

Nos. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT
BUSINESS, *ET AL.*,

v.

KATHLEEN SEBELIUS, *ET AL.*

STATES OF FLORIDA, *ET AL.*,

v.

UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES, *ET AL.*

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

**BRIEF FOR STATE PETITIONERS
ON SEVERABILITY**

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QUESTION PRESENTED

If the Affordable Care Act's mandate that virtually every individual obtain insurance exceeds Congress' enumerated powers, to what extent (if any) can the mandate be severed from the remainder of the Act?

PARTIES TO THE PROCEEDINGS

Petitioners in No. 11-400, who were the appellees/cross-appellants below, are 26 States: Florida, by and through Attorney General Pam Bondi; South Carolina, by and through Attorney General Alan Wilson; Nebraska, by and through Attorney General Jon Bruning; Texas, by and through Attorney General Greg Abbott; Utah, by and through Attorney General Mark L. Shurtleff; Louisiana, by and through Attorney General James D. “Buddy” Caldwell; Alabama, by and through Attorney General Luther Strange; Attorney General Bill Schuette, on behalf of the People of Michigan; Colorado, by and through Attorney General John W. Suthers; Pennsylvania, by and through Governor Thomas W. Corbett, Jr., and Attorney General Linda L. Kelly; Washington, by and through Attorney General Robert M. McKenna; Idaho, by and through Attorney General Lawrence G. Wasden; South Dakota, by and through Attorney General Marty J. Jackley; Indiana, by and through Attorney General Gregory F. Zoeller; North Dakota, by and through Attorney General Wayne Stenehjem; Mississippi, by and through Governor Haley Barbour; Arizona, by and through Governor Janice K. Brewer and Attorney General Thomas C. Horne; Nevada, by and through Governor Brian Sandoval; Georgia, by and through Attorney General Samuel S. Olens; Alaska, by and through Acting Attorney General Richard Svobodny; Ohio, by and through Attorney General Michael DeWine; Kansas, by and through Attorney General Derek Schmidt; Wyoming, by and through Governor Matthew H. Mead; Wisconsin, by and through Attorney General J.B. Van Hollen; Maine,

by and through Attorney General William J. Schneider; and Governor Terry E. Branstad, on behalf of the People of Iowa.

Petitioners in No. 11-393 are the National Federation of Independent Business, Kaj Ahlburg, and Mary Brown, who were also appellees below.

Respondents in both cases, who were the appellants/cross-appellees below, are the U.S. Department of Health & Human Services; Kathleen Sebelius, Secretary, U.S. Department of Health & Human Services; the U.S. Department of Treasury; Timothy F. Geithner, Secretary, U.S. Department of Treasury; the U.S. Department of Labor; and Hilda L. Solis, Secretary, U.S. Department of Labor. The States are also Respondents by rule in No. 11-393, and NFIB, *et al.*, are also Respondents by rule in No. 11-400.

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OPINIONS BELOW

The Eleventh Circuit's opinion (Pet. App. 1a) is reported at 648 F.3d 1235.¹ The District Court's summary judgment opinion (Pet. App. 274a) is reported at 780 F. Supp. 2d 1256.

JURISDICTION

The Eleventh Circuit rendered its decision on August 12, 2011. The States and the private parties filed timely petitions for certiorari, and this Court granted review of the third question presented in the States' petition and of the private parties' petition on November 14, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The table of contents to and relevant provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, are reproduced in an appendix to this brief.²

¹ For ease of reference, all citations of the Petition Appendix in all briefs arising out of the decision below are of the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398. Citations of the Eleventh Circuit Record Excerpts are designated "R.E."

² All citations of provisions of the "ACA" are of the Affordable Care Act as amended by the Reconciliation Act.

STATEMENT OF THE CASE

A. The Tortuous Path to Enactment of the Affordable Care Act

The Affordable Care Act is a 2,700-page collection of “sweeping and comprehensive” provisions, Pet. App. 20a, intended to impose “near-universal” health insurance coverage on the Nation. ACA § 1501(a)(2)(D). While it took Congress nearly a year to put together the massive health insurance overhaul that the President requested in early 2009, *see* 111 Cong. Rec. S11607-816 (daily ed. Nov. 19, 2009), the Senate passed the ACA a mere 35 days after it was introduced, and the Act became law only through unusual procedural machinations and by the barest of margins.

The slim majority of Senators who supported the Act succeeded in forcing it through on December 24, 2009, in the Senate’s first Christmas Eve vote since 1895.³ The process of reconciling the Senate bill and an earlier version passed by the House—and sending the reconciled bill back for passage in each—had barely begun when, in a special election on January 19, 2010, the people of Massachusetts elected Scott Brown, who had pledged to be “the 41st vote” in the Senate to “stop” the health care proposal from becoming law.⁴ With further Senate action

³ Robert Pear, *Senate Passes Health Care Overhaul on Party-Line Vote*, N.Y. Times, Dec. 24, 2009, <http://www.nytimes.com/2009/12/25/health/policy/25health.html>.

⁴ *Republican Scott Brown Vying for Kennedy Senate Seat*, <http://www.foxnews.com/story/0,2933,582797,00.html>; Gail Russell Chaddock, *Mr. Brown Goes to Washington, Signs His*

foreclosed, leaders in the House searched for a means of addressing their considerable reservations to the Senate-passed version of the law without necessitating an additional vote in the Senate. The leadership considered and rejected a number of remarkable proposals, including one that would have “deemed” a version enacted without an actual vote on the legislation.⁵ Ultimately, they determined that the only course open to them was to vote on the Senate bill without the possibility of amendment, and address their reservations to the extent possible in later legislation on limited topics that would be procedurally privileged and exempt from the cloture rule in the Senate. *See* H.R. Res. 1203, 111th Cong. (Mar. 21, 2010). The unamended Senate bill passed the House by a narrow 219-212 vote, 111 Cong. Rec. H2153 (daily ed. Mar. 21, 2010), and the President signed the Patient Protection and Affordable Care Act into law on March 23, 2010.

“Amendments” to that Act were made days later through a separate Health Care and Education Reconciliation Act of 2010 (HCERA), deemed a “reconciliation” bill to circumvent the now very real threat of a filibuster. As a result of that procedural maneuvering, that bill had to be limited to amendments that would have a direct budgetary

Autograph “41”, The Christian Science Monitor, Jan. 21, 2010, <http://www.csmonitor.com/USA/Politics/2010/0121/Mr.-Brown-goes-to-Washington-signs-his-autograph-41>.

⁵ Lori Montgomery & Paul Kane, *House May Try to Pass Senate Health-Care Bill Without Voting On It*, Wash. Post, Mar. 16, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/15/AR2010031503742.html>.

impact on the Act. 2 U.S.C. § 644. Like with the ACA's final passage, that act was presented under a no-amendments rule and made it through the House and Senate by a bare majority. *See* H.R. Res. 1225, 111th Cong. (Mar. 25, 2010).

B. The Substance of the Affordable Care Act

Together, the PPACA and the HCERA (collectively, the “ACA” or “Act”) impose new and substantial obligations on every corner of society, from individuals to insurers to employers to States. Those obligations are designed to work in tandem to expand both the demand for and the supply of health insurance, so as to achieve Congress’ ultimate goal of “near-universal coverage.” ACA § 1501(a)(2)(D).

1. At the center of the ACA is a new mandate that commands nearly every individual to obtain and maintain a minimum level of health insurance coverage, thereby artificially increasing the demand for health insurance. ACA § 1501(b), 26 U.S.C.A. § 5000A(a). This mandate to maintain insurance applies to all individuals except foreign nationals residing here unlawfully, incarcerated individuals, and individuals falling within two very narrow religious exemptions. *Id.* § 5000A(d). A covered individual who fails to comply with the mandate is subject to a financial “penalty.” *Id.* § 5000A(b)(1), (c). That penalty provision contains its own limited set of exemptions that differ from the exemptions set forth with respect to the mandate itself. *See id.* § 5000A(e). Thus, individuals fully subject to the mandate may be exempt from the penalty provisions designed to enforce the mandate. But exemption

from the penalty does not obviate such individuals' obligation to comply with the mandate. The two are separate. For example, while members of Indian tribes and certain low-income individuals are not subject to the penalty, *id.*, they are still subject to the mandate and must maintain a minimum level of health insurance coverage at all times.

The constitutionality of a mandate to maintain insurance was subject to serious question long before Congress enacted the ACA. When the concept first arose in the early 1990s, the Congressional Budget Office (CBO) informed Congress that “[a] mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action.” CBO, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance* 1 (August 1994).⁶ In the course of debate over the current legislation, the Congressional Research Service (CRS) advised that “[d]espite the breadth of powers that have been exercised under the Commerce Clause, it is unclear whether the clause would provide a solid constitutional foundation for legislation containing a requirement to have health insurance.” CRS, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis* 3 (July 24, 2009).⁷ CRS deemed that constitutional uncertainty “the most challenging question posed by such a proposal.” *Id.*

In keeping with the constitutional concerns about a mandate to maintain insurance, the version

⁶ Available at <http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf>.

⁷ Available at http://assets.opencrs.com/rpts/R40725_20090724.pdf.

of the Act that the House passed before the Senate passed the ACA included, along with a tax upon individuals who fail to obtain and maintain insurance, a severability clause instructing that, in the event any provision were held unconstitutional, the remainder of the Act should not be affected. *See* H.R. 3962, §§ 255, 501. The ACA that emerged from the Senate and was subsequently forced through the House, however, contained the individual mandate but no severability clause.

Although numerous amendments were proposed during the ACA's drafting process to alleviate constitutional concerns by eliminating or limiting the reach of the mandate, each was defeated on the ground that doing so would make the Act's objective of near-universal insurance coverage unattainable. As one of the Act's principal architects put it, eliminating or limiting the mandate would "gut[] and kill[] health reform," as "[t]he effect [would be] to say no more ... universal coverage." *Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform of the S. Comm. on Finance*, 111th Cong. 21-22 (Oct. 1, 2009) (statement of Sen. Baucus); *see also Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform of the S. Comm. on Finance*, 111th Cong. 216 (Sept. 24, 2009) (statement of Sen. Baucus) (describing one such amendment as "a mortally

wounding amendment” that would “undermine this whole system”).⁸

2. The individual mandate addressed the demand side of the equation for near-universal coverage by requiring virtually every American to obtain health insurance. But Congress recognized that compliance with the mandate would not be possible for many individuals absent some set of additional provisions designed to increase the supply of insurance to meet the mandated increase in demand. Accordingly, Congress imposed four accompanying categories of insurance reforms, each of which targets a distinct segment of the then-uninsured population, so as to ensure that the Act would increase both the demand for *and* the supply of insurance, which, in turn, would bring the Nation closer to Congress’ goal of near-universal coverage.

The first set of supply-side provisions is found principally in Subtitle C of Title I, which prohibits insurance practices that Congress concluded had prevented certain “high-risk” individuals from obtaining private insurance. Chief among those are the so-called “guaranteed issue” and “community rating” provisions, which require insurers to enroll every applicant for insurance and preclude insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual’s preexisting health conditions, medical history, or past experience with respect to insurance claims. ACA

⁸ Available at <http://finance.senate.gov/hearings/hearing/?id=d7e5e3c3-eb4e-e366-c063-76040ad6da87>; <http://finance.senate.gov/hearings/hearing/?id=d8083e61-f98b-0204-3389-428e5a1a78e7>.

§ 1201. Subtitle C and other sections of Title I also imposes numerous other requirements on insurers, including restrictions on how much they can charge for various plans and various services.

Congress predicted that those insurance market regulations would “have significant negative effects on the business costs of insurers because they require insurers to accept unhealthy entrants, raising insurers’ costs.” Pet. App. 178a; *see also* CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, 6 (Nov. 30, 2009) (predicting that insurance regulations without individual mandate would increase premiums by 27 to 30 percent).⁹ Indeed, as Congress was aware, similar state-wide regulations enacted without an offsetting subsidy to insurers had caused insurers to exit the market.¹⁰

⁹ Available at <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf>.

¹⁰ *See, e.g., Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health*, 111th Cong. 10 (Mar. 17, 2009) (Testimony, of Prof. Uwe Reinhardt) (“It is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance.”), available at http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/031709_Health_Affordable_Coverage_Hearing/3.17.09_Reinhardt_Health_Affordable_Coverage.pdf;

Mark A. Hall, *An Evaluation of New York’s Reform Law*, 25 *J. Health Politics, Pol’y & Law* 71, 91–92 (2000) (documenting “dramatic exodus of indemnity insurers from New York’s individual market” after similar regulations were enacted); *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 117 (Apr. 22, 2009) (submission for the record of Phil

Accordingly, without any subsidy to help insurers cover those substantial new costs, the insurance industry would have had an obvious incentive to oppose those expensive new proposals, which, in turn, could have jeopardized the entire legislative effort.

The ACA's second set of supply-side provisions is found in Subtitles D and E of Title I. Subtitle D mandates the creation in each State of "health benefit exchanges," which will be run by either the State or the federal government. ACA §§ 1301–1343. Congress intended those exchanges to allow certain lower-income individuals and small businesses to pool their resources together to purchase private insurance plans comparable to plans purchased by larger employers. ACA § 1311. If a State is not willing to create and operate an exchange, the federal government will step in and do so itself. ACA § 1321(c). Subtitle E then establishes tax credits and other subsidies for the lower-income individuals and small businesses that purchase plans on the exchanges. ACA §§ 1401–21. Congress has estimated that getting these new exchanges up and running will cost at least \$350 billion in federal spending by decade's end. Letter from Douglas Elmendorf, Director, CBO, to the Hon. Nancy Pelosi,

Caper, M.D., and Joe Lendvai) (confirming same result in Maine), available at <http://www.gpo.gov/fdsys/pkg/CHRG-111hhr52258/html/CHRG-111hhr52258.htm>.

Speaker, U.S. House of Reps. (“CBO Estimate”), Table 2 (Mar. 20, 2010).¹¹

Third, Subtitle F of Title I contains a collection of “employer responsibility” provisions that Congress designed to force the expansion of employer-based insurance. ACA § 1511–15. Among other things, these provisions impose significant monetary penalties on any employer (including a State) with an average of at least 50 full-time equivalent employees that fails to provide all of those employees with a federally approved level of insurance coverage. ACA § 1513. The Act also offers tax incentives for small businesses that purchase health insurance plans for their employees. ACA § 1421.

Finally, whereas Congress designed the provisions found throughout Title I to expand the supply of private insurance, it designed Title II to force a comparable expansion of public insurance. Most prominently, Subtitle A effects a massive expansion of Medicaid by requiring all participating States (which is to say, all States) to offer Medicaid to all individuals under the age of 65 with incomes up to 133% of the poverty level, with a 5% “income disregard” provision that effectively raises that number to 138%. ACA §§ 2001, 2002(a). (Individuals who are 65 or older are eligible for Medicare.) In addition to providing coverage for these newly eligible individuals, States must also provide coverage for millions of individuals who are uninsured despite being currently eligible for

¹¹ Available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

Medicaid, as those individuals will be forced onto the Medicaid rolls by the individual mandate. The CBO predicts that at least 16 million individuals will enroll in Medicaid as a result of the combined effect of the expansion and the mandate, and that the federal component of Medicaid spending will increase by \$434 billion by 2020 to cover the costs generated by that massive increase in enrollment. CBO Estimate 9 & Table 4 (Mar. 20, 2010).

3. Congress' intentions as to the manner in which the ACA would function are best reflected in the findings accompanying the individual mandate. As those findings explain, Congress did not enact the mandate just to increase the demand for insurance in the abstract, and it did not enact the other core components just to increase the supply. Rather, Congress' paramount goal was "near-universal" health insurance coverage, ACA § 1501(a)(2)(D), something it believed could be achieved only if each of the Act's central provisions works in unison so that near-universal supply can meet the mandated near-universal demand.

In keeping with that understanding, the findings explain how Congress envisioned a comprehensive health insurance scheme in which the individual mandate would work "together with the other provisions of the Act [to] add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services," thereby "increas[ing] the number and share of Americans who are insured." ACA § 1501(a)(2)(C). The intended relationship among the various provisions is evident, for example, in Congress' finding that the mandate "build[s] upon

and strengthen[s] the private employer-based health insurance system.” ACA § 1501(a)(2)(D). Because employer-based insurance is one of the primary sources of coverage, Congress deemed the “employer responsibility” provisions necessary to ensure that employers would supply the insurance that individuals would be forced to maintain. The same understanding is evident with respect to the guaranteed issue and community ratings provisions, which Congress deemed key to ensuring that higher risk individuals who must purchase insurance will not be left uninsured by the privately financed market. *See* ACA § 1501(a)(2)(I).

Conversely, Congress also made explicit that it considered the individual mandate critical to the viability and success of the ACA’s other core provisions. It did so most expressly with respect to the Act’s insurance market regulations, deeming the mandate “essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.” *Id.* In Congress’ view, if insurance companies were forced to provide coverage to all applicants and cover pre-existing conditions, and “if there were no requirement [that currently healthy individuals purchase insurance], many individuals would wait to purchase health insurance until they needed care.” *Id.* By forcing all individuals to purchase insurance regardless of their needs or desires, Congress expected the individual mandate to “minimize this adverse selection” that had doomed similar regulations in some States. *Id.*

Congress also explained that it intended the mandate to “broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums” by forcing into the market individuals unlikely to use the insurance they must purchase. *Id.* Congress considered that forced subsidization by individuals who might otherwise rationally choose not to purchase health insurance critical because, without it, the guaranteed issue, community rating, and other insurance market regulations would generate unmanageable new costs for insurers—and would have been strenuously opposed by the insurance industry. Indeed, the insurance industry made quite explicit its position that it would not support legislation that contained those regulations without an individual mandate. *See, e.g.,* Robert Pear, *Health Insurers Offer to Accept All Applicants, on Condition*, N.Y. Times, Nov. 20, 2008, at A30¹²; Br. of America’s Health Insurance Plans in Partial Supp. of Cert. Review 15–19.

Congress also explained how it considered the mandate an “essential” component of its global regulatory scheme and overarching objective. According to Congress, “[b]y significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the [individual mandate], together with other provisions of th[e] Act, will significantly reduce administrative costs and lower health insurance premiums.” ACA

¹² Available at <http://www.nytimes.com/2008/11/20/us/20health.html>.

§ 1501(a)(2)(J). For those same reasons, Congress deemed inclusion of the mandate “essential to creating effective health insurance markets that do not require underwriting and eliminate its associated costs,” *id.*, which Congress, in turn, considered essential to achieving its paramount goal of “near-universal” insurance coverage, ACA § 1501(a)(2)(D).

4. Many of the several hundred provisions found elsewhere in the ACA do not bear as obvious of a relationship to increasing the demand for or supply of health insurance. Upon closer analysis, however, those provisions also were designed to play an integral role in Congress’ scheme for near-universal health insurance coverage and, equally importantly, in securing support for the Act. They achieve those ends by attempting either to “offset” the massive new spending generated by core provisions such as the Medicaid expansion and the exchanges, or to decrease the cost of the health care services that drive up the cost of insurance. Those cost-cutting measures were every bit as critical to the Act’s passage as its provisions expanding the demand for and supply of insurance, as the President and key supporters of the Act emphatically refused to pass a bill that was not, at the very least, deficit neutral. *See, e.g.*, Letter from President Obama to Senators Kennedy and Baucus (June 3, 2009).¹³ One day before the slim majority of the House passed the

¹³ Available at http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus.

ACA, the CBO provided a requested report to Congress estimating that the Act satisfied that condition, based in large part on cost savings and new revenue attributable to the provisions found throughout Titles III through IX. *See* CBO Estimate, Table 2 (Mar. 20, 2010).¹⁴

For example, Title III of the Act primarily consists of alterations to Medicare, a massive federally funded program that provides insurance to individuals who are over the age of 65 and therefore not subject to the individual mandate. *See* ACA § 1501(b). Title VI also makes changes to Medicare and other publicly funded programs in an effort to increase the effectiveness of the penalty and incentive systems designed to prevent provider and supplier fraud. While these provisions may not appear to bear a close relationship to increasing the demand for or supply of insurance, collectively, they were designed to achieve an estimated \$455 billion in savings to counteract the \$434 billion in costs generated by the Medicaid expansion and the \$350 billion generated by the health benefit exchanges, both of which were critical components of Congress' scheme for near-universal insurance. CBO Estimate, Table 2 (Mar. 20, 2010).

The same cost-cutting intent is made manifest in the text of Title IX of the Act, which contains a subtitle expressly designated "Revenue Offset Provisions." As Congress' use of the term "offset" makes clear, the point of those penalties and taxes

¹⁴ Title X of the Act is the HCERA, which primarily makes amendments to Titles I–IX.

was not just to generate revenue, but to generate revenue for the specific purpose of counterbalancing the enormous costs of the Act's central provisions. As with the Medicare amendments, the CBO report estimated that these provisions would produce hundreds of billions of dollars in new revenue to offset the hundreds of billions of dollars in new spending on the exchanges and Medicaid. CBO Estimate, Table 2 (Mar. 20, 2010).

Other sections of the Act reflect a more global effort to defray the underlying costs of medical care itself. For example, Title IV includes provisions aimed at increasing the availability and use of preventative services (particularly for those enrolled in publicly funded insurance programs) and promoting general wellness measures. Title V seeks to increase the supply of health care providers in an attempt to decrease the costs of the services they provide. And Title VII seeks to improve access to new medical therapies that Congress intended as cost-saving alternatives to current treatments. (Congress expressly instructed federal agencies to “determine the amount of savings to the Federal Government generated as a result of th[at] enactment” and to use any such savings “for deficit reduction.” ACA § 7003.)

In context, these other sections of the ACA clearly are designed to decrease the cost of the health care services that drive up the cost of health insurance. By doing so, these sections play a key role in Congress' effort to make provisions such as guaranteed issue, community rating, and expanded employer-based insurance more palatable to insurers and employers who might otherwise oppose them,

and to defray ongoing costs that the Medicaid expansion will generate. As a result, they are part and parcel of the Congress' supply-meets-demand vision of near-universal insurance coverage.

C. The Proceedings Below

Shortly after a bare majority of Congress enacted the ACA, Florida and 12 other States brought this action seeking a declaration that the Act is unconstitutional. They have since been joined by 13 additional States, the National Federation of Independent Business, and multiple individuals. The States argued that various aspects of the Act are unconstitutional, including the individual mandate and the Medicaid expansion. The States maintained that if those central provisions were struck down as unconstitutional, the entire Act must fall because the balance of the Act is not severable from the unconstitutional provisions at its heart.

The federal government defended the challenged provisions of the Act as constitutional and repeatedly emphasized the centrality of the individual mandate in achieving Congress' broader goals. The federal government stressed that Congress considered the Act's core provisions "interrelated," Mem. Supp. Govt.'s Mot. Dismiss 3 [R.E. 98], and considered the mandate "necessary to make the other regulations in the Act effective." Mem. Supp. Govt.'s Mot. Dismiss 48 [R.E. 143]; *see also* Mem. Supp. Govt.'s Mot. Summ. J. 16 [R.E. 999] (describing mandate as "an integral part of the ACA's larger reforms of health insurance industry practices").

The federal government explained Congress' view that many of the "individuals whose conduct is regulated by the minimum coverage provision ... affirmatively seek insurance but are unable to obtain it without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide." Mem. Supp. Govt.'s Mot. Summ. J. 1–2 [R.E. 984–85]. Accordingly, Congress envisioned the mandate "work[ing] in tandem with these and other reforms" to increase *both* supply and demand, thereby furthering Congress' ultimate goal of near-universal insurance coverage. Mem. Supp. Govt.'s Mot. Dismiss 46 [R.E. 141]; *see also* Mem. Supp. Govt.'s Mot. Dismiss 3 [R.E. 98] (arguing that insurance market regulations "make health insurance more available," while exchanges, tax credits, and Medicaid expansion "make insurance more affordable"). Based on that integrated relationship, and the reality that the insurance industry would not have supported the Act without the individual mandate, the federal government expressly conceded that, at a minimum, the Act's insurance market regulations are inextricably linked to the mandate, such that Congress would not have intended either to survive without the other. Mem. Supp. Govt.'s Mot. Dismiss 46–48 [R.E. 141–43].

The federal government also explained the intended integral relationship between the Act's less prominent pieces and its core components. The federal government argued that "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions." Mem. Supp. Govt.'s Mot. Summ. J. 41

[R.E. 1024]. The federal government made similar arguments as to how central provisions were designed to offset each other—for example, it argued that Congress assumed insurance market regulation would create significant savings for States when it deemed it appropriate to force cash-strapped States to pay \$20 billion to cover the Medicaid expansion. Mem. Supp. Govt.’s Mot. Summ. J. 41 [R.E. 1024].

1. The District Court’s Decision

The District Court agreed with the States that the individual mandate is unconstitutional. Pet. App. 350a. Although the court rejected the States’ challenges to the Medicaid expansion and other provisions of the ACA, the court also agreed with the States that the mandate cannot be severed from the rest of the Act and therefore declared the entire ACA invalid. Pet. App. 363a.

In its severability analysis, the court first noted the federal government’s concession that “the individual mandate and the Act’s health insurance reforms, including the guaranteed issue and community rating, will rise or fall together.” Pet. App. 350a. That, in turn, led the court to conclude that “the only question is whether the Act’s other, non-health-insurance-related provisions can stand independently.” Pet. App. 350a. Although the court acknowledged the presumption in favor of severability, it noted that “this is anything but the typical case.” Pet. App. 351a. As the court put it, “[i]f ... the statute is viewed as a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal, and if that goal would be

undermined if a central part of the legislation is found to be unconstitutional, then severability is not appropriate.” Pet. App. 352a. Examining the statute and the context in which it was passed, the court found that the ACA fits that description.

In doing so, the court observed that “some (perhaps even most) of the remaining provisions can stand alone and function independently of the individual mandate,” Pet. App. 352a, but recognized that “the ‘more relevant inquiry’ is whether these provisions will comprise a statute that will function ‘in a *manner* consistent with the intent of Congress.’” Pet. App. 353a (quoting *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987)). As to that inquiry, the court noted that a severability clause “had been included in an earlier version of the Act, but ... was removed in the bill that subsequently became law,” which the court found significant given that “Congress was undoubtedly well aware that legal challenges [to the mandate] were coming.” Pet. App. 355a. The court also found the federal government’s concession that the Act’s insurance provisions must fall with the mandate “extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself.” Pet. App. 356a. “In other words, the individual mandate is indisputably necessary to the Act’s insurance market reforms, which are, in turn, indisputably necessary to the purpose of the Act.” Pet. App. 359a.

In light of those findings, the court concluded that “[s]evering the individual mandate from the Act along with the other insurance reform provisions ... cannot be done consistent with the principles set out” in this Court’s cases. Pet. App. 361a. The court

explained that any attempt to rescue some hodge-podge of independently functional provisions would “be tantamount to rewriting a statute in an attempt to salvage it.” Pet. App. 361a. The court therefore declared the Act invalid in its entirety.

2. The Eleventh Circuit’s Decision

The Eleventh Circuit affirmed the District Court’s holding that the individual mandate is unconstitutional but reached precisely the opposite conclusion as the District Court did when it came to severability: It deemed the mandate completely severable and left the entirety of the Act except the mandate standing. Pet. App. 186a.

As to the bulk of the Act, the Eleventh Circuit found it sufficient that “[e]xcising the individual mandate ... does not prevent the remaining provisions from being ‘fully operative as a law.’” Pet. App. 174a (quoting *Brock*, 480 U.S. at 684). In the court’s view, the mandate could be severed from all provisions of a “stand-alone nature” that “lack [a] connection to the individual mandate.” Pet. App. 176a. As to the District Court’s finding that Congress did not intend those provisions to stand without the mandate, the court maintained that the District Court “placed undue emphasis on the Act’s lack of a severability clause,” and that Congress’ removal of the earlier severability clause should have “no probative impact.” Pet. App. 175a–76a. The court then suggested that the lack of a *non*-severability clause makes the States’ “burden” of establishing non-severability particularly “heavy.” Pet. App. 176a.

The court next turned to the guaranteed issue and community rating provisions, as to which the court characterized the severability inquiry as “not so summarily answered.” Pet. App. 176a. The court acknowledged Congress’ express finding that the individual mandate is “essential” to those provisions, Pet. App. 177a, and Congress’ evident intent that the mandate “mitigate the reforms’ cost on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers’ costs in covering the unhealthy.” Pet. App. 178a. But the court again suggested that “Congress could easily have included in the Act a non-severability clause” if it intended those provisions to fall with the mandate, and noted that “none of the insurance reforms ... contain[s] any cross-reference to the individual mandate or make[s] their implementation dependent on the mandate’s continued existence.” Pet. App. 179a. The court further concluded that “a basic objective of the Act is to make health insurance coverage accessible,” and that, “[a]ll other things being equal, ... a version of the Act that contains these two reforms would hew more closely to Congress’s likely intent than one that lacks them.” Pet. App. 180a.

The court then proceeded to engage in its own analysis of whether the mandate is, in fact, essential to the two insurance market regulations. According to the court, “many other provisions,” including the exchanges and the employer regulations, “help to accomplish some of the same objectives as the individual mandate.” Pet. App. 181a. And the court found it relevant that the “mandate has a comparatively limited field of operation vis-à-vis the

number of uninsured” given its exemptions and the limited means of enforcing its penalty provision. Pet. App. 182a. According to the court, these “multiple features ... all serve to weaken the mandate’s practical influence on the two insurance product reforms.” Pet. App. 183a.

While the court recognized that it must be “[m]indful” of Congress’ express findings to the contrary, it nonetheless deemed those findings “not particularly relevant” because they arose in the context of Congress’ Commerce Clause authority. Pet. App. 184a. The court further maintained that “[t]he fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable,” and found that “particularly true here because the reforms of health insurance help consumers who need it the most.” Pet. App. 185a.

“In light of all th[o]se factors,” the court found itself “not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.” Pet. App. 185a. Although the court acknowledged the federal government’s express concession to the contrary, it deemed that concession irrelevant, observing that “the touchstone of severability analysis is legislative intent, not arguments made during litigation.” Pet. App. 186a n.144. The court therefore severed the individual mandate and left the rest of the ACA standing.

SUMMARY OF ARGUMENT

Severability is a remedial inquiry that turns on legislative intent. The ultimate question is not

whether the balance of an act can function independently without an invalidated provision. That is a necessary, but not sufficient, condition for preserving the balance of the statute. The ultimate question is whether Congress would have enacted the statute without the invalidated provision. Here, the answer is clear. Congress considered the individual mandate essential to the Act's functioning, to its passage, and to its ability to achieve Congress' goal of near-universal health insurance. This Court cannot remove the hub of the individual mandate while leaving the spokes in place without violating Congress' evident intent.

Precisely because severability is a remedial inquiry, the federal government is wrong to suggest that this Court can address severability only as to the provisions of the Act that independently burden the States. Non-severability is not an independent basis for challenging discrete components of a statute. Rather, severability is an inquiry into the remedial consequences for the rest of a statute of invalidating a successfully challenged provision. If this Court strikes down the individual mandate as unconstitutional, it must also consider the remedial consequences of that decision for the balance of the Act, without regard to whether the rest of the Act independently burdens the States or other plaintiffs. There is no obstacle to the Court fully considering the severability question.

The severability question is always one of legislative intent, and discerning that intent is often difficult because it requires a counterfactual inquiry into whether Congress would have passed a statute without a provision it intentionally included. But

here Congress made the essential role of the individual mandate and its relationship to the other key provisions of the ACA manifest in its legislative findings. What is more, as a practical matter, it is clear that every provision of the ACA was critical to its passage. Not only did Congress consider the individual mandate central to the Act and necessary to make the other provisions work as intended; it considered the mandate a critical means of achieving its overall goal of providing near-universal health insurance. Congress enacted the individual mandate to ensure that there would be near-universal demand and enacted a series of costly provisions—insurance market regulations, exchanges, employer regulations, and Medicaid expansion—to ensure that there would be near-universal supply. But Congress did not pursue either supply or demand for its own sake. If this Court invalidates the demand side, there is no basis for leaving the supply side standing.

Even the federal government recognizes that the individual mandate cannot be decoupled from the Act's guaranteed issue and community rating provisions. Quite simply, the guaranteed issue and community rating provisions would not have been enacted without the individual mandate. As a policy matter, Congress was told that States that had enacted those regulations without mandating individual coverage drove insurers from the State and insureds out of the market by dramatically increasing the cost of insurance. And as a practical matter, the insurance companies would have resisted those costly requirements without the subsidization created by a mandate that forces healthy individuals into the insurance market.

But while the federal government acknowledges that the guaranteed issue and community rating provisions must fall with the individual mandate, it ignores the consequences for the rest of the Act. If the individual mandate is the key to how the Act was to function, the guaranteed issue and community rating provisions were the key impetus for getting the Act passed. Without the promise of insuring the uninsured, there is no prospect that the ACA ever would have become law.

While some of the remaining provisions of the ACA do not bear the same direct demand-supply relationship as the individual mandate and the supply-side provisions, they too cannot survive the invalidation of the Act's core components. Many of those provisions were designed to offset the costs of the expensive supply-side provisions necessitated by Congress' goal of near-universal insurance. Indeed, Congress expressly labeled some of those provisions "offsets." The massive expansion of Medicaid was a costly endeavor that Congress attempted to counterbalance with projected cost savings. If the Medicaid expansion is invalidated directly or falls as a consequence of invalidation of the individual mandate, then these offsetting provisions cannot survive while respecting Congress' intent.

The Court of Appeals erred by giving only summary treatment to most of the Act and then substituting its own view for Congress' when it came to the guaranteed issue and community rating provisions. It also focused unduly on the absence of a non-severability clause while giving no weight to the removal of a severability clause during the legislative process. Ultimately, however, the key to

Congress' intent is not the absence or presence of a clause specifically addressing severability. Congress made its intent clear when it identified the individual mandate as an essential provision addressing the demand side of its goal of providing near-universal coverage. To invalidate that central provision while leaving in place provisions designed to supply the forced demand created by the individual mandate would ignore both this Court's severability precedents and Congress' evident intent.

ARGUMENT

I. Severability Is A Remedial Inquiry That Is Properly Before This Court.

There is no obstacle to this Court considering the issue of severability and the remedial consequences for the balance of the Act if the Court invalidates certain provisions of the ACA. While the federal government has suggested that the Court may not consider severability unless the States "demonstrate that each of the Act's provisions they contend is inseverable ... 'burden[s]' them," Govt.'s Response Pet. Cert. 29 (quoting *Printz v. United States*, 521 U.S. 898, 935 (1997)), that argument reflects a fundamental misunderstanding of the nature of the severability inquiry. Severability does not involve a distinct challenge to the remaining provisions of an act that must be supported by independent standing. Instead, severability considers the consequences for the balance of the statute of the invalidation of provisions that the challenger has already successfully attacked.

Severability is a *remedial* doctrine. See *Ayotte v. Planned Parenthood of Northern New England*, 546

U.S. 320, 328–29 (2006). It becomes relevant only when a court has struck down a provision of a broader statute or statutory scheme, and its purpose is to allow courts to give effect to “what ‘Congress would have intended’” had it known that a piece of broader legislation would be invalidated. *United States v. Booker*, 543 U.S. 220, 246 (2005) (quoting *Denver Area Ed. Telecomm. Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996)).

The ultimate touchstone of this remedial inquiry is the legislature’s intent. *See Brock*, 480 U.S. at 683 n.5 (severability is “a question of legislative intent”). Just as courts should use their remedial power to avoid invalidating more of an act than necessary when doing so would be contrary to Congress’ intent, courts should use their remedial power to avoid leaving the remnants of an act in place when “it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not.” *Champlin Ref. Co. v. Corp. Comm’n of Okla.*, 286 U.S. 210, 234 (1932). To do so “would be to substitute, for the law intended by the legislature, one they may never have been willing, by itself, to enact.” *Pollock v. Farmers’ Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (internal quotation marks omitted).

As the very nature of the inquiry reflects, severability is a shield for the legislature, not a sword for the challenging party. It is the Court’s obligation to craft a suitable remedy that reflects Congress’ intent, not the challenger’s independent right to particular relief, that gives rise to the severability inquiry. *See, e.g., Ayotte*, 546 U.S. at 330 (“After finding an application or portion of a

statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?"); *New York v. United States*, 505 U.S. 144, 186 (1992) (“Having determined that the take title provision exceeds the powers of Congress, we must consider whether it is severable from the rest of the Act.”).

Whether the party contending that the balance of the statute does not survive the invalidation of the provision it has successfully challenged (and, *a fortiori*, had standing to challenge) has independent standing to challenge the balance of the act is thus irrelevant. That party is not bringing a separate “non-severability” claim to the balance of the statute, but is merely assisting the Court in ascertaining what remedial consequences flow from the invalidation of the provision successfully challenged, *i.e.*, what remedy will adhere most closely to the legislature’s intent. That the parties may have an interest in one outcome or another does not change that basic fact.¹⁵

¹⁵ Indeed, in some cases, the party that has successfully challenged one provision will have an affirmative interest in arguing that other provisions of the statute are severable and survive in order to obtain the most advantageous remedy. *See, e.g., INS v. Chadha*, 462 U.S. 919, 934 (1982). In other cases, a party’s right to effective relief may depend on prevailing on the principal challenge *and* on the severability analysis that follows. *See, e.g., Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010); *Brock*, 480 U.S. at 684. In either case, the severability analysis is a distinct remedial question.

The federal government's attempt to insert a separate standing requirement into the severability analysis therefore would frustrate the remedial powers of the courts, as it would preclude courts from employing appropriate measures to ensure that their decisions do not "substitute the judicial for the legislative department of the government." *United States v. Reese*, 92 U.S. 214, 221 (1875). That point is evident from the federal government's arguments in this case. For example, by the federal government's own telling, Congress would not have enacted the guaranteed issue and community rating provisions had it known the individual mandate would be held unconstitutional. Yet the federal government insists the Court *must* leave those provisions in place if it invalidates the mandate because, "even when particular provisions are integrally related, a court may not address provisions that do not burden parties to the litigation." Govt.'s 11th Cir. Br. 59. By the federal government's reasoning, that would seem to be the case even if the ACA contained an express *non-severability* provision directing that those provisions should stand or fall with the individual mandate. Even such an unmistakable indication of congressional intent could not make up for the lack of independent standing to challenge the balance of the statute that the federal government would erroneously demand.

Nothing in this Court's precedent compels that illogical result. The federal government attempts to ground its novel argument in the Court's decision in *Printz*. But *Printz* did not adopt the extreme position that the federal government advocates. The

Court in *Printz* merely declined to consider an argument that discrete provisions of an act were non-severable when severability had not been raised in the petition for certiorari, had not been addressed by the court of appeals, and would not have had *any* effect on the parties before the Court. *See Printz*, 521 U.S. at 935. In doing so, the Court did not hold that it was without remedial power to fashion an appropriate remedy, but rather simply “decline[d] to speculate” on the severability inquiry in the absence of a party with an interest in the particular provisions subject to dispute. *Id.*

Printz may reflect nothing more than the unremarkable proposition that courts will not “speculate” concerning issues that have not been fully developed at each stage of the litigation. *See, e.g., Legal Servs. Corp. v. Valazquez*, 531 U.S. 533, 549 (2001) (exercising Court’s “discretion and prudential judgment” to decline to reach severability question that was not briefed); *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 553 (2001) (declining to consider severability when it was not addressed below). At most, *Printz* might be read to suggest a prudential rule of restraint when the party asserting non-severability has *no* stake in whether the remainder of the legislation stands or falls. *Cf. New York*, 505 U.S. at 186–87 (addressing severability where remaining provisions affected plaintiffs). But any such rule would have no application in this case. As the federal government concedes, the States are affected, at a minimum, by the ACA’s extensive amendments to Medicaid and its various employer regulations. *See* Govt.’s Response Pet. Cert. 30. That is more than sufficient to supply any requisite

interest in whether the individual mandate is severable from the remainder of the Act.

The federal government appears to read *Printz* as demanding much more and confining this Court's inquiry to whether the specific provisions that independently burden the States survive. But neither *Printz* nor anything else limits the Court's remedial role in that way. The point of the severability inquiry is to determine whether Congress "would ... have been satisfied with what remains" after the invalid portion of the statute is removed. *Williams v. Standard Oil Co.*, 278 U.S. 235, 242 (1929). It would be entirely artificial for courts to engage in that analysis by examining in isolation the relationship between the invalid provision and the remaining provisions that burden the challenger, rather than the relationship between the invalid provision and the broader legislative effort of which it was a part. *See, e.g., Brock*, 480 U.S. at 685 (examining "the importance of the [invalid provision] in the original legislative bargain"); *INS v. Chadha*, 462 U.S. 919, 934 (1982) (invalid provision "cannot be considered in isolation but must be viewed in the context of Congress" broader legislative goals).

The artificial inquiry the federal government urges also would produce wholly unworkable results. That much is clear from how the federal government would have the Court resolve this case. The States' argument is not just that the individual mandate was central to Congress' decision to enact *the employer regulations*, but that it was central to Congress' decision to enact *the ACA*. Yet the federal government would require the Court to leave every

other provision of the ACA in place even if it *agreed* with the States that Congress “would not have enacted those provisions which are within its power, independently of” the individual mandate. *Champlin Ref.*, 286 U.S. at 234.

Nor is it clear how the federal government envisions Congress’ intent being vindicated even in subsequent cases. Presumably, if the severability inquiry in the case that invalidates part of a statute on constitutional grounds were limited to other provisions that independently burdened the party bringing the successful constitutional challenge, the validity of the balance of the statute would need to await a party independently burdened by those other provisions. But it is not at all clear what claim such a party would bring. There is no independent cause of action for non-severability or interference with congressional intent. The reality is that those other provisions fall, if at all, not because of an independent defect that must be supported by independent standing, but as a remedial consequence of the earlier action.

To take the insurance market provisions as an example, insurance companies certainly have standing to challenge the guaranteed issue and community rating provisions, but they have little incentive to challenge the individual mandate. Indeed, the individual mandate’s requirement that healthy individuals join the risk pool to the benefit of insurers was the key to eliminating the insurance industry’s natural incentive to block legislation (whether through lobbying or litigation) that imposed massive new costs on the industry. And the fact that the mandate was the sweet that caused the

insurance industry to accept the bitter market regulations is both the reason the insurance industry would not challenge the mandate's constitutionality and the reason the provisions stand or fall together. But if the failure of insurers to join the challenge to the individual mandate means this Court cannot consider the severability of the guaranteed issue and community rating provisions, it is unclear how that question can ever be considered. Without the sweet of the individual mandate, insurers would have every incentive to challenge the guaranteed issue and community rating provisions, but it is not clear what cause of action they could bring.

Those practical problems reveal the basic flaw in the federal government's reasoning. The argument that the individual mandate is not severable from the remainder of the ACA is not a series of discrete challenges to each of the Act's hundreds of remaining provisions. It is an argument about which *remedy* would do the least damage to Congress' intent if the States' challenge *to the individual mandate* (and/or their challenge to the Medicaid expansion) succeeds. Any standing questions that might arise if the States were raising separate challenges to separate provisions of the ACA are irrelevant to that remedial inquiry. If it is evident that Congress did not intend the ACA to survive without its unconstitutional provisions, then this Court can and should use its remedial power to give effect to that intent *in this case*, rather than leaving in place a fragmented version of legislation that Congress would "never have been willing, by itself, to enact." *Pollock*, 158 U.S. at 636.

II. The ACA Is A Delicate Balance Of Inextricably Intertwined Provisions, None Of Which Can Survive Without The Act's Core Components.

As noted, severability analysis is, at its core, an inquiry into legislative intent. A proper application of the correct severability analysis reveals that the individual mandate not only was central to “the original legislative bargain” that produced the ACA, *Brock*, 480 U.S. at 685, but also was deliberately designed to work as an essential complement to the Act’s other core provisions to achieve Congress’ overarching objective of near-universal insurance coverage. Congress’ goal was neither to increase demand for insurance in the abstract nor to increase supply for its own sake. Instead, Congress sought to ensure an adequate supply to meet the artificial demand forcibly created by the individual mandate, all in service of the ultimate goal of supply and demand meeting at the point of near-universal coverage. Without the constitutionally invalid individual mandate, Congress would not have enacted the provisions designed to ensure a supply adequate to meet the demand created by the mandate or the cost-savings provisions designed to counterbalance the expensive supply-side provisions. Accordingly, this truly is a case in which “it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not.” *Champlin Ref.*, 286 U.S. at 234. The Court should therefore hold the ACA invalid in its entirety.

A. The Touchstone of Severability Analysis Is Legislative Intent.

As is clear from the conflicting decisions addressing the severability of the individual mandate, the contours of the severability inquiry are a source of confusion among lower courts. Indeed, four different courts, all purporting to apply the same “well established” severability standard, *Brock*, 480 U.S. at 684, have reached four different conclusions as to whether and how the individual mandate should be severed from the rest of the ACA. See *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010) (holding mandate non-severable from only “directly-dependent provisions”); Pet. App. 363a–64a (holding mandate non-severable from entire Act); Pet. App. 186a (holding mandate severable from entire Act); *Goudy-Bachman v. U.S. Dep’t of Health and Human Servs.*, — F. Supp. 2d —, No. 1:10-CV-763, 2011 WL 4072875 (M.D. Penn. Sept. 13, 2011) (holding mandate non-severable from only guaranteed issue and community rating provisions). The Court should take this opportunity to clarify the relevant legal principles and, in particular, the primacy of legislative intent. This is a case where Congress made the co-dependence of the various provisions evident in the text of the statute itself. Nonetheless, the Court of Appeals below lost sight of that critical indicator of legislative intent and instead essentially imposed a “non-severability” clause requirement that finds no support in this Court’s precedents.

“[T]he touchstone for any decision about remedy is legislative intent, for a court cannot ‘use its remedial powers to circumvent the intent of the

legislature.” *Ayotte*, 546 U.S. at 330 (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)). Accordingly, the ultimate question in a severability inquiry is whether “it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not.” *Champlin Ref.*, 286 U.S. at 234. While courts do not lightly strike down any statute, the standard is “evident” legislative intent, not a clear statement test, or whether the balance can operate independently, or whether there are cross-references, let alone a rule that the balance of a statute always survives absent a non-severability clause. If the legislature still would have enacted the remainder, then “the invalid part may be dropped if what is left is fully operative as a law.” *Id.* But if a court arrives at the conclusion that the legislation would not have been enacted without the invalid provision, the court must give effect to Congress’ evident intent and hold the legislation invalid in its entirety. *Id.*

As that “well established” severability test makes clear, *Brock*, 480 U.S. at 684, there is a critical difference between whether an act *can* stand and whether an act *should* stand without an invalid provision. That distinction is made manifest in this Court’s decision in *Brock*. *Brock* involved an inquiry into the severability of a legislative veto, a provision “which by its very nature is separate from the operation of the substantive provisions of a statute.” *Id.* If the only requirement for severability were the capacity for independent operation, then *Brock* could have ended its severability analysis with that single observation. But this Court did not end its analysis

there, and instead reiterated that “[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress.” *Id.* at 685.¹⁶

To be sure, “Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently.” *Id.* at 684; *see also Hill v. Wallace*, 259 U.S. 44, 70 (1922) (“We are not able to reject a part which is unconstitutional and retain the remainder, because it is not possible to separate that which is unconstitutional, if there be any such, from that which is not.” (quoting *Trade-Mark Cases*, 100 U.S. 82, 98–99 (1879))). But while the capacity for independent functionality is a necessary condition for severability, it is by no means sufficient. “[E]ven in a case where legal provisions may be severed from those which are illegal,” a court may sever “only where it is plain that Congress would have enacted the legislation with the unconstitutional provisions eliminated.” *Employers’ Liability Cases (Howard v. Ill. Cent. R.R. Co.)*, 207 U.S. 463, 501 (1908).

¹⁶ In that respect, severability analysis differs from constitutional analysis and inquiry under the Necessary and Proper Clause. Whereas severability focuses solely on Congress’ motivations and intentions, constitutional analysis often encompasses consideration of whether legislative provisions *in fact* serve the purposes Congress claims they were intended to serve. *See, e.g., United States v. Lopez*, 514 U.S. 549, 567 (1995); *United States v. Comstock*, 130 S. Ct. 1949, 1966–67 (2010) (Kennedy, J., concurring). That Congress considers one legislative provision “necessary” to another does not make it so.

Nor is it sufficient that “Congress would have enacted *some* form of” legislation on the same subject matter even without the invalid provision. *Brock*, 480 U.S. at 685 n.7. “Any such inquiry, of course, would be tautological, as Congress’ intent to enact a statute on the subject is apparent from the existence of” the legislation at hand. *Id.* The inquiry instead must focus on whether “the statute created in [the] absence [of the invalid provision] is legislation that Congress would not have enacted.” *Id.* at 685. If so, to retain that legislation “would be to substitute for the law intended by the legislature one they may never have been willing, by itself, to enact.” *Pollock*, 158 U.S. at 636.

That concern is nowhere more relevant than in a case like the present one, where the Act in question was the product of a divisive legislative process in which proponents of the bill consciously decided that changing *any* aspect of the Senate bill would endanger the entire enterprise. To deem it sufficient that Congress would have passed some form of health insurance legislation would be to turn a blind eye to the actual process that produced the ACA, and the unique circumstances calling into serious question whether Congress would have passed health insurance legislation at all if even a single word of the ACA was altered, let alone if there were no individual mandate to secure the critical support of the insurance industry. In fact, the procedural wrangling that produced the ACA was such that the House leadership decided that adding or removing *anything* from the Senate bill the House viewed as suboptimal would preclude passage of the Act. See *supra*, pp. 2–4. This case thus vividly illustrates

that any meaningful inquiry into legislative intent cannot be satisfied by mere generalizations about legislative interest in broad subject matter areas, but instead must involve careful consideration of the particular legislation at hand and the unique circumstances under which it was enacted.

As with any inquiry into legislative intent, the severability analysis of course begins with the text of the statute. “The inquiry is eased when Congress has explicitly provided for severance by including a severability clause in the statute” or has included a non-severability clause. *Brock*, 480 U.S. at 686. But when Congress does not include such a clause, “Congress’ silence is just that.” *Id.* And even a severability clause can be overcome by convincing evidence to the contrary, such as the absence of any feasible means of separating the valid from the invalid. *See Hill*, 259 U.S. at 70 (deeming invalid provision “so interwoven with [other] regulations that they cannot be separated,” even though Congress included severability clause); *cf. Elec. Bond & Share Co. v. SEC*, 303 U.S. 419, 435 (1938) (engaging in detailed analysis of other evidence of legislative intent despite presence of severability clause). Thus, while a severability clause is certainly relevant, “the ultimate determination of severability will rarely turn on the presence or absence of such a clause.” *United States v. Jackson*, 390 U.S. 570, 586 n.27 (1968). Moreover, the presence or absence of a severability clause is not the only means by which Congress can address severability in the text of the statute. In a case like this one, where Congress expressly addressed the intended interrelationship of various provisions in

findings included in the enacted text, such findings directly inform the severability analysis.

In the end, while there are objective criteria that in some instances can make the severability inquiry an easy one, the inquiry by its nature is often more complex. That is because the basic goal is to determine whether “the purpose of the Act is ... defeated by the invalidation of the [challenged] provision.” *New York*, 505 U.S. at 187; *see also Free Enter. Fund*, 130 S. Ct. at 3162 (asking whether Congress “would have preferred no Board at all to a Board whose members are removable at will”); *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion) (asking whether “the policies Congress sought to advance ... can be effectuated even though [the invalid provision] is unenforceable”); *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935) (asking whether invalid parts “so affect[ed] the dominant aim of the whole statute as to carry it down with them”). Because even when Congress anticipates constitutional challenges, it rarely directly addresses a scenario of partial invalidation, courts often cannot answer that “elusive inquiry,” *Chadha*, 462 U.S. at 932, without considering a broad spectrum of indicia of legislative intent, including “the importance of the [invalid provision] in the original legislative bargain,” *Brock*, 480 U.S. at 685, and “the historical context” in which legislation was enacted, *Free Enter. Fund*, 130 S. Ct. at 3162; *see also Chadha*, 462 U.S. at 934.

Taking all of that evidence into account, a court’s ultimate duty is to answer the remedial question of what “Congress would have intended in light of the Court’s constitutional holding.” *Booker*,

543 U.S. at 246. If “it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not,” *Champlin Ref.*, 286 U.S. at 234, then the reviewing court has an obligation not to leave the balance of the legislation in place.

B. The ACA’s Core Components Cannot Survive Without the Individual Mandate.

Applying these core precepts, the answer to the severability question here is clear: The ACA cannot stand without the individual mandate. Congress itself declared the individual mandate a core component of the ACA and identified its intended interrelationship with the other central provisions of the Act. Congress did not address either the demand or the supply side of the insurance equation for its own sake, but instead sought to ensure that supply would be sufficient to meet the demand created by the individual mandate, in service of a goal of near-universal coverage. Without the demand mandated by the individual mandate, Congress would not have enacted the various supply-side provisions. And without those core components, Congress would not have enacted the Act. As the District Court found, the ACA is akin to “a finely crafted watch.” Pet. App. 362a. Its pieces “all work toward one primary legislative goal ... that ... would be undermined if a central part of the legislation is found to be unconstitutional.” Pet. App. 352a. Because at least “one essential piece (the individual mandate) is defective and must be removed,” Pet. App. 362a, the Act cannot function in the manner that Congress intended. Accordingly, the Court should give effect

to Congress' evident intent and hold the ACA invalid in its entirety.

1. The ACA's core provisions are carefully constructed to work in unison to achieve Congress' paramount goal of "near-universal" insurance coverage. ACA § 1501(a)(2)(D). In determining how to obtain that objective, Congress perceived two basic barriers: Not everyone who wants insurance can get it, and not everyone who can get insurance wants it. Because addressing either in isolation would not solve—and, indeed, could exacerbate—the problem, Congress crafted a two-pronged attack of increasing both supply *and* demand to achieve near-universal coverage. On the demand side, Congress enacted the individual mandate to force individuals who do not want insurance to obtain it, even if (indeed, especially if) they are unlikely to need it. That, in turn, would make it more affordable for insurers to provide insurance to higher risk and lower income individuals. On the supply side, Congress enacted a series of measures—insurance market regulations, exchanges and subsidies, employer regulations, and expanded Medicaid—designed to force an increase in the supply of private, employer-based, and public insurance. That, in turn, would guarantee that everyone—including individuals previously unable to obtain it and individuals forced into the market by the mandate—would have a ready supply of insurance available.

Because Congress was not seeking to deal with perceived supply-side defects (those who want insurance but cannot get it) or perceived demand-side problems (those who can get insurance but do

not want it) in isolation, the ACA can only operate in the manner that Congress intended—a manner that achieves near-*universal* insurance coverage—if both sides of the equation are intact. In Congress’ view, without the artificially increased demand that the individual mandate creates in general, and the forced subsidization created by the mandate’s effect on healthy individuals in particular, the Act’s corresponding increase in supply would be potentially unnecessary and in all events unaffordable. Without the forced subsidization worked by the mandate, the insurance companies could not comply with the mandate to insure higher risk individuals without dramatically driving up costs and potentially exacerbating the problem. And without the mandated increase in supply, universal compliance with the individual mandate would be unattainable because forced demand would outstrip voluntary supply. Thus, once any of the Act’s core supply and demand provisions is removed, it ceases to be an act designed to achieve near-universal health insurance coverage, let alone an act designed to achieve it in the manner Congress envisioned.

In keeping with that understanding of the ACA’s animating logic, both Congress and the federal government have repeatedly emphasized that *all* of the Act’s central provisions were designed to “work in tandem” to further Congress’ basic goal of near-universal insurance coverage. Pet. App. 358a; *see also* Pet. App. 185 n.142 (“Congress itself states that *all* the provisions of the Act operate together to achieve its goals”). As the federal government put it, in Congress’ estimation, many of the “individuals whose conduct is regulated by the minimum

coverage provision ... affirmatively seek insurance but are unable to obtain it without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide.” Govt.’s Mem. Support Summ. J. 1–2 [R.E. 984–85]. That is why Congress considered the mandate alone insufficient to expand the number of insured, and deemed it necessary to identify and remedy whatever deficiencies Congress perceived in the availability of insurance in each discrete segment of the uninsured population. Only by working “together with the other provisions of th[e] Act” did Congress believe the mandate could further its overarching goal of “increas[ing] the number and share of Americans who are insured.” ACA § 1501(a)(2)(C).

That is not to suggest that Congress considered the mandate less critical than the provisions mandating an increase in the supply of insurance. Quite the contrary, Congress explicitly and repeatedly deemed the mandate “essential” to the entire regulatory scheme it endeavored to create, both in terms of the universality and the affordability of insurance. *See* ACA § 1501(a)(2)(H) (“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.”); § 1501(a)(2)(I) (“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 preexisting conditions can be sold.”); § 1501(a)(2)(J) (“The requirement is essential to creating effective health insurance markets that

do not require underwriting and eliminate its associated administrative costs.”). Indeed, one of the Act’s principal architects labeled amendments to remove the mandate efforts to “gut” or “mortally wound” the bill. *See supra*, p. 6. Moreover, the CBO has estimated that about 16 million of the 32 million individuals that the Act was intended to insure would choose to remain uninsured if there were no individual mandate to obtain insurance. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010) (estimating that 4–5 million fewer would obtain employer-based coverage, 5 million fewer would purchase insurance, and 6–7 million fewer would enroll in Medicaid).¹⁷

The individual mandate was essential not only to Congress’ envisioned operation of the Act, but also to another key aspect of the severability inquiry: “the importance of the [invalidated provision] in the original legislative bargain.” *Brock*, 480 U.S. at 685. Based on their experiences in States that enacted guaranteed issue and community rating provisions *without* an individual mandate, insurance companies made it clear to Congress that they did not consider the significant costs generated by those twin requirements affordable without the forced subsidy that a mandate to purchase insurance creates. *See supra*, pp. 12–13. As a result, the bill’s proponents were acutely aware that the insurance industry would not accept the bitter without the sweet. It would not support the insurance market regulations

¹⁷ Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

that the bill's proponents wanted to enact without an individual mandate that would "broaden the health insurance risk pool to include healthy individuals." ACA § 1501(a)(2)(I); *see also* Pet. App. 178a (recognizing that the mandate "mitigate[s] the reforms' cost on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers' costs in covering the unhealthy"). Thus, as the District Court put it, the individual mandate was, in a very real sense, the "lynchpin of the entire health reform effort." Pet. App. 354a.

2. Precisely because Congress made its understanding of the mandate's key role in the legislation so evident, including in its textual findings, the federal government has conceded throughout this litigation that, issues of "standing" aside, the mandate cannot be severed from the guaranteed issue and community rating provisions. *See, e.g.*, Govt.'s Response Pet. Cert. 10 ("Without the minimum coverage provision, the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available."); Govt.'s 11th Cir. Br. 59 ("the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions"); Govt.'s Mem. Supp. Summ. J. 16 [R.E. 999] ("the minimum coverage provision forms an integral part of the ACA's larger reforms of health insurance industry practices"). But the federal government fails to appreciate the full significance of that unavoidable concession. It not only means that the guaranteed issue and community rating provisions must fall with the mandate; it means that

all the supply-side provisions, and in turn their “offsets,” *see infra*, Part II.C, cannot survive the mandate’s invalidation.

As the District Court explained, the insurance regulations that stand or fall with the mandate “are the very heart of the Act itself.” Pet. App. 356a. Together with the mandate, those provisions not only “were instrumental in passing the Act,” Pet. App. 356a, but “were the chief engines that drove the entire legislative effort.” Pet. App. 362a; *see also* Pet. App. 356a & nn.28–29 (noting that insurance regulations were repeatedly touted by the President, Congress, and other supporters as central achievements of the ACA). Just as the individual mandate was necessary to ensure that everyone who *can* purchase insurance *will*, the insurance market regulations were necessary to ensure that everyone who *wants* to purchase insurance *can*. And the latter was as popular in some quarters as the former was unpopular in others, so without the ability to guarantee insurance for the uninsured, Congress would never have enacted the ACA.

Simply put, without guaranteed issue and community rating, the impetus for the ACA would disappear, and the Act’s whole private insurance expansion would unravel, for insurance companies would remain free to turn away millions of the very same uninsured individuals to whom the Act promised insurance. Accordingly, it is even less plausible to think Congress would have enacted a comprehensive regulatory scheme without the insurance market regulations than to think that Congress would have enacted the insurance market regulations without an individual mandate. Thus, if,

as the federal government concedes, the remedial consequences of invalidating the individual mandate necessarily include eliminating the guaranteed issue and community rating provisions, then it is even more evident that the remedial consequences cannot possibly end there. An ACA without the individual mandate and the inextricably intertwined insurance regulations “is legislation that Congress would not have enacted,” *Brock*, 480 U.S. at 685, as “the purpose of the Act is ... defeated by the invalidation of th[ose] provision[s].” *New York*, 505 U.S. at 187.

The Eleventh Circuit effectively reached that same conclusion as to the guaranteed issue and community rating provisions—that Congress “would have preferred no [ACA] at all to a[n ACA]” without them, *Free Enter. Fund*, 130 S. Ct. at 3162. *See* Pet. App. 158a. But it failed to follow that conclusion to its logical end. If it is evident that Congress could not have passed the insurance regulations without the mandate, and would not have passed the ACA without the insurance regulations, then the remedy most consistent with Congress’ intent is to invalidate the entire ACA, not to sever the mandate and leave the insurance regulations standing. That is true regardless of a court’s assessment of the value of those regulations or of their ability to function independently. *But see* Pet. App. 185a (suggesting that presumption of severability should be stronger because insurance regulations will “help consumers who need it most”); Pet. App. 183a (rejecting Congress’ finding that the mandate is “essential” because “multiple features of the individual mandate all serve to weaken the mandate’s practical influence on the two insurance product reforms”). Congress’

judgment, not the court's, is what matters, and if Congress viewed the mandate and the insurance regulations as co-dependent and would not have enacted one without the other, then that evident intent is what controls.

3. For largely the same reasons, the argument that the entire Act must be invalidated is even stronger if the Court holds the ACA's Medicaid expansion unconstitutional. That expansion is every bit as critical to the publicly financed supply side as the guaranteed issue and community rating provisions are to the privately financed supply side when it comes to Congress' objective of near-universal health insurance coverage. Of the 32 million uninsured that Congress envisioned obtaining insurance as a result of the ACA and its individual mandate, Congress expected at least half—*16 million individuals*—to do so through the Medicaid expansion. CBO Estimate 9 (Mar. 20, 2010). Accordingly, the individual mandate plainly could not operate in the manner Congress intended without that expansion, as a huge chunk of the uninsured population that Congress was targeting would be left with no means of complying with the mandate to obtain insurance.

Indeed, without the Medicaid expansion, the ACA would not just fall far short of “near-universal” insurance coverage. It would fail to address in any meaningful manner the problem of providing affordable insurance for the millions of lowest-income individuals that Congress considered in greatest need of assistance. Congress provided no back-up plan for supplying insurance to these 16 million individuals. And, of course, if both the

individual mandate and the Medicaid provisions are unconstitutional, then the remnants of the ACA would be wholly unrecognizable to Congress and wholly unable to achieve Congress' goal. With the entirety of the demand side and at least half of the supply side invalidated, Congress' goal of supply meeting demand at the point of near-universal health insurance would be completely unattainable.

While the relationship between the supply side and the demand side of the ACA is uniquely acute with respect to the massive increase in supply that the Medicaid expansion creates, the same basic principle holds true with respect to each of the Act's core provisions: "[T]he policies Congress sought to advance ... can[not] be effectuated," *Regan*, 468 U.S. at 653, by an Act that increases demand without a corresponding increase in supply, or an Act that increases supply without a corresponding increase in demand, because Congress premised its entire regulatory scheme on the notion that each is necessary to make the other effective, and to achieve the overarching objective of near-universal insurance coverage. Accordingly, there is simply no reason to think that Congress would have passed an Act that lacks *any one* of the ACA's core components, let alone an Act that lacks the individual mandate, the insurance market regulations, *and* the Medicaid expansion.

C. The ACA's Remaining Components Cannot Survive Without Its Core Ones.

The federal government cannot and does not deny the co-dependent nature of the relationships at the heart of the massive regulatory web that

comprises the ACA. It instead attempts to shift the focus entirely, by insisting that the severability inquiry requires independent analysis of each and every one of the ACA's hundreds of remaining provisions to determine which ones, standing alone, "would properly work independently of the" mandate. Govt.'s Response Pet. Cert. 28. Operating within that artificial framework, the federal government proceeds to pick and choose provisions that it claims are independently functional, such as discrete wellness measures and excise taxes, and contend that the existence of such provisions is sufficient to defeat any argument against severability.

Once again, the federal government misconceives the nature of the severability analysis. The question is not whether some subset of the ACA might be cobbled together to form a fully functional collection of health insurance regulations that are not directly dependent on the individual mandate. As noted, independent functionality is a necessary, but not sufficient, condition for severability. *See supra*, pp. 36–38. "The more relevant inquiry ... is whether the statute will function in a *manner* consistent with the intent of Congress," *Brock*, 480 U.S. at 685, without the mandate. That question must be answered by looking at the Act as a whole, mindful of the basic purposes Congress sought to achieve, not by examining in isolation particular relationships between discrete components.

That broader inquiry into the manner in which Congress intended the ACA to function reveals an interconnectedness that does not stop with the relationship between the mandate and the insurance market regulations, or the relationship between

those and the Act's other core supply-side provisions. Congress crafted *the entire Act* to function as "a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal." Pet. App. 352a. Because the very "purpose of the Act is ... defeated by the invalidation of" any of its core components, *New York*, 505 U.S. at 187, "the policies Congress sought to advance ... can[not] be effectuated," *Regan*, 468 U.S. at 653, by removing its hub but leaving the spokes.

That is nowhere more evident than when considering the delicate fiscal balance that Congress designed the ACA to achieve. Congress was acutely aware of the fact that the Act would not pass if it were not scored as deficit neutral, and also was acutely aware of just how much some of the Act's core provisions were going to cost. Most prominently, the CBO estimated just before the House voted on the Act that the Medicaid expansion will cost at least \$434 billion over the next decade and the health benefit exchanges will cost another \$350 billion. CBO Estimate, Table 2 (Mar. 20, 2010). Congress could not and did not simply authorize that massive and politically unpalatable spending increase and call it a day; to do so would have derailed the entire legislative effort. It authorized that spending increase only after including other components specifically designed to offset it, and only after obtaining the CBO's opinion that those

components would achieve the necessary condition of deficit neutrality.¹⁸

Once that basic legislative dynamic is understood, it is clear that even seemingly unrelated aspects of the Act in fact all work together toward the single central goal of buying and paying for “near-universal coverage.” ACA § 1501(a)(2)(D). To take the District Court’s example, the relationship between the mandate and the Act’s provision requiring businesses to issue 1099 tax forms to certain individuals or corporations may not be obvious at first blush. Pet. App. 362a (citing ACA § 9006). But it is obvious once one takes a step back and realizes that that provision is one of the many “Revenue *Offset* Provisions” in Title IX that were a critical part of the delicate fiscal and legislative compromise that produced the ACA. The same is true as to the excise tax on indoor tanning salons highlighted by the Eleventh Circuit. While that provision may appear to “ha[ve] nothing to do with private insurance,” Pet. App. 175a–76a, it, too, is one of Title IX’s “revenue offset” provisions. ACA § 9017.

As those integrated budgetary relationships reveal, the case for the balance of the ACA falling with the individual mandate rests not just on “the importance of the [individual mandate] in the original legislative bargain,” *Brock*, 480 U.S. at 685,

¹⁸ That is not to suggest that the Act actually *achieves* the fiscal balance that Congress intended. One need not be a cynic to suspect that projected cost savings have a stubborn tendency to underperform, while projected outlays often overperform. But, for purposes of severability analysis, what Congress intended is what matters.

or the inextricably intertwined nature of the mandate and the Act's core supply-side provisions. That remedy also follows from the tenuous fiscal balance upon which the entire Act hinged.

That is particularly true if the Medicaid expansion is invalidated, either on its own or as a consequence of invalidation of the mandate. The *\$434 billion in new federal spending* that the Medicaid expansion will generate makes it the single most expensive component of the Act. Not surprisingly, given the interest in budget neutrality, that costly expansion is immediately followed in the Act by a collection of massive reductions in *Medicare* spending, which Congress envisioned generating *\$455 billion in cost savings*. CBO Estimate, Table 2 (Mar. 20, 2010). That mirror image is no mere coincidence. As the federal government explained, “[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions.” Mem. Supp. Govt.’s Mot. Summ. J. 41 [R.E. 1024].

Just as the desire to provide insurance to the uninsured was the impetus for the ACA as a whole, the need to provide offsets for the enormously costly supply-side provisions such as Medicaid and the exchanges was the critical impetus for the Act's projected cost-saving measures. In an era of massive budget deficits that no one professes to like, Congress presumably had its reasons for not enacting those cost-saving measures earlier. Without the felt-need to offset \$434 billion in new Medicaid spending, those offsets would simply not have happened. It thus would do violence to

Congress' intent to have those cost-saving provisions survive the invalidation of the provisions that impelled them in the first place.

That intentional interrelationship among all of the Act's provisions is what the Eleventh Circuit failed to consider when it held the mandate severable from the entirety of the Act. As to every aspect of the ACA except the guaranteed issue and preexisting condition provisions, the court "summarily" rejected any question of severability without even considering how Congress intended those provisions to operate, instead simply noting that "excising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.'" Pet. App. 176a, 174a (quoting *Brock*, 480 U.S. at 684). The two District Courts that left much of the ACA standing evinced the same unwillingness to engage in any meaningful analysis of the broader purposes that seemingly discrete segments of the ACA serve. See *Virginia*, 728 F. Supp. 2d at 789 (declaring it "virtually impossible within the present record" to determine which provisions should stand without the mandate), *Goudy-Bachman*, 2011 WL 4072875 at *20 (suggesting any inquiry into how Congress intended various provisions of the Act to operate "would be a[n] immense undertaking, and ultimately speculative at best").

But neither the size nor the speculative nature of the task is any excuse for failing to examine Congress' intent. As to the former, there is no "too big to fail" exception to severability analysis. To be sure, the ACA is an immense and intimidating statute. But that does not make the essential interrelationship of

its core provisions and offsetting function of its remaining provisions any less evident. And as to the latter, the inquiry into what the legislature would have intended had it known a provision would be invalidated by the courts is inherently counterfactual and speculative, but that is no excuse for not undertaking it. Many remedial questions faced by courts are counterfactual and speculative, but they are nonetheless critically important to provide an appropriate remedy—and, in this context, to honor Congress' evident intent that the ACA stand or fall with the individual mandate.

Nor does the absence of a non-severability clause in the ACA provide any basis for ignoring all the evidence that Congress intended the individual mandate to be non-severable. The Eleventh Circuit seemed to view that absence as highly relevant, *Pet. App.* 175a–76a, but such clauses are rare and would make little sense in a vast enactment like the ACA. Both severability and non-severability clauses are typically all-or-nothing propositions, as Congress rarely combs through a bill section by section to explain its intentions as to the severability of each and every provision. One can imagine Congress including a severability clause in a sprawling multi-subject bill to reflect an intent to preserve as much of the act as possible. But in a massive bill with critical central provisions and peripheral complementary provisions, it would make little sense to treat the invalidation of a minor, peripheral provision the same as the invalidation of a core provision of the act. This Court's severability analysis distinguishes between those two circumstances by focusing on Congress' evident

intent. A one-size-fits-all non-severability clause would not. But the Court of Appeals bypassed the more sensitive analysis demanded by this Court's cases by giving undue weight to the absence of a non-severability clause.

The Eleventh Circuit compounded that error by dismissing the significance of Congress' decision to eliminate a severability clause during the drafting process. Contrary to the court's conclusion, it is both relevant and probative that Congress included a severability clause in an earlier version of the bill but excluded it from the ACA. To be sure, as the District Court recognized, Pet. App. 355a, the Act's lack of a severability clause does not create a presumption of non-severability. But "[w]here Congress includes ... language in an earlier version of a bill, but deletes it prior to enactment, it may be presumed that the [excluded language] was not intended." *Russello v. United States*, 464 U.S. 16, 23–24 (1983). Particularly in the unusual context of an Act with a central provision subjected to constitutional scrutiny even before it became law, there is every reason to think that Congress made a conscious decision when it eliminated a severability clause from an Act that it knew would be subject to serious legal challenges. At a bare minimum, the elimination of that clause should put added focus on Congress' express statements about the interrelationship and co-dependence of the Act's provisions.

In the end, Congress' express and repeated findings that the mandate was "essential" to the Act's broader regulatory goals speak to the question presented here far more directly than the presence or absence of any severability or non-severability

clause. Congress made clear that the Act was structured so that it could not achieve its goal of near-universal coverage without the individual mandate. Those textual findings are reinforced by a variety of other indicia of Congress' intent, including: the labeling of amendments designed to remove the mandate as efforts to "gut" or "mortally wound" the bill, the interrelated and co-dependent nature of the supply and demand sides of the Act, and the reality that the Act passed through a series of legislative maneuvers that permitted no changes and made every provision critical. It is thus clear that without the mandate, Congress would not have enacted the supply-side provisions, and without those costly provisions to offset, the balance of the Act never would have emerged.

In these unique circumstances, leaving the remnants of spokes of the ACA in place without its hub runs a very real risk of "substitut[ing] for the law intended by the legislature one they may never have been willing, by itself, to enact." *Pollock*, 158 U.S. at 636. It does not require "speculati[on]" or an "immense" study of every minute detail of the ACA, *Goudy-Bachman*, 2011 WL 4072875 at *21, to arrive at the conclusion plain to all who recall the tortuous and tenuous process that produced it: An ACA without the individual mandate "is legislation that Congress would not have enacted." *Brock*, 480 U.S. at 685.

CONCLUSION

The Court should hold the ACA invalid in its entirety.

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**RELEVANT PROVISIONS OF THE
PATIENT PROTECTION & AFFORDABLE
CARE ACT, PUB. L. NO. 111-148, AS AMENDED
BY THE HEALTH CARE & EDUCATION
RECONCILIATION ACT OF 2010,
PUB. L. NO. 111-152**

**SEC. 1201. AMENDMENT TO THE PUBLIC
HEALTH SERVICE ACT.**

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

“Subpart I—General Reform”;

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

**“SEC. 2704 [42 U.S.C. 300gg-3].
PROHIBITION OF PREEXISTING CONDITION
EXCLUSIONS OR OTHER DISCRIMINATION
BASED ON HEALTH STATUS.**

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg-1)—

(i) by striking the section heading and all that follow through subsection (a);

(ii) in subsection (b)—

(I) by striking “health insurance issuer offering health insurance coverage in connection with a group health plan” each place that such appears and inserting “health insurance issuer offering group or individual health insurance coverage”; and

(II) in paragraph (2)(A)—

(aa) by inserting “or individual” after “employer”; and

(bb) by inserting “or individual health coverage, as the case may be” before the semicolon; and

(iii) in subsection (e)—

(I) by striking “(a)(1)(F)” and inserting “(a)(6)”;

(II) by striking “2701” and inserting “2704”; and

(III) by striking “2721(a)” and inserting “2735(a)”;

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

**“SEC. 2701 [42 U.S.C. 300gg]. FAIR
HEALTH INSURANCE PREMIUMS.**

**“(a) PROHIBITING DISCRIMINATORY
PREMIUM RATES.—**

“(1) IN GENERAL.—With respect to the premium rate charged by a health insurance

issuer for health insurance coverage offered in the individual or small group market—

“(A) such rate shall vary with respect to the particular plan or coverage involved only by—

“(i) whether such plan or coverage covers an individual or family;

“(ii) rating area, as established in accordance with paragraph (2);

“(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

“(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

“(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

“(2) RATING AREA.—

“(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

“(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not

establish such areas, the Secretary may establish rating areas for that State.

“(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

“(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

“(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

“SEC. 2702 [42 U.S.C. 300gg–1]. GUARANTEED AVAILABILITY OF COVERAGE.

“(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that

offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

“(b) ENROLLMENT.—

“(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

“(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

“(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

“SEC. 2703 [42 U.S.C. 300gg-2]. GUARANTEED RENEWABILITY OF COVERAGE.

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

“SEC. 2705 [42 U.S.C. 300gg-4]. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL

PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(1) Health status.

“(2) Medical condition (including both physical and mental illnesses).

“(3) Claims experience.

“(4) Receipt of health care.

“(5) Medical history.

“(6) Genetic information.

“(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(8) Disability.

“(9) Any other health status-related factor determined appropriate by the Secretary.

“(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

“(1) GENERAL PROVISIONS.—

“(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an

employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

“(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.— If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

“(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.— If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

“(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.— If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program

shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

“(A) A program that reimburses all or part of the cost for memberships in a fitness center.

“(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

“(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

“(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

“(E) A program that provides a reward to individuals for attending a periodic health education seminar.

“(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual

satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

“(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward

available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

“(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

“(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

“(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

“(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is

unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

“(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual’s physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

“(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

“(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was

established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

“(1) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

“(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

“(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

“(3) REQUIREMENTS.—

“(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section

unless the Secretaries determine that the State's project is designed in a manner that—

“(i) will not result in any decrease in coverage; and

“(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

“(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

“(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

“(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

“(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

“(I) do not create undue burdens for individuals insured in the individual market;

“(II) do not lead to cost shifting; and

“(III) are not a subterfuge for discrimination;

“(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

“(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

“(m) REPORT.—

“(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

“(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

“(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

“(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

“(D) the effectiveness of different types of rewards.

“(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

“(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection

with this section.

“SEC. 2706 [42 U.S.C. 300gg-5]. NON-DISCRIMINATION IN HEALTH CARE.

“(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. This section shall not require that a

group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

“(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

**“SEC. 2707 [42 U.S.C. 300gg-6].
COMPREHENSIVE HEALTH INSURANCE
COVERAGE.**

“(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

“(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

“(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section

1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

“(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

“SEC. 2708 [42 U.S.C. 300gg–7]. PROHIBITION ON EXCESSIVE WAITING PERIODS.

“A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.

“SEC. 2709 [42 U.S.C. 300gg–8]. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

“(a) COVERAGE.—

“(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

“(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

“(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

“(C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

“(2) ROUTINE PATIENT COSTS.—

“(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

“(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

“(i) the investigational item, device, or service, itself;

“(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

“(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if

the provider will accept the individual as a participant in the trial.

“(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

“(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ‘qualified individual’ means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

“(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

“(2) Either—

“(A) the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

“(B) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

“(c) LIMITATIONS ON COVERAGE.—

This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘approved clinical trial’ means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

“(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

“(i) The National Institutes of Health.

“(ii) The Centers for Disease Control and Prevention.

“(iii) The Agency for Health Care Research and Quality.

“(iv) The Centers for Medicare & Medicaid Services.

“(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

“(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

“(vii) Any of the following if the conditions described in paragraph (2) are met:

“(I) The Department of Veterans Affairs.

“(II) The Department of Defense.

“(III) The Department of Energy.

“(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

“(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

“(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or

investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

“(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

“(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

“(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term ‘life-threatening condition’ means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.

“(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

“(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.”.

SEC. 1501. [42 U.S.C. 18091]. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection 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 (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.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

**“CHAPTER 48—MAINTENANCE OF
MINIMUM ESSENTIAL COVERAGE**

“Sec. 5000A. Requirement to maintain minimum essential coverage.

**“SEC. 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) 2.5 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 \$695.

“(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$350 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.

“(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the

applicable dollar amount shall be equal to \$750, increased by an amount equal to—

“(i) \$695, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2015’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

“(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 gross income’ means gross income—

“(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 EXEMPTION.—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 such individual is—

“(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1) and

“(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

“(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 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,

“(iv) the TRICARE for Life program,

“(v) the veteran’s health care program under chapter 17 of title 38, United States Code, or

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

“(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.”.

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code

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of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

“CHAPTER 48—MAINTENANCE OF
MINIMUM ESSENTIAL COVERAGE.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking “or” at the end of subclause (VI);

(B) by adding “or” at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

“(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);”.

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

“(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.”.

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking “or” at the end;

(ii) in paragraph (25), by striking the period and inserting “; or”; and

(iii) by adding at the end the following:

“(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).”.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting “subsection (y) and” before “section 1933(d)”; and

(B) by adding at the end the following new subsection:

“(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

“(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

“(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

“(B) 95 percent for calendar quarters in 2017;

“(C) 94 percent for calendar quarters in 2018;

“(D) 93 percent for calendar quarters in 2019; and

“(E) 90 percent for calendar quarters in 2020 and each year thereafter.

“(2) DEFINITIONS.—In this subsection:

“(A) NEWLY ELIGIBLE.—The term ‘newly eligible’ means, with respect to an individual

described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

“(B) FULL BENEFITS.—The term ‘full benefits’ means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).”.

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by

paragraph (2)), is amended by inserting after paragraph (1) the following:

“(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”.

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

“(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.”.

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking “and (XIV)” and inserting “(XIV)” and by inserting “and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)” before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking “100” and inserting “133”.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xii);

(ii) by inserting “or” at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

“(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),”.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(i)(VIII),” after “1902(a)(10)(A)(i)(VII),”.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u-7(a)(1)(B)) is amended by inserting “subclause (VIII) of section 1902(a)(10)(A)(i) or under” after “eligible under”.

(b) **MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting “; and”; and

(C) by inserting after paragraph (73) the following new paragraph:

“(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).”; and

(2) by adding at the end the following new subsection:

“(gg) **MAINTENANCE OF EFFORT.**—

“(1) **GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE**

EXCHANGE IS FULLY OPERATIONAL.—

Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

“(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on

December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

“(4) DETERMINATION OF COMPLIANCE.—

“(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.— A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

“(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO

COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).”.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6),” before “each”;

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6)” after “subsection (a)(1),”;

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses

(vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

“(iv) Coverage of prescription drugs.

“(v) Mental health services.”; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

“(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

“(6) MENTAL HEALTH SERVICES PARITY.—

“(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph

(1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

“(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).”.

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking “and” at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting “; and”; and

(C) by inserting after paragraph (74) the following new paragraph:

“(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

“(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

“(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

“(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.”.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national

and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.— Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking “or” at the end;

(ii) in subclause (XIX), by adding “or” at the end; and

(iii) by adding at the end the following new subclause:

“(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);” and

(B) by adding at the end the following new subsection:

“(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xiii);

(ii) by inserting “or” at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

“(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),”.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(ii)(XX),” after “1902(a)(10)(A)(ii)(XIX),”.

(C) Section 1920(e) of such Act (42 U.S.C. 1396r-1(e)), as added by subsection (a)(4)(B), is amended by inserting “or clause (ii)(XX)” after “clause (i)(VIII)”.