No. 19-10011

In the United States Court of Appeals for the Fifth Circuit

STATE OF TEXAS; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, BY AND THROUGH GOVERNOR PHIL BRYANT; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INTERNAL REVENUE,

Defendants-Appellants,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

Intervenor Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas, Fort Worth Division

BRIEF FOR STATE APPELLEES

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Certificate of Interested Persons

No. 19-10011

State of Texas; State of Alabama; State of Arizona; State of Florida; State of Georgia; State of Indiana; State of Kansas; State of Louisiana; State of Mississippi, by and through Governor Phil Bryant; State of Missouri; State of Nebraska; State of North Dakota; State of South Carolina; State of South Dakota; State of Tennessee; State of Utah; State of West Virginia; State of Arkansas; Neill Hurley; John Nantz,

Plaintiffs-Appellees,

v.

United States of America; United States Department of Health and Human Services; Alex Azar, II, Secretary, U.S. Department of Health and Human Services; United States Department of Internal Revenue; Charles P. Rettig, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

State of California; State of Connecticut; District of Columbia; State of Delaware; State of Hawaii; State of Illinois; State of Kentucky; State of Massachusetts; State of New Jersey; State of New York; State of North Carolina; State of Oregon; State of Rhode Island; State of Vermont; State of Virginia; State of Washington; State of Minnesota,

Intervenor Defendants-Appellants.

Under the fourth sentence of Fifth Circuit Rule 28.2.1, Appellees, as governmental parties, need not furnish a certificate of interested parties.

/s/ Kyle D. Hawkins
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Statement Regarding Oral Argument

Because this case presents issues of exceptional importance, the State Appellees believe that oral argument is likely to aid the Court's decisional process.

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INTRODUCTION

"The Federal Government does not have the power to order people to buy health insurance." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575 (2012) (Roberts, C.J.). The Affordable Care Act's individual mandate does just that. In *NFIB v. Sibelius*, the Supreme Court upheld the mandate anyway by discerning a saving construction. The majority reasoned that as it stood in 2012, the mandate "may reasonably be characterized as a tax." *Id.* at 574. That saving construction was "fairly possible," *id.*, only because the judicially combined individual-mandate-and-tax-penalty had the "essential feature of any tax"—the raising of at least "some revenue"—and thus could be enacted constitutionally under Congress's taxing power. *Id.* at 563-64.

But in 2017, Congress eliminated the statutory foundation that made the saving construction "fairly possible." In the Tax Cuts and Jobs Act, Congress reduced the tax to zero. The individual mandate still commands individuals to purchase insurance, but it does so without generating any revenue. The individual mandate now does exactly what five Justices in *NFIB* proclaimed Congress may not do: order Americans to engage in commerce by buying particular insurance products in accordance with the government's view of their best interests.

Since binding precedent confirms that the individual mandate is now unconstitutional, the remaining question is what other parts of the ACA remain. The ACA's text answers that question explicitly: nothing. In multiple separate provisions, Congress stated its view that the mandate is "essential"; without it, the rest of the law cannot stand. It thus is no surprise that the Department of Justice has consistently

argued for nine years across two different presidential administrations that the community-rating and guaranteed-issue provisions are inseverable from the mandate. So, too, are the ACA's other provisions, for the reasons identified by the four-Justice dissent in *NFIB*. The district court correctly recognized all this in declaring the ACA unlawful in its entirety. The Department of Justice now agrees—and so too should this Court.

The ACA is defended now by a collection of States and the U.S. House of Representatives as intervenors. They lead their defense with a challenge to the plaintiffs' standing, but their standing arguments distort the law and misunderstand the record. The individual plaintiffs plainly have standing, and that is enough to satisfy Article III. The state plaintiffs also have standing in their own right because, as the Congressional Budget Office has confirmed, the individual mandate directly causes higher enrollment in state-funded coverage programs. No record evidence rebuts the data proving that the States suffer a pocketbook injury. Whether that injury is large or small matters not, as any economic injury in any amount satisfies the constitutional threshold for federal jurisdiction.

The intervenors' arguments on the merits contravene both *NFIB* and the text of the ACA itself. They claim that *NFIB*'s saving construction once again saves the mandate because it binds this Court, but that cannot be true where, as here, the *sole* justification for the saving construction no longer exists. They further insist that the Court must excise only the unconstitutional mandate without impacting any other provision—but that argument overlooks the many textual declarations in the ACA itself that the mandate is "essential." The intervenors ask this Court to consider

everything except the statutory text itself. That argument cannot prevail in a Court that "begins with the text." *Ross v. Blake*, 136 S. Ct. 1850, 1856 (2016). The Court does not interpret a statute by "psychoanalyzing those who enacted it." *Carter v. United States*, 530 U.S. 255, 271 (2000) (citation omitted). And here, the text answers the question before the Court.

This case is not about whether the ACA is good or bad policy. *See NFIB*, 567 U.S. at 531-32 ("We do not consider whether the [ACA] embodies sound policies. That judgment is entrusted to the Nation's elected leaders."). It is about the constitutional limits on our federal government and the proper text-based interpretation of statutes. At issue is not what health-insurance system is optimal, but "only whether Congress has the power under the Constitution" to command the people as the ACA does. *Id.* at 532. In the end, the ACA is a naked command to buy an insurance product the government deems suitable. And Congress declared that command "essential" to the ACA throughout the statute. The Court should take Congress at its word and affirm the judgment of the district court.

Statement of Jurisdiction

The district court had jurisdiction under 28 U.S.C. § 1331. ROA.508-509. On December 30, 2018, the court entered partial final judgment under Fed. R. Civ. P. 54(b). ROA.2785. The intervenor States and the United States filed notices of appeal on January 3 and 4, 2019, respectively. ROA.2787; ROA.2844. This Court has jurisdiction under 28 U.S.C. § 1291.

Issues Presented

1. Whether the plaintiffs have standing.
2. Whether the individual mandate exceeds Congress's powers under the Constitution.
3. Whether the Affordable Care Act remains valid despite the unconstitutionality of its most "essential" provision.

Statement of the Case

I. Statutory Background

A. The Affordable Care Act

In 2010, Congress sought to transform this Nation's healthcare system with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119-1024 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010). Congress designed the ACA to achieve three express statutory goals: "near-universal [health-insurance] coverage," 42 U.S.C. § 18091(2)(D), "lower health insurance premiums," *id.* § 18091(2)(F), and the "creat[ion] [of] effective health insurance markets," *id.* § 18091(2)(I). President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590, 111th Cong.) into law on March 23, 2010. Pub. L. No. 111-148, 124 Stat. 119.

As relevant here, the ACA has four core and "closely interrelated" features, almost all located within Title I. *See NFIB*, 567 U.S. at 691 (dissenting op.). Those provisions are the individual mandate, the accompanying tax penalty, the guaranteed-issue provision, and the community-rating provision.

1. The individual mandate and accompanying tax penalty

The ACA's core feature is the individual mandate and its accompanying tax penalty enforceable against those who do not comply with it. Subsection (a) of section 5000A imposes an individual mandate on most individuals, whom the ACA calls "applicable individual[s]." 26 U.S.C. § 5000A(a). The statutory text provides: "An applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage." *Id.* The statutory title of this subsection reiterates that it imposes a "requirement" on applicable individuals "to maintain minimum essential coverage." *Id.* (capitalization altered).

Subsection (b) imposes a tax penalty on many "applicable individual[s]" who fail to comply with the individual mandate. *Id.* § 5000A(b). Congress titled this tax penalty a "Shared [R]esponsibility [P]ayment," *id.*, providing: "If a taxpayer who is an applicable individual . . . fails to meet the requirement of subsection (a) . . . then . . . there is hereby imposed on the taxpayer a penalty with respect to such failure[]." *Id.* § 5000A(b)(1).[1]

Some individuals who are bound by the mandate's command are nonetheless exempt from any tax penalty. *See id.* § 5000A(e)(1)-(5). Five classes of people fall into this category. First, "[i]ndividuals who cannot afford coverage." *Id.* § 5000A(e)(1). Second, "[t]axpayers with income below [the] [tax-return] filing

[1] Congress excluded from the mandate's requirements three categories of individuals, including those with certain religious and conscientious objections, non-citizens and unlawfully present aliens, and the incarcerated. *See* 26 U.S.C. § 1402(g)(1), 5000A(d)(2) (religious and conscientious objectors); *id.* § 5000A(d)(3) (non-citizens and unlawfully present aliens); *id.* § 5000A(d)(4) (the incarcerated).

threshold." *Id.* § 5000A(e)(2). Third, "member[s] of an Indian tribe." *Id.* § 5000A(e)(3). Fourth, those experiencing only "short coverage gaps" in health insurance. *Id.* § 5000A(e)(4). And fifth, those who receive a "hardship" exemption from "the Secretary of Health and Human Services." *Id.* § 5000A(e)(5). Still these individuals must obtain "minimum essential coverage" in order to "comply with [the] mandate, even in the absence of penalties." CBO, Key Issues in Analyzing Major Health Insurance Proposals 53 (Dec. 2008), *available at* https://tinyurl.com/CBO2008Report ("CBO 2008 Report").

Congress's reason for subjecting many individuals to the mandate, but not to the tax penalty, was sensible: for many, especially the poor, imposing a tax penalty would be unjust. Nevertheless, Congress still wanted to require those individuals to sign up for ACA-compliant health insurance. A core purpose of the ACA was to prevent the emergency-room cost-shifting problem—where individuals without health insurance obtain uncompensated care via an emergency room, inevitably requiring medical providers to increase costs on those with insurance. *See* 42 U.S.C. § 18091(2)(A), (F), (I); *see also infra* pp. 35-36. So Congress mandated that these individuals obtain coverage, offered them the means to satisfy the mandate through the Medicaid system, 26 U.S.C. § 5000A(f)(1)(A)(i)-(iii); *see also infra* pp. 21-22, 35, but then exempted them from the tax penalty if they nevertheless failed to comply with the mandate, *id.* § 5000A(e)(1). As the CBO found, "[m]any individuals" subject to the mandate, but not to the penalty, will obtain coverage to comply with the mandate "because they believe in abiding by the nation's laws." CBO 2008 Report at 53.

2. Guaranteed issue and community rating

The ACA imposes voluminous regulations on health-insurance companies, with the most prominent being "guaranteed issue" and "community rating" requirements. *See* 42 U.S.C. § 300gg to gg-4. The guaranteed-issue provision mandates that health-insurance companies "accept every employer and individual in the State that applies for . . . coverage," regardless of preexisting conditions. *Id.* § 300gg-1(a). This prevents health-insurance companies from completely denying coverage to individuals deemed too high-risk. *See NFIB*, 567 U.S. at 547-48 (Roberts, C.J.); *King v. Burwell*, 135 S. Ct. 2480, 2485-86 (2015). The guaranteed-issue provision thus furthers the ACA's goal of "near-universal coverage." 42 U.S.C. § 18091(2)(D).

The community-rating provision prohibits health insurers from charging higher rates to individuals within a given geographic area based on their age, sex, health status, or other factors. *See id.* §§ 300gg, 300gg-4(a)(1); *NFIB*, 567 U.S. at 547-48 (Roberts, C.J.). Together, these two provisions "are designed to make qualifying insurance available and affordable for persons with medical conditions that may require expensive care," *NFIB*, 567 U.S. at 685 (dissenting op.), furthering the ACA's goal of "creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," 42 U.S.C. § 18091(2)(I).

3. Other provisions

Essential health benefits; cost-sharing limits; elimination of coverage limits. Separate from and in addition to the above provisions, the ACA imposes numerous

coverage requirements on all health-insurance plans, called "essential health benefits." The "essential health benefits" that all plans must cover "shall include" "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services," and several other costly services. *Id.* § 18022(b)(1) (capitalization altered). The Secretary is authorized to define "essential health benefits" beyond those expressly listed. *Id.* While imposing these burdens on providers, the ACA also limits the "cost-sharing" that providers may require of beneficiaries seeking these costly services, *id.* § 18022, and prohibits providers from imposing coverage limits, *id.* § 300gg-11.

Employer mandate. The ACA includes an "employer mandate," which requires employers of 50 or more full-time employees to offer affordable health insurance if one employee qualifies for a subsidy to purchase insurance on the ACA exchanges. *See* 26 U.S.C. § 4980H. This necessarily includes government employers. "Full time employees" are defined as those working "on average at least 30 hours . . . per week." *Id.* § 4980H(c)(4). An employer's failure to offer insurance results in a penalty of $2,000 per year per employee, *id.* §§ 4980H(a), (c)(1), while the failure to offer affordable insurance results in a penalty of $3,000 per year per employee, *id.* § 4980H(b); 79 Fed. Reg. 8544, 8544 (Feb. 12, 2014). The ACA also levies a 40% excise tax on high-cost employer-sponsored health coverage. *See* 26 U.S.C. § 4980I(a). Due to "medical inflation," "nearly every employer health plan" will eventually trigger the 40% excise tax unless the employer takes affirmative steps to

modify plan offerings. Segal Consulting, First Report—Observations and 2016 Recommendations, at 61 (March 25, 2015), *available at* http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c1.pdf.

Medicaid expansion. The ACA substantially expands Medicaid. The so-called Medicaid Expansion requires States, as a condition for all Medicaid funding, 42 U.S.C. § 1396c, to cover all individuals under 65 earning income below 133% of the poverty line, *id.* § 1396a(a)(10)(A)(i)(VIII), and to provide a new "[e]ssential health benefits" package, *id.* §§ 1396u-7(b)(5), 18022(b). The ACA also made two new populations eligible for Medicaid: individuals under age 26 who were enrolled in federally funded Medicaid when they aged out of foster care, *id.* § 1396a(a)(10)(A)(i)(IX), and children ages 6 to 18 who were eligible for the Children's Health Insurance Program (CHIP) prior to the ACA, *id.* § 1396a(a)(10)(A)(i)(VII). And the ACA restricted States to considering only one factor to determine eligibility for populations other than the elderly and disabled—Modified Adjusted Gross Income ("MAGI"), *id.* § 1396a(e)(14)—thereby broadening the pool of persons who will meet Medicaid's income thresholds.

Other regulations of the insurance industry. The 900-plus pages of the ACA contain scattered provisions impacting state economies in myriad ways. For example, the ACA imposes a 2.3% tax on certain medical devices, 26 U.S.C. § 4191(a), and creates mechanisms for the Secretary to issue compliance waivers to States attempting to reduce costs through otherwise-prohibited means, 42 U.S.C. § 1315; *see generally* NFIB, 567 U.S. at 704-06 (dissenting op.) (describing other provisions); *Fla. ex rel. Att'y. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1249 (11th

Cir. 2011), *aff'd in part, rev'd in part sub nom. NFIB*, 567 U.S. 519 (describing ACA titles).

B. Congress Repeatedly Declares the Individual Mandate "Essential" to the ACA's Functioning.

According to Congress's own legislative findings, codified in the ACA, the individual mandate is critical to the functioning of the ACA's major features. *See* 42 U.S.C. § 18091. These findings identify the individual mandate itself—"[t]he requirement" to purchase health insurance, *id.* (emphasis added); *compare* 26 U.S.C. § 5000A(a) ("Requirement to maintain minimum essential coverage")—making no mention of the separate tax penalty that attaches to some individuals' failure to comply with the mandate.

Central among these legislative findings is section 18091(2)(I), which explains that "if there were no requirement [to buy health insurance], many individuals would wait to purchase health insurance until they needed care," since the guaranteed-issue and community-ratings provisions would guarantee those individuals coverage irrespective of their current medical status. *See* 42 U.S.C. § 18091(2)(I). So "[b]y significantly increasing health insurance coverage, the requirement [to buy health insurance], 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." *Id.* Thus "*[t]he 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." *Id.* (emphasis added).

Other legislative findings reinforce this point: "By significantly reducing the number of the uninsured, the requirement, together with the other provisions of th[e] [ACA], will significantly reduce [healthcare's] economic cost," *id.* § 18091(2)(E), "lower health insurance premiums," *id.* § 18091(2)(F), and "reduce administrative costs," *id.* § 18091(2)(J). "The *requirement is an essential part* of [the Government's] regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market." *Id.* § 18091(2)(H) (emphasis added). "*The requirement is essential* to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." *Id.* § 18091(2)(J) (emphasis added).

Congress thus stated in the statutory text that the ACA's provisions are "closely intertwined," such that "the guaranteed issue and community rating requirements *would not work* without the coverage requirement [i.e., the individual mandate]." *King*, 135 S. Ct. at 2487 (emphasis added); *NFIB*, 567 U.S. at 547-48 (Roberts, C.J). Upsetting the balance between these core provisions "would destabilize the individual insurance market" in the manner "Congress designed the Act to avoid." *King*, 135 S. Ct. at 2493.

C. The ACA Impacts State Expenditures, Programs, and Insurance Markets.

States primarily interact with the healthcare system and the ACA in three capacities: as Medicaid participants, as sovereigns that have traditionally regulated local health-insurance markets, and as large employers that provide employees health-insurance coverage.

Medicaid participants. The individual mandate has substantially increased States' Medicaid rolls and costs. Many individuals have met and will continue to meet their individual-mandate obligations by participating in Medicaid. *See, e.g.*, CBO 2008 Report at 9-10; CBO, Repealing the Individual Health Insurance Mandate: An Updated Estimate, at 1, 3 (Nov. 8, 2017), *available at* https://tinyurl.com/CBO2017Report ("CBO 2017 Report"). This costs States money because "Medicaid is funded by both the state and federal governments," and "cost is determined by the caseload—the volume or number of individuals served . . . —and cost per client." ROA.660. The ACA also increases costs because it requires Medicaid to cover two new groups of people, and it requires States to determine Medicaid eligibility using a measurement (MAGI) that does not permit considering an individual's assets or certain types of income. 42 U.S.C. § 1396a(e)(14). And rising healthcare costs caused by the ACA result in higher State costs through Medicaid.

Regulating health-insurance markets. By fundamentally changing healthcare, the ACA substantially affects how States can regulate health-insurance markets. Before the ACA, the States played a central role in regulating healthcare and insurance, carefully crafting programs to respond to public needs and preferences. For example, multiple States created high-risk pools that "operated as an insurer of last resort for people when private insurers refused to issue coverage to them due to expensive anticipated medical costs." ROA.767. These programs "effectively managed the health-insurance needs of high-risk individuals," ROA.707-708, while "keep[ing] high-cost individuals from driving up premiums for insurance purchasers of average or good health," ROA.767. *See* ROA.676-677; ROA.773. Similarly, States addressed

cost-sharing for preventative services, treatment of preexisting conditions, and the ability to rescind health-insurance contracts for false statements in their comprehensive effort to ensure health-insurance markets worked for everyone. ROA.707-708. And because their regulatory effort was comprehensive, decisions not to regulate—such as not to mandate that individuals purchase health-insurance coverage—reflected carefully considered policy choices, not an abdication of responsibility.

The ACA preempted, or effectively displaced, most of these policy choices, and the States have been dealing with the consequences ever since. They have spent countless hours ensuring ACA compliance by, for example, creating programs to help individuals navigate the ACA, ROA.675-676, providing direction to insurers, ROA.708-709, and "reading and enforcing thousands of pages of federal regulations [and] guidance," ROA.766.

The ACA harms States in other ways, too. "Because of the ACA's burdensome regulations, many insurers . . . have left the individual market, scaled back their offerings in the individual market, or otherwise limited their exposure in the individual market." ROA.705. "[A] major Wisconsin health insurer, Assurant Health, ceased its Wisconsin operations because of the ACA," costing Wisconsin 1,200 jobs. ROA.706. United Health Care "withdrew from participation in the Arkansas exchange" "as a result of the ACA costs." ROA.726. And "[i]n 2017, two major carriers"—Aetna and Blue Cross and Blue Shield—"exited Nebraska's individual market" because of significant financial losses, leaving only one major carrier in a State that had 30 major carriers offering coverage in 2010. ROA.765; *see also* ROA.772 (ex-

plaining lack of competition); ROA.720-722 (same). Even those States without significant carrier losses have had major carriers threaten to leave if the market continues to worsen. ROA.674-675.

This insurance-carrier flight is part of a vicious cycle of rising premiums and healthcare costs. ROA.706 (loss of carriers "contributes to the harms to the individual markets"). "Premiums have consistently risen since the ACA was enacted," with the average premium rates rising 17% in 2017 and 42% in 2018. ROA.705; *see also* ROA.725-726 ("The embedded mandates . . . have added to health insurer costs in this market putting upward premium pressure on insurers in the Arkansas market."). Indeed, the CBO's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, federal outlays for health insurance subsidies and related spending will rise by about 60% over the next ten years. CBO, The Budget and Economic Outlook: 2018 to 2028 at 51 (April 2018), *available at* https://tinyurl.com/CBOBudgetEconOutlook-2018-2028. It is no surprise, then, that the only major carrier remaining in Nebraska's individual market raised premiums 31% in plan-year 2018 alone. ROA.765.

The States are now attempting to do what they can to mitigate the effects of the ACA, re-stabilize markets, and make health insurance affordable. "[T]he Wisconsin Legislature passed a reinsurance program in February 2018 to stabilize the individual market"—a program expected to cost $200 million, split between state and federal funds. ROA.705-706. And in Missouri, a bipartisan committee voted to create the "Missouri Reinsurance Plan," which, if instituted, would help stabilize the individual-insurance market. *See* H.B. 2539, 99th Gen. Assem., 2d Reg. Sess. (Mo. 2017),

available at https://tinyurl.com/Mo-HB2539-2017. Other States may find it necessary to enact similar programs if the markets continue to destabilize.

Large employers. The ACA also affects States as large employers subject to the ACA's employer mandate. 26 U.S.C. § 4980H. Besides keeping up with rising healthcare costs generally, States have had to increase their plans' benefits to ensure that they meet "minimum essential coverage" requirements. States have spent hundreds of millions of dollars providing employees these new benefits, such as coverage of dependents up to age 26 and no-cost-share coverage for certain preventative-care services. *See* ROA.645-646; ROA.729; ROA.759; ROA.775-776. They have also had to allow employees who work between 30 and 40 hours per week to purchase insurance, thereby increasing the number of individuals covered and, therefore, the States' costs. *See* ROA.647-648; ROA.756; ROA.757; ROA.766. Moreover, due to medical inflation, States face the ACA's 40% excise tax if they cannot adjust or reduce plan costs. *See* ROA.715; *see supra* pp. 8-9 (explaining excise tax).

D. The Tax Cuts and Jobs Act of 2017

In December 2017, Congress enacted, and President Trump signed into law, the Tax Cuts and Jobs Act of 2017 ("TCJA"), which reduced the operative parts of section 5000A(c)'s tax penalty formula to "[z]ero percent" and "$0." Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). This change applies after December 31, 2018. *Id.* After the TCJA, section 5000A(a) still contains the individual mandate in subsection (a), requiring "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage," 26 U.S.C. § 5000A(a), but subsection (b)'s tax "penalty" for an individual who "fails to meet th[is] requirement" is

now $0, meaning that it is repealed, *id.* § 5000A(b). The ACA also still contains the express legislative findings that the individual mandate—subsection (a)—is "essential" to the operation of the ACA, as those findings were untouched by the TCJA. 42 U.S.C. § 18091(2)(I).

The CBO Report for the Tax Cuts and Jobs Act explains that the ACA "eliminate[s]" the "individual mandate penalty . . . but [not] the mandate itself." CBO 2017 Report at 1. The CBO report adds that at least "a small number of people who enroll in insurance because of the mandate under current law would continue to do so [post elimination of the individual mandate's penalty] solely because of a willingness to comply with the law." *Id.* This mirrors the CBO's conclusion, before passage of the ACA in 2009, that "[m]any individuals" who are subject to the mandate, but are not subject to the penalty, will obtain coverage "because they believe in abiding by the nation's laws." CBO 2008 Report at 53.

II. Proceedings Below

The TCJA's enactment made explicit what *NFIB* implied: unless saved as a tax, the ACA is unconstitutional. Because the ACA as amended "forces an unconstitutional and irrational regime onto the States and their citizens," a group of 18 States, joined by two Governors of States and two private individuals, brought this action. *See* ROA.504; ROA.507-508 (amended complaint). Their operative complaint documented at length the various harms they suffer under the ACA. *See* ROA.518-529. They pleaded five claims for relief: (1) a declaratory judgment that the individual mandate exceeds Congress's enumerated powers; (2) a declaratory judgment that

the ACA violates the Due Process Clause of the Fifth Amendment to the Constitution; (3) a declaratory judgment that the ACA violates the Tenth Amendment to the Constitution; (4) a declaratory judgment under 5 U.S.C. § 706 that agency rules promulgated pursuant to the ACA are unlawful; and (5) injunctive relief against federal officials from implementing, regulating, or otherwise enforcing the ACA. ROA.530-535.

A group of States led by California moved successfully to intervene. ROA.220; ROA.946-952 (order granting intervention). The Government agreed that plaintiffs satisfy Article III, that the individual mandate is unconstitutional, and that the community-rating and guaranteed-issue provisions are inseverable, but argued initially that the ACA's remaining provisions stood notwithstanding the mandate's unlawfulness. ROA.1557-1583.

The district court convened a hearing on September 5, 2018. ROA.61. Three months later, the district court issued a comprehensive memorandum opinion and order, ROA.2611-2665, concluding that the individual mandate, 26 U.S.C. § 5000A(a), is unconstitutional, ROA.2665. The court further held the mandate inseverable from the remaining portions of the ACA. ROA.2665. The court therefore granted the plaintiffs' claim for declaratory relief in count one of the operative complaint. ROA.2665. The court denied the plaintiffs' application for injunctive relief. ROA.2612.

Two weeks later, the district court entered partial final judgment as to count one of the operative complaint, ROA.2784; ROA.2785, but stayed judgment pending appeal, ROA.2784. This appeal followed.

SUMMARY OF THE ARGUMENT

Plaintiffs have standing to challenge the ACA. As the individual plaintiffs explain in their separate brief, the law as it currently stands mandates that they purchase costly and unnecessary ACA-compliant healthcare coverage—coverage that they do not want. That alone is sufficient to satisfy Article III. The States also presented reams of evidence below about the economic costs they have incurred due to the mandate and its closely related provisions. Those costs will continue to mount because some law-abiding Americans like the individual plaintiffs will comply with the mandate to secure ACA-compliant health insurance even in the absence of enforcement penalties. That is not the States' mere supposition. The Congressional Budget Office has repeatedly concluded as much. And then there are the hosts of other costs the ACA inflicts on States—ranging from direct expenditures to comply with employer health-coverage mandates and expanded Medicaid eligibility, to administrative costs to ensure compliance with the ACA's byzantine regulations and reporting requirements, to having to implement costly policies to correct for disruptions in the healthcare market occasioned by the ACA in lieu of policies the States would have pursued to meet the specific healthcare needs of their citizens.

The ACA's individual mandate is unconstitutional. That conclusion follows ineluctably from *NFIB v. Sebelius*, where a majority of the Supreme Court concluded that the Commerce Clause and the Necessary and Proper Clause do not permit Congress to mandate the purchase of health insurance. A different majority upheld the ACA's individual mandate only because, with its associated penalty provision, the individual mandate could be conceived of as a lawful exercise of Congress's taxing

power. But with Congress's passage of the Tax Cuts and Jobs Act of 2017, the penalty previously associated with the individual mandate is gone. Only the mandate remains. Bereft of penalties, the mandate now raises no revenue and therefore cannot by any conceivable definition be considered a tax. Stripped of its tax status, the individual mandate is nothing more than an unconstitutional congressional mandate to purchase health insurance.

The individual mandate's unconstitutionality necessarily brings down the rest of the ACA with it. The ACA itself repeatedly describes the mandate as essential to the Act's community-rating and guaranteed-issue provisions. The Department of Justice—across both the current administration and the Obama administration in *NFIB*—has consistently recognized that those provisions are inseverable from the mandate. And the Supreme Court has observed that those provisions "would not work" without the mandate. *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). Likewise, the various other provisions in the ACA—both major and minor—cannot operate in the manner Congress intended without the Act's essential feature of a mandate for individuals to secure health insurance.

Standard of Review

This Court reviews a district court's "grant of summary judgment de novo." *Smith v. Reg'l Transit Auth.*, 827 F.3d 412, 417 (5th Cir. 2016).

ARGUMENT

I. The Plaintiffs Have Standing.

A. Article III Is Satisfied Because the Individual Plaintiffs Have Standing.

For the reasons set out in the individual plaintiffs' brief, the district court correctly concluded that the individual plaintiffs have standing. The state appellees adopt those arguments by reference. *See* Fed. R. App. P. 28(i). Since only "one party with standing is sufficient to satisfy Article III's case-or-controversy requirement," *Texas v. United States*, 809 F.3d 134, 151 (5th Cir. 2015) (citation omitted), that is all the Court needs to proceed to the merits.

B. The State Plaintiffs Have Standing in Their Own Right.

1. The ACA inflicts on the States a straightforward pocketbook injury.

The individual mandate increases State outlays, and such economic harm "is an injury in fact for standing purposes." *Tex. Democratic Party v. Benkiser*, 459 F.3d 582, 586 (5th Cir. 2006); *see also Cooper v. Tex. Alcoholic Beverage Comm'n*, 820 F.3d 730, 738 (5th Cir. 2016) (concluding that "actual economic injury" supports standing). In particular, the individual mandate forces individuals into the States' Medicaid and CHIP programs. As the CBO has twice explained, at least some people obtain health insurance solely out of a "willingness to comply with the law," whether or not they are threatened with a tax penalty for non-compliance. CBO 2017 Report at 1; *see also* CBO 2008 Report at 53 ("many individuals" will comply with the mandate despite not being subject to a penalty). And the ACA specifically provides that enrolling in

Medicaid—a program for which the States share coverage expenses for enrollees—complies with the mandate. 26 U.S.C. § 5000A(f)(1)(A)(ii). It necessarily follows that many individuals will do just what Congress expected and comply with the mandate by applying for and (if eligible) enrolling in Medicaid or CHIP. *See generally* 42 U.S.C. §§ 1396-1396w (Medicaid); *id.* § 1397aa (CHIP).

The ACA's inseverable provisions deepen that pocketbook injury. For example, the employer mandate forces States to spend millions of dollars on expanded employee health-insurance coverage. Under the employer mandate, States must offer their full-time employees (and qualified dependents) "minimum essential coverage under an eligible employer-sponsored plan," or else pay a substantial tax penalty. 26 U.S.C. § 4980H(a). The States have complied with this mandate and will continue to after January 1, 2019 to avoid the penalty—but at significant cost. Texas has already spent $473.2 million in fiscal years 2011 through 2017 to provide new ACA-mandated employee health-insurance benefits. ROA.650; *cf.* ROA.650 (noting that during this same time, Texas received only $241.9 million in offsetting benefits). Indeed, in fiscal year 2017 alone Texas paid $19.2 million to cover newly eligible dependent children and $27.2 million to provide new, no-cost-share coverage for certain preventative-care services. *See* ROA.645-646. Other States are in the same boat. Missouri, for instance, estimates that keeping its Consolidated Health Care Plan compliant with the ACA will cost "nearly $3 million" in 2019, beyond millions already spent. ROA.759; *see also* ROA.776 (net financial impact to South Carolina from providing expanded ACA coverage from 2011 through 2017 was $29.2 million);

ROA.729 (Kansas); ROA.780-784 (South Dakota); ROA.713-716 (Wisconsin). There could not be a clearer economic injury.[2]

The ACA also requires States to expand Medicaid eligibility and thus increase their Medicaid expenditures. Under the ACA, States must determine Medicaid eligibility using MAGI. *See* 42 U.S.C. § 1396a(e)(14). This statutory command adds hundreds of thousands of individuals to States' Medicaid rolls. *See* ROA.657; ROA.666-671; ROA.745-747; ROA.735-739.[3] So, too, does the ACA's command that States add to Medicaid individuals previously in foster care or CHIP. *See, e.g.*, ROA.654; ROA.657.

The ACA causes yet another pocketbook injury by forcing States to spend significant time, effort, and money to ensure that they meet the ACA's vast and complex rules and regulations. *See* ROA.708-709; ROA.766; ROA.745-746; ROA.784-785. This "increased regulatory burden" and the costs associated with meeting it are

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[2] The intervenors' argument that injuries from the ACA's other provisions do not support the States' standing to challenge the individual mandate, *see* House Br. 34, cannot be reconciled with *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987). There, a group of airlines challenged various provisions of the Airline Deregulation Act on the basis that a *different* provision involving a legislative veto was unconstitutional and inseverable. *Id.* at 680. The Supreme Court agreed that the legislative-veto provision was unconstitutional but found it severable. *Id.* at 683. The Court at no point questioned the airlines' standing or otherwise expressed doubt as to its jurisdiction. Intervenors cite *Alaska Airlines* repeatedly in support of their severability argument, but fail to acknowledge that it confirms jurisdiction here.

[3] The intervenors' concession that "a State has standing to challenge a federal policy that *itself* expands the pool of beneficiaries eligible for a state benefit" confirms the States' standing, as no one doubts that the MAGI provision expands Medicaid eligibility. House Br. 33.

plainly an injury in fact. *See Contender Farms L.L.P. v. U.S. Dep't of Agric.*, 779 F.3d 258, 266 (5th Cir. 2015) ("An increased regulatory burden typically satisfies the injury in fact requirement."); *see also Texas v. United States*, 497 F.3d 491, 496-97 (5th Cir. 2007) ("Texas has suffered the injury of being compelled to participate in an invalid administrative process, and we agree that standing exists on this basis.").

Take, for instance, States' continuing administrative costs to comply with the IRS reporting requirements occasioned by the ACA's mandate. *See* Pub. L. No. 111-148, § 1502(a), 124 Stat. at 250 (*codified at* 26 U.S.C. § 6055) (requiring employers, including state governments, that provide minimum essential coverage to file a return identifying, among other things, dates during which employees were covered); *id.* § 1514(a), 124 Stat. at 256 (*codified at* 26 U.S.C. § 6056) (requiring certain employers, including state governments, to report, among other things, calendar-year dates for which minimum essential coverage was available). These requirements have led to the ubiquitous Form 1095-B and 1095-C statements employees receive around tax time, filled with a series of check boxes indicating the months that employees had ACA-compliant health coverage, so that employees filing their taxes can attest to being "covered under minimum essential coverage for such month." 26 U.S.C. § 5000A(a).

These required forms for each employee, and the personal and health data included on them, do not generate themselves. Unsurprisingly, as industry professionals have noted, filling out and submitting these required reporting forms "have been and continue to be difficult and costly for employers." *After AHCA Withdrawal, Eyes Turn to Executive Branch*, 25 No. 2 Coordination of Benefits Hndbk. Newsl. 8 (April

2017). Indeed, one commentator observed that the Form 1095 reporting requirements constitute the "greatest administrative burden imposed on employers since the Tax Payment Act of 1943 demanded payroll reporting."[4] The IRS recognized this burden when it delayed implementation of the ACA's mandate-related reporting requirements for a year to allow employers "additional time to develop their systems for assembling and reporting the needed data." IRS Notice 2013-45, 2013-31 I.R.B. 116, Q/A-1, at 2, *available at* https://www.irs.gov/pub/irs-drop/n-13-45.PDF. And these reporting "burdens are a function of the statute" itself. Zachary S. Price, *Enforcement Discretion & Executive Duty*, 67 Vand. L. Rev. 671, 753 (2014); *see also* 26 U.S.C. §§ 6055, 6066.

Finally, the ACA causes a pocketbook injury by forcing States to spend funds to fix problems, including market instability and rising healthcare costs, directly caused by the ACA. A "forced choice between incurring costs" and changing the law is "itself an injury." *Texas v. United States*, 787 F.3d 733, 749 (5th Cir. 2015). And that is exactly what is happening. Wisconsin was recently compelled to enact an estimated $200 million reinsurance program (split between state and federal funds) because the ACA's individual-market regulations have caused health-insurance premiums to rise substantially. *See* ROA.705-706. States are being pressured to stave off runaway healthcare costs, *see* ROA.705-707, counter the threat of major insurance companies

[4] Adam Okun, Reporting Acrobatics, https://frenkelbenefits.com/blog/2015/07/20/reporting-acrobatics/ (July 20, 2015).

leaving the market, *see, e.g.*, ROA.675 (noting increase in insurer threats), and otherwise minimize the ACA's harmful effects. States may do nothing and bear the ACA's full budgetary brunt, or they may enact new laws at substantial cost that they would not have but for the ACA's effects. *Cf. New York v. United States*, 505 U.S. 144, 188 (1992). Either way, they suffer an injury in fact. *See Texas*, 787 F.3d at 749.

2. The ACA prevents States from enforcing their own laws and policies.

The ACA—through its core individual mandate and the rest of its inseverable provisions—irreparably harms States as sovereigns because it prevents them from applying their own laws and policies governing their own healthcare markets. It is well-established that "[S]tates have a sovereign interest in 'the power to create and enforce a legal code.'" *Tex. Office of Pub. Util. Counsel v. F.C.C.*, 183 F.3d 393, 449 (5th Cir. 1999) (quoting *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 601 (1982)). Thus, whenever "a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301, 1301 (2012) (Roberts, C.J., in chambers); *see also Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013) ("When a statute is enjoined, the State necessarily suffers the irreparable harm of denying the public interest in the enforcement of its laws.").

That irreparable injury is no less real when a federal law—not a federal court—prevents a State from administering its own law and policy preferences. *See Ill. Dep't of Transp. v. Hinson*, 122 F.3d 370, 372 (7th Cir. 1997) (holding that a State has standing where it "complains that a federal regulation will preempt one of the state's

laws"); *see also Wyoming ex rel. Crank v. United States*, 539 F.3d 1236, 1242 (10th Cir. 2008) (holding that a State has standing to defend the efficacy of its expungement statute from threatened federal preemption).

The ACA's myriad requirements do just that. For example, both Wisconsin and Texas, among other States, established and operated high-risk insurance pools that "effectively managed the health-insurance needs of high-risk individuals." ROA.707-708 (citing Wis. Stat. §§ 149.10-.53 (2011-2012)); *see also* Tex. Ins. Code §§ 1506.001-.205. These pools explicitly addressed difficult and contentious issues such as the treatment of preexisting conditions, *see* Tex. Ins. Code § 1506.155, and the appropriate scope of coverage, *see* Wis. Stat. § 149.14. But after *NFIB* upheld the ACA, both Texas and Wisconsin had to repeal their high-risk-pool laws because they could no longer serve any functional purpose. *See* Act of May 21, 2013, 83d Leg., R.S., ch.615, 2013 Tex. Gen Laws 1640, 1640 (abolishing Texas Health Insurance Pool); Wis. Stat §§ 149.10-.53 (2011-2012), *repealed by* 2013 Wis. Act 20, § 1900n; ROA.707-708; ROA.676-677. The ACA prevents States from reinstating these high-risk pools and regulating the insurance market as they—not the federal government—see fit.

3. The Intervenors' contrary arguments misstate the law and the record.

The intervenors all but concede that the States have standing. The House admits (at 30) that "a small number of people" will enroll in state programs due to the mandate. And California agrees (at 26) that any "fiscal injury caused by a federal statute can of course be a basis for state standing." That gives away the game because the

amount of injury does not matter; any nonzero economic injury satisfies Article III. *See, e.g.*, *Sprint Commc'ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 274 (2008) (any "concrete and particularized injury in fact" suffices). As set out above, the ACA inflicts on States a nonzero economic injury that can be redressed by declaratory and injunctive relief precluding further enforcement of the ACA. *See supra* Part I.B.1.

Intervenors argue (House Br. at 28-31) that the States lack standing because any injury they suffer is the product of an unfettered choice by independent actors. But the States' pocketbook injury is a necessary and intended consequence of the ACA, which requires covered individuals to secure health insurance. Medicaid and CHIP are the only practical mechanisms for many poor individuals to comply with the mandate. And those individuals cannot choose not to maintain coverage; the law orders them to do so. *See* 26 U.S.C. § 5000A(a); *see also infra* Part II (discussing the individual mandate). That chain of causation is not "speculative," as the House alleges (at 28), but rather concrete and supported by unrebutted CBO analysis. *See supra* pp. 6, 16, 20 (discussing various CBO reports).[5]

Finally, the House claims (at 31-32) that the plaintiffs did not put on adequate summary-judgment evidence to support their standing. But as the dozens of record

[5] Intervenors speculate that individuals are "exceedingly unlikely to enroll now" because of the mandate. House Br. 31. They provide zero record support for that claim. And it is contradicted by the CBO. *See, e.g.*, CBO 2008 Report at 53; CBO 2017 Report at 1.

citations provided above confirm, the States offered extensive evidence of the myriad harms they suffer under the ACA. *See supra* pp. 21-26. In any event, no defendant pointed to any evidentiary deficiency before the district court. *See* ROA.2529 (statement of intervenor States regarding summary judgment). Arguments not presented below are forfeited on appeal. *Meyers ex rel. Benzing v. Texas*, 410 F.3d 236, 248 n.15 (5th Cir. 2005).

II. The Individual Mandate Is Unconstitutional.

The district court correctly concluded that the individual mandate is unconstitutional. The TCJA squarely eliminated the availability of the saving construction at the heart of *NFIB*. The intervenors barely even attempt to defend the mandate's constitutionality, focusing almost all their argument on severability. To the extent the intervenors muster a defense of the mandate, they misstate the law.

A. *NFIB* Already Held That the Commerce Clause and the Necessary and Proper Clause Do Not Permit Congress to Mandate the Purchase of Health Insurance.

We begin by explaining what *NFIB* did—and did not—hold. In *NFIB*, 26 States argued (1) that the individual mandate "exceeded Congress's powers under Article I of the Constitution," and (2) that, if the Court invalidated the mandate, it should enjoin the entire ACA because the mandate could not be severed from the rest of the Act. *NFIB*, 567 U.S. at 540-41 (Roberts, C.J.).

A controlling majority of Justices—via the opinion of Chief Justice Roberts and the joint dissenting opinion of Justices Scalia, Kennedy, Thomas, and Alito—agreed with the States that the individual mandate exceeded Congress's power under the

Commerce Clause. *Id.* at 558-61 (Roberts, C.J.) (also concluding that the Necessary and Proper Clause did not alter this conclusion); *id.* at 657 (dissenting op.); *cf. United States v. Jacobsen*, 466 U.S. 109, 115-17 & n.12 (1984) (binding Supreme Court precedent derived from combining two-Justice plurality and four-Justice dissent); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 17 (1983) (similar); *see generally Marks v. United States*, 430 U.S. 188, 193 (1977) (similar). Both the Chief Justice and the four-Justice dissent explained that, although the Court had construed the Commerce Clause to give Congress "broad authority" over both interstate and intrastate economic activity, its precedents "uniformly describe the power as reaching 'activity.'" *NFIB*, 567 U.S. at 548-49, 551 (Roberts, C.J.); *id.* at 653 (dissenting op.) ("The lesson of [the Court's] cases is that the Commerce Clause . . . is not *carte blanche* for doing whatever will help achieve the ends Congress seeks by the regulation of commerce."). "The individual mandate, however, does not regulate existing commercial activity"; it instead "compels individuals to *become* active in commerce by purchasing a product." *Id.* at 552 (Roberts, C.J.); *id.* at 650 (dissenting op.) ("[the individual mandate] provides that (nearly) all citizens must buy an insurance contract"). Therefore, "[s]uch a law cannot be sustained under [the] clause authorizing Congress to 'regulate Commerce.'" *Id.* at 558 (Roberts, C.J.); *id.* at 652-53, 657 (dissenting op.) ("If Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power[.]").

A different majority of Justices—via the opinion of Chief Justice Roberts and the concurring opinion of Justices Ginsburg, Breyer, Sotomayor, and Kagan—held that

it was "fairly possible," under the doctrine of constitutional avoidance, to read the individual mandate and the tax-penalty provisions as a unified tax, supported by Congress's tax power. *Id.* at 563 (Roberts, C.J.). This majority could only adopt this saving construction because the combined operation of section 5000A contained "the essential feature of any tax: It produces at least some revenue for the Government." *Id.* at 563-64 (citing *United States v. Kahriger*, 345 U.S. 22, 28 n.4 (1953), *overruled in part on other grounds by Marchetti v. United States*, 390 U.S. 39 (1968)); *see* U.S. Const. art. I, § 8, cl. 1. "Indeed, the payment" of the tax penalty was "expected to raise about $4 billion per year by 2017." *NFIB*, 567 U.S. at 564 (Roberts, C.J.). Under this tax interpretation, section 5000A is no longer "a legal command to buy insurance" backed by a threat of paying a penalty—a threat applicable to many, but not all, individuals subject to the mandate. *Id.* at 563. "Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income." *Id.* Individuals who forgo purchasing insurance must simply "pay money into the Federal Treasury." *Id.* at 574. They are left "with a lawful choice to do or not do a certain act, so long as [they are] willing to pay a tax levied on that choice." *Id.*

The four dissenting Justices rejected the majority's saving construction as not a "fairly possible" reading of the text. These Justices explained that section 5000A is "a mandate that individuals maintain minimum essential coverage [that is] *enforced by a penalty*." *Id.* at 662 (dissenting op.) (emphasis added). It is "a mandate to which a penalty is attached," not "a simple tax." *Id.* at 665. The structure of section 5000A supported this reading: Section 5000A mandates that individuals buy insurance in

subsection (a), and then in subsection (b) it imposes the penalty for failure to comply with subsection (a). *Id.* at 663. Section 5000A "exempts [some] people" from the mandate, but not the penalty—"those with religious objections," who "participate in a health care sharing ministry," and "those who are not lawfully present in the United States." *Id.* at 665 (citations and internal quotation marks omitted). "If [section] 5000A were [simply] a tax" and "no[t] [a] requirement" to obtain health insurance, exempting anyone from the mandate provision, but not the penalty provision, "would make no sense." *Id.*

The Chief Justice explicitly agreed that the "most straightforward reading of" section 5000A "is that it commands individuals to purchase insurance." *Id.* at 562 (Roberts, C.J.). As the Chief Justice explained, the "most natural interpretation of the mandate" is that it is a "command," not a tax. *Id.* at 563. "Congress thought it could enact such a command under the Commerce Clause, and the Government primarily defended the law on that basis." *Id.* Thus, the Chief Justice's only disagreement with the four dissenting Justices was whether the saving construction was "fairly possible." *Id.*

To sum up, *NFIB* stands for the proposition that Congress cannot enact the individual mandate under its Commerce Clause authority. *See id.* at 552 (Roberts, C.J.); *id.* at 649 (dissenting op.). Nor does the Necessary & Proper Clause permit it. *Id.* at 558-61 (Roberts, C.J.). The mandate is justified only to the extent it functions as a tax. *Id.* at 574.

B. In Light of the Tax Cuts and Jobs Act of 2017, It Is No Longer "Fairly Possible" to Save the Mandate's Constitutionality under Congress's Taxing Power.

The Tax Clause grants to Congress the power to "lay and collect Taxes . . . to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1. Congress can use this authority to achieve a variety of goals consistent with its view of the "common Defence and general Welfare of the United States," like collecting funds for government programs, *e.g.*, 26 U.S.C. § 3102 (social-security taxes), discouraging undesirable activity, *e.g.*, *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937), or incentivizing purchases, *e.g.*, 26 U.S.C. § 30D. But no matter Congress's goals, a statute is only valid under the Tax Clause if it is "productive of some revenue" for the Government. *Sonzinsky*, 300 U.S. at 514.

The "some revenue" requirement for any valid exercise of the tax power is well-established and, so far as the States can determine, has never been subject to any exceptions. This requirement follows directly from the Tax Clause's constitutional text, given that only revenue-generating taxes could be "collect[ed]," be used to "pay the Debts," or "provide for the common Defence." U.S. Const. art. I, § 8, cl. 1. This requirement is also deeply grounded in the Supreme Court's tax-power jurisprudence. For example, in *In re Kollock*, 165 U.S. 526, 536 (1897), the Court upheld a tax on "oleomargarine"—although one aim of the tax was "to prevent deception in the sale" of that product—because "its primary object" (the Court "assumed") was "the raising of revenue." Similarly, in *Sonzinsky*, the Court upheld a "special

excise tax of $200 a year" on "every dealer in firearms"—although the tax was designed to "interpose[] an economic impediment" on some firearms dealings—because the tax "produc[ed] some revenue." 300 U.S. at 511-14. And in *Kahriger*, 345 U.S. at 28 & n.4, the Court upheld a tax on "wagering," although "the revenue obtained [from the tax]" was arguably "negligible," because even a "negligible" collection "produces revenue."

After the Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, section 5000A no longer raises "some revenue" for the Government, thus the Tax Clause loses all relevance to the constitutional analysis. The TCJA reduced the operative parts of section 5000A's tax-penalty formula to "[z]ero percent" and "$0," Pub. L. 115-97, § 11081, 131 Stat. at 2092, meaning "the amount of the individual responsibility payment[] enacted as part of the Affordable Care Act" (i.e., subsection (b) of section 5000A) is now "reduce[d]" to "zero," H.R. Rep. No. 115-466, at 324. Importantly, the TCJA "eliminated" only the "individual mandate penalty . . . but [not] the mandate itself." CBO 2017 Report at 1. So after this 2017 change, section 5000A(a) still requires "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage," but section 5000A(b)'s "penalty" for an individual who "fails to meet th[is] requirement" is now $0. See CBO 2017 Report 1 (explaining that some individuals will purchase insurance because of the mandate, even absent a tax penalty). Since section 5000A now fails to raise at least "some revenue," this provision cannot be justified under Congress's Tax Clause authority. *See Sonzinsky*, 300 U.S. at 514; *Kahriger*, 345 U.S. at 28 & n.4.

It follows directly from *NFIB* that section 5000A, post-TCJA, no longer finds support in the Tax Clause. In *NFIB*, a majority of the Court (Chief Justice Roberts, along with Justices Ginsburg, Breyer, Sotomayor, and Kagan) read section 5000A's individual mandate and associated tax penalty as a single tax on "going without insurance" as a matter of constitutional avoidance, 567 U.S. at 562-63 (Roberts, C.J.), because a different majority had concluded that the straightforward reading of section 5000A as mandate to buy insurance, backed up for some by a tax penalty, exceeded Congress's Commerce Clause authority, *see id.* at 548, 561 (Roberts, C.J.); *id.* at 657 (dissenting op.). The Tax Clause's "some revenue" requirement was "essential" to the majority's saving construction. The Court's combined reading of section 5000A(a) and section 5000A(b) was "fairly possible," *id.* at 563 (Roberts, C.J.), only because the combination "yields the essential feature of any tax: It produces a least some revenue for the Government." *Id.* at 564 (citing *Kahriger*, 345 U.S. at 28 n.4). At the time of *NFIB*, section 5000(A)(b)'s tax-penalty provision was "expected to raise about $4 billion per year by 2017" for the Government. *Id.* The Government endorsed the "some revenue" requirement in support of the saving construction. *See* Br. for Fed. Gov't on Minimum Coverage Provision 54, *NFIB*, 567 U.S. 519 ("In short, the [originally enacted] minimum coverage provision will plainly be 'productive of some revenue' and thus satisfies a key attribute of taxation.").

Although the Chief Justice accepted the saving construction as "fairly possible," he made clear that "the statute reads more naturally as a command to buy insurance than as a tax." *NFIB*, 567 U.S. at 574-75 (Roberts, C.J.). "The most straight-

forward reading of the mandate is that it commands individuals to purchase insurance," not that it taxes those who choose to forgo insurance. *Id.* at 562. The four dissenting Justices agreed, only parting ways with the Chief Justice on the availability of a saving construction. They concluded that section 5000A was "a mandate that individuals maintain minimum essential coverage" that was (prior to the Tax Cuts and Jobs Act) "enforced by a penalty" for most individuals. *Id.* at 662 (dissenting op.). "What the statute says . . . is entirely clear": it is a "command[]" that applicable individuals acquire health insurance, a "legal requirement," and an "assertion of regulatory power"—not "a simple tax." *Id.* at 663-66.[6]

After the TCJA, the Chief Justice and the four dissenting Justices' "most straightforward reading" of section 5000A as a mandate to purchase insurance is the now the only available reading. *NFIB*, 567 U.S. at 562 (Roberts, C.J.); *id.* at 661 (dissenting op.); *see Jacobsen*, 466 U.S. at 115-18 & n.12; *Moses H. Cone*, 460 U.S. at 17; *see generally Marks*, 430 U.S. at 193. Section 5000A no longer raises "some revenue," meaning it now lacks the "essential feature of any tax," *NFIB*, 567 U.S. at 564 (Roberts, C.J.), and renders the alterative saving construction no longer "fairly possible,"

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[6] The ACA's statutory structure confirms that the mandate operates independently of the penalty. Section 5000A imposes the mandate and tax penalty in separate subsections and exempts different categories of people from each. *Compare* 26 U.S.C. § 5000A(d)(2)-(4), *with id.* § 5000A(e)(1)-(5). For instance, Congress wanted even those who "cannot afford coverage" (26 U.S.C. § 5000A(e)(1)) to obtain insurance and thereby eliminate the strain from their uncompensated emergency-room care, *see* 42 U.S.C. § 18091(2)(A), (F), (I). So it included these individuals in the mandate despite exempting them from the tax penalty for noncompliance. *Id.* § 5000A(e)(1). Instead, Congress provided a means for them to comply with the mandate through Medicaid. 26 U.S.C. § 5000A(f)(1)(A)(ii).

id. at 563 (Roberts, C.J.), or constitutionally permissible. The only reading that remains available is its "most natural interpretation": it is "a command to buy insurance," a command that "[t]he Federal Government does not have the power" to impose. *Id.* at 563, 574-75 (Roberts, C.J.); *id.* at 657, 662 (dissenting op.); *see generally Kimble v. Marvel Entm't LLC*, 135 S. Ct. 2401, 2409 (2015) (amended statutory language controls over a prior judicial interpretation of unamended language). Accordingly, the individual mandate is unconstitutional.

III. The Remaining Portions Of The ACA Cannot Be Severed From The Unconstitutional Mandate.

The district court correctly relied on operative statutory text to hold the ACA's remaining provisions inseverable from the unconstitutional mandate. Courts undertake two inquiries in assessing severability, both of which must be satisfied. *See NFIB*, 567 U.S. at 692-94 (dissenting op.). First, provisions are inseverable if they would not "function in a manner consistent with the intent of Congress" after the unconstitutional provision is enjoined. *Alaska Airlines*, 480 U.S. at 685; *see Med. Ctr. Pharmacy v. Mukasey*, 536 F.3d 383, 401 (5th Cir. 2008). If the operation of the unconstitutional provision is "so interwoven with" the intended operation of the other provisions "that they cannot be separated," then "[n]one of [the provisions] can stand." *Hill v. Wallace*, 259 U.S. 44, 70 (1922). In other words, this inquiry asks whether the constitutional provisions (standing without the unconstitutional provisions) are "fully operative as a law," *Free Enter. Fund v. Pub. Co. Accounting Oversight*

Bd., 561 U.S. 477, 509 (2010), not whether they would simply "operate in some coherent way" not designed by Congress, *NFIB*, 567 U.S. at 692 (dissenting op.); *Med. Ctr. Pharmacy*, 536 F.3d at 403-05.

Second, provisions are inseverable if "the Legislature would not have enacted [them] . . . independently of" the provisions found unconstitutional, even if those provisions operated in some otherwise meaningful way. *Alaska Airlines*, 480 U.S. at 684; *NFIB*, 567 U.S. at 692-93 (dissenting op.). Courts look to whether the statute at issue "embodie[s] a single, coherent policy" or a "predominant purpose," and whether the unconstitutional provisions were necessary to that purpose. *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *see Med. Ctr. Pharmacy*, 536 F.3d at 403 (severed provisions "would continue to effect Congress's purpose."). If so, then other provisions that do not by themselves further Congress's "predominant purpose" for the broader statute are inseverable. *Mille Lacs Band*, 526 U.S. at 191. When the "purpose of the Act is . . . defeated by the invalidation" of an unconstitutional provision, the Court "may [not] leave the remainder of the Act in force." *New York*, 505 U.S. at 187.

Because both severability inquiries are "essentially an inquiry into legislative intent," *Mille Lacs Band*, 526 U.S. at 191, a textual instruction in the statute as to severability carries presumptive, or even dispositive, sway. In *NFIB*, for example, after the seven-Justice majority held the forced Medicaid expansion provision unconstitutional, the Chief Justice concluded that the provision was severable from the existing Medicaid regime solely because that regime "includes a severability clause." 567 U.S. at 585-86 (Roberts, C.J.). This "explicit textual instruction" "confirm[ed]"

that the Court "need go no further" on the question of whether "to leave unaffected" the remainder of the Medicaid program: Congress already provided that all other provisions "'shall not be affected.'" *Id.* at 586 (quoting 42 U.S.C. § 1303). And Justice Ginsburg—writing for four Justices—agreed with this severability-clause-only approach. *Id.* at 645-46 ("[T]he Medicaid Act's severability clause determines the appropriate remedy.").

This focus on textual indications of Congress's intent applies likewise to conclusions of non-severability. *See, e.g.*, *Exec. Benefits Ins. Agency v. Arkison*, 573 U.S. 25, 37 (2014) ("the statutory text" may make "'evident' . . . that Congress would have preferred no statute at all" if the Court were to declare one part of the statute invalid); *Bowsher v. Synar*, 478 U.S. 714, 735 (1986) (the Court "need not enter" the severability-analysis "thicket" when "the language of the [statute] itself settles the issue"); *Zobel v. Williams*, 457 U.S. 55, 65 (1982) (similar); *accord Koog v. United States*, 79 F.3d 452, 462 (5th Cir. 1996) ("Where Congress itself has provided the [severability] answer . . . [this answer] may be overcome only by 'strong evidence.'").

In the present case, because the ACA's individual mandate is unconstitutional, the question becomes what portions, if any, of the Act can survive a severability analysis. Given the ACA's complexity, it is useful to divide its remaining provisions into three tranches: (1) community-rating and guaranteed-issue provisions, (2) remaining major provisions, and (3) minor provisions. *See generally NFIB*, 567 U.S. at 697-706 (dissenting op.). Each tranche is inseverable from the unconstitutional individual

mandate under either the explicit statutory text or the two-part severability inquiry. *See id.*

A. As the United States Has Consistently Held for Nine Years Across Two Administrations, the Community-Rating and Guaranteed-Issue Provisions Are Inseverable.

1. As the United States conceded in *NFIB*, "the guaranteed-issue and community-rating provisions of the Act are inseverable from the minimum-coverage provision[s]," Br. for Fed. Gov't on Severability 11, *NFIB v. Sebelius*, 567 U.S. 519, because of specific findings that Congress inserted into the statutory text, which remain there today, *see* 42 U.S.C. § 18091(2). That point cannot be overstated and is dispositive of the severability analysis. Although Congress removed the tax penalty in 2017, Congress retained the express statutory findings that the individual mandate is central to the viability of the community-rating and guaranteed-issue provisions.

These findings make plain that Congress believed that the community-rating and guaranteed-issue provisions are "so interwoven" with the mandate "that they cannot be separated" or "stand" alone, *Hill*, 259 U.S. at 70, providing reason enough to declare those provisions inseverable based upon Congress's explicit statutory text. *See NFIB*, 567 U.S. at 586 (Roberts, C.J.); *id.* at 645-46 (concurring op.); *Exec. Benefits*, 573 U.S. at 37; *Zobel*, 457 U.S. at 65.

The ACA states that "[t]he requirement [to buy health insurance] is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I) (emphasis added). As the United

States conceded in *NFIB*, "the minimum coverage provision is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms." Br. for Fed. Gov't on Severability 26. The Government explained that "Congress's findings expressly state that enforcement of [community-rating and guaranteed issue] without a minimum coverage provision would restrict the availability of health insurance and make it less affordable—the opposite of Congress's goals in enacting the Affordable Care Act." *Id.* at 44-45. This is so because, "in a market with guaranteed issue and community rating, but without a minimum coverage provision, 'many individuals would wait to purchase health insurance until they needed care.'" *Id.* at 45 (quoting 42 U.S.C. § 18091(2)(I)). This "adverse selection" problem would cause premiums to "go up, further impeding entry into the market by those currently without acute medical needs, risking a 'marketwide adverse-selection death spiral.'" *Id.* at 46; 42 U.S.C. § 18091(2)(J). This is why Congress "twice described" minimum coverage "as 'essential'" to "the guaranteed-issue and community-rating reforms" in the ACA's text. Br. for Fed. Gov't on Severability 46-47. In sum, "without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals." *Id.* at 26. For that reason, the D.C. Circuit has described these three provisions as "like the legs of a three-legged stool; remove any one, and the ACA will collapse." *Halbig v. Burwell*, 758 F.3d 390, 409 (D.C. Cir. 2014), *vacated on other grounds*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014).

Moreover, "Congress had firm empirical support for its conclusion that the minimum coverage provision is essential to make the guaranteed-issue and community-

rating reforms effective." Br. for Fed. Gov't on Severability 47. Prior to the ACA, "a number of States had enacted guaranteed-issue and community-rating requirements without a minimum coverage provision." *Id.* Overall, "premiums increased and coverage decreased" in these States, the very adverse-selection problem the text of the ACA identifies. *Id.* at 48-50 (discussing experiences in Washington, Kentucky, New Hampshire, Maine, and Massachusetts). Indeed, Congress was gravely warned, prior to the ACA, that "'if [it] put' . . . guaranteed issue and community rating [on the insurance industry, it] 'must also mandate the individual to be insured or the market will blow up.'" *Id.* at 47 (citing Congressional Record).

Other findings in the ACA memorialize this exact warning. Guaranteed issue and community rating without the mandate would create an "adverse selection" problem where "many individuals . . . wait to purchase health insurance until they need[] care," since insurance companies may no longer deny coverage to such individuals, or charge those individuals more than others. 42 U.S.C. § 18091(2)(I). To correct for these increased costs, insurance companies would either raise premiums on everyone or dilute the quality of their plans. *See id.* To prevent that result, the mandate forces "healthy individuals" into the health insurance market, "broaden[ing] the health insurance risk pool" to create "effective health insurance . . . products." *Id.*

Both these Congressional conclusions and the considered severability concessions made by the United States during *NFIB*—that the individual mandate is inseverable from (at least) guaranteed-issue and community rating—retain their full

force today. The TCJA merely reduced the individual mandate's associated tax-penalty formula to "[z]ero percent" and "$0." Pub. L. 115-97, § 11081, 131 Stat. at 2092. It did not alter the ACA's structure. Section 5000A(a) still requires "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage." And the ACA's express statutory findings—including, notably, that the mandate to purchase insurance is "essential" to the ACA's operation, 42 U.S.C. § 18091(2)(I)—also remain.

2. Even if this Court were to look beyond this statutory text to congressional intent under the more open-ended two-part severability inquiry, the guaranteed-issue and community-rating provisions would fail either part of that analysis.

As for the first part—whether those two provisions would not "function in a manner consistent with the intent of Congress" (*Alaska Airlines*, 480 U.S. at 685-86)—Congress declared its intent that the mandate is not severable. Further, there was ample empirical support from the experiences of many States that had enacted community rating and guaranteed issue, but not a mandate. *See* Br. for Fed. Gov't on Severability 46-47. In those States, premiums rose and coverage became less accessible—the exact opposite of the ACA's goal. *Id.* Indeed, the Supreme Court has twice recognized Congress's design here: "[G]uaranteed-issue and community-rating reforms . . . sharply exacerbate" the problem of "healthy individuals" forgoing coverage "until they become sick"; "[t]he individual mandate was Congress's solution to th[is] problem[]." *NFIB*, 567 U.S. at 548 (Roberts, C.J.). The ACA's "three reforms"—community rating, guaranteed issue, and an individual mandate—are

"closely intertwined," such that "the guaranteed issue and community rating requirements would not work without the coverage requirement." *King*, 135 S. Ct. at 2486-87.

The second part also, and independently, renders the community-rating and guaranteed-issue provisions inseverable from the mandate. Congress's "design of the Act [was] to balance the costs and benefits affecting each set of regulated parties": "individuals, insurers, governments, hospitals, and employers." *NFIB*, 567 U.S. at 694-95 (dissenting op.). Yet "without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals." Br. for Fed. Gov't on Severability 26; *compare Alaska Airlines*, 480 U.S. at 684; *NFIB*, 567 U.S. at 693 (dissenting op.). Put another way, enforcing the community-rating and guaranteed-issue provisions without the mandate would upset the balance Congress struck in the ACA, *id.* at 694-95 (dissenting op.), causing the very access and affordability problems that "Congress designed the Act to avoid," *King*, 135 S. Ct. at 2493; *see also id.* at 2487 ("[The] guaranteed issue and community rating requirements *would not work* without the coverage requirement [i.e., section 5000A]."") (emphasis added).

In effect, the mandate is a direct subsidy to insurance companies to balance the costs imposed by community-rating and guaranteed-issue requirements to cover all individuals, no matter their health status, without resorting to higher rates. *See* 42 U.S.C. § 300gg-1 to gg-4. With no mandate, "individuals would wait to purchase health insurance until they needed care." *King*, 135 S. Ct. at 2486 (quoting 42 U.S.C. § 18091(2)(I)). And this "adverse selection" problem, *id.*, would in turn "impose

risks on insurance companies and their customers," *NFIB*, 567 U.S. at 698 (dissenting op.), driving premiums to prohibitively expensive levels, 42 U.S.C.§ 18091(2)(I).

Indeed, around the time of the ACA's enactment, the CBO estimated that guaranteed issue and community rating, in isolation from the mandate, would raise premiums in the individual market by 27% to 30%. *See* CBO, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, at 6 (Nov. 30, 2009), *available at* https://tinyurl.com/CBO2009Report ("CBO 2009 Report"). And in 2017, the CBO estimated that "repealing the mandate . . . and making no other changes to current law," would result in premiums rising by 10% per year relative to "baseline projections." CBO 2017 Report at 1. Such an unmitigated spike in costs is directly contrary to the "manner" in which Congress designed the ACA to "function," meaning community rating and guaranteed issue cannot stand without the mandate. *Alaska Airlines*, 480 U.S. at 685; *see also Free Enter. Fund*, 561 U.S. at 509 (holding that a regulatory board could operate in manner Congress intended without unconstitutional tenure provision, since it retained all its powers); *Williams v. Std. Oil Co. of La.*, 278 U.S. 235, 243 (1929) (holding that a division could not operate in manner legislature intended since its sole duty of fixing gasoline prices was unconstitutional).

B. As the *NFIB* Dissenting Justices Concluded, the Major Provisions of the ACA are Inseverable.

As the dissenting Justices explained in *NFIB*, the major provisions of the ACA—beyond community rating and guaranteed issue—are inseverable under either or both prongs of the severability test. 567 U.S. at 691-703 (dissenting op.). These major

provisions are the "insurance regulations and taxes," "reductions in reimbursements to hospitals and other Medicare reductions," the "exchanges and their federal subsidies," and "the employer responsibility assessment." *Id.* at 697. They are predominantly located in Title I, and failing to invalidate them would "impose significant risks and real uncertainties on insurance companies, their customers, all other major actors in the system, and," inevitably, "the government treasury"—all in "absolute conflict with the ACA's design of 'shared responsibility.'" *Id.* at 698-99.[7]

Insurance regulations and taxes. The ACA's insurance regulations and taxes (beyond the mandate, community rating, and guaranteed issue) include the "essential health benefits" coverage requirements, the limits on "cost-sharing" on all plans, and the elimination of coverage limits. These regulations impose "higher costs for insurance companies" that could "dwarf the industry's current profit margin." *Id.* at 698. Congress intended the individual mandate—along with the forced Medicaid expansion, invalidated in *NFIB*—to offset these increased costs. *See id.* Thus, without the mandate, maintaining these regulations and taxes "would impose significant risks and real uncertainties on insurance companies, their customers, all other major actors in the system, and the government treasury." *Id.* at 699. This

[7] The House's claim (at 43) that the court below "did not identify a single case" supporting its severability holding is incorrect. The district court relied on the same authorities put forward here, including the clear expression of four Supreme Court Justices that the ACA is invalid in its entirety. The paucity of other cases precisely like this one simply reflects that the ACA's takeover of one-fifth of the national economy is unprecedented.

"undermine[s] Congress's scheme of 'shared responsibility'" within the ACA. *Id.* at 698 (quoting 26 U.S.C. § 4980I); *cf. Alaska Airlines*, 480 U.S. at 685; *New York*, 505 U.S. at 187.

Reductions in hospital reimbursements and other reductions in Medicare expenditures. The ACA "reduces [Medicare and Medicaid] payments by the Federal Government to hospitals," because the mandate compels individuals to obtain coverage to "reduce uncompensated care, which will increase hospitals' revenues," which will then "offset" the "reductions" and "reimbursements." *NFIB*, 567 U.S. at 699 (dissenting op.) ("This is typical of the whole dynamic of the Act."). Thus, "[i]nvalidating the key mechanisms for expanding insurance coverage . . . without invalidating the reductions in Medicare and Medicaid, distorts the ACA's design of 'shared responsibility.'" *Id.*; *cf. Alaska Airlines*, 480 U.S. at 685.

Health-insurance exchanges and their federal subsidies. "The ACA requires each State to establish a health-insurance 'exchange'" where individuals may purchase individual health-insurance policies. *NFIB*, 567 U.S. at 701 (dissenting op.). The ACA then "allocate[s] billions of federal dollars" to issue subsidies to purchase policies, valued according to the cost of premiums on the exchanges. *Id.* Without the individual mandate, community rating, and guaranteed issue, neither the subsidies nor the exchanges will function as Congress intended. *Cf. Alaska Airlines*, 480 U.S. at 685. Congress designed those provisions to keep the cost of premiums on the exchanges in check; without them, the Government would have to increase federal subsidies drastically in lockstep with rising premiums. *NFIB*, 567 U.S. at 701 (dissenting

op.). "The result would be an unintended boon to insurance companies, an unintended harm to the federal fisc, and a corresponding breakdown of the 'shared responsibility' between the industry and the federal budget that Congress intended." *Id.* at 702; *see King*, 135 S. Ct. at 2493-94 (describing interconnectedness of the exchanges with other ACA provisions). Indeed, if the exchanges and tax subsidies operated without community rating, the federal government effectively would be paying insurance companies to charge higher rates to individuals with preexisting conditions: the very practice Congress sought to end with the ACA. *See* 42 U.S.C. § 18091(2)(I); *cf. Alaska Airlines*, 480 U.S. at 685. As for the exchanges, "[i]n the absence of federal subsidies to purchasers, insurance companies will have little incentive to sell insurance on [them]." *NFIB*, 567 U.S. at 702 (dissenting op.). And without participating insurance companies, the exchanges would be futile—a market with nothing for sale. *Cf. Alaska Airlines*, 480 U.S. at 684; *Williams*, 278 U.S. at 238, 243.

Employer-responsibility provisions. The ACA requires employers "to make a payment to the Federal Government if they do not offer insurance to employees and if insurance is bought on an exchange by an employee who qualifies for the exchange's federal subsidies." *NFIB*, 567 U.S. at 703 (dissenting op.). Since the operation of the employer-responsibility provisions is keyed to whether an employee buys insurance "on an exchange" and "qualifies for the exchange's federal subsidies," if the Court invalidates the subsidies and the exchanges, then no employee could purchase on the exchange or qualify for a subsidy, so "there [would be] nothing to trigger the employer-responsibility" provisions. *Id.*; *cf. Alaska Airlines*, 480 U.S. at 684.

Further, "the preservation of the employer-responsibility assessment" in the face of the above-described invalidations "would upset the ACA's design of 'shared responsibility,'" leaving "employers as the only parties bearing any significant responsibility." *NFIB*, 567 U.S. at 703 (dissenting op.). "That was not the congressional intent." *Id.*; *cf. Mille Lacs Band*, 526 U.S. at 191; *Alaska Airlines*, 480 U.S. at 685.

Medicaid expansion. Finally, the ACA substantially expanded Medicaid by "requir[ing] States . . . to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line" and to offer an expanded "'[e]ssential health benefits' package." *NFIB*, 567 U.S. at 575-80 (Roberts, C.J.). Although in *NFIB* a seven-Justice majority held the forced state-expansion unconstitutional, a five-Justice majority concluded that an optional state-expansion, without the danger of losing existing funds, was constitutional. *Id.* at 587-88. This optional expansion is inseverable from the individual mandate. The ACA's goal is "'near-universal' health insurance coverage" via "'shared responsibility.'" *Id.* at 694, 696 (dissenting op.). "The whole design of the Act is to balance the costs and benefits affecting each set of regulated parties," not "to impose the inevitable costs on any one [group]." *Id.* at 694. Leaving only the optional Medicaid expansion operative, while all other major regulations fall, upsets this "shared responsibility." *Accord id.* at 704 (similar conclusion for employer-responsibility payment); *cf. Alaska Airlines*, 480 U.S. at 685. Further, Congress designed this Medicaid expansion to "offset the cost to the insurance industry imposed by the ACA's insurance regulations and taxes." *NFIB*, 567 U.S. at 689-90 (dissenting op.). Because those regulations and taxes are inseverable, *see supra* pp. 45-46, the corresponding Medicaid-expansion benefits should also be

inseverable; a contrary conclusion would not comport with Congress's intent to enact a regime that "balance[d] the costs and benefits." *Id.* at 694; *cf. Alaska Airlines*, 480 U.S. at 684; *Williams*, 278 U.S. at 238, 243.

C. As the *NFIB* Dissenting Justices Concluded, the ACA's Minor Provisions are Inseverable.

The district court correctly declared inseverable all other minor provisions scattered throughout the 900-page ACA. *See NFIB*, 567 U.S. at 704-06 (dissenting op.). The ACA's minor provisions include, for example, a tax on medical devices, 26 U.S.C. § 4191(a), a mechanism for the Secretary to issue States compliance waivers, 42 U.S.C. § 1315, regulations on the display of nutritional content at restaurants, 21 U.S.C. § 343(q)(5)(H), and "a number of provisions that provide benefits to the State of a particular legislator"—which were "[o]ften . . . the price paid for [the legislator's] support of a major provision," *NFIB*, 567 U.S. at 704 (dissenting op.). Each of the ACA's minor provisions fails at least one part of the severability standard.

The first part of the severability analysis—whether the provisions would "function in a manner consistent with the intent of Congress" absent the invalid provisions, *Alaska Airlines*, 480 U.S. at 685—renders inseverable all miscellaneous "tax increases," like the medical-device tax, *NFIB*, 567 U.S. at 705 (dissenting op.). Without the ACA's main provisions, "the tax increases no longer operate to offset costs, and they no longer serve the purpose in the Act's scheme of 'shared responsibility' that Congress intended." *Id.* This part also invalidates the ACA's lingering administrative measures, like provisions for States to obtain compliance waivers from the

Secretary of HHS, *see* 42 U.S.C. § 1315, since these would serve no meaningful purpose. *Cf. Williams*, 278 U.S. at 238, 243.

The second part of the standard—"whether Congress would have enacted the remaining provisions standing alone"—renders inseverable all other minor provisions, like the regulation of nutritional displays and the "provisions that provide benefits to the State of a particular legislature." *NFIB*, 567 U.S. at 693, 704 (dissenting op.). "There is no reason to believe that Congress would have enacted them independently," *id.* at 705, given that they are "mere adjuncts of the [main] provisions of the law," *Williams*, 278 U.S. at 243, and only (if at all) tangentially further the law's main purpose of near-universal affordable care.[8]

[8] The intervenors misunderstand the law of severability and wrongly ask this Court to focus on legislative history rather than text. The state appellees adopt by reference the individual appellees' responses to these arguments. *See* Fed. R. App. P. 28(i).

Conclusion

The district court's judgment should be affirmed.

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Certificate of Compliance

This brief complies with: (1) the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 12,996 words, excluding the parts of the brief exempted by Rule 32(f); and (2) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Equity) using Microsoft Word (the same program used to calculate the word count).

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