DEPARTMENT OF THE ATTORNEY GENERAL

DAVID Y. IGE
GOVERNOR

CLARE E. CONNORS
ATTORNEY GENERAL

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Hawaii Continues Fight to Protect the Affordable Care Act

Attorney General Joins Coalition of 21 Attorneys General Challenging Plaintiffs' Lack of Standing in Texas v. US

HONOLULU – Attorney General Clare E. Connors, joined a coalition led by Attorney General Becerra of 20 states and the District of Columbia, in filing a response in *Texas v. U.S.*, defending the Affordable Care Act (ACA) and the healthcare of tens of millions of Americans. The brief, filed in the U.S. Court of Appeals for the Fifth Circuit on Wednesday, argues that every provision of the ACA remains valid. It further argues that the position taken by the Trump Administration and the Texas-led coalition is legally incorrect and dangerous to our healthcare system.

"This is another important step in our ongoing efforts to ensure affordable health care for Hawaii residents and millions of other Americans," Attorney General Connors said.

The plaintiffs, two individuals and 18 States led by Texas, filed this lawsuit in February 2018, challenging one provision of the Affordable Care Act—the requirement that individuals maintain health insurance or pay a tax. Texas' lawsuit came after Congress reduced that tax to zero dollars in December 2017. Opponents of the ACA had attempted and failed to repeal the ACA over 70 times since its instatement. The plaintiffs argued that this reduction in the tax made the minimum coverage provision unconstitutional. They further argued that this provision could not be "severed" from the rest of the ACA, meaning that the entire Act must be struck down. In the district court, the Trump Administration agreed with the plaintiffs that the minimum coverage provision, as amended, was unconstitutional, and further argued that it could not be severed from two of the ACA's important provisions—the community-rating and guaranteed-issue reforms. Then, in March, the Trump Administration signaled that it would change course and argue that the entire ACA is now invalid. The Trump Administration filed its brief in support of its new position on May 1, 2019, alongside a brief filed by the Texas-led coalition and the two individual plaintiffs.

The most recent filing responds to these arguments by the Trump Administration and the plaintiffs, and continues the legal defense of the ACA, the backbone of our healthcare system. In their brief, the Attorneys General argue that none of the plaintiffs

have standing to challenge the individual mandate provision, because the individual plaintiffs are not injured by a provision that now offers a lawful choice between buying insurance and paying a zero-dollar tax. The Attorneys General further argue that the individual mandate remains constitutional, and is similar to many other laws that Congress has adopted. The brief further argues that, even if the individual mandate is unconstitutional, it should be severed from the rest of the ACA because Congress clearly wanted to preserve every provision of the Affordable Care Act when it reduced the tax amount to zero.

Moreover, as the Attorneys General explained in their opening brief, this case would wreak havoc on the entire American healthcare system and risk lives in every state. If affirmed, the District Court's decision would affect nearly every American, including:

- 133 million Americans, including 17 million kids, with pre-existing health conditions.
- Young adults under 26 years of age, who are covered under a parent's health plan.
- More than 12 million Americans who received coverage through Medicaid expansion.
- 12 million seniors who receive a Medicare benefit to afford prescription drugs.
- Working families who rely on tax credits and employer-sponsored plans to afford insurance.

Oral argument in the matter is set in the Fifth Circuit for July 9, 2019, in New Orleans. Copies of the briefs are attached.

# # #

For more information, contact:

Krishna F. Jayaram
Special Assistant to the Attorney General
(808) 586-1284
Email: Krishna.F.Jayaram@hawaii.gov
Web: http://ag.hawaii.gov
Twitter: @ATGHIgov

No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; STATE OF WISCONSIN; 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 & 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
No. 4:18-cv-167-O
Hon. Reed O'Connor, Judge

STATE DEFENDANTS' OPENING BRIEF

Counsel listed on the inside cover

Xavier Becerra
Attorney General of California
Edward C. DuMont
Solicitor General
Michael L. Newman
Senior Assistant Attorney General
Michael J. Mongan
Samuel P. Siegel
Deputy Solicitors General
Kathleen Boergers
Supervising Deputy Attorney General
Nimrod P. Elias
Neli N. Palma
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
1300 I Street
Sacramento, CA 95814
(916) 210-6269
Sam.Siegel@doj.ca.gov
Attorneys for the State of California

March 25, 2019

Additional Counsel Listed on Signature Page

CERTIFICATE OF INTERESTED PERSONS

Because the state defendants are governmental entities, a certificate of interested parties is not required. 5th Cir. R. 28.2.1.

s/ Samuel P. Siegel
Samuel P. Siegel

STATEMENT REGARDING ORAL ARGUMENT

This appeal concerns a constitutional challenge to the Patient Protection and Affordable Care Act of 2010. The decision below declared one provision of that Act, as amended, unconstitutional, and held that the unconstitutional provision could not be severed from the remainder of the Act. That ruling, if implemented, would seriously disrupt the nation's healthcare system. Oral argument is therefore appropriate in this case.

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 transformed the nation's healthcare system. Because of the ACA, more than 20 million Americans have access to high-quality, affordable healthcare coverage; tens of millions of others cannot be denied coverage because of pre-existing conditions; the growth in healthcare costs has slowed; States and hospitals have realized substantial savings; and the health of millions of Americans has improved. The Act's reforms are woven into nearly every aspect of our healthcare system and, indeed, the broader economy.

The ACA has also been controversial. Congress considered repealing or substantially revising the Act several times between 2010 and 2017. It rejected all but a few minor changes. Lawsuits also challenged a number of the Act's provisions, including the requirement in the original law that individuals maintain a minimum level of healthcare coverage or pay a tax. Addressing that issue, the Supreme Court held that the Commerce Clause did not give Congress the power to enact an enforceable, stand-alone mandate requiring individuals to purchase health insurance. But it construed the relevant provision of the ACA, 26 U.S.C. § 5000A, as affording individuals a "lawful choice" between buying insurance or paying a tax, and upheld the provision as an exercise of Congress's taxing power. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012) (*NFIB*).

After the change in presidential administrations in 2017, Congress again considered several bills that would have repealed major provisions of the Act. As before, the 2017 Congress ultimately decided not to disturb most of the ACA. It did, however, make one change: it amended Section 5000A to set at zero the amount of the tax imposed on those who choose not to maintain healthcare coverage. Legislators who supported that amendment emphasized that it did not affect any other provision of the Act.

The plaintiffs in this case—two individuals and several States—argue that the 2017 amendment critically changes the application of *NFIB*, turning the remaining minimum coverage provision into a stand-alone command to buy insurance and making it unconstitutional. The district court held that the individual plaintiffs had standing to make that argument, and then accepted it. It went on to hold that the minimum coverage provision could not be severed from any other provision of the ACA, and declared the entire Act invalid.

That judgment is unsound in all respects. Congress's 2017 amendment sets at zero the amount of the tax that *NFIB* holds an individual may lawfully choose to pay as an alternative to maintaining healthcare coverage. The individual plaintiffs do not have standing to challenge the resulting law, because they suffer no legal harm from the existence of a provision that offers them a lawful choice between buying insurance or doing nothing. And the States (whose standing the district

court did not address) cannot step into that void on appeal, because in the court below they failed to provide any evidence to support a finding of actual (or even potential) financial harm.

In any event, the minimum coverage provision remains constitutional. With the amount of the alternative tax set to zero, Section 5000A no longer compels any individual to maintain healthcare coverage—or to take any other action. At most, the remaining provision is a precatory encouragement to buy health insurance, which poses no constitutional problem. And even if that provision were now invalid, it would be severable from the rest of the Act. When Congress amended Section 5000A in 2017, it chose to make the minimum coverage provision effectively unenforceable—while leaving every other part of the ACA in place. If zeroing-out that provision's alternative tax creates a constitutional problem, then it is evident what Congress would have wanted the remedy to be: a judicial order declaring the minimum coverage provision unenforceable, and nothing more.

JURISDICTION

The district court had jurisdiction over this case under 28 U.S.C. § 1331, because it raises a federal constitutional challenge to a federal statute. On December 30, 2018, the district court entered partial final judgment on Count I of the plaintiffs' amended complaint under Federal Rule of Civil Procedure 54(b). ROA.2784-2785. The state defendants filed their notice of appeal on January 3,

2019, ROA.2787-2788, and the federal defendants filed their notice of appeal on January 4, 2019, ROA.2844-2845. This Court has jurisdiction under 28 U.S.C. § 1291. *See United States v. Phillips*, 303 F.3d 548, 550 (5th Cir. 2002).

STATEMENT OF ISSUES

1. Whether the plaintiffs in this case have demonstrated Article III standing to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act of 2010, 26 U.S.C. § 5000A(a), now that Congress has set the amount of the tax imposed for not maintaining coverage at zero dollars.

2. Whether the minimum coverage provision remains constitutional now that there is no legal consequence for not maintaining coverage.

3. If reducing the tax to zero makes the minimum coverage provision unconstitutional, whether that provision is severable from the rest of the ACA.

STATEMENT OF THE CASE

A. The Affordable Care Act

The Affordable Care Act is landmark legislation that has transformed the nation's healthcare system. Adopted in 2010, the Act aimed to increase the number of Americans with healthcare coverage, lower the cost of healthcare, and improve families' well-being. *See NFIB*, 567 U.S. at 538. It affects every level of government and most aspects of an industry that accounts for nearly one-fifth of the nation's economy. ROA.1523.

Among other important reforms, the ACA strengthens consumer protections in the private health insurance market. *See generally* ROA.1130-1133, 1213-1215. It bars insurance companies from denying individuals coverage because of their health status (the "guaranteed-issue" requirement), refusing to cover pre-existing health conditions, or charging individuals with health issues higher premiums than healthy individuals (the "community-rating" requirement). *See* 42 U.S.C. §§ 300gg, 300gg-1 (guaranteed-issue), 300gg-3 (pre-existing conditions), 300gg-4 (community-rating).[1] Because of these protections, the 133 million Americans with pre-existing conditions—which include cancer, asthma, high blood pressure, diabetes, and pregnancy, *see* ROA.1278-1284—cannot be denied coverage or charged more because of their health status. ROA.1131, 1149-1183, 1210. The ACA also requires insurers to allow young adults to stay on their parents' health insurance plans until age 26, 42 U.S.C. § 300gg-14; prohibits them from imposing lifetime or annual limits on the value of benefits provided to any individual, *id.* § 300gg-11; and mandates that the plans they offer cover ten "essential health benefits," including emergency services, prescription drugs, and maternity and newborn care, *id.* § 18022.

[1] References to the guaranteed-issue requirement often include the requirement to cover pre-existing conditions.

In addition, the ACA expands access to healthcare coverage, through two key reforms. *See generally* ROA.1133-1139. First, it increases the number of people eligible for healthcare coverage through Medicaid. Adopted in 1965, Medicaid offers federal funding to States to assist certain vulnerable populations—pregnant women, children, and needy families among them—in obtaining medical care. *NFIB*, 567 U.S. at 541 (citing 42 U.S.C. § 1396a(a)(10)). The ACA expands the program by "increas[ing] the number of individuals the States must cover" to include childless adults with incomes up to 138 percent of the federal poverty line. *Id.* at 542; *see also* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i). And it obligates the federal government to cover most of the cost of the expansion. *See* 42 U.S.C. § 1396d(y)(1) (federal government will cover 93 percent of cost of expansion in 2019 and 90 percent in later years).

The ACA originally required each State to expand its Medicaid program or risk losing "all of its federal Medicaid funds." *NFIB*, 567 U.S. at 542. In *NFIB*, however, the Supreme Court held that under the Spending Clause, Congress could not threaten States that declined to expand Medicaid with such a substantial loss of federal funds. *Id.* at 575-585 (plurality opinion); *id.* at 671-689 (joint dissent).[2] But the Court also allowed those States that wanted to accept Medicaid expansion

[2] This brief refers to Part IV of Chief Justice Roberts's opinion in *NFIB*, 567 U.S. at 575-588, which Justices Breyer and Kagan joined, as the plurality opinion.

funds to do so, *see id.* at 585-586 (plurality opinion); *id* at 645-646 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); and 36 States and the District of Columbia had expanded their Medicaid programs as of February 2019.[3] In 2016, nearly 12 million individuals received healthcare coverage because of the expansion of Medicaid. ROA.365-366.[4] That number rose to over 12.5 million people in 2017.[5]

The ACA also expanded access to healthcare by making a series of reforms in the individual health insurance market that made healthcare more affordable. *See generally King v. Burwell*, 135 S. Ct. 2480, 2485-2487 (2015); ROA.1133-1136.[6] Insurers that offer health insurance in the individual market must comply with the community-rating and guaranteed-issue requirements. *King*, 135 S. Ct. at 2486. But the ACA originally included three additional measures designed to strengthen

[3] *See* Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision*, https://tinyurl.com/y6uw6rhy (last visited Mar. 24, 2019).

[4] More than half of these newly-eligible Medicaid recipients reside in States that are defendants in this case, while 1.3 million of them reside in States that are plaintiffs. ROA.351, 1160-1182, 1188-1190, 1206, 1239, 1242-1243, 1493-1495, 1498-1499, 1509-1510, 1521-1523, 1540-1541.

[5] *See* Kaiser Family Found., *Medicaid Expansion Enrollment*, https://tinyurl.com/yxtpxpbn (last visited Mar. 24, 2019).

[6] While most Americans receive healthcare coverage through their employers or government programs (such as Medicaid), about 20.5 million are covered through plans purchased directly from insurers in the "individual" or "nongroup" market. *See* Kaiser Family Found., *Health Insurance Coverage of the Total Population*, https://tinyurl.com/y8q9m8q4 (last visited Mar. 24, 2019).

coverage in the individual market. *Id.* at 2485-2487. First, it adopted the provision at issue in this case, 26 U.S.C. § 5000A, which "generally require[d] individuals to maintain health insurance coverage or make a payment to the IRS." *King*, 135 S. Ct. at 2486; *see also infra* 12-13 (describing Section 5000A). Second, the ACA made health insurance more affordable by providing billions of dollars of subsidies in the form of refundable tax credits to low- and middle-income Americans. *King*, 135 S. Ct. at 2487 (citing 26 U.S.C. § 36B, 42 U.S.C. §§ 18081, 18082). Third, it created government-run health insurance marketplaces (known as Exchanges) that allow consumers "to compare and purchase insurance plans." *Id.* at 2485, 2487; *see also* 42 U.S.C. § 18031.[7] In 2017, 10.3 million people received coverage through the Exchanges, with over eight million receiving tax credits to help them pay their premiums. ROA.353-354, 1134.

The ACA made several other changes to the nation's healthcare system as well. It reformed the way Medicare payments are made, encouraging healthcare providers to deliver higher quality and less expensive care. ROA.1140-1142,

[7] States may establish their own Exchanges, or use the federal government's Exchange. *King*, 135 S. Ct. at 2482; *see also* 42 U.S.C. §§ 18031, 18041. Eleven States—nine of which are defendants in this appeal—and the District of Columbia operate their own Exchanges, while 28 rely on federally-facilitated Exchanges and 11 partner with the federal government to run "hybrid" or partnership Exchanges. ROA.1133-1134.

1146-1147, 1226-1227; *see also* 42 U.S.C. § 1395ww.[8] It created the Prevention and Public Health Fund, which has funded state and local community responses to emerging public health risks like flu outbreaks and the opioid epidemic. ROA.1144, 1147; *see also* 42 U.S.C. §§ 280h-5, 280k, 280k-1, 280k-2, 280k-3, 294e-1, 299b-33, 299b-34, 300u-13, 300u-14, 1396a. It made funds available to States to strengthen their Medicaid programs through initiatives like the Community First Choice Option, which allows States to pay for in-home and community-based care for persons with disabilities. ROA.1139; 42 U.S.C. § 1396n(k). And it invested billions of dollars in local community health programs. ROA.1144-1146.

Through these reforms, the ACA has achieved many of the goals that Congress set when it adopted the legislation. ROA.1216-1218. Less than three years after the Act's major reforms took effect in January 2014, the nation's uninsured rate had dropped by 43 percent. ROA.1126; *see also* ROA.365-366, 1136-1137, 1216. An estimated 125,000 fewer patients have died from conditions acquired in hospitals, thanks in part to an ACA-funded program. ROA.1128.

[8] Medicare is "a comprehensive insurance program designed to provide health insurance benefits for individuals 65 and over, as well as for certain others who come within its terms." *United Seniors Ass'n, Inc. v. Shalala*, 182 F.3d 965, 967 (D.C. Cir. 1999).

Nearly 9.5 million fewer Americans reported having problems paying medical bills in March 2015 than in September 2013; and in the six years following passage of the Act, healthcare costs grew at a slower rate than during any comparable period since data collection began in 1959. ROA.1128-1129, 1217-1218. Uncompensated care costs—the value of healthcare services provided to individuals either unable or unwilling to pay—fell by a quarter between 2013 and 2015 nationwide, and by nearly half in States that expanded Medicaid. ROA.1129-1130, 1218. And the ACA has had broader economic effects, including generating budget savings for States and reducing "job lock" by freeing workers to change jobs or stay home to care for a loved one without fear of losing their healthcare coverage. ROA.1129-1130.

B. Attempts at Repeal

Despite its successes, the ACA has been the subject of passionate and extended political debate. Between 2010 and 2016, Congress considered several bills to repeal, defund, delay, or otherwise amend the ACA—including legislation that would have repealed the entire Act. *See* Redhead & Kinzer, Cong. Research Serv., *Legislative Actions in the 112th, 113th, and the 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act* at 1 (Feb. 7, 2017).[9] Except for a few

[9] *Available at* https://fas.org/sgp/crs/misc/R43289.pdf.

modest changes that attracted bipartisan support, those efforts failed. *Id.*; *see also id.* at 10-22.

After the change in presidential administrations in 2017, opponents renewed their efforts to repeal many of the ACA's most important reforms. *See generally* Roubein, *Timeline: The GOP's Failed Effort to Repeal Obamacare*, The Hill, Sept. 26, 2017.[10] In March 2017, House leaders pulled a bill, scheduled for a floor vote, that would have repealed many the ACA's core provisions and made several other significant changes. *Id.* Two months later, the House approved a revised version of that bill. *Id.* In July, the Senate voted on three separate bills that likewise would have repealed major provisions of the Act. *See* Parlapiano, et al., *How Each Senator Voted on Obamacare Repeal Proposals*, N.Y. Times, July 28, 2017.[11] Each vote failed. *Id.* In September, several Senators introduced another bill that would have repealed several of the Act's most important provisions; but Senate leaders ultimately chose not to bring that bill to the floor for a vote. *See*

[10] *Available at* https://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare. *See also* Kaiser Family Found., *Compare Proposals to Replace the Affordable Care Act*, https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/ (last visited Mar. 24, 2019) (detailing bills considered by the House and Senate in 2017).

[11] *Available at* https://www.nytimes.com/interactive/2017/07/25/us/politics/senate-votes-repeal-obamacare.html.

Kaplan & Pear, *Senate Republicans Say They Will Not Vote on Health Bill*, N.Y. Times, Sept. 26, 2017.[12]

C. Court Challenges

The ACA has also generated numerous lawsuits, including several that reached the Supreme Court. *See NFIB*, 567 U.S. 519; *King*, 135 S. Ct. 2480. That Court's decision in *NFIB* is especially relevant here. Among other things, *NFIB* addressed the constitutionality of 26 U.S.C. § 5000A. As originally enacted, that section first provided that all "applicable individual[s] shall" ensure that they are "covered under minimum essential coverage." 26 U.S.C. § 5000A(a); *see also id.* § 5000A(f) (defining "minimum essential coverage"). Any "taxpayer" who did not obtain such coverage was required to make a "shared responsibility payment" in the amount specified in Section 5000A(c). *Id.* § 5000A(b). The specified "amount of the penalty" was the lesser of a dollar amount or a specified percentage of income, which varied depending on the relevant taxable year. *Id.* § 5000A(c) (2010) (amended 2017). With shifting majorities, the Court in *NFIB* upheld the ACA's requirement that individuals either maintain healthcare coverage or make a

[12] *Available at* https://www.nytimes.com/2017/09/26/us/politics/mcconnell-obamacare-repeal-graham-cassidy-trump.html.

payment to the IRS. 567 U.S. at 530-531, 574, 588; *id.* at 589 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).[13]

Chief Justice Roberts, writing for himself, concluded that if Section 5000A were construed to impose an enforceable, stand-alone requirement that individuals purchase health insurance, then it exceeded Congress's Commerce Clause powers. *NFIB*, 567 U.S. at 547-558 (Roberts, C.J.)[14] While recognizing that "Congress has broad authority under the Clause," the Chief Justice reasoned that Congress could not "rely on that power to compel individuals not engaged in commerce to purchase an unwanted product." *Id.* at 549, 552 (Roberts, C.J.). The Commerce Clause, he concluded, gave Congress the power to "'*regulate* Commerce,'" not to

[13] As noted above, a majority also held that Congress could not "coerce[]" States to expand their Medicaid programs. *NFIB*, 567 U.S. at 575-585 (plurality opinion); *id.* at 671-689 (joint dissent). A different majority held that the federal government could offer Medicaid expansion funds to those States that chose to accept them, and that the Medicaid expansion program was severable from the rest of the ACA. *Id.* at 585-586 (plurality opinion); *id.* at 645-646 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

[14] As the district court noted, although "no other Justice joined this part of the Chief Justice's opinion, the 'joint dissent'—consisting of Justices Scalia, Kennedy, Thomas, and Alito—reached the same conclusion" on the Commerce Clause question. ROA.2616 (citing *NFIB*, 567 U.S. at 657 (joint dissent)). The same five Justices also held that an enforceable minimum coverage requirement could not be sustained under the Necessary and Proper Clause. *Id.* (citing *NFIB*, 567 U.S. at 560 (Roberts, C.J.); *id*. at 654-655 (joint dissent)). Like the district court, this brief uses the parenthetical (Roberts, C.J.) when referring to portions of the Chief Justice's opinion that were not formally joined by any other justice.

require individuals to "*become* active in commerce by purchasing a product." *Id.* at 550, 552 (Roberts, C.J.).

In another part of his opinion, however, the Chief Justice, now writing for a Court majority, held that Section 5000A as a whole could be upheld as a valid exercise of Congress's power to "'lay and collect Taxes.'" *NFIB*, 567 U.S. at 561, 574.[15] Read in isolation, the "most straightforward" understanding of Section 5000A(a) was that it "command[ed] individuals to purchase insurance." *Id.* at 562 (Roberts, C.J.). But that was not the only way to interpret Section 5000A as a whole; rather, it was "'fairly possible'" to read that provision as imposing "a tax hike on certain taxpayers who do not have health insurance." *Id.* at 563 (Roberts, C.J.). The Court pointed to several features of Section 5000A, including that it "yield[ed] the essential feature of any tax: It produces at least some revenue for the government." *Id.* at 563-564.[16] The Court also noted that Section 5000A did

[15] Four justices joined Part III-C of the Chief Justice's opinion, which upheld Section 5000A under Congress's taxing powers. *See NFIB*, 567 U.S. at 589 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part). But they did not formally join Parts III-B and III-D of that opinion, which discuss the interpretation of Section 5000A and Congress's taxing power. *Id.*

[16] The Court also observed that the alternative tax imposed by Section 5000A(b)-(c) was "paid into the Treasury by 'taxpayers' when they file their tax returns"; did not apply to individuals whose household income was less than the filing threshold in the Internal Revenue Code; was determined by reference to "such familiar factors as taxable income, number of dependents, and joint filing status"; and was "found in the Internal Revenue Code and enforced by the IRS." *NFIB*, 567 U.S. at 563-564.

not impose any criminal sanction on individuals who did not maintain healthcare coverage; instead, the only "negative legal consequence[]" for not obtaining such coverage was the requirement to make a "payment to the IRS." *Id.* at 568, 573. Accordingly, the Court concluded that Section 5000A as a whole was not a command to purchase insurance, but instead offered individuals a "lawful choice" between forgoing health insurance and paying higher taxes, or buying health insurance and paying lower taxes. *Id.* at 573-574 & n.11.

Justices Scalia, Kennedy, Thomas, and Alito authored a joint dissent in which they concluded that Section 5000A's minimum coverage provision could not be sustained either under the Commerce Clause or as an exercise of Congress's taxing power. *NFIB*, 567 U.S. at 646-669. The joint dissent also would have held that the Medicaid expansion exceeded Congress's authority under the Spending Clause, *id.* at 671-689; and that that the minimum coverage provision and the Medicaid expansion could not be severed from the rest of the ACA, *id.* at 691-706. The joint dissent reasoned that without the invalid provisions, the ACA would impose "unexpected burdens on patients, the health-care community, and the federal budget," thereby disrupting the "ACA's design of 'shared responsibility.'" *Id*. at 697-698. In light of that observation, the joint dissent would have held that none of the Act's "major provisions"—including the consumer protections and the

ACA's provisions establishing Exchanges and providing subsidies—could survive the invalidation of Section 5000A and the Medicaid expansion. *Id.* at 697-703.[17]

D. The 2017 Amendment

While Congress repeatedly declined to repeal or substantially revise most of the ACA, it did make one change to the law in December 2017. As part of the Tax Cuts and Jobs Act, Congress reduced to zero the amount of the tax imposed by Section 5000A(b)-(c), which *NFIB* had recognized individuals could pay as a lawful alternative to maintaining the healthcare coverage otherwise called for by Section 5000A(a). Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). The reduction was scheduled to take effect on January 1, 2019. *Id.*

Shortly before Congress adopted this amendment, the Congressional Budget Office issued a report estimating the effects of setting Section 5000A's alternative tax at zero—thus leaving the minimum coverage provision effectively unenforceable. Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017).[18] The report informed Congress that "nongroup insurance markets would continue to be stable in almost all areas of the

[17] The joint dissent reached a similar conclusion with respect to the ACA's "minor provisions," including break requirements for nursing mothers and the mandate that chain restaurants display the nutritional content of their food. 567 U.S. at 704-706.

[18] *Available at* https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

country throughout the coming decade." *Id.* at 1. And members of Congress who voted for the amendment emphasized that Congress was not making any other change to the ACA. Echoing several of his colleagues, for example, Senator Pat Toomey of Pennsylvania explained that Congress was not "chang[ing] any of the subsidies. They are all available to anyone who wants to participate. We don't change the rules. We don't change eligibility. We don't change anything else." 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017).

E. This Litigation

Two months after Congress voted to reduce Section 5000A's alternative tax to zero, the plaintiffs here—two private citizens and 19 States—filed suit. ROA.34, 68, 503.[19] They argued that, in light of the holding in *NFIB* and the 2017 amendment, the remaining minimum coverage provision was unconstitutional, and that it could not be severed from the rest of the ACA. ROA.503-536. The plaintiffs sought preliminary and permanent relief enjoining the federal defendants from enforcing any provision of the ACA or its associated regulations. ROA.535,

[19] This Court dismissed former Governor LePage from this appeal on February 26, 2019. *See* Doc. No. 514852018. On March 21, 2019, the State of Wisconsin moved to be dismissed from this appeal. *See* Doc. No. 514882751.

565-633. On the other side, 16 States and the District of Columbia intervened to defend the ACA. ROA.220-256, 946-952.[20]

The state defendants opposed the plaintiffs' motion for preliminary relief in its entirety. ROA.1051-1117. The federal defendants agreed that "immediate relief" was not warranted, because the reduction in Section 5000A's alternative tax amount would not take effect until January 1, 2019. ROA.1581. But they agreed with the plaintiffs that once the alternative tax was reduced to zero the remaining minimum coverage provision would be unconstitutional, and that it could not be severed from the ACA's guaranteed-issue and community-rating requirements. ROA.1562-1563, 1570-1577. Unlike the plaintiffs, however, the federal defendants contended that those three provisions could be severed from the rest of the ACA. ROA.1563, 1577-1580. The federal defendants urged the district court to construe the plaintiffs' motion for a preliminary injunction as a request for partial summary judgment and to declare the ACA's minimum coverage, community-rating, and guaranteed-issue provisions invalid. ROA.1581.[21]

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[20] On February 14, 2019, this Court allowed the U.S. House of Representatives and the States of Colorado, Iowa, Michigan, and Nevada to intervene on appeal. *See* Doc. Nos. 514836052, 514836075.

[21] In response to the federal defendants' suggestion, the district court ordered the parties to file "any additional information they wish[ed] to present in opposition to considering these issues on summary judgment." ROA.2501. The state defendants explained that they wished to brief additional arguments if the court intended to

On December 14, 2018, the district court denied the motion for a preliminary injunction but granted partial summary judgment. ROA.2612. It held that (1) the individual plaintiffs had standing, ROA.2625-2629, (2) setting the alternative tax amount at zero made the remaining minimum coverage provision unconstitutional, ROA.2629-2644, and (3) the unconstitutional provision could not be severed from the remainder of the ACA, which must therefore be invalidated in its entirety, ROA.2644-2665. With respect to the constitutional question, the district court concluded that Section 5000A as a whole could no longer be construed as an exercise of Congress's taxing power, principally because it would no longer "'produce[] at least some revenue for the Government.'" ROA.2635 (alteration changed). Instead, the court construed Section 5000A(a) as now constituting a "standalone command" to purchase health insurance. ROA.2644. Based on that construction, the court held that the provision exceeded Congress's power under the Commerce Clause. ROA.2637-2644.

With respect to severability, the district court asked primarily whether the 2010 Congress that originally enacted the ACA would have adopted the rest of the

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convert the motion for preliminary relief into one for summary judgment. ROA.2528-2531. The district court did not afford them that opportunity. The plaintiffs reiterated their request for preliminary relief, but did not oppose the court "*also* and *simultaneously* considering" their motion as one for partial summary judgment. ROA.2521-2522.

ACA, had it known that it could not include an enforceable minimum coverage provision. ROA.2647-2662. In concluding that it would not have done so, the court relied heavily on legislative findings that the 2010 Congress adopted as part of the ACA. ROA.2648-2651 (citing 42 U.S.C. § 18091). The district court also cited the Supreme Court's decisions in *NFIB* and *King*, particularly portions explaining why the 2010 Congress included the minimum coverage provision in the original Act. ROA.2651-2654. The district court concluded that "all nine Justices to address the issue" agreed that the minimum coverage provision was "inseverable from at least the pre-existing condition provisions." ROA.2651-2652. The court then adopted the *NFIB* joint dissent's analysis in concluding that the 2010 Congress would not have adopted any other provision of the ACA without an enforceable requirement to maintain healthcare coverage. ROA.2654-2662.

The district court also briefly addressed the intent of the 2017 Congress. ROA.2662-2664. It concluded that that Congress had "no intent" with respect to the severability of the minimum coverage provision. ROA.2664. But it also reasoned that if the 2017 Congress had considered the issue it "must have agreed" that the minimum coverage provision was "essential to the ACA" because it only reduced the alternative tax amount specified by Section 5000A(c) to zero, it did not repeal Section 5000A(a) or the 2010 Congress's findings, and it did not "repudiate

or otherwise supersede" the Supreme Court's decisions in *NFIB* and *King*. ROA.2663-2664.

In a separate order, the district court entered a partial final judgment under Federal Rule of Civil Procedure 54(b) but stayed the effect of that judgment pending appeal. ROA.2755-2785.[22] The state and federal defendants filed separate timely notices of appeal. ROA.2787-2788, 2844-2845.

SUMMARY OF ARGUMENT

1. The plaintiffs have not established standing on the record in this case. The individual plaintiffs contend that Section 5000A(a) harms them because it requires them to purchase health insurance. But in *NFIB*, the Supreme Court held that Section 5000A as a whole must be read as offering affected individuals a choice between maintaining healthcare coverage or paying a tax of a specified amount. Now that Congress has reduced that amount to zero, the individual plaintiffs need not do anything to comply with the law. A statutory provision that gives individuals a choice between purchasing health insurance and doing nothing does not impose any legal harm.

The state plaintiffs allege that Section 5000A will cost them money. While fiscal harm imposed by a federal statute can of course be a basis for state standing,

[22] The district court also stayed all further proceedings in that court pending the outcome of this appeal. ROA.2786.

in this case the States have not substantiated their position with any evidence that Section 5000A actually has increased or likely will increase their costs. They speculate that some of their residents will enroll in their Medicaid or Children's Health Insurance Program (CHIP) based on a mistaken belief that the amended Section 5000A requires individuals to maintain healthcare coverage. But in the absence of supporting evidence, that conjecture is insufficient to establish standing.

2. The minimum coverage provision remains constitutional now that Congress has reduced the amount of the alternative tax to zero. The district court held that Section 5000A(a) must be read as a freestanding "command" to buy health insurance. Again, however, the Supreme Court reached a different conclusion in *NFIB*, construing Section 5000A as offering a choice between buying insurance and paying a tax. *See* 567 U.S. at 574. And when Congress amended Section 5000A in 2017, the only change it made was to reduce the amount of the alternative tax to zero.

That change does not make Section 5000A(a) unconstitutional. With the amount of the tax set at zero, the remaining minimum coverage provision becomes simply precatory—precisely as the amending Congress intended. It is no more constitutionally objectionable than the "sense of the Congress" resolutions that Congress often adopts. Alternatively, Section 5000A as a whole may still be fairly read as a lawful exercise of Congress's taxing powers. Although it will not

produce current revenue so long as the amount of the alternative tax is set to zero, under the circumstances here that hardly requires striking the statutory framework from the books. *See United States v. Ardoin*, 19 F.3d 177, 179-180 (5th Cir. 1994) (recognizing "preserved, but unused, power to tax"). Under either analysis, the district court erred in concluding that the 2017 amendment reducing Section 5000A's alternative tax to zero had the effect of changing the result in *NFIB* and rendering the minimum coverage provision unconstitutional.

3. If, however, the minimum coverage provision is now unconstitutional, then under the circumstances of this case it is readily severable from the rest of the ACA. Severability analysis is a question of congressional intent; it asks what the Congress that crafted a provision would have wanted the remedy to be, had it known of the court's later constitutional ruling. Here, Congress changed the tax amount imposed by Section 5000A(b)-(c) to zero, so that there is no longer any legal or practical consequence for choosing not to maintain healthcare coverage. If that change has the effect of rendering the remaining minimum coverage provision in Section 5000A(a) unconstitutional (for any period during which the tax remains set at zero), it seems self-evident what remedy best comports with congressional intent. A judicial order precluding any legal enforcement of Section 5000A(a) while the alternative tax remains set at zero would, as a practical matter, leave matters precisely as Congress itself arranged them.

In contrast, there is no basis for concluding that Congress would have preferred a "remedial" order invalidating not only the minimum coverage provision—which Congress had decided not to enforce anyway—but the rest of the ACA as well. Any such order would strip existing healthcare coverage from millions of Americans. Popular provisions such as the guaranteed-issue, community-rating, and young-adult coverage reforms would be abolished. Millions of jobs would be lost. That result would be contrary to every indication of congressional intent. It would be inconsistent with the special budget procedure through which Congress acted, which allows only certain kinds of legislative changes. And it would make a mockery of the dramatic votes in which the same Congress rejected earlier efforts to repeal or substantially revise the ACA.

In concluding differently, the district court focused on whether the 2010 Congress that created the ACA would have wanted the rest of the Act to stand without the minimum coverage provision. The court's analysis of Congress's intent in 2010 is flawed; but in any event it addresses the wrong question. The 2010 Congress adopted a minimum coverage provision enforced by imposing a tax on those who chose not to maintain healthcare coverage. If *NFIB* had held that statute unconstitutional, the Supreme Court would have had to decide whether the 2010 Congress would have wanted the rest of the Act to stand without it. The 2017 Congress expressly decided to zero-out the alternative tax, thus making the

minimum coverage provision effectively *un*enforceable, while leaving the rest of the Act intact. It is the intent of that Congress, with respect to the version of ACA that it created, that matters for purposes of this case. And the 2017 Congress's intent is evident from what it did: eliminating any legal consequence for not maintaining minimum healthcare coverage, while preserving every other provision of the Act.

STANDARD OF REVIEW

This Court reviews a district court's grant of summary judgment de novo. *Magee v. Reed*, 912 F.3d 820, 822 (5th Cir. 2019).

ARGUMENT

I. THE PLAINTIFFS DO NOT HAVE STANDING

The plaintiffs have not carried their burden of establishing standing to challenge the minimum coverage provision. The individual plaintiffs allege that Section 5000A(a) injures them because they "value compliance with [their] legal obligations," and the only way to comply with that provision is by maintaining "minimum essential health insurance coverage." ROA.637, 641. But that subsection must be understood in light of the statutory construction adopted by *NFIB*, which held that Section 5000A as a whole allows individuals to choose between maintaining minimum coverage (Section 5000A(a)) or paying a tax in a particular amount (Section 5000A(b)-(c)). *See* 567 U.S. at 574 & n.11. Before 2019, a person could violate Section 5000A by "not buy[ing] health insurance and

not pay[ing] the resulting tax." *Id.* at 574 n.11. But now that Congress has reduced the amount of the tax to zero, the individual plaintiffs do not need to do anything to comply with the law. A statute that offers plaintiffs a choice between purchasing insurance or doing nothing does not impose any legally cognizable harm. *Cf. Crane v. Johnson*, 783 F.3d 244, 253 (5th Cir. 2015) ("[V]iolation of one's oath alone is an insufficient injury to support standing.").

The state plaintiffs allege that Section 5000A will cost them money. A fiscal injury caused by a federal statute can of course be a basis for state standing. *See, e.g.*, *Texas v. United States*, 787 F.3d 733, 752-53 (5th Cir. 2015) (standing based on state driver's license costs of $130.89 for each of up to "500,000 potential beneficiaries"). But allegations of financial injury that are "purely speculative" and unsupported by any "concrete evidence that [the State's] costs ha[ve] increased or will increase" are not sufficient to establish Article III standing. *Crane*, 783 F.3d at 252; *see also id.* (no standing where State asserted it would incur costs "provid[ing] social benefits to illegal immigrants" but "submitted no evidence" supporting that assertion). The state plaintiffs' theory of standing in this case—which the district court did not address (ROA.2628-2629)—involves the same kind of unsupported speculation that this Court viewed as insufficient in *Crane*. They assert that they will spend more on their Medicaid and Children's Health Insurance Program (CHIP) because some of their residents will enroll in those programs

based on a mistaken belief that Section 5000A requires them to maintain healthcare coverage. ROA.623. But that theory rests entirely on conjecture: The state plaintiffs did not introduce any evidence to support it. In the absence of such support, the States' argument is insufficient to establish standing.

II. THE MINIMUM COVERAGE PROVISION REMAINS CONSTITUTIONAL

In holding the minimum coverage provision unconstitutional, the district court interpreted Section 5000A(a) as imposing "a standalone command" to purchase health insurance. ROA.2644; *see also* ROA.2640-2644 (noting that the title of subsection (a) describes a "[r]equirement" and the text uses the word "shall"). As discussed, above, however, the Supreme Court had the same provision before it in *NFIB*, and construed it differently. *See supra* 14-15, 25-26. While recognizing that Section 5000A(a) might "more naturally" be read "as a command to buy insurance," the Court adopted a reasonable contrary interpretation as a means of saving the statute from constitutional infirmity. *NFIB*, 567 U.S. at 574 (Roberts, C.J.). Under that construction, Section 5000A as a whole "establish[es] a condition—not owning health insurance—that triggers a tax." *Id.* at 563 (Roberts, C.J.); *see id.* at 574 & n.11. Section 5000A(a) does not "order people to buy health insurance" (which would have violated the Commerce Clause); instead, interpreted along with the other provisions in Section 5000A, it

"impose[s] a tax on those without health insurance" (consistent with Congress's taxing power). *Id.* at 575 (Roberts, C.J.).

When Congress amended Section 5000A in 2017, the only change it made was to modify subsection (c) by reducing the amount of this alternative tax to zero. *See* Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). After that amendment, individuals may freely choose between having health insurance and not having health insurance, without paying any tax if they make the latter choice. In light of the construction adopted in *NFIB* and the 2017 amendment, Section 5000A(a) is now simply precatory. It may encourage Americans to buy health insurance, but it imposes no legal obligation to do so.

That change did not make Section 5000A(a) unconstitutional. Stripped of any consequence for non-compliance, the provision is no more constitutionally problematic than the "sense of the Congress" resolutions of the sort that Congress frequently adopts, which are equivalent to "non-binding, legislative dicta." *Yang v. Cal. Dep't of Soc. Servs.*, 183 F.3d 953, 958 & n.3, 961-962 (9th Cir. 1999); *see Monahan v. Dorchester Counseling Ctr., Inc.*, 961 F.2d 987, 994-995 (1st Cir. 1992) (similar); *cf.* 4 U.S.C. § 8 ("No disrespect should be shown to the flag of the

United States of America; the flag should not be dipped to any person or thing.").[23] There can be no concern that Section 5000A(a) violates the Commerce Clause by "compel[ling] individuals not engaged in commerce to purchase an unwanted product," *NFIB*, 567 U.S. at 549 (Roberts, C.J.), now that Congress has eliminated any form of compulsion.[24]

Moreover, as *NFIB* recognized, courts "have a duty to construe a statute to save it, if fairly possible." 567 U.S. at 574 (Roberts, C.J.). And even after the 2017 amendment, Section 5000A may, if necessary, be fairly interpreted as a lawful exercise of Congress's taxing powers (albeit one whose practical effects have at least temporarily been suspended). Section 5000A is still set out in the Internal Revenue Code; it still provides a statutory structure through which "taxpayer[s]" could at some point be directed to pay a tax for choosing not to maintain minimum healthcare coverage, 26 U.S.C. § 5000A(b); it still includes references to taxable income, number of dependents, and joint filing status, *id.*

[23] Other examples of this kind of statute include 42 U.S.C. § 1751, which declares it the policy of Congress to "encourage the domestic consumption of nutritious agricultural commodities," and 22 U.S.C. § 7674, a sense of Congress provision encouraging businesses to provide assistance to sub-Saharan African countries to prevent and reduce the incidence of HIV/AIDS.

[24] Of course, Congress may not adopt even precatory provisions that violate one of the Constitution's express prohibitions. *See, e.g.*, U.S. Const. amend. I ("Congress shall make no law respecting an establishment of religion."). But the amended Section 5000A does not contravene any such prohibition.

§ 5000A(b)(3), (c)(2), (c)(4); and by its terms, it remains inapplicable to individuals who do not pay federal income taxes, *id.* § 5000A(e)(2). *Compare NFIB*, 567 U.S. at 563.

The district court concluded that, with the amount of the tax reduced to zero, Section 5000A could no longer be construed as an exercise of the taxing power. ROA.2637. It relied primarily on the fact that Section 5000A no longer "'produce[s] at least some revenue'" for the federal government. ROA.2634-2635; *see also* ROA.2634 (after 2017 amendment, Section 5000A does not cause payment "into the Treasury" and payment amount is not "determined with reference to income and other familiar factors"); *NFIB*, 567 U.S. at 563-564. But while a potential to generate revenue at some point is an essential feature of a tax, *see NFIB*, 567 U.S. at 564, a statute does not need to produce revenue at all times to be sustained as an exercise of Congress's taxing powers. In *United States v. Ardoin*, 19 F.3d 177, 179-180 (5th Cir. 1994), for example, the defendant was convicted for failing to pay a tax on the manufacture of machineguns—even though Congress had made it illegal to possess machineguns and the federal government had stopped collecting the tax years before the defendant was indicted. This Court upheld the tax as a lawful exercise of Congress's "preserved, but unused, power to tax." *Id.* *Ardoin* forecloses any argument that Section 5000A

must generate revenue at all times to remain a valid exercise of Congress's taxing power. ROA.2635.[25]

The district court's contrary rule would yield troubling consequences extending beyond the circumstances of this case. A strict "revenue production" requirement could cast constitutional doubt on taxes with delayed start dates or that Congress has temporarily suspended for periods of time, both of which are common. For example, the ACA imposed a 40 percent excise tax on employer-sponsored healthcare plans with premiums above specified thresholds, but provided that this "Cadillac Tax" would not take effect until 2013, and Congress later delayed the effective date of that tax until 2021.[26] Similarly, the Medical Device Tax (which imposed a 2.3 percent excise tax on medical devices) was adopted in 2010; did not become effective until the end of 2012; was collected

[25] While the federal government theoretically retained the ability to collect the machinegun tax at issue in *Ardoin* (as the district court noted in attempting to distinguish the case, *see* ROA.2772-2773 n.35), *Ardoin* stands squarely for the principle that a provision may be upheld as a lawful exercise of Congress's taxing power even if it is not currently producing any revenue. Congress of course retains the option of increasing (from zero) the amount of the alternative tax sustained in *NFIB* at some point. In the meantime, there is nothing unconstitutional about leaving in place the statutory structure that would make it easiest to take that step at a future time.

[26] *See* 26 U.S.C. § 4980I; Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 9001, 124 Stat. 119, 853; Act of Jan. 22, 2018, Pub. L. No. 115-120, § 4002, 132 Stat. 28, 38.

from 2013 through 2015; and was suspended by Congress from 2016 through 2019.[27] Congress also routinely imposes taxes to discourage a particular activity. *See, e.g.*, *NFIB*, 567 U.S. at 567; *United States v. Sanchez*, 340 U.S. 42, 44 (1950). If successful, this type of measure "deters the activity taxed" such that "the revenue obtained is negligible"—or even nonexistent—but the "statute does not cease to be a valid tax measure" as a result. *Minor v. United States*, 396 U.S. 87, 98 n.13 (1969). Under the district court's logic, however, a delayed or suspended tax would apparently be "unconstitutional" until it took or went back into effect; and a tax that succeeded in completely eliminating an undesirable activity would apparently become unconstitutional in the following year.

The Supreme Court has admonished that "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." *NFIB*, 567 U.S. at 563 (Roberts, C.J.) (quoting *Hooper v. California*, 155 U.S. 648, 657 (1895)). The amended Section 5000A can reasonably be construed as encouraging (but not requiring) the purchase of health insurance, or as an exercise of the taxing power where Congress has temporarily decided to suspend collection. Section 5000A(a)

[27] *See* 26 U.S.C. § 4191; Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1404, 124 Stat. 1029, 1064-1065; Consolidated Appropriations Act of 2016, Pub. L. No. 114-113, § 174, 129 Stat. 2242, 3071-3072; Act of January 22, 2018, Pub. L. No. 115-120, § 4001, 132 Stat. 28, 38.

need not—and therefore must not—be interpreted "as a standalone command that [is] unconstitutional under the Interstate Commerce Clause." ROA.2644.

III. IF THE MINIMUM COVERAGE PROVISION IS NOW UNCONSTITUTIONAL, IT IS SEVERABLE FROM THE REST OF THE ACA

The district court held that when Congress reduced to zero the amount of the alternative tax provided for in 26 U.S.C. § 5000A(b)-(c), the minimum coverage provision in 26 U.S.C. § 5000A(a) became not only unenforceable but unconstitutional. The court then held that Section 5000A(a) could not be severed from the rest of the ACA—a 974-page Act that enacted or amended hundreds of provisions spread across the United States Code. The resulting "remedial" order would invalidate the guaranteed-issue and community-rating reforms, the Medicaid expansion that now covers more than 12 million Americans, tax credits that have made health insurance affordable for eight million others, the provision that allows young adults to stay on their parents' health insurance plans until age 26, and scores of other programs and protections. That result has no basis in the law.

1. When a court concludes that a statute is unconstitutional, it generally tries "to limit the solution to the problem." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006). That approach reflects "[t]hree interrelated principles." *Id.* at 329. First, courts "try not to nullify more of a legislature's work than is necessary," because a "'ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'" *Id.* Second, mindful of their limited

"constitutional mandate and institutional competence," courts refrain from rewriting laws "even as [they] strive to salvage [them]." *Id.* Third, "the touchstone for any decision about remedy is legislative intent, for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'" *Id.* at 330.

Consistent with these principles, when a court holds one part of a statute unconstitutional, it will generally "sever its problematic portions while leaving the remainder intact." *Ayotte*, 546 U.S. at 329. That is the appropriate course "unless it is evident that [Congress] would not have enacted" the valid provisions "independently of that which is invalid." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010) (brackets and quotation marks omitted); *see also Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018) (to hold that provisions are not severable, "it must be evident that Congress would not have enacted those provisions which are within its power, independently of those which are not") (brackets and quotation marks omitted).

2. Here, the intent inquiry is straightforward. If Section 5000A(a) is now viewed as an unconstitutional command to purchase health insurance, it is one that the 2017 Congress plainly intended to make unenforceable. By reducing the amount of the alternative tax imposed by Section 5000A(b)-(c) to zero, Congress eliminated the only potential consequence for choosing not to maintain healthcare coverage. At the same time, it left every other provision of the ACA in place. In

these unique circumstances, there is no need to hypothesize about whether Congress "would have preferred" to preserve the rest of the ACA if it had known that the minimum coverage provision could not be enforced. *Free Enter.*, 561 U.S. at 509. That is the exact situation that the 2017 Congress itself created. In other words, in this case we already know—for certain—that Congress would "have preferred what is left" of the ACA to "no [Act] at all." *Ayotte*, 546 U.S. at 330; *see also Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 560 (Scalia, J., dissenting) ("One determines what Congress would have done by examining what it did.").

Unsurprisingly, other standard indicia of severability yield the same result. The ACA is "fully operative" without an enforceable requirement to maintain healthcare coverage. *Free Enter.*, 561 U.S. at 509 (quotation marks omitted).[28] The ACA will function in exactly the manner that the 2017 Congress envisioned

[28] Some courts have treated this inquiry as a proxy for legislative intent. *See New Mexico v. Dep't of Interior*, 854 F.3d 1207, 1233 n.10 (10th Cir. 2017). Some justices and judges have concluded that it is a separate step in the severability analysis (while recognizing that the two questions are closely related). *See NFIB*, 567 U.S. at 691-694 (joint dissent); *see also PHH Corp. v. Consumer Fin. Prot. Bureau*, 881 F.3d 75, 199 (D.C. Cir. 2018) (en banc) (Kavanaugh, J., dissenting). Under either view, the result here is the same.

whether or not this Court declares Section 5000A(a) unconstitutional. In either event, no one will pay a tax for not maintaining healthcare coverage.

The circumstances surrounding the 2017 amendment provide additional evidence that Congress would not have wanted to completely invalidate the ACA, had it known that reducing Section 5000A(b)-(c)'s tax to zero would make 5000A(a) unconstitutional. By the time of that amendment, Congress was well aware of the far-reaching consequences that would result from making major changes to the ACA. Over twelve million Americans were receiving healthcare coverage through the ACA's expansion of Medicaid, and eight million others were using ACA-funded tax credits to purchase insurance through the Act's Exchanges. ROA.365-366, 1134; *see also supra* 7 & n.5. The ACA forbade insurers from denying coverage to the 133 million Americans with pre-existing conditions and from charging them more because of their health status. ROA.1131, 1149-1183, 1210. Young adults were allowed to stay on their parents' insurance plans through age 26, 42 U.S.C. § 300gg-14; and insurers could not cap the total value of services provided to individuals over the course of a lifetime, *id.* § 300gg-11. States and local communities were also receiving billions of dollars each year through the ACA, which they used to expand access to healthcare and fight emerging public health threats such as the opioid epidemic. ROA.1144-1147, 1151-1183.

At the same time, a series of reports issued by the Congressional Budget Office and others had underscored for Congress how harmful it would be to dismantle the ACA. *See generally* ROA.1147-1183, 1224-1227. For example, even partially repealing the Act would have left 32 million more people without healthcare coverage by 2026. Cong. Budget Office, *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017* (July 19, 2017).[29] Premiums in the individual market would have doubled over the same period. *Id.* Undoing the ACA's reforms also would have seriously undermined public health. In Pennsylvania, for example, rescinding just the Medicaid expansion and tax-credit provisions would have resulted in 3,425 premature deaths each year. Stier, Pennsylvania Budget and Policy Ctr., *Devastation, Death, and Deficits: The Impact of ACA Repeal on Pennsylvania* at 1 (Jan. 19, 2017).[30] Medicare's ability to make payments to Medicare Advantage plans—through which 19 million seniors receive healthcare—would have been called into question, because of the ACA's reforms to that payment system. ROA.1146-1147, 1226-1227. Uncompensated care costs would have increased by more than a trillion dollars

[29] *Available at* https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[30] *Available at* https://pennbpc.org/sites/pennbpc.org/files/Impact_of_ACA_Repeal_Final.pdf.

over the course of a decade, stressing financial markets, state budgets, and hospitals. Blumberg, et al., Urban Inst., *Implications of Partial Repeal of the ACA Through Reconciliation* at 2 (Dec. 2016).[31] And about 2.6 million jobs would have been lost as a result of abolishing just the Medicaid expansion and tax-credit provisions. Ku, et al., The Commonwealth Fund, *Repealing Federal Health Reform: Economic and Employment Consequences for States* at 4 (Jan. 2017).[32]

There is no reason to believe that Congress would have chosen to incur these and similar costs as a preferred remedy in this case. On the contrary, there is every indication that it wanted to preserve the rest of the ACA when it reduced the amount of the tax imposed by Section 5000A(b)-(c) to zero. Indeed, a full repeal of the Act was not even an option under the procedural mechanism that Congress used to make that change. The 2017 Congress amend Section 5000A through budget reconciliation, a specialized procedure that allows the Senate to consider certain tax, spending, and debt-limit legislation on an expedited basis, but which may not be used to pass laws unrelated to reducing the deficit. *See* Heniff, Cong.

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[31] *Available at* https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

[32] *Available at* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jan_ku_aca_repeal_job_loss_1924_ku_repealing_federal_hlt_reform_ib.pdf.

Research Serv., *The Budget Reconciliation Process: The Senate's "Byrd Rule*" at 1 (Nov. 22, 2016).[33] Several provisions of the ACA could not have been repealed using this mechanism. *See* U.S. Senate, S. Comm. on the Budget, *Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff*.[34] Thus, even if it were remotely plausible that the 2017 Congress would have preferred repealing the entire ACA to eliminating just the minimum coverage provision, under the procedural circumstances of this case that choice was not even on the table.

Moreover, by the time the 2017 Congress voted to reduce Section 5000A's alternative tax to zero, it had considered and rejected—sometimes in close and dramatic votes—several bills that would have repealed major provisions of the ACA. *See supra* 11-12 (recounting the 2017 Congress's efforts to change the ACA). And members of Congress who voted to zero-out the tax—thus rendering the minimum coverage provision unenforceable—repeatedly disclaimed any intent to affect any other provision of the Act. For example:

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[33] *Available at* https://fas.org/sgp/crs/misc/RL30862.pdf. *See also* 2 U.S.C. § 644 (provisions are "extraneous" if they produce changes in outlays or revenues "which are merely incidental to the non-budgetary components of the provision").

[34] *Available at* https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21%5B1%5D.pdf. *See also* Pear, *Senate Rules Entangle Bid to Repeal Health Care Law*, N.Y. Times, Nov. 12, 2015, https://www.nytimes.com/2015/11/13/us/senate-rules-entangle-bid-to-repeal-health-care-law.html.

- Senator Orrin Hatch, Chairman of the Senate Finance Committee, explained that "repealing the tax does not take anyone's health insurance away. . . . The bill does nothing to alter Title I of [the ACA], which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits." *Continuation of the Open Executive Session to Consider an Original Bill Entitled the Tax Cuts and Jobs Act Before the S. Comm. on Fin.*, U.S. Senate, 115th Cong., Nov. 15, 2017, at 106, 286.

- Senator Shelley Moore Capito emphasized that "[n]o one is being forced off of Medicaid or a private health insurance plan . . . . By eliminating the individual mandate, we are simply stopping penalizing and taxing people who either cannot afford or decide not to buy health insurance plans." 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017).

- Senator Tim Scott told his colleagues that the 2017 tax act "take[s] nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage—it does not have a single letter in there about preexisting conditions or any actual health feature." 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017).

Under these circumstances, the district court's remedial order, invalidating the entire ACA, goes far beyond what the record, the law, or logic could support. *Cf. Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001) (Congress does not "hide elephants in mouseholes").

If a remedy is needed in this case, the one that best comports with congressional intent would be a judicial order mirroring what Congress itself did: eliminating any enforcement of the minimum coverage provision, but not more. Such an order would "nullify [no] more of [the] legislature's work than necessary," "limit the solution to the problem," and respect Congress's wishes. *Ayotte*, 546 U.S. at 328-329. An alternative would be to invalidate the amendment that created

the constitutional infirmity (Section 11081 of the 2017 tax act), restore the alternative tax set by Section 5000A(c) to its original amount, and preserve the ACA as sustained in *NFIB*. *See Frost v. Corp. Comm'n of State of Okla.*, 278 U.S. 515, 526-527 (1929) (where amendment rendered previously valid statute unconstitutional, Court held that amendment was a "nullity" and original statute "must stand as the only valid expression of the legislative intent"); *cf. Truax v. Corrigan*, 257 U.S. 312, 341-342 (1921).[35] Of course, that approach would resurrect a tax that the political branches decided to reduce to zero. But even that anomalous result would do far less violence to congressional intent than the sweeping remedy adopted by the district court.

3. The district court arrived at the wrong remedy in part because it focused on the "intent manifested by the 2010 Congress" as to whether Section 5000A(a) could be severed from the rest of the ACA. ROA.2647. The court reasoned that it was "the intent of the ACA-enacting Congress" that "control[led]," ROA.2662, apparently because "the test for severability is often stated" as whether "the Legislature would . . . have enacted those provisions which are within its power,

[35] *See also Med. Ctr. Pharmacy v. Mukasey*, 536 F.3d 383, 401 (5th Cir. 2008) (if an act of amendment is invalid, "the act is *void ab initio*, and it is as though Congress has not acted at all").

independently of that which is not," ROA.2646 (quoting *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987)).

Even on its own terms, the district court's analysis of congressional intent is flawed. The 2010 Congress did not express any "unambiguous intent" that the minimum coverage provision in Section 5000A(a) "not be severed" from the rest of the ACA. ROA.2647. Indeed, the "lion's share" of the Act has "nothing to do with private insurance, much less the mandate that individuals buy insurance." *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1322 (11th Cir. 2011), *aff'd in part, rev'd in part on other grounds by NFIB*, 567 U.S. 519. It is perhaps a closer question whether the 2010 Congress would have adopted the guaranteed-issue and community-rating requirements without an enforceable minimum coverage provision. *See id.* at 1323. But even with respect to those reforms, the answer is not "*evident.*" *Id.* at 1327. That is true even though Congress "found" that the minimum coverage provision was "an essential part" of its "regulation of the health insurance market." ROA. 2649 (quoting 42 U.S.C. § 18091(2)(H)). That finding was made to support a conclusion that the provision was "commercial and economic in nature, and substantially affect[ed] interstate commerce." 42 U.S.C. § 18091(1). As the Eleventh Circuit concluded, language "respecting Congress's constitutional authority does not govern, and is not

particularly relevant to, the different question of severability." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1326.

In any event, the intent of the 2010 Congress is not the question here. Where a court strikes down part of a statute that has not changed since it was first adopted, the severability inquiry focuses on the intent of the enacting Congress. *See, e.g.*, *Free Enter.*, 561 U. S. 508-510. But that is not the relevant inquiry where the original statutory structure is held to be constitutional, and then a later Congress amends the law in a way that turns out to make a particular provision constitutionally infirm. In that situation, it makes no sense to ask what the original Congress would have preferred as a remedy had it known what the later Congress would do. The question is the intent of the amending Congress. In some cases, the answer might in theory be that if Congress knew it could not change the law in the way it wanted, it would have repealed the entire law. More commonly, it will be that the amending Congress would, as usual, want a court to be as circumspect as possible in crafting a narrow response to the particular problem that has been identified. The latter course is the correct one here.

The district court's brief analysis of the intent of the 2017 Congress relied principally on the fact that Congress did not repeal the minimum coverage provision (26 U.S.C. § 5000A(a)), or the jurisdictional finding from 2010 that the provision was an "essential part" of Congress's "regulation of the health insurance

market" (42 U.S.C. § 18091(2)(H)). *See* ROA.2662-2663. But the lack of any change to those provisions is not evidence that the 2017 Congress had "no intent" with respect to severability, should its decision to zero-out Section 5000A(b)-(c)'s alternative tax render the minimum coverage provision unconstitutional. ROA.2664. Still less does it show any affirmative intent on the part of that Congress that the minimum coverage provision "not be severed" from the entire rest of the ACA. ROA.2647. On the contrary, as discussed above, the evidence of congressional intent is plain from what the 2017 Congress actually did to the statute. It reduced the tax amount to zero, thus rendering the coverage provision unenforceable, but made no change to any of the Act's many other provisions. *See supra* 34-35. That is powerful evidence that the remedy that the 2017 Congress would have wanted in this case is one that, in all but the most formal sense, preserves the law precisely as that Congress left it.

Similarly, Congress's failure to "repudiate or otherwise supersede" the Supreme Court's decisions in *NFIB* and *King v. Burwell*, 135 S. Ct. 2480 (2015), does not show that it implicitly endorsed the view that the minimum coverage provision was indispensable to the rest of the ACA. ROA.2663. Those decisions recount the considerations that led the *2010* Congress, in the course of setting up the ACA system in the first instance, to adopt a tax as a means of enforcing the minimum coverage requirement. *See, e.g.*, *NFIB*, 567 U.S. at 547-548 (Roberts,

C.J.); *King*, 135 S. Ct. at 2485-2487. The 2017 Congress made a different choice, in light of different circumstances.

Indeed, by 2017, years of experience with the ACA had shown Congress that the individual insurance markets could now be "fully operative" without imposing any legal consequence on those who did not maintain healthcare coverage. *Free Enter.*, 561 U.S. at 509 (quotation marks omitted). According to the current Administration's Council of Economic Advisers, for example, "the common argument that the individual mandate is valuable is misguided." Council of Economic Advisers, *Deregulating Health Insurance Markets: Value to Market Participants* at 5 (Feb. 2019) ("CEA Report").[36] The ACA includes "large . . . premium subsidies," which are "far more important" to the proper functioning of the individual markets. *Id.* And the same message was delivered to the 2017 Congress shortly before it amended the ACA. In a November 2017 report, the Congressional Budget Office concluded that the individual "insurance markets would continue to be stable in almost all areas of the country throughout the coming decade" even if the "individual mandate penalty" were eliminated. Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated*

[36] *Available at* https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf.

Estimate at 1 (Nov. 2017).[37] So when Congress decided to zero-out the alternative tax amount in Section 5000A, it had no intention of condemning the individual markets to "failure." ROA.2657. Instead, having decided repeatedly *not* to repeal major components of the ACA, it adopted a policy change that kept in place the Act's subsidies, guaranteed-issue, and community-rating reforms, Medicaid expansion, Medicare reforms, and myriad other provisions, while reducing one perceived regulatory burden by setting the tax on those who chose to forgo healthcare coverage at zero. *See also* CEA Report at 9 (tax "not needed to support the guaranteed issue of community-rated health insurance to all consumers, including those with preexisting conditions," because the "ACA premium subsidies stabilize the exchanges").

* * *

There is, of course, no need to reach the question of severability in this case. A provision that offers individuals a choice between buying health insurance and suffering no legal consequences for not doing so neither imposes any legal injury

[37] *Available at* https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf. *See also* Cong. Budget Office, *Options for Reducing the Deficit: 2017 to 2016* at 227 (Dec. 2016), *available at* https://www.cbo.gov/system/files?file=2018-09/52142-budgetoptions2.pdf (adverse selection problem created by repeal of individual mandate would be "mitigated" by premium subsidies, which "would greatly reduce the effect of premium increases on coverage among subsidized enrollees")

nor violates the Constitution. But even if it did, under the circumstances of this case the only appropriate remedy would be the one that Congress itself effectively selected: making that provision—and only that provision—unenforceable.

CONCLUSION

The district court's judgment should be reversed.

Dated: March 25, 2019

Respectfully submitted,

s/ Samuel P. Siegel

Xavier Becerra
Attorney General of California
Edward C. DuMont
Solicitor General
Michael L. Newman
Senior Assistant Attorney General
Michael J. Mongan
Samuel P. Siegel
Deputy Solicitors General
Kathleen Boergers
Supervising Deputy Attorney General
Nimrod P. Elias
Neli N. Palma
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
1300 I Street
Sacramento, CA 95814
(916) 210-6269
Sam.Siegel@doj.ca.gov
Attorneys for the State of California

(Additional Counsel Listed on Next Page)

William Tong
Attorney General of Connecticut
Joseph Rubin
Associate Attorney General
Attorneys for the State of Connecticut

Kathleen Jennings
Attorney General of Delaware
Ilona Kirshon
Deputy State Solicitor
Jessica M. Willey
David J. Lyons
Deputy Attorneys General
Attorneys for the State of Delaware

Clare E. Connors
Attorney General of Hawaii
Robert T. Nakatsuji
Deputy Solicitor General
Attorneys for the State of Hawaii

Kwame Raoul
Attorney General of Illinois
David F. Buysse
Deputy Chief, Public Interest Division
Matthew V. Chimienti
Assistant Attorney General, Special Litigation Bureau
Attorneys for the State of Illinois

Andy Beshear
Attorney General of Kentucky
La Tasha Buckner
Assistant Deputy Attorney General
S. Travis Mayo
Executive Director, Office of Civil and Environmental Law
Taylor Payne
Assistant Attorney General
Attorneys for the Commonwealth of Kentucky

Maura Healey
Attorney General of Massachusetts
Stephen B. Vogel
Assistant Attorney General
Attorneys the Commonwealth of Massachusetts

Keith Ellison
Attorney General of Minnesota
Scott Ikeda
Assistant Attorney General
Attorneys for the State of Minnesota, by and through its Department of Commerce

Gurbir S. Grewal
Attorney General of New Jersey
Matthew J. Berns
Assistant Attorney General
Kimberly A. Cahall
Deputy Attorney General
Attorneys for the State of New Jersey

Letitia James
Attorney General of New York
Barbara D. Underwood
Solicitor General
Steven C. Wu
Deputy Solicitor General
Lisa Landau
Bureau Chief, Health Care Bureau
Elizabeth Chesler
Assistant Attorney General, Health Care Bureau
Attorneys for the State of New York

Joshua H. Stein
Attorney General of North Carolina
Sripriya Narasimhan
Deputy General Counsel
Attorneys for the State of North Carolina

Ellen F. Rosenblum
Attorney General of Oregon
Henry Kantor
Special Counsel to the Attorney General
Scott Kaplan
Assistant Attorney General
Attorneys for the State of Oregon

Peter F. Neronha
Attorney General of Rhode Island
Michael W. Field
Assistant Attorney General
Maria R. Lenz
Assistant Attorney General
Attorneys for the State of Rhode Island

Thomas J. Donovan, Jr.
Attorney General of Vermont
Benjamin D. Battles
Solicitor General
Attorneys for the State of Vermont

Mark R. Herring
Attorney General of Virginia
Toby J. Heytens
Solicitor General
Matthew R. McGuire
Principal Deputy Solicitor General
Attorneys for the Commonwealth of Virginia

Robert W. Ferguson
Attorney General of Washington
Jeffrey G. Rupert
Chief, Complex Litigation Division
Jeffrey T. Sprung
Assistant Attorney General
Attorneys for the State of Washington

Karl A. Racine
Attorney General for the District of Columbia
Loren L. AliKhan
Solicitor General
Caroline S. Van Zile
Deputy Solicitor General
Attorneys for the District of Columbia

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 10,841 words, according to the count of Microsoft Word. I further certify that this brief complies with typeface and style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared in Microsoft Word using 14-point Times New Roman font.

Dated: March 25, 2019

/s Samuel P. Siegel
Samuel P. Siegel

CERTIFICATE OF SERVICE

I certify that on March 25, 2019, I electronically filed the forgoing document with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: March 25, 2019

/s Samuel P. Siegel
Samuel P. Siegel

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 & 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
No. 4:18-cv-167-O
Hon. Reed O'Connor, Judge

STATE DEFENDANTS' REPLY BRIEF

Counsel listed on the inside cover

Xavier Becerra
Attorney General of California
Edward C. DuMont
Solicitor General
Michael L. Newman
Senior Assistant Attorney General
Michael J. Mongan
Samuel P. Siegel
Deputy Solicitors General
Kathleen Boergers
Supervising Deputy Attorney General
Nimrod P. Elias
Neli N. Palma
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
1300 I Street
Sacramento, CA 95814
(916) 210-6269
Sam.Siegel@doj.ca.gov
Attorneys for the State of California

May 22, 2019

Additional Counsel Listed on Signature Page

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INTRODUCTION

Plaintiffs assert that this "case is not about whether the ACA is good or bad policy," but rather about "the proper text-based interpretation of statutes." Texas Br. 3. Yet they ask this Court to do what Congress—after years of debate and deliberation—repeatedly refused to do: dismantle the entire Affordable Care Act. It is no secret that the plaintiffs, and their new-found allies in the federal Executive Branch, oppose the ACA as a policy matter—even though it has fundamentally changed our nation's healthcare system and provided access to high-quality, affordable healthcare coverage to tens of millions of Americans. But they can articulate no plausible legal ground for the breathtakingly broad policy change that they ask this Court to uphold under the guise of constitutional adjudication.

The standing and merits arguments advanced by plaintiffs depend on construing the ACA's minimum coverage provision, 26 U.S.C. § 5000A, as a stand-alone command to buy health insurance. The Supreme Court, however, already interpreted that provision not as a command but as offering individuals a "lawful choice" between maintaining healthcare coverage or paying a tax. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 574 (2012) (*NFIB*). Congress has since reduced the amount of the alternative tax to zero, meaning that there is presently no adverse legal consequence—tax or otherwise—for not having healthcare coverage. The individual plaintiffs thus suffer no legally cognizable

harm from Section 5000A in its present form. And while the state plaintiffs allege that the amended provision will cause them financial injury, they have failed to support that allegation with the type of evidence necessary to establish Article III standing.

As to the merits, plaintiffs and the federal defendants insist that Congress's decision to zero-out the alternative tax requires this Court to read Section 5000A(a) in isolation as containing an unconstitutional "command to buy insurance." Hurley Br. 38. But it remains fairly possible to construe Section 5000A as a whole in a way that does not impose any such mandate. After the 2017 amendment, Section 5000A may be understood as a precatory provision, encouraging individuals to maintain coverage without imposing any legal consequence if they do not. Or it may be understood as a tax provision, which Congress decided to leave on the books but, for the moment, not to use for generating revenue. Either of these approaches preserves the constitutionality of Section 5000A. Plaintiffs' approach, on the other hand, is calculated to destroy it. And the legal rule—underscored in this very context by *NFIB*—is that courts must construe statutes to uphold them if they can.

Even if the minimum coverage provision in Section 5000A(a) were now invalid, the proper remedy would be limited to that provision. Plaintiffs and the federal defendants emphasize statutory findings that, for example, state that the

requirement to maintain healthcare coverage was "essential to creating effective health insurance markets," 42 U.S.C. § 18091(2)(I). But those findings expressed the reasons why the 2010 Congress believed the statute was within its Commerce Clause power. They are not an expression of congressional intent on the separate issue of severability. More importantly, plaintiffs ignore that when Congress amended Section 5000A in 2017, it affirmatively chose to make the minimum coverage provision effectively unenforceable by zeroing-out the alternative tax, while leaving the rest of the ACA in place. Under these circumstances, it is apparent what remedy the 2017 Congress would have wanted for any constitutional problem created by that change. An order declaring Section 5000A(a) invalid but severing it from the rest of the ACA would result in essentially the same situation that Congress itself created. In contrast, the remedy plaintiffs seek—a judicial order striking down the entire ACA, causing massive disruption and harming tens of millions of Americans—has no possible basis in congressional intent.

ARGUMENT

I. THE PLAINTIFFS DO NOT HAVE STANDING

The individual plaintiffs recognize that Section 5000A no longer imposes any "monetary penalty" on those who do not maintain healthcare coverage. Hurley Br. 29. But they insist that they have standing to challenge that provision because it now "compel[s] them to purchase health insurance." *Id.* at 15-16; *see also id.* at

20-22 (arguing that the individual plaintiffs have standing because "they are the object of the ACA's individual mandate to purchase health insurance").

That contention cannot be squared with the Supreme Court's construction of Section 5000A. *See* State Defs. Br. 25-26; House Br. 13-16, 21-28. As *NFIB* held, Section 5000A as a whole is not a "legal command to buy insurance." 567 U.S. at 563 (Roberts, C.J.). Instead, it offers individuals a choice between obtaining healthcare coverage or paying a tax. *Id.* at 574 & n.11. Now that Congress has reduced the tax amount to zero, Section 5000A does not impose any legally cognizable harm on those who choose not to maintain coverage. If the individual plaintiffs decide to "spend their own hard-earned money" on health insurance that they do not "want or need," Hurley Br. 16, 19, that volitional act will not establish a cognizable injury for Article III purposes. *See, e.g.*, *Glass v. Paxton*, 900 F.3d 233, 238 (5th Cir. 2018) ("We know that standing cannot be conferred by a self-inflicted injury.").[1]

[1] On appeal, the individual plaintiffs for the first time argue in passing that Section 5000A injures them by requiring them to report on their tax returns "that they have complied with the individual mandate." Hurley Br. 19; *see also id.* at 21. They do not explain how the provision requires them to report anything, why any reporting requirement imposes a cognizable harm, or how any such harm would be redressed by a decision holding Section 5000A(a) unenforceable.

The federal defendants concede that the individual plaintiffs do not face a "credible threat of enforcement" of Section 5000A. U.S. Br. 23.[2] They instead argue that *other* provisions of the ACA "impose concrete financial injuries" on the individual plaintiffs by increasing the cost of health insurance and limiting the kinds of plans that may be purchased. *Id.*; *see also* Hurley Br. 2-4, 9 (similar). But they do not address a recent decision from this Court that considered and rejected the same argument. In *Hotze v. Burwell*, 784 F.3d 984, 995 (5th Cir. 2015), an individual plaintiff challenged the constitutionality of Section 5000A and sought to establish injury based on "increased health-insurance premiums." This Court held that such an "injury must be 'fairly traceable' to the statutory provision that Dr. Hotze seeks to challenge." *Id.* The plaintiff could not establish standing because he did not show that the asserted injury was "traceable to the individual mandate, instead of to the ACA generally." *Id.*[3] The same is true here: neither the plaintiffs

[2] The lack of any possibility of enforcement against any of the plaintiffs (individual or state) means that the result as to justiciability would be the same if the matter were analyzed as a question of statutory jurisdiction under the Declaratory Judgment Act, as suggested by Professors Bray, McConnell, and Walsh. *See* Br. of Samuel Bray, et al. (ECF No. 514897527); *see generally Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 671-672 (1950). As that brief argues (at 5), in this case the statutory question "overlaps with the absence of Article III jurisdiction owing to the absence of a true case or controversy."

[3] In addition, the asserted harm based on "increased health-insurance premiums [was] a paradigmatic 'generalized grievance'" that was insufficient to confer standing. *Hotze*, 784 F.3d at 995; *compare* U.S. Br. 23 ("[N]umerous provisions of the ACA operate to increase the cost of insurance for individuals like plaintiffs.").

nor the federal defendants have established that any injury arising from other provisions of the ACA is traceable to Section 5000A.

To the extent that plaintiffs advance the similar argument that they are injured by ACA provisions that are "inseverable" from Section 5000A, *e.g.*, Texas Br. 21, that argument is contrary to circuit precedent as well. The "normal rule" is that "severability analysis should almost always be deferred until after the determination that the portion of a statute that a litigant has standing to challenge is unconstitutional." *Nat'l Fed'n of the Blind of Texas, Inc. v. Abbott*, 647 F.3d 202, 211 (5th Cir. 2011). Thus, the district court in *National Federation* erred when it held that the plaintiffs had standing to challenge a statutory provision that did not harm them on the theory that it was inseverable from a provision that did. *See id.* at 209-211.[4] Extraordinary circumstances may occasionally justify a departure from this normal rule. *See id.* at 211 (discussing *I.N.S. v. Chadha*, 462 U.S. 919,

[4] The federal defendants attempt to distinguish *National Federation* by arguing that the plaintiffs in that case "sought to challenge the constitutionality of a provision that *did not actually apply to them*." U.S. Br. 24-25 (emphasis in original). But the challenged provision did not "apply" to those plaintiffs in much the same way that Section 5000A does not apply to the individual plaintiffs here: under the circumstances, there was no evidence that it caused them any actual "injury-in-fact." 647 F.3d at 209. In that case, like this one, the plaintiffs asked the Court to address the constitutionality of a provision that did not harm them on the theory that it was inseverable from other provisions of the challenged law that allegedly did harm them. *Id.* This Court properly declined to do so.

931 & n.7 (1983)). But plaintiffs do not identify any such circumstance here. *See generally* Walsh, *The Ghost that Slayed the Mandate*, 64 Stan. L. Rev. 55, 75, 77 (2012) (theory of "standing-through-asserted-inseverability" would reduce standing doctrine "to a sport for clever counsel").[5]

The state plaintiffs also assert that Section 5000A harms them directly, on the theory that it "increases State outlays" by requiring individuals to "obtain health insurance" and "forc[ing] individuals into the States' Medicaid and CHIP programs." Texas Br. 20. Even before Congress amended Section 5000A, however, the law did not *compel* anyone to enroll in Medicaid or CHIP. More importantly, the state plaintiffs have not provided any sufficient factual basis to support their allegation that Section 5000A in its current form will cause their residents to seek coverage through Medicaid or CHIP. They rely entirely on two Congressional Budget Office reports. *See* Texas Br. 20. One report was written 15 months before the ACA became law; the other predicted that "only a small number of people who enroll in insurance because of the mandate under current law would

[5] *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987), does not require a different result. *See* Texas Br. 22 n.2. The Supreme Court did not address whether the legislative-veto provision at issue in that case injured the plaintiffs before deciding whether it was constitutional. Issues not ruled on are "'not to be considered as having been . . . decided'" merely because they might "'lurk in the record.'" *Thomas v. Texas Dep't of Criminal Justice*, 297 F.3d 361, 370 n.11 (5th Cir. 2002).

continue to do so" if Section 5000A's alternative tax were reduced to zero. Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* at 1 (Nov. 2017) (CBO Report).[6] While financial harm to States can certainly be a valid basis for Article III standing, the speculative assertions advanced by the state plaintiffs here fall well short of the "concrete evidence" necessary to establish it in a particular case. *Crane v. Johnson*, 783 F.3d 244, 252 (5th Cir. 2015). *Compare Texas v. United States*, 787 F.3d 733, 748, 752 (5th Cir. 2015) (state introduced evidence that up to 500,000 individuals would become eligible for driver's licenses because of a federal policy, and that it spent $130.89 on each license).[7]

II. THE MINIMUM COVERAGE PROVISION REMAINS CONSTITUTIONAL

On the merits, this case involves an unusual situation. As plaintiffs and the federal defendants point out, one "straightforward reading" of Section 5000A(a),

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[6] *Available at* https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[7] Like the individual plaintiffs, *see supra* 4 n.1, the state plaintiffs argue for the first time on appeal that they are injured by the "IRS reporting requirements occasioned by the ACA's mandate." Texas Br. 23. But nowhere in the "reams of evidence" they submitted to the district court (Texas Br. 18) did the state plaintiffs provide any concrete evidence establishing particular compliance costs. In addition, the reporting requirements identified by the state plaintiffs are imposed by provisions of the ACA other than Section 5000A. *See* 26 U.S.C. §§ 6055, 6056. The state plaintiffs have not demonstrated how a declaration that Section 5000A(a) is unconstitutional would remedy these purported harms.

standing by itself, would be that "it commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562 (Roberts, C.J.); *see also* U.S. Br. 8; Texas Br. 34-35; Hurley Br. 46. They acknowledge, however, that in *NFIB* the Supreme Court expressly rejected the approach of reading Section 5000A(a) as a stand-alone provision. The Court instead construed Section 5000A as a whole as offering individuals a lawful choice between obtaining healthcare coverage or paying a tax. 567 U.S. at 574 & n.11. And it did so because courts "have a duty to construe a statute to save it, if fairly possible." *Id.* at 574 (Roberts, C.J.).

In 2017, Congress amended Section 5000A by reducing to zero the amount of the tax that individuals may pay in lieu of maintaining healthcare coverage. Plaintiffs and the federal defendants point out that so long as the amount of this alternative tax remains at zero, Section 5000A will raise no revenue. They argue that, consequently, the provision as a whole can no longer be read as an exercise of the taxing power, and that Section 5000A(a) now *must* be read as an unconstitutional stand-alone "command to buy insurance." Hurley Br. 38. And they seek a judicial order declaring not only that Section 5000A(a) is unconstitutional, but that the rest of the Affordable Care Act must fall as well. *See Id.* at 38-50; Texas Br. 28-50; U.S. Br. 29-49; *see also* ROA.2640-2665.

This argument is directly contrary to *NFIB*'s command that courts must "construe a statute to save it, if fairly possible." 567 U.S. at 574 (Roberts, C.J.).

As the state defendants and the House have demonstrated, nothing about the 2017 amendment requires abandoning the holistic construction of Section 5000A already adopted by the Supreme Court. *See* State Defs. Br. 27-28; House Br. 35-38. The provision continues to offer individuals a choice about whether or not to maintain specified healthcare coverage. *See NFIB*, 567 U.S. at 574. The only difference is that now the amount of the tax imposed for choosing not to maintain coverage has been reduced to zero. That change renders Section 5000A no more than precatory, and certainly not enforceable. But it does not change the statutory structure or require any change in the constitutional analysis.

Neither plaintiffs nor the federal defendants explain why Section 5000A cannot now be understood as a precatory provision. Plaintiffs do not even respond to this argument. For their part, the federal defendants argue that continuing to interpret Section 5000A as offering a choice would permit individuals to "ignore a legislative mandate to engage in certain conduct." U.S. Br. 35. But the whole point is that so long as Congress keeps the alternative tax set to zero, Section 5000A imposes no legislative "mandate" at all. So construed, Section 5000A is no more constitutionally problematic than many other provisions adopted by Congress that declare, exhort, or encourage, but do not impose any enforceable requirement or prohibition. *See* State Defs. Br. 28-29 & n. 23 (collecting examples); House Br. 37 (same). The federal defendants attempt to distinguish these examples on the

ground that they use the word "should" while Section 5000A(a) retains the word "shall," U.S. Br. 34-35, but that misses the point. What all of these statutes have in common is that none imposes any legal consequence for doing or not doing the activity that the statue encourages or discourages.

There is nothing "gratuitous" or "inappropriate" (U.S. Br. 34) about preserving a statutory provision that has no current mandatory or prohibitory effect. Indeed, that kind of provision is quite common in the United States Code. In addition to the many "sense of Congress" provisions discussed in the opening briefs, Congress frequently adopts "statutory findings" (like the ones that plaintiffs rely on so heavily here, *see infra* 18-20). Statutory findings merely "reveal[] the rationale of the legislation," without affecting primary conduct any "more than the reports of the Congressional committees." *United States v. Carolene Products Co.*, 304 U.S. 144, 152, 153 (1938). Congress also regularly adopts severability clauses. *See, e.g.*, 15 U.S.C. § 719n ("If any provision of this chapter . . . is held invalid, the remainder of the chapter shall not be affected thereby."). Severability provisions often speak in mandatory terms, but courts treat them as an interpretative aid, "'not an inexorable command.'" *Reno v. Am. Civil Liberties Union*, 521 U.S. 844, 884 n.49 (1997). Other statutory provisions remain on the books but have no current effect, because of intervening events or the passage of time. *See, e.g.*, 4 U.S.C. § 1 ("[T]he union of the [United States] flag

shall be forty-eight stars, white in a blue field."); 26 U.S.C. § 5000A(c)(2)(B)(i)-(ii) (detailing the amount of the alternative tax for the 2014 and 2015 taxable years). But no one believes that these provisions are unconstitutional simply because they do not presently command or require anything.

Nor have plaintiffs or the federal defendants shown why Section 5000A cannot continue to be sustained under the Taxing Clause. Plaintiffs make no effort to reconcile their strict revenue-generation requirement with the fact that Congress routinely delays the start date of tax provisions or suspends collection of a tax for a period of time. *See* State Defs. Br. 31-32 (collecting examples). The federal defendants contend that Section 5000A is unlike taxes that have been delayed or suspended because it "will never raise any revenue." U.S. Br. 34. But there is nothing certain about that. Section 5000A will generate revenue again at any time that Congress decides to increase the amount of the tax above zero. In the meantime, there is nothing unconstitutional about leaving Section 5000A(a) on the books so that Congress can make that change easily if it decides to do so—perhaps through the same budget reconciliation process it used to zero out the tax in 2017. Indeed, maintaining the rest of the structure would seem to be the most efficient course.

Despite repeatedly insisting that a tax provision must raise revenue at all times, *e.g.*, Texas Br. 19, 32, 33, 34, 35, the plaintiffs fail to acknowledge that, in

United States v. Ardoin, 19 F.3d 177, 179-180 (5th Cir. 1994), this Court upheld a statute that had not produced revenue for several years as a lawful exercise of Congress's taxing powers. The federal defendants at least address *Ardoin*, attempting to distinguish it on the ground that the defendant there was "responsible for a tax payment of $200." U.S. Br. 32. But *Ardoin* is significant here because the government had stopped collecting the tax entirely, and this Court nonetheless upheld the provision. 19 F.3d at 179-180. That holding squarely refutes plaintiffs' theory that a statute must generate revenue at all times to be sustained as a proper exercise of Congress's taxing power.[8]

III. IF THE MINIMUM COVERAGE PROVISION IS NOW UNCONSTITUTIONAL, IT IS SEVERABLE FROM THE REST OF THE ACA

The federal defendants acknowledge both that severability is a question of congressional intent and that the "normal rule" is "partial, rather than facial, invalidation." U.S. Br. 36 (quoting *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010)). The plaintiffs similarly recognize that invalid provisions of a law should be severed unless it is "'evident' that Congress would have preferred no statute at all." Texas Br. 38 (quoting *Exec. Benefits Ins.*

[8] The federal defendants also observe that the tax at issue in *Ardoin* "could have been regulated" under Congress's Commerce Clause powers. U.S. Br. 32. That is true, but it does not undermine *Ardoin*'s significance to this case, because the Court also held that Congress could have adopted the statute under its "power to tax." *Ardoin*, 19 F.3d at 180.

Agency v. Arkison, 573 U.S. 25, 37 (2014)) (ellipses omitted). Nonetheless, they all urge this Court to take the extraordinary step of invalidating the entire Affordable Care Act to remedy a purported infirmity in a single statutory provision—a provision that Congress has already intentionally rendered unenforceable. There is no reason to believe that Congress would have wanted that result. *See* State Defs. Br. 34-40; House Br. 41-51.

1. The "touchstone for any decision about remedy is legislative intent." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006). Here we know for certain that Congress would have preferred "what is left" of the Affordable Care Act to "no [Act] at all." *Id.* Congress rendered Section 5000A(a) unenforceable in 2017 by eliminating the only statutory consequence for not maintaining healthcare coverage. At the same time, Congress left every other provision of the ACA in place. These circumstances allow us to "determine[] what Congress would have done by examining what it did." *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 560 (2001) (Scalia, J., dissenting). We know that Congress would have wanted to preserve the rest of the ACA even if Section 5000A(a) is not enforceable because that is the situation that Congress itself created.

That conclusion is confirmed by the fact that the ACA will continue to function in a manner that is precisely "consistent with the intent of Congress" even

if Section 5000A(a) is stricken. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987). By reducing the alternative tax to zero and leaving the rest of the ACA in place, Congress made a considered determination that it wanted a version of the Act without any enforceable requirement to maintain healthcare coverage. That is the exact statutory scheme that would result from a court order invalidating Section 5000A(a) on constitutional grounds.

The context surrounding the 2017 amendment further demonstrates that Congress's preferred remedy would not have been to invalidate the entire ACA. *Arkison*, 573 U.S. at 37. In the months before it reduced the alternative tax to zero, Congress considered—and rejected—several bills that would have repealed many of the Act's most important protections. *See* State Defs. Br. 11-12, 39; House Br. 7-8. As a result, Congress was well aware of the devastating consequences that would have resulted from repealing the ACA. *See* State Defs. Br. 36-38.[9] There is no reason to believe that Congress would have wanted to impose those costs had it known that reducing the alternative tax to zero would create a constitutional problem. On the contrary, several members of Congress who voted to zero-out the

[9] *See also* Br. of AARP, et al. (ECF No. 514897185); Br. of American Cancer Society, et al. (ECF No. 514896778); Br. of National Women's Law Center, et al. (ECF No. 514897602); Br. of American Medical Association, et al. (ECF No. 514896475); Br. of Families USA, et al. (ECF No. 514897533); Br. of American Association of People with Disabilities (ECF No. 514897614).

tax proclaimed that they were not "changing anything else." 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017) (statement of Sen. Pat Toomey); *see also* State Defs. Br. 39-40 (collecting additional statements). In any event, Congress well understood that it could not have repealed several of the ACA's most important protections under its own rules governing the budget reconciliation mechanism that it used to change the tax amount. *See* State Defs. Br. 38.

Together, these indicia of congressional intent establish that if Section 5000A(a) is now unconstitutional, the most appropriate remedy is one that reflects what Congress itself did: declare the minimum coverage provision unenforceable, but leave the rest of the ACA intact. *See* State Defs. Br. 40. Alternatively, this Court could eliminate any constitutional problem caused by the 2017 amendment by invalidating that amendment, thus restoring the alternative tax to its previous amount. *Id.* at 40-41 (citing *Frost v. Corp. Comm'n of State of Okla.*, 278 U.S. 515 (1929)).[10]

[10] The plaintiffs do not address *Frost*, and the federal defendants offer little response other than to assert that *Frost* is "inapposite," U.S. Br. 42. It is not. In *Frost*, an amendment to a previously valid statute rendered the law unconstitutional. *See* 278 U.S. at 525-526. The amendment was not "'unconstitutional itself.'" U.S. Br. 42. Rather, the Court concluded that an equal protection problem arose when the amendment dispensed with the requirement that some cotton gin operators make a showing of "public necessity" to obtain a license. *Frost*, 278 U.S. at 522-524. It was the fusing of that amendment with the "'original statute,'" U.S. Br. 42, that created the constitutional problem. If Section

2. Plaintiffs and the federal defendants agree that severability analysis turns on the question of congressional intent. *See* U.S. Br. 36-37; Texas Br. 36-37. And they appear to acknowledge that the relevant intent here is that of the 2017 Congress. *See* U.S. Br. 40; Texas Br. 39, 41-42. But their analysis of the intent of the 2017 Congress focuses almost entirely on the considerations that led the *2010* Congress to adopt the minimum coverage provision. *See* U.S. Br. 37-40; Texas Br. 38-50; Hurley Br. 47-50. They argue that the 2010 Congress would have wanted the entire Act to fall without an enforceable requirement to maintain healthcare coverage, and then seek to impute the intent of that Congress to its 2017 successor. *See* U.S. Br. 40, 43; Texas Br. 39, 41-42; Hurley Br. 48. That analysis is flawed at every step.

As a preliminary matter, it is not at all clear that the 2010 Congress would have preferred "no statute at all" over a remedy severing Section 5000A(a) from the rest of the ACA. *Ayotte*, 546 U.S. at 330; *see* State Defs. Br. 42-43; House Br. 51-53. It appears more likely that the 2010 Congress would have wanted to preserve many other ACA provisions. *See Florida ex rel. Atty. Gen. v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1320-1328 (11th Cir. 2011), *aff'd in*

5000A(a) is now unconstitutional, it is for the same reason: the 2017 amendment changed Section 5000A in a way that makes it invalid. *Frost* thus suggests that a permissible remedy here would be to declare the amendment a "nullity" and restore the statute to its former self. *Id.* at 526-527.

part, rev'd in part on other grounds by NFIB, 567 U.S. 519. As the Eleventh Circuit reasoned, most of the ACA has nothing to do with the individual market reforms, much less the requirement to choose between maintaining healthcare coverage or paying a tax. *Id.* at 1322. And it is not "*evident*" that Congress would have declined to adopt even the community-rating and guaranteed-issue reforms without an enforceable requirement to maintain healthcare coverage. *Id.* at 1327.

The statutory findings adopted by the 2010 Congress—such as the finding that the requirement to purchase minimum coverage was "essential to creating effective health insurance markets," 42 U.S.C. § 18091(2)(I); *see also id.* § 18091(2)(H), (J)—do not support a different conclusion. *See* Texas Br. 39-40; Hurley Br. 48; U.S. Br. 37-38. Statutory findings "aid[] informed judicial review, as do the reports of legislative committees, by revealing the rationale of the legislation." *Carolene Products*, 304 U.S. at 152. They are commonly used to memorialize a legislative judgment that a statute is within the scope of Congress's Commerce Clause power, by establishing that the regulated activity "'substantially affect[s] interstate commerce.'" *United States v. Morrison*, 529 U.S. 598, 612 (2000). And that was the clear purpose of the findings in 42 U.S.C. § 18091, which begins by pronouncing that the "individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce." 42 U.S.C. § 18091(1). This type of statutory finding "respecting

Congress's constitutional authority does not govern, and is not particularly relevant to, the different question of severability." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1326.

In any event, whatever these statutory findings tell us about the intent of the 2010 Congress, they do not establish that the 2017 Congress would have wanted Section 5000A(a) to be inseverable from the rest of the ACA. Even if the 2010 Congress believed that the ACA could not work without an enforceable requirement to maintain healthcare coverage, the 2017 Congress plainly had a different view. *See supra* 14-16. As discussed, the best evidence of Congress's intent on that point is "what it did." *Legal Servs. Corp.*, 531 U.S. at 560 (Scalia, J., dissenting). If Congress believed that the "individual mandate [was] essential" to the proper functioning of the entire ACA in 2017, U.S. Br. 37, it would not have left the rest of the Act in place when it reduced the alternative tax to zero. Focusing on what Congress actually did in 2017 is not an improper "effort to 'psychoanalyze those who enacted' the law." Hurley Br. 48; *see also* Texas Br. 3 (same). Rather, it is the best way of determining what that Congress actually "would have done" if faced with the remedial question before the Court. *Legal Servs. Corp.*, 531 U.S. at 560 (Scalia, J., dissenting).

Plaintiffs and the federal defendants discern a contrary intent from the fact that the 2017 Congress did not "amend[] or repeal[]" the statutory findings

discussed above. U.S. Br. 41; *see* Texas Br. 39. But those findings reflected the reasons why the 2010 Congress concluded that an enforceable requirement to maintain healthcare coverage was a proper exercise of the Commerce Clause power. *See supra* 18-19. By 2017, the Supreme Court had rendered them irrelevant by holding that Section 5000A(a) could not be justified under the Commerce Clause. *NFIB*, 567 U.S. at 547-558 (Roberts, C.J.); *id.* at 657 (joint dissent). The findings now have a status similar to that of the current Section 5000A: they remain on the books but have little or no current operative effect.[11] There was no need for the 2017 Congress to amend or repeal them in order to express its own intent—plainly conveyed by the 2017 amendment—that the rest of the ACA should remain in place even without an enforceable requirement to maintain healthcare coverage.

The federal defendants similarly emphasize that Congress left Section 5000A(a) "on the books" when it reduced the amount of the tax in Section 5000A(b)-(c) to zero. U.S. Br. 40-41. But that is not evidence of any intent that the provision would be inseverable from the rest of the ACA—any more than it shows an intent to depart from *NFIB*'s construction and turn subsection (a) into a

[11] It is not uncommon for statutory findings, reflective of the intent or rationale of a prior Congress on a matter that is no longer relevant, to remain in the United States Code. *See, e.g.*, 15 U.S.C. § 6601(a) (findings regarding dangers posed by "year 2000 computer date-change problems").

stand-alone command to maintain healthcare coverage. To the contrary, Congress's decision to make the minimum coverage provision unenforceable while leaving the balance of the ACA intact is a powerful indication that Congress wanted to preserve the Act's other provisions.

Plaintiffs also contend that the Supreme Court's decisions in *NFIB* and *King v. Burwell*, 135 S. Ct. 2480 (2015) support treating Section 5000A(a) as inseverable. *See* Texas Br. 42-44; *see also* U.S. Br. 38-40. Those decisions, however, were issued long before the 2017 amendment. They recount the considerations that led the 2010 Congress to adopt a tax as a means of enforcing the requirement to maintain healthcare coverage. *See NFIB*, 567 U.S. at 547-548 (Roberts, C.J.); *King*, 135 S. Ct. at 2485-2487. They do not—and could not—address the different question of whether the 2017 Congress would have wanted the rest of the ACA to fall without an enforceable requirement to maintain healthcare coverage. And the statutory changes that Congress actually made in 2017 plainly demonstrate its belief that the individual markets created by the ACA,

as well as the Act's many other provisions, could continue to function without such a requirement.[12]

That belief could be explained by the fact that, as an empirical matter, many of the concerns about "'adverse selection'" and the possibility of a "'death spiral'" that contributed to the decision to adopt Section 5000A in 2010 (Texas Br. 40) had largely dissipated by 2017. By that time, the individual markets were up and running, and experience had demonstrated that they could function effectively without a tax on those who chose not to maintain healthcare coverage. *See* State Defs. Br. 45-46; House Br. 49-50. The CBO predicted as much shortly before Congress amended Section 5000A, reporting that the individual insurance markets "would continue to be stable in almost all areas of the country throughout the coming decade" even without the "individual mandate penalty." CBO Report at 1.[13] And thus far, the individual market *has* continued to function without an enforceable requirement to maintain healthcare coverage. As compared with 2018

[12] For similar reasons, the brief regarding severability filed by the United States in *NFIB* in 2012 (*see* Texas Br. 39-43) is inapposite here. The analysis in that brief was based on the intent of the Congress that adopted the ACA, not the intent of the Congress that amended it.

[13] The state plaintiffs note that the CBO also projected that premiums in the individual market would "'ris[e] by 10% per year'" more than if the alternative tax had remained in effect. Texas Br. 44. But the CBO did not conclude that such an increase would make health insurance "prohibitively expensive," *id.*, much less cause the individual markets to "'blow up,'" *id.* at 41.

(the last year during which the alternative tax was collected), in 2019 insurer participation in the ACA's Exchanges increased or remained the same in most parts of the country; premium increases for the benchmark plans offered through the Exchanges were lower; and overall enrollment in those plans dipped by only three percent. Br. of Bipartisan Economic Scholars 26-30 (ECF No. 514897608).[14]

To be sure, the prediction that the individual markets can function effectively without an enforceable requirement to maintain healthcare coverage could, in time, turn out to be wrong. If so, then perhaps Congress will use the statutory structure left on the books in Section 5000A to reinstate a positive alternative tax as an incentive to individuals to maintain coverage. But speculation about how the ACA's individual markets may or may not function in the future does not provide any legal basis for a court to disregard the clear choice that the 2017 Congress

[14] *See also* Br. of America's Health Insurance Plans 25-29 (ECF No. 514896554) (explaining that the ACA's "preexisting-condition provisions would continue to function properly without the mandate in today's individual market"); Br. of Blue Cross Blue Shield Association 20-27 (ECF No. 514897500) (similar); Br. of the American Hospital Association, et al. 8-16 (ECF No. 514896636) (similar); Cong. Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* at 31 (May 2019), *available at* https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf (estimating that the individual market will "remain stable" over the "next decade").

made when it eliminated any enforcement of the minimum coverage provision while preserving every other part of the ACA.

* * *

Plaintiffs are right that this case is "not about whether the ACA is good or bad policy." Texas Br. 3. It is about the correct application of legal principles that limit the role and power of federal courts. The district court's order invalidating the entire Affordable Care Act "extend[s] judicial power . . . beyond its constitutional limits." Br. of Ohio and Montana 23 (ECF No. 514896372). The district court adjudicated the constitutionality of a statutory provision that does not harm anyone; rejected plausible interpretations of that statute that avoid any constitutional problem; and adopted a sweeping "remedy" that conflicts with the plain intent of Congress and would create chaos and harm tens of millions of Americans. Nothing in the law permits that result.

CONCLUSION

The judgment of the district court should be reversed.

Dated: May 22, 2019

Respectfully submitted,

s/ Samuel P. Siegel

Xavier Becerra
Attorney General of California
Edward C. DuMont
Solicitor General
Michael L. Newman
Senior Assistant Attorney General
Michael J. Mongan
Samuel P. Siegel
Deputy Solicitors General
Kathleen Boergers
Supervising Deputy Attorney General
Nimrod P. Elias
Neli N. Palma
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
1300 I Street
Sacramento, CA 95814
(916) 210-6269
Sam.Siegel@doj.ca.gov
Attorneys for the State of California

(Additional Counsel Listed on Next Page)

William Tong
Attorney General of Connecticut
Joseph Rubin
Assistant Deputy Attorney General
Attorneys for the State of Connecticut

Kathleen Jennings
Attorney General of Delaware
Ilona Kirshon
Deputy State Solicitor
Jessica M. Willey
David J. Lyons
Deputy Attorneys General
Attorneys for the State of Delaware

Clare E. Connors
Attorney General of Hawaii
Robert T. Nakatsuji
Deputy Solicitor General
Attorneys for the State of Hawaii

Kwame Raoul
Attorney General of Illinois
David F. Buysse
Deputy Chief, Public Interest Division
Matthew V. Chimienti
Assistant Attorney General, Special Litigation Bureau
Attorneys for the State of Illinois

Andy Beshear
Attorney General of Kentucky
La Tasha Buckner
Assistant Deputy Attorney General
S. Travis Mayo
Executive Director, Office of Civil and Environmental Law
Taylor Payne
Assistant Attorney General
Attorneys for the Commonwealth of Kentucky

Maura Healey
Attorney General of Massachusetts
Stephen B. Vogel
Assistant Attorney General
Attorneys the Commonwealth of Massachusetts

Keith Ellison
Attorney General of Minnesota
Scott Ikeda
Assistant Attorney General
Attorneys for the State of Minnesota, by and through its Department of Commerce

Gurbir S. Grewal
Attorney General of New Jersey
Matthew J. Berns
Assistant Attorney General
Marie Soueid
Deputy Attorney General
Attorneys for the State of New Jersey

Letitia James
Attorney General of New York
Barbara D. Underwood
Solicitor General
Steven C. Wu
Deputy Solicitor General
Lisa Landau
Bureau Chief, Health Care Bureau
Elizabeth Chesler
Assistant Attorney General, Health Care Bureau
Attorneys for the State of New York

Joshua H. Stein
Attorney General of North Carolina
Sripriya Narasimhan
Deputy General Counsel
Attorneys for the State of North Carolina

Ellen F. Rosenblum
Attorney General of Oregon
Henry Kantor
Special Counsel to the Attorney General
Scott Kaplan
Assistant Attorney General
Attorneys for the State of Oregon

Peter F. Neronha
Attorney General of Rhode Island
Michael W. Field
Assistant Attorney General
Maria R. Lenz
Assistant Attorney General
Attorneys for the State of Rhode Island

Thomas J. Donovan, Jr.
Attorney General of Vermont
Benjamin D. Battles
Solicitor General
Attorneys for the State of Vermont

Mark R. Herring
Attorney General of Virginia
Toby J. Heytens
Solicitor General
Matthew R. McGuire
Principal Deputy Solicitor General
Attorneys for the Commonwealth of Virginia

Robert W. Ferguson
Attorney General of Washington
Jeffrey G. Rupert
Chief, Complex Litigation Division
Jeffrey T. Sprung
Assistant Attorney General
Attorneys for the State of Washington

Karl A. Racine
Attorney General for the District of Columbia
Loren L. AliKhan
Solicitor General
Caroline S. Van Zile
Deputy Solicitor General
Attorneys for the District of Columbia

CERTIFICATE OF SERVICE

I certify that on May 22, 2019, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: May 22, 2019

/s Samuel P. Siegel
Samuel P. Siegel

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,011 words, according to the count of Microsoft Word. I further certify that this brief complies with typeface and style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared in Microsoft Word using 14-point Times New Roman font.

Dated: May 22, 2019

/s Samuel P. Siegel
Samuel P. Siegel

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

Counsel Listed on Inside Cover

KEN PAXTON
Attorney General of Texas

JEFFREY C. MATEER
First Assistant Attorney General

DARREN L. MCCARTY
Deputy Attorney General for
Civil Litigation

DAVID J. HACKER
Special Counsel for Civil Litigation

KYLE D. HAWKINS
Solicitor General

MATTHEW H. FREDERICK
Deputy Solicitor General

ERIC A. WHITE
Assistant Solicitor General

Office of the Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Tel.: (512) 936-1700
Fax: (512) 474-2697
Kyle.Hawkins@oag.texas.gov

Counsel for State Plaintiffs-Appellees

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
Kyle D. Hawkins
Counsel of Record for Plaintiffs-Appellees

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.

Respectfully submitted.

Steve Marshall
Attorney General of Alabama

Mark Brnovich
Attorney General of Arizona

Leslie Rutledge
Attorney General of Arkansas

Ashley Moody
Attorney General of Florida

Christopher M. Carr
Attorney General of Georgia

Curtis Hill
Attorney General of Indiana

Derek Schmidt
Attorney General of Kansas

Jeff Landry
Attorney General of Louisiana

Phil Bryant
Governor of Mississippi

Eric Schmitt
Attorney General of Missouri

Doug Peterson
Attorney General of Nebraska

Ken Paxton
Attorney General of Texas

Jeffrey C. Mateer
First Assistant Attorney General

/s/Kyle D. Hawkins
Kyle D. Hawkins
Solicitor General
Kyle.Hawkins@oag.texas.gov

Matthew H. Frederick
Deputy Solicitor General

Eric A. White
Assistant Solicitor General

Darren L. McCarty
Deputy Attorney General for
Civil Litigation

David J. Hacker
Special Counsel for Civil Litigation

Office of the Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Tel.: (512) 936-1700
Fax: (512) 474-2697

Counsel for State Plaintiffs-Appellees

WAYNE STENEHJEM
Attorney General of North Dakota

ALAN WILSON
Attorney General of South Carolina

JASON RAVNSBORG
Attorney General of South Dakota

HERBERT SLATERY, III
Attorney General of Tennessee

SEAN REYES
Attorney General of Utah

PATRICK MORRISEY
Attorney General of West Virginia

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/s/ Kyle D. Hawkins
Kyle D. Hawkins

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).

/s/ Kyle D. Hawkins
Kyle D. Hawkins