "underscore" subsection (a)'s "mandatory nature" by using the permissive "may" in contrast to the mandatory shall. *Id.*; *see* 26 U.S.C. §5000A(d)(2)(A)(ii)(I) (defining "medical health services" not to include "other services" that the HHS secretary "may provide" in implementing the Act). *Maine Community Health Options* requires rejecting the House's "propos[al] that [this Court] convert" §5000A(a) "into a non-binding legislative recommendation." *Shrink Missouri Gov't PAC v. Maupin*, 71 F.3d 1422, 1427 (8th Cir. 1995). Subsection 5000A(a) "did not enact a set of suggestions." *Id.*

Second, the House contends that "the purpose of imposing the *shared-responsibility payment* in the originally enacted version of Section 5000A was 'plain[]': to create a mechanism that would induce the purchase of insurance by people who would not do so otherwise." House Br. 43-44 (quoting *NFIB*, 567 U.S. at 567) (emphasis added). But this again fails to distinguish §5000A(b)'s *shared responsibility payment* from §5000A(a)'s *mandate*. And *NFIB* recognized that the *mandate* does the work of inducing insurance purchases that the House now ascribes to the *penalty*. *See, e.g.*, 567 U.S. at 547-48, 556, 558; *id.* at 619 (Ginsburg, J.).

In a variation on that theme, the House also contends (at 45) that §18091 has been "[f]actually" superseded because its findings related only to the mandate's role "in *creating* health-care markets," not in maintaining them. Thus, the House suggests the "2017 Congress … made the different judgment that

the Act could continue to operate even without an enforceable mandate." *Id.* But once again, this conflates §5000A(a) and §5000A(b). The 2017 Congress decided that the Act could operate without a *shared responsibility payment*, but *not* without the *mandate*, which it left intact.

That decision makes sense based on what the 2017 Congress knew about how the ACA's provisions fund its reforms. The massive subsidies and capital inflows the Act needs to accomplish its goals come from premiums for insurance, not from penalties for noncompliance. Compliance with the mandate (by purchasing insurance) was expected to generate $350 billion in insurance premiums over 10 years, but shared responsibility payments—penalties for *noncompliance* with the mandate—would generate only $4 billion per year. *See NFIB*, 567 U.S. at 564 (penalties to raise $4 billion per year); *id.* at 698 (joint dissent) (mandate to raise $350 billion in new revenues for insurance industry over ten years). And recent history confirms that eliminating the penalty did not undermine the mandate's force. Insurance rolls in 2019 remained virtually identical to 2018, when the penalty was in place. *Supra* at 20-21.

Exhausting all hope of a textual anchor, the House pivots (at 41-42) to legislative history, seeking evidence of Congress's intent in bills that it did not pass and statements by members of Congress in the TCJA's debate. But "unsuccessful attempts at legislation are not the best of guides to legislative intent." *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381 n.11 (1969). And "[f]loor statements …

cannot amend the clear and unambiguous language of a statute." *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 457 (2002). There is "no reason" to give floor statements "greater weight" than "the collective views of both Houses, which are memorialized in the unambiguous statutory text." *Id.* The unambiguous text in §18091 and §5000A(a) confirms that the 2017 Congress continued to view the mandate as essential.

d. Nor do "[t]he remainder of the ACA's provisions … function[] independently from the invalidated provision and in a manner consistent with Congress's objectives in enacting the statute." House Br. 46. The House's suggestion (at 46) that the "guaranteed-issue and community-rating insurance market reforms function independently of Section 5000A, and in the manner that Congress intended," is question-begging: Those provisions may function independently of the *shared responsibility payment*, but they are not now functioning—and *never have* functioned— independently of the *mandate itself*.

And the House's suggestion (at 46-47) that the ACA's remaining provisions suffice to induce insurance purchases contradicts §18091. It also would have been news to both the 2010 Congress and to the seven states that unsuccessfully implemented those reforms without the mandate. Indeed, the House cites *no* evidence that the "robust participation" (House Br. 47) in the insurance markets stems from anything *other than* the mandate—the very tool Congress found was necessary to compel that behavior. More to the point, Congress "would not have enacted those provisions," *Murphy*, 138 S. Ct. at 1482—and the

"hundreds of other provisions" in the Act, House Br. 48—"independently of" the individual mandate, *Murphy*, 138 S. Ct. at 1482.

C. The entire Act must be held inseverable and that judgment applied nationwide.

Because the Act's plain text shows that both the 2010 and the 2017 Congresses deemed the individual mandate inextricable from it, there is no basis to retain any part of it.

At a minimum, the guaranteed-issue, community-rating, and tax-subsidy provisions—all also found in Title I—must fall. No other outcome faithfully adheres to this Court's correct conclusion that those "three reforms are closely intertwined," *King*, 135 S. Ct. at 2487, and "only work when combined" with each other, *id.* at 2494. Those core reforms "furnish mutual aid and support; and their associated force—not one or the other but [all] combined—was deemed by Congress to be necessary to achieve the end sought." *Carter Coal*, 298 U.S. at 314. As a result, the individual mandate is "so interwoven with those regulations that they cannot be separated." *Hill*, 259 U.S. at 70.

Stripped of those provisions, Title I cannot possibly "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. To take just a few examples, Title I establishes the exchanges, 42 U.S.C. §18031, and obligates employers to provide insurance for their employees or pay a penalty, 26 U.S.C. §4980H. But without the community-rating provisions, "the average federal

subsidy" for policies purchased on the exchange "could be much higher," resulting in "an unintended boon to insurance companies" and "an unintended harm to the federal fisc." *NFIB*, 567 U.S. at 701-02 (joint dissent). And invalidating the mandate for individuals but *not* for employers would make the cash-infusion engine Congress designed to fund the ACA operate at only partial capacity.

Retaining Titles II through IX after excising Title I "would be [to] make a new law, not to enforce an old one." *United States v. Reese*, 92 U.S. 214, 221 (1875). Congress knew full well that mandating near-universal insurance coverage would impose stratospheric costs, so "[t]he whole design of the Act is to balance the costs and benefits affecting each set of regulated parties." *NFIB*, 567 U.S. at 694 (joint dissent). It "spread[s] its costs to individuals, insurers, governments, hospitals, and employers—while, at the same time, offsetting significant portions of those costs with new benefits to each group." *Id.* at 695 (joint dissent).

Removing the individual mandate and its intertwined provisions in Title I would produce a cost-spreading design unrecognizable to the 2010 or 2017 Congresses. Besides the problems for the exchanges and for employers already discussed, consider the impacts to the Act's other "[m]ajor provisions"—"the insurance regulations and taxes" and "the reductions in federal reimbursements to hospitals and other Medicare spending reductions." *Id.* at 697 (joint dissent). Without the individual mandate and its related provisions, the ACA's "insurance regulations

and insurance taxes impose risks on insurance companies and their customers that this Court cannot measure." *Id.* at 698. And "[i]nvalidating the key mechanisms for expanding insurance coverage" but not *also* "invalidating the reductions in Medicare and Medicaid" would "distort[] the ACA's design of 'shared responsibility'" and could force hospitals either "to raise the cost of care in order to offset the reductions in reimbursements" or "shut down." *Id.* at 699-700. Nothing about any of those outcomes comports with "congressional intent." *Id.* at 703.

The same conclusion follows for the Act's minor provisions. No prior holding of this Court has "consider[ed] severability in the context of an omnibus enactment like the ACA, which includes not only many provisions that are ancillary to its central provisions, but also many that are entirely unrelated—hitched on because it was a quick way to get them passed despite opposition" or as a *quid pro quo*. *Id.* at 705. The straightforward response to "such a so-called 'Christmas tree,' a law to which many nongermane ornaments have been attached," is to hold "that when the tree no longer exists the ornaments are superfluous." *Id.* Otherwise, the Court is left to "guess which" nongermane portions would have passed alone and which wouldn't have—an undertaking that "is not a proper function of this Court." *Id.*

Nor can the Act be stricken just as to the Individual and State Respondents/Cross-Petitioners. Declaring it unconstitutional and unenforceable nationwide is the only way to "provide complete relief

to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). A geographically limited injunction would result in taxpayers from the Respondent/Cross-Petitioner States—including Hurley and Nantz themselves—subsidizing programs and services no longer available to them *precisely because* they could not be severed from an unconstitutional individual mandate. Equity cannot tolerate that outcome.

D. The same severability test applies to all statutes.

Both California and the House repeatedly invoke "naked policy appeals," *Bostock*, 2020 WL 3146686, at *17, to contend that the ACA merits special severability treatment because it "transformed our Nation's healthcare system," Cal. Br. 1; *e.g.*, House Br. 50 (urging this Court to hold §5000A(a) severable and not "invalidate the entirety of the most transformative public health-care law of the last half-century"). But the Court's severability jurisprudence contains no exception for laws deemed "transformative" by their proponents. On the contrary, the Court's prior decisions demonstrate just the opposite.

In the late 1800s, Congress passed a transformative law to increase federal revenues by levying federal taxes "on income derived from real estate, and from invested property." *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 635 (1895). Though doing so threatened the federal government's very lifeblood, the Court struck down those taxes as unconstitutional direct taxes—and then *further* held them inseverable from taxes on "the income from all invested [personal] property, bonds, stocks, [and]

investments of all kinds." *Id.* at 637. The Nation ultimately disagreed with that result, so it overruled *Pollock* by adopting the Sixteenth Amendment. *See NFIB*, 567 U.S. at 571.

Pollock shows how our system should work. The Court's power extends to measuring Congress's enactments against the Constitution, not against public opinion. "[D]eference in matters of policy cannot … become abdication in matters of law." *NFIB*, 567 U.S. at 538 (Roberts, C.J.). If the public demands the kind of "transformative" health-care reforms that *NFIB* held the Constitution forbids, Congress can enact those reforms in ways that comport with our founding charter—or the Nation can amend the Constitution to give Congress powers it would not otherwise have.

Using any other measuring stick threatens the separation of powers. For "[i]f judges could rewrite laws based on their own policy views, or based on their own assessments of likely future legislative action, the critical distinction between legislative authority and judicial authority … would collapse, thereby threatening the impartial rule of law and individual liberty." *Bostock*, 2020 WL 3146686, at *56 (Kavanaugh, J., dissenting).

That course is all the more critical when "legally correct decision[s]" arise in "politically controversial" cases. *Dep't of Homeland Security v. Regents of the Univ. of Cal.*, — S. Ct. — , 2020 WL 3271746, at *19 (2020) (Thomas, J., dissenting). When the Court "prolong[s]" the government's "initial overreach by providing a stopgap measure of its own" instead of

insisting that "solution[s] … come from the Legislative Branch," it "give[s] the green light for future political battles to be fought in this Court rather than where they rightfully belong—the political branches." *Id.*

The ACA itself confirms as much. Even after *NFIB* and *King*, the ACA still falls woefully short of creating "near-universal coverage." 42 U.S.C. §18091(2)(D). In fact, as of 2018, 15.8 million uninsured Americans qualified for free or substantially subsidized health insurance—6.6 million through Medicaid or other public programs, and 9.2 million through the exchanges—but apparently thought so little of that benefit that they did not bother signing up. Kaiser Family Foundation, *Distribution of Eligibility for ACA Health Coverage Among those Remaining Uninsured as of 2018*, https://bit.ly/3fE11Jb.

Striking down only the mandate will take a statute already apparently deemed useless by at least 15.8 million of its intended beneficiaries and make it more "maimed and enfeebled—in truth, zombified." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2425 (2019) (Gorsuch, J., dissenting). That will only compound the disparities between what Congress wanted the ACA to do and what it actually does, perhaps even by continuing to increase the number of uninsured Americans.

Healthcare remains a critical national issue. But the ACA already isn't working. Striking just the mandate will only make it worse. Rather than leaving the Country and its citizens to make do with a

patchwork of what Congress originally enacted, the Court should hold the mandate inseverable. Nothing would spur Congress more quickly to restart the important work of fixing America's still-broken healthcare system—this time following the Constitution while doing so.

CONCLUSION

The Court should affirm the Fifth Circuit's judgment that the individual mandate violates the Commerce Clause, and affirm the District Court's judgment that the individual mandate is not severable from the ACA.

Respectfully submitted,

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APPENDIX

APPENDIX

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U.S. Const. art. I. § 8, cl.3

Section 8.

To regulate commerce with foreign nations, and among the several states, and with the Indian tribes;

26 U.S.C. § 5000A.

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment

(1) In general

If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return

Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty
If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty

(1) In general The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) Zero percent for taxable years beginning after 2015.

(3) Applicable dollar amount For purposes of paragraph (1)—

(A) In general
Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $0.

(B) Phase in
The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18
If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(4) Terms relating to income and families For purposes of this section—

(A) Family size
The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income
The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) Applicable individual For purposes of this section—

(1) In general
The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemptions

(i) In general Such term shall not include any individual for any month if such individual has in effect an exemption under section

1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that—

(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section; or

(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

(ii) Special rules

(I) Medical health services defined
For purposes of this subparagraph, the term "medical health services" does not include routine dental, vision and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(II) Attestation required
Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.

(B) Health care sharing ministry

(i) In general
Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present
Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals
Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage

(A) In general
Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's

household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan

offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to [1] required contribution of the employee.

(D) Indexing

In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold

Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes

Any applicable individual for any month during

which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps

(A) In general
Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships
Any applicable individual who for any month is determined by the Secretary of Health and Human

Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage For purposes of this section—

(1) In general The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act),

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan
Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market
Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan
Coverage under a grandfathered health plan.

(E) Other coverage
Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as

determined under section 937(a)) for such month.

(5) Insurance-related terms
Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure

(1) In general
The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules Notwithstanding any other provision of law—

(A) Waiver of criminal penalties
In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

42 U.S.C. § 18091

Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general
The individual responsibility requirement provided for in this section (in this section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private

health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for

this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg–3, 300gg–4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement 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.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.