Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

STATES OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

CONSOLIDATED BRIEF FOR RESPONDENTS

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QUESTIONS PRESENTED

Petitioners challenge the constitutionality of certain provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, and urge, further, that none of the Act's provisions could be severed from the Act's minimum coverage provision if that provision were invalidated. The questions presented are:

1. Whether the provision of the Act that expands eligibility for Medicaid to cover individuals with income up to 133% of the federal poverty level, 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII), is a valid exercise of Congress's power to set the terms on which it will appropriate federal funds. (No. 11-400 only)

2. Whether the provision of the Act that, under certain circumstances, establishes penalties for large employers that do not offer adequate health insurance coverage to full-time employees, 26 U.S.C.A. 4980H, is constitutional as applied to state employers. (No. 11-400 only)

3. Whether other provisions of the Act could be severed from the Act's minimum coverage provision, 26 U.S.C.A. 5000A, if that provision were found to be unconstitutional.

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OPINIONS BELOW

The opinion of the court of appeals (App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss (App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The dis-

[1] Cites are to the appendix to the federal government's petition for a writ of certiorari in *Department of Health & Human Services* v. *Florida*, No. 11-398 (filed Sept. 28, 2011).

trict court's opinion on the parties' cross-motions for summary judgment (App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's opinion entering a stay of its declaratory judgment (App. 369a-393a) is reported at 780 F. Supp. 2d 1307.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act),[2] to address a profound and enduring crisis in the market for health care, which accounts for more than 17% of the Nation's gross domestic product. Millions of people do not have health insurance and thus consume health care services for which they do not pay, shifting billions of dollars of health care costs to other market participants. The result is higher health insurance premiums that, in turn, make health insurance unaffordable to even greater numbers of people. At the same time, insurance companies use restrictive underwriting practices to deny coverage or charge more to millions of people because of pre-existing medical conditions.

In the Affordable Care Act, Congress addressed these problems through a comprehensive program of economic regulation and tax measures. The Act includes provisions designed to make affordable health insurance more widely available, to protect consumers from re-

[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

strictive insurance underwriting practices, and to reduce the amount of uncompensated medical care.

First, the Act builds upon the existing nationwide system of employer-based health insurance that is the principal private mechanism for financing health care. The Act creates new tax incentives for small businesses to purchase health insurance for their employees, 26 U.S.C.A. 45R,[3] and, under certain circumstances, imposes assessable payments on large employers that do not offer adequate coverage to full-time employees, 26 U.S.C.A. 4980H (the employer responsibility provision).[4]

Second, the Act provides for the creation of health insurance exchanges to allow individuals, families, and

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[3] Because the Affordable Care Act has not yet been codified in the United States Code, this brief cites to the United States Code Annotated (U.S.C.A.) for ease of reference. All such citations are either to the 2011 Edition or the 2011 Supplement to the U.S.C.A.

[4] Subject to certain exceptions, the provision (which will take effect in 2014) will apply to all employers that employ an average of at least 50 full-time equivalent employees during the preceding calendar year. 26 U.S.C.A. 4980H(c)(2)(A) & (E); 26 U.S.C.A. 4980H note. Such an employer will be required to make an assessable payment if it "fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan," and at least one of its full-time employees has enrolled in a qualified health plan purchased on an exchange "with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee." 26 U.S.C.A. 4980H(a)(1) and (2). Such a large employer is also subject to making an assessable payment if it offers coverage but one or more of its full-time employees receive a tax credit or cost-sharing reduction for coverage on an exchange because the employer-provided coverage is not affordable or because the employer pays for less than 60% of the total allowed costs of benefits provided under the plan. 26 U.S.C.A. 36B(c)(2)(C), 4980H(b)(1).

small businesses to leverage their collective buying power to obtain health insurance at rates that are competitive with those of typical large employer group plans. 42 U.S.C.A. 18031. The Act also establishes federal tax credits to assist eligible households with incomes from 133% to 400% of the federal poverty level to purchase insurance through the exchanges. 26 U.S.C.A. 36B.

Third, the Act extends eligibility for Medicaid to individuals under age 65 with incomes up to 133% of the federal poverty level. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII) (Medicaid eligibility expansion). The Act provides that the federal government will pay 100% of the expenditures required to cover these newly eligible Medicaid recipients through 2016. 42 U.S.C.A. 1396d(y)(1). The federal government's share thereafter will decline slightly and level off at 90% in 2020 and beyond—far above the usual federal matching rates for Medicaid. Compare *ibid.* with 42 U.S.C.A. 1396d(b) (50% to 83%).

Fourth, the Act regulates insurers to prohibit industry practices that have prevented individuals from obtaining and maintaining health insurance. The Act will bar insurers from refusing coverage because of a preexisting medical condition, 42 U.S.C.A. 300gg-1(a), 300gg-3(a) (the guaranteed-issue provision), thereby guaranteeing access to insurance for many previously unable to obtain it. The Act also bars insurers from charging higher premiums based on a person's medical history, 42 U.S.C.A. 300gg (the community-rating provision), requiring instead that premiums generally be based on community-wide criteria.

Fifth, the Act amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of health insurance coverage

must pay a tax penalty. 26 U.S.C.A. 5000A (the minimum coverage provision).

2. a. Petitioners in No. 11-393 are two individuals, Mary Brown and Kaj Ahlburg, and the National Federation of Independent Business (NFIB), of which Brown is a member. Petitioners in No. 11-400 are 24 States, a state attorney general, and a governor.

Petitioners filed suit in the Northern District of Florida, challenging the constitutionality of several provisions of the Affordable Care Act. As relevant here, all petitioners challenged the minimum coverage provision as beyond Congress's Article I powers. The state petitioners asserted constitutional challenges both to the Medicaid eligibility expansion, and to the employer responsibility provision as applied to the state petitioners as large employers. All petitioners also argued that if the minimum coverage provision were found to be unconstitutional, the whole Act should be invalidated.

b. The district court held that the minimum coverage provision is not a valid exercise of Congress's Article I powers. App. 278a n.4, 296a-350a, 401a-424a. At the same time, the court rejected petitioners' claim that the Medicaid eligibility expansion is unduly "coercive" in violation of Congress's spending power, concluding that "there is simply no support for [petitioners'] coercion argument in existing case law." App. 282a, 283a. The district court also rejected the state petitioners' challenge to the employer responsibility provision as applied to them in their capacity as large employers. App. 445a-451a.[5]

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[5] Although the federal government argued that the Anti-Injunction Act, 26 U.S.C. 7421(a), barred consideration of the state petitioners' challenge to the employer responsibility provision, see Memo. in Supp. of Fed. Govt's Mot. to Dismiss at 21-22, the district court did not

Despite having found only one provision of the Act unconstitutional, the district court declared the entire Act invalid, based on its view that conducting a "section-by-section" severability analysis would require "considerable time and extensive briefing" and that "[t]he Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker." App. 361a, 363a. The district court stayed its declaratory judgment pending appellate review. App. 387a-392a.

3. The court of appeals affirmed in part and reversed in part. The panel unanimously rejected the state petitioners' challenge to the Act's expansion of Medicaid eligibility. App. 50a-63a, 189a n.1. The court concluded that, under certain circumstances, a condition on federal funds may be invalidated because it is unduly "coercive," but held that the Act's expansion of Medicaid eligibility did not run afoul of that rule. App. 60a. The court observed that Congress long ago had expressly reserved the right to alter the Medicaid program; that, since the program's inception, Congress has repeatedly enacted amendments that expanded Medicaid eligibility; and that none of those amendments has been deemed unduly coercive. App. 60a-61a & n.66. The court further emphasized that the federal government will bear nearly all of

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address that question. The federal government also argued in the district court that the Anti-Injunction Act barred consideration of petitioners' challenge to the minimum coverage provision, see *id.* at 33-34, and the district court rejected that contention, App. 401a-425a. The federal government no longer contends that the Anti-Injunction Act applies to pre-enforcement challenges to the minimum coverage provision. See note 9, *infra*.

the costs associated with the Affordable Care Act's expansion of the Medicaid program. App. 61a.[6]

The court of appeals next held that the minimum coverage provision is not a valid exercise of Congress's commerce power, App. 63a-156a, or taxing power, App. 157a-172a. The court further held, however, that the rest of the Act could be severed from the minimum coverage provision. App. 172a-186a.

As an initial matter, the court rejected the district court's conclusion that no other provision was severable from the minimum coverage provision such that "wholesale invalidation" of the Act was required. App. 174a-176a. The court of appeals then separately analyzed the severability of the guaranteed-issue and community-rating provisions, which all parties had agreed could not be severed from the minimum coverage provision. App. 176a-186a; see n.13, *infra*; States' C.A. Br. 62; NFIB C.A. Br. 60-61. The court disagreed with that shared judgment, as well as an explicit Congressional finding, and held that, even without the minimum coverage provision, the guaranteed-issue and community-rating provisions (together with other provisions of the Act) would still further the Act's "basic objective * * * to make health insurance coverage accessible and thereby to reduce the number of uninsured persons." App. 180a-186a.

Judge Marcus dissented from the majority's Commerce Clause ruling, explaining that he would uphold the minimum coverage provision as a valid exercise of Congress's commerce power. App. 189a-262a.

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[6] The court of appeals did not address the state petitioners' Tenth Amendment challenge to the employer responsibility provision in light of their express concession that the challenge was foreclosed by this Court's decision in *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). See States' C.A. Br. 59 n.6.

4. The federal government has filed a petition for a writ of certiorari in No. 11-398 that presents the question whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision.[7]

ARGUMENT

Petitioners challenge three components of the Affordable Care Act's comprehensive scheme for addressing the crisis in the national healthcare market. First, the state petitioners challenge a provision in the Act, 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII), that will expand Medicaid eligibility to include individuals under age 65 with incomes up to 133% of the federal poverty level. See States' Pet. 16-26. Second, the state petitioners challenge the applicability to them as employers of the provision in the Act, 26 U.S.C.A. 4980H, that, under certain circumstances, will impose assessable tax payments on large employers that do not offer adequate coverage to full-time employees. See States' Pet. 26-29. Third, both sets of petitioners contend that, if the minimum coverage provision is held unconstitutional, the entire Act should be declared inseverable and invalidated. See *id.* at 29-37; NFIB Pet. 19-21. As explained below, the federal government respectfully suggests that the Court should deny review of the first two questions (Medicaid and employer responsibility) and grant review of the third question (severability).

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[7] In addition to the federal government's petition and the two petitions to which this brief responds, there are three other pending petitions presenting questions regarding the constitutionality of the minimum coverage provision and threshold questions of whether the claims can be adjudicated. See *Liberty University, Inc.* v. *Geithner*, No. 11-438 (filed Oct. 7, 2011); *Virginia* v. *Sebelius*, No. 11-420 (filed Sept. 30, 2011); *Thomas More Law Ctr.* v. *Obama*, No. 11-117 (filed July 26, 2011).

The court of appeals correctly rejected the state petitioners' challenge to the Medicaid eligibility expansion, and further review of that ruling is not warranted. No court has ever invalidated a federal funding condition on the coercion theory the state petitioners urge here. It is settled that Congress may fix the terms on which it appropriates federal funds, and since the inception of the Medicaid program, Congress has made coverage of specified categories of individuals a condition of state participation. Congress expressly reserved the right to amend the Medicaid statute, and, over the years, it has done so repeatedly to expand the categories of individuals for whom coverage under the program is mandatory. Finally, the federal government will bear nearly the entire financial burden of the Act's Medicaid eligibility expansion. That expansion does not exceed Congress's spending power.

The state petitioners' Tenth Amendment challenge to the employer responsibility provision likewise does not merit review. As an initial matter, that claim is barred by the Anti-Injunction Act, 26 U.S.C. 7421(a), which generally prohibits pre-enforcement challenges to "the assessment or collection of any tax." Even apart from that threshold barrier, review of this claim would be unwarranted. The state petitioners acknowledge that their claim is foreclosed by *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), and they fail to make the demanding showing this Court requires before determining that one of its precedents should be overruled. Finally, the employer responsibility provision is independently supported by Congress's Article I power to lay and collect taxes, and *Garcia* has no bearing on that separate basis of authority.

For the reasons stated in its certiorari petition, the federal government believes Congress had Article I authority to enact the minimum coverage provision. See 11-398 Pet. 14-29. In the event this Court disagrees, however, the federal government believes it would be appropriate for the Court to consider certain issues concerning whether additional provisions of the Act should be held inseverable in this case. The court of appeals correctly rejected petitioners' sweeping contention that if the minimum coverage provision were struck down as unconstitutional, the entire Affordable Care Act should be declared invalid. Most of the Act's myriad provisions have nothing to do with the minimum coverage provision, and many of them have already taken effect, demonstrating that Congress believed they could operate independently.

The court of appeals did err, however, in holding that the guaranteed-issue and community-rating provisions that will take effect in 2014 can be severed from the minimum coverage provision. As an initial matter, the court of appeals should not have reached that question at petitioners' behest because those provisions do not "burden" petitioners. *Printz* v. *United States*, 521 U.S. 898, 935 (1997). In any event, the court's conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect. Without the minimum coverage provision, the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available. Indeed, Congress's findings expressly recognized the integral relationship between those provisions. 42 U.S.C.A. 18091(a)(2)(I). Because of the importance of severability issues in this case, the

Court should grant the States' petition limited to question three, and also grant NFIB's petition.

1. The court of appeals correctly rejected the state petitioners' contention that the Affordable Care Act's expansion of Medicaid eligibility is unconstitutionally coercive (Pet. 16-26), and that ruling does not conflict with any decision of this Court or any other court of appeals. Further review is unwarranted.

a. Medicaid "is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). "Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the [statutory] requirements." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).

To be eligible for federal funds, a participating State must submit a plan to the Department of Health and Human Services (HHS) demonstrating that the State is in compliance with the Medicaid Act's requirements. 42 U.S.C.A. 1396a. Since the inception of the program in 1965, the Medicaid Act has specified categories of individuals to whom state programs must provide medical assistance, as well as the kinds of medical care and services the programs must cover. See *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650-651 & n.4 (2003). For example, the Medicaid Act requires state programs to make medical assistance available to low-income families with dependent children and to low-income individuals who are elderly, blind, or disabled. 42 U.S.C.A. 1396a(a)(10)(A)(i). The Medicaid Act also requires state programs to cover specified benefits for Medicaid enrollees. 42 U.S.C.A. 1396a(a)(10).

If the Secretary of HHS approves a state plan, the federal government reimburses a percentage of most Medicaid expenses the State incurs. That percentage ranges from 50% to 83%, depending on the State's per capita income. 42 U.S.C.A. 1396d(b).

From the outset, Congress reserved the "right to alter, amend, or repeal any provision" of the Social Security Act, 42 U.S.C. 301 *et seq.* (of which the Medicaid Act is a part). 42 U.S.C. 1304; *Bowen* v. *Public Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 44 (1986) (*Public Agencies*). With this "language of reservation," Congress gave "special notice of its intention to retain[] full and complete power to make such alterations and amendments as come within the just scope of legislative power." *Id.* at 53 (quoting *Sinking-Fund Cases*, 99 U.S. 700, 720 (1879)). The reservation clause "makes express what is implicit in the institutional needs of the program" —that "it was inevitable that amendment of its provisions would be necessary in response to evolving social and economic conditions." *Id.* at 51-52 (quoting *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960)). Accordingly, each State has signed a Medicaid plan that includes an express statement that the plan "will be amended whenever necessary to reflect new or revised Federal statutes." *E.g.*, Florida Agency for Health Care Admin., *State Plan Under Title XIX of the Social Security Act Medical Assistance Program* § 7.1, at 86 (Oct. 6, 1992); see 42 C.F.R. 430.12(c)(1)(i) (requiring all States participating in Medicaid to include such provisions in their plans).

Congress has amended the Medicaid Act many times. As a result, between 1966 and 2008, Medicaid enrollment increased from four million to 47.6 million recipients. Centers for Medicare & Medicaid Servs., HHS, *2010 Ac-*

tuarial Report on the Financial Outlook for Medicaid 19 Tbl. 3 (Dec. 21, 2010). For example, in 1972, Congress required participating States to extend Medicaid to recipients of Supplemental Security Income, thereby significantly expanding Medicaid enrollment. Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329. In 1989, Congress again expanded enrollment by requiring States to extend Medicaid to pregnant women and children under age six who meet certain income limits. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Tit. VI, Subtit. B, 103 Stat. 2258; see 42 U.S.C.A. 1396a note (listing amendments).

b. In the Affordable Care Act, Congress expanded Medicaid eligibility to include individuals under age 65 with incomes up to 133% of the federal poverty level. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII). The federal government will bear nearly the entire cost of coverage for newly eligible individuals. From 2014 through 2016, the federal government will pay 100% of the costs associated with the expansion. 42 U.S.C.A. 1396d(y). That amount will gradually decrease, to 95% in 2017, 94% in 2018, and 93% in 2019. *Ibid.* In 2020 and thereafter, the federal government will continue to pay 90% of these costs. *Ibid.*

The state petitioners provide no basis to invalidate these amendments to the Medicaid program. "The Constitution empowers Congress to 'lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States.'" *South Dakota* v. *Dole*, 483 U.S. 203, 206 (1987) (quoting U.S. Const. Art. I, § 8, Cl. 1). "Incident to this power, Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by condi-

tioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.'" *Ibid.* (citations omitted). It is thus settled that Congress may "fix the terms on which it shall disburse federal money to the States." *New York* v. *United States*, 505 U.S. 144, 158 (1992) (quoting *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981)).

This Court has identified four general constraints on Congress's spending power. First, conditions attached by Congress on the expenditure of federal funds must promote the general welfare. *Dole*, 483 U.S. at 207. Second, conditions on a State's receipt of federal funds must be unambiguous. *Ibid.* Third, the Court has "suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs.'" *Ibid.* (citation omitted). Fourth, no condition attached to receipt of federal funds may violate other provisions of the Constitution. *Id.* at 208.

"The state [petitioners] do not contend that the Act's Medicaid expansion violates any of these restrictions." App. 53a. They also do not dispute that participation in Medicaid is voluntary and that States are permitted to withdraw from the program. *Virginia Hosp. Ass'n*, 496 U.S. at 502; *McRae*, 448 U.S. at 301. Nor do they deny that they "accepted" participation in Medicaid "under an Act that contained * * * language of reservation," *i.e.*, 42 U.S.C. 1304, "expressly notif[ying] [them] that Congress retained the power to amend the law." *Public Agencies*, 477 U.S. at 54. Nonetheless, the state petitioners point to this Court's statement in *Dole* that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" States' Pet. 17 (quot-

ing 483 U.S. at 211). They then assert that federal Medicaid funding is so generous that it would be very difficult for them to stop accepting it, and that Congress may therefore no longer establish the terms on which it appropriates Medicaid funds. See *id.* at 22.

Every court of appeals to consider such coercion challenges—even where a State's entire federal Medicaid grant was potentially at stake—has rejected them. App. 58a ("[O]ur review of the relevant case law indicates that no court has ever struck down a law such as this one as unduly coercive."); see *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir.), cert. denied, 522 U.S. 806 (1997); *Padavan* v. *United States*, 82 F.3d 23, 29 (2d Cir. 1996); *Oklahoma* v. *Schweiker*, 655 F.2d 401, 405-411 (D.C. Cir. 1981). The courts of appeals have likewise consistently rejected coercion claims with respect to other federal spending programs in which loss of all federal funding was a possible consequence of state noncompliance. See, *e.g.*, *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (entire federal grant for state prisons), cert. denied, 130 S. Ct. 3323 (2010), and 131 S. Ct. 2149 (2011); *Jim C.* v. *United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (entire federal education grant), cert. denied, 533 U.S. 949 (2001); *Kansas* v. *United States*, 214 F.3d 1196, 1198, 1201-1202 (10th Cir.) (entire federal welfare grant), cert. denied, 531 U.S. 1035 (2000); see also *Nevada* v. *Skinner*, 884 F.2d 445, 448-449 (9th Cir. 1989) (95% of federal highway grant), cert. denied, 493 U.S. 1070 (1990).

The state petitioners rely (Pet. 18-20) on Judge Luttig's plurality opinion in *Virginia Department of Education* v. *Riley*, 106 F.3d 559 (4th Cir. 1997) (en banc) (per curiam), which suggested, in *dicta*, that there would be a "substantial constitutional question," *id.* at 561,

whether it would be impermissibly coercive for a federal agency to withhold a State's $60 million education grant because of a failure to provide educational services to 126 of the State's 128,000 special education students, *id.* at 569. In a later case, the Fourth Circuit recognized that Judge Luttig's "analysis, of course, cannot be viewed as the holding of the court in *Riley* given that [his] Tenth Amendment analysis was not necessary to the disposition of the case" and also given that Judge Luttig's Tenth Amendment discussion "represented the views of only" a minority of the en banc court. *West Virginia* v. *HHS*, 289 F.3d 281, 290-291 (4th Cir. 2002). In that same *West Virginia* case, the Fourth Circuit rejected a coercion challenge to a Medicaid provision. *Id.* at 291-297.

In any event, the state petitioners' coercion claim would fail even under Judge Luttig's analysis. He opined that a valid Tenth Amendment claim would lie where the federal government "withholds the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some *insubstantial* respect." *Riley*, 106 F.3d at 570 (emphasis added). The Affordable Care Act's amendments to the Medicaid program are in no sense "insubstantial"; to the contrary, the state petitioners acknowledge that they are "core program requirements." States' Pet. 26. The Act's Medicaid expansion is expected to provide health care coverage to more than 16 million individuals, see *CBO's March 2011 Estimate of the Effects of Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011), and concerns the very contours of the Medicaid program—its basic eligibility requirements. If Congress could not define the basic features of the cooperative spending programs it offers to the States, it could no longer "fix the terms on which

it shall disburse federal money to the States." *New York*, 505 U.S. at 158 (internal citation omitted). The States could instead insist upon receiving federal funds on their own terms, contrary to the Constitution's express grant of exclusive authority over appropriations to Congress. See Art. I, § 9, Cl. 7; *OPM* v. *Richmond*, 496 U.S. 414, 424-425 (1990).

Contrary to the state petitioners' suggestion (Pet. 6, 21), the structure of the Affordable Care Act amendments to Medicaid does not differ materially from the structure of the prior Medicaid amendments extending eligibility to recipients of Supplemental Security Income in 1972 and to low-income pregnant women and children under age six in 1989. See p. 13, *supra*. Under those amendments, as under the Affordable Care Act amendments, state coverage of the newly eligible individuals was a condition of a State's continued participation in the Medicaid program.[8]

The state petitioners suggest that the Court grant review in order to correct those courts of appeals that, in the state petitioners' view, have concluded that "the coercion doctrine is not viable or does not exist." Pet. 18

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[8] While the state petitioners have sought to have the Affordable Care Act's expansion of Medicaid eligibility declared unconstitutional, other state officials have defended the expansion "as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such populations." Dist. Ct. Amicus Br. of the Governors of Wash., Colo., Mich., & Pa. 13 (Docket No. 133); see also Dist. Ct. Amicus Br. of Or., Iowa, Vt., Md., & Ky. at 7-8 (Docket No. 130) ("By seeking to block the expansion of Medicaid coverage, [petitioners] are trying to achieve their policy preferences through litigation at the expense of states that want Medicaid expanded and that worked through the democratic process to achieve that policy goal at the national level.").

(quoting App. 59a). This case would not provide an appropriate vehicle for consideration of that question. The court of appeals here criticized those same courts and expressly held that there *is* a judicially enforceable coercion limitation on Congress's spending power. App. 59a-60a. It simply held that the state petitioners had failed to establish their claim of impermissible coercion—in which they challenge the basic contours of the federal funding program Congress has offered. App. 60a-63a.

2. The state petitioners' Tenth Amendment challenge to the employer responsibility provision (Pet. 26-29) likewise does not merit review.

a. As an initial matter, the Anti-Injunction Act bars the state petitioners' request for pre-enforcement review of the employer responsibility provision. That Act, with express exceptions not relevant here, provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. 7421(a). The purpose of the Anti-Injunction Act is to preserve the government's ability to assess and collect taxes with "a minimum of preenforcement judicial interference, and to require that the legal right to the disputed sums be determined in a suit for refund." *Bob Jones University* v. *Simon*, 416 U.S. 725, 736 (1974) (internal quotation marks and citation omitted). The Anti-Injunction Act, when applicable, bars any suit seeking relief that "would necessarily preclude" the assessment or collection of taxes under the Internal Revenue Code, regardless of the plaintiff's professed motivation for the suit. *Id.* at 731-732.

Pre-enforcement review of the employer responsibility provision is prohibited by the Anti-Injunction Act.

That provision, under specified circumstances, imposes an "assessable payment" under the Internal Revenue Code on large employers that do not offer their full-time employees adequate health insurance. See 26 U.S.C.A. 4980H(a); see also 26 U.S.C.A. 4980H(b). The Affordable Care Act expressly refers to that assessable payment as a "tax." 26 U.S.C.A. 4980H(b)(2) and (c)(7).[9] If successful, the state petitioners' pre-enforcement challenge "would necessarily preclude" the assessment and collection of that tax; the challenge is therefore barred by the Anti-Injunction Act. *Bob Jones University*, 416 U.S. at 731-732. The state petitioners may pay the tax and then pursue refund actions in order to assert their Tenth Amendment challenge. See 26 U.S.C. 7422.

The state petitioners contend that the Anti-Injunction Act does not bar their separate challenge to the mini-

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[9] In this respect, the employer responsibility provision is distinct from the minimum coverage provision, 26 U.S.C.A. 5000A, which consistently refers to the exaction it imposes for failure to maintain minimum essential coverage as a "penalty." Because only certain "penalties" are deemed "taxes" for purposes of the Anti-Injunction Act, the federal government has argued that pre-enforcement challenges to the minimum coverage provision are not barred. See Fed. Gov't Supplemental Br. at 2-9, *Liberty University, Inc.* v. *Geithner*, No. 10-2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011), petition for cert. pending, No. 11-438 (filed Oct. 7, 2011); accord *Liberty University*, 2011 WL 3962915, at *24 (Davis, J., dissenting); *Thomas More Law Ctr.* v. *Obama*, 651 F.3d 529, 539-540 (6th Cir. 2011), petition for cert. pending, No. 11-117 (filed July 26, 2011). That analysis is inapposite here, given that Congress expressly referred to the "assessable payment" in the employer responsibility provision as a "tax." 26 U.S.C.A. 4980H(b)(2) and (c)(7). Accordingly, the federal government believes that the Fourth Circuit erred when it concluded that the Anti-Injunction Act bars pre-enforcement challenges to the minimum coverage provision, but correctly determined that it bars pre-enforcement challenges to the employer responsibility provision. See *Liberty University*, 2011 WL 3962915, at *4-*14.

mum coverage provision because "they are not taxpayers subject" to it. States' Pet. 37 n.3. Whatever the force of that contention with respect to the minimum coverage provision, it is not relevant here because the States *are* subject to the employer responsibility provision and therefore may assert their claim in a refund action. The state petitioners also asserted in the district court that they are not "person[s]" whose pre-enforcement suits are barred by the Anti-Injunction Act. Pls. Dist. Ct. Memo. in Opp. to Defs.' Mot. to Dismiss 22 (Docket No. 68). That contention is incorrect. See *Ohio* v. *Helvering*, 292 U.S. 360, 370-371 (1934) ("We find no merit in the * * * contention that a state is not embraced within the meaning of the word 'person,' as used in" a provision of the Internal Revenue Code); see also *Jefferson County Pharm. Ass'n* v. *Abbott Labs.*, 460 U.S. 150, 154-155 & n.10 (1983). From 1867 to 1966, the Anti-Injunction Act provided simply that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court," without any use of the word "person." *Bob Jones University*, 416 U.S. at 731-732 n.6 (emphasis omitted) (quoting 26 U.S.C. 7421(a) (1964)). Congress added the phrase beginning with "by any person" in 1966, not to narrow the Anti-Injunction Act, but to make clear that it *extended* to third parties. *Ibid.* The addition of this phrase thus "reaffirm[ed] the plain meaning of the original language of the Act," *Alexander* v. *"Americans United" Inc.*, 416 U.S. 752, 760 n.11 (1974), and that plain meaning encompasses state taxpayers.

In any event, the court of appeals did not address the state petitioners' contention that States are not "person[s]" for purposes of the Anti-Injunction Act, and no other court of appeals has done so either. For that reason, and because this Court would need to resolve that

novel threshold question in the first instance, there is a substantial reason at the outset not to accept review of the state petitioners' challenge to the employer responsibility provision.[10]

b. Even apart from the Anti-Injunction Act bar, the state petitioners' challenge to the employer responsibility provision would not merit review. The state petitioners acknowledge that in order for them to prevail on this claim the Court would have to overrule its decision in *Garcia*. See States' Pet. 29. "[E]ven in constitutional cases," *stare decisis* "carries such persuasive force" that the Court has "always required a departure from precedent to be supported by some 'special justification.'" *United States* v. *IBM Corp.*, 517 U.S. 843, 856 (1996) (brackets in original) (citation omitted). No such special justification is present here.

In *National League of Cities* v. *Usery*, 426 U.S. 833 (1976), this Court held that "the Commerce Clause [did]

[10] To the extent the state petitioners seek to challenge the Affordable Care Act provision that will require large employers to provide for automatic enrollment of their employees in a health insurance plan "[i]n accordance with regulations promulgated by" the Department of Labor, 29 U.S.C.A. 218a; see States' Pet. 7-8 (citing Affordable Care Act § 1511, 124 Stat. 252), that challenge would be premature. The Department of Labor has explained that compliance with that provision will not be required until it issues implementing regulations, which it intends to do by 2014. Employee Benefits Sec. Admin., U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation* 2 (Dec. 22, 2010). "The Department of Labor expects to work with stakeholders to ensure that it has the necessary information and data it needs to develop regulations in this area that take into account the practices employers currently use for auto-enrollment and to solicit the views and practices of a broad range of stakeholders, including employers, workers, and their families." *Ibid.* Review by this Court would be unwarranted until the features of this requirement are fully established.

not empower Congress to enforce the minimum-wage and overtime provisions of the Fair Labor Standards Act * * * against the States 'in areas of traditional governmental functions.'" *Garcia*, 469 U.S. at 530 (quoting *National League of Cities*, 426 U.S. at 852). At the same time, the Court in *National League of Cities* noted that Congress continued to have the power under the Commerce Clause to regulate state functions that were not traditionally "regarded as integral parts of their governmental activities." 426 U.S. at 854 n.18; see *id.* at 851. In the years after that decision, the courts found it "difficult, if not impossible, to identify an organizing principle" that could reliably identify whether state functions were "traditional" under the *National League of Cities* standard. *Garcia*, 469 U.S. at 538-539. The Court in *Garcia* thus abandoned the *National League of Cities* approach as "unsound in principle and unworkable in practice" and held that Congress has power under the Commerce Clause to apply employment laws to both private and state employers. *Id.* at 546, 554.

In seeking a return to the approach of *National League of Cities*, the state petitioners offer no clues as to how they would define the "areas of traditional governmental functions" (426 U.S. at 852) that would be immune from regulation under the Commerce Clause. Given that it was the lack of any workable standard on precisely that question that in large part led the Court to abandon *National League of Cities*, see *Garcia*, 469 U.S. at 531, 537-540, the state petitioners' silence fatally weakens their request to overrule *Garcia*.

State petitioners likewise make no effort to show that they would prevail under the approach of *National League of Cities*. Not all state employees work in "areas of traditional governmental functions" (however that

category is defined). *National League of Cities*, 426 U.S. at 852. The state petitioners also fail to demonstrate that the employer responsibility provision would require them to "substantially restructure traditional ways in which [they] have arranged their affairs." *Id.* at 849. Finally, the state petitioners fail to acknowledge that *National League of Cities* allowed for the possibility of federal regulation of state employers where, as is the case with the national health care crisis, there is "an extremely serious problem which endanger[s] the well-being of all the component parts of our federal system and which only collective action by the National Government might forestall." *Id.* at 853.

The only argument the state petitioners advance for departing from *stare decisis* and overruling *Garcia* is the purported inconsistency of its "animating reasoning" with this Court's subsequent decisions in *New York*, *supra*, and *Printz*, *supra*. Pet. 28. That contention lacks merit. *New York* and *Printz* established that the federal government cannot commandeer a State or state officials to regulate private parties on the federal government's behalf and that it must, instead, regulate private parties directly. *New York*, 505 U.S. at 149; *Printz*, 521 U.S. at 925. Neither decision called into question the reasoning of *Garcia,* which concerned a federal statute applicable to States as employers, not regulators. See, *e.g.*, *New York*, 505 U.S. at 160 ("This litigation presents no occasion to apply or revisit the holding[] of [*Garcia*], as this is not a case in which Congress has subjected a State to the same legislation applicable to private parties.").

The state petitioners' contention that *Printz* and *New York* provide support for overruling *Garcia* is also irreconcilable with *Reno* v. *Condon*, 528 U.S. 141 (2000). In that case, this Court expressly distinguished the kind of

impermissible commandeering at issue in *New York* and *Printz* from direct federal regulation of a State's own activities, and the Court unanimously reaffirmed that such direct regulation presents no Tenth Amendment issue, at least where, as in *Condon* and this case, the regulation is one of general applicability. *Id.* at 149-151. *Condon* upheld the Driver's Privacy Protection Act of 1994 (DPPA), 18 U.S.C. 2721 *et seq.*, which regulates the disclosure of personal information contained in the records of state motor vehicle departments. 528 U.S. at 143. The Court explained that the statute "does not require the States in their sovereign capacity to regulate their own citizens"; it instead "regulates the States as owners of data bases." *Id.* at 151. The Court noted that the DPPA does not require the State "to enact any laws or regulations, and it does not require state officials to assist in the enforcement of federal statutes regulating private individuals." *Ibid.* Accordingly, the Court held that the statute "is consistent with the constitutional principles enunciated in *New York* and *Printz*." *Ibid.*

The same logic applies here. The employer responsibility provision regulates the States' own activities; it does not compel their regulation of private individuals. Moreover, the Court in *Reno* found it unnecessary to consider South Carolina's contention "that Congress may only regulate the States by means of 'generally applicable' laws, or laws that apply to individuals as well as States," because it concluded that the DPPA was "generally applicable." 528 U.S. at 151. Here too, the employer responsibility provision applies to large private employers just as it applies to States. In *Reno*, "[t]he DPPA regulate[d] the universe of entities that participate as suppliers to the market for motor vehicle information," *id.* at 151, and here the employer responsibility

provision regulates the universe of large employers that participate in the market for labor. In neither situation does the Constitution compel an exemption for States as market participants. *Ibid.*

c. Finally, the States' petition would provide a poor vehicle for reexamination of *Garcia* because the employer responsibility provision is authorized not only by Congress's commerce power (at issue in *Garcia*) but also by its taxing power. The taxing power is "comprehensive," *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 581-582 (1937), and, in "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson* v. *Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (quoting *Lawrence* v. *State Tax Comm'n*, 286 U.S. 276, 280 (1932)).

The "practical operation" of the employer responsibility provision is as a tax. *Nelson*, 312 U.S. at 363. Under certain circumstances, the provision imposes an "assessable payment" on large employers that do not offer adequate health insurance coverage to their full-time employees. 26 U.S.C. 4980H(a); see also 26 U.S.C.A. 4980H(b). The provision is administered exclusively by the Internal Revenue Service, see 26 U.S.C.A. 4980H(d), and it will unquestionably be "productive of some revenue," *Sonzinsky* v. *United States*, 300 U.S. 506, 514 (1937).

Moreover, the provision is just one example of Congress's use of its taxing power to encourage employers to provide adequate health insurance. See Congressional Budget Office, *Key Issues In Analyzing Major Health Proposals* 29 (Dec. 2008); 11-398 Pet. 27-28 & n.4. The fact that Congress had a regulatory motivation in enacting the employer responsibility provision is immaterial.

A tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States* v. *Sanchez*, 340 U.S. 42, 44 (1950).

The Court should not consider whether to overrule *Garcia*'s holding on the Commerce Clause in a case in which such a ruling would be unnecessary to the outcome.[11]

3. The government's petition for a writ of certiorari in No. 11-398 demonstrates that the court of appeals fundamentally erred in invalidating the minimum coverage provision, which is a proper exercise of Congress's commerce power and, independently, its taxing power. In the event the Court disagrees, however, it would be appropriate for the Court to grant certiorari to determine certain issues concerning whether additional provisions of the Act may be severed from the minimum coverage provision. Accordingly, the federal government believes that the Court should grant NFIB's petition and the third question presented in the States' petition.

a. The court of appeals correctly rejected petitioners' call for "wholesale invalidation" of the Act on the asserted ground that *none* of the Act's other provisions could be severed from the minimum coverage provision. App. 174a-176a. This Court has repeatedly held that, "when confronting a constitutional flaw in a statute," a

[11] Before the district court, the state petitioners attempted to argue that the taxes that might be imposed on them by the employer responsibility provision would violate the "inter-governmental-tax-immunity doctrine." Docket No. 68, at 58. The district court held, however, that the state petitioners had failed to plead that claim, and, in the alternative, concluded that it failed as a matter of law. App. 451a n.14. The state petitioners challenged neither determination in the court of appeals, and they have not sought review of them in their petition for a writ of certiorari.

court must "try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (internal quotation marks and citation omitted). "[T]he 'normal rule,'" therefore, "is that 'partial, rather than facial, invalidation is the required course' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 329 (2006) (citation omitted). If provisions are "fully operative as a law," they must be sustained "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Free Enterprise Fund*, 130 S. Ct. at 3161 (brackets in original) (quoting *New York*, 505 U.S. at 186).

The court of appeals correctly explained that many of the Act's provisions are "wholly unrelated" to the minimum coverage provision, such as the provision that requires employers to provide reasonable break times for nursing mothers and the one establishing an epidemiology-laboratory capacity grant program. App. 174a-175a (providing additional examples); see also States' C.A. Br. 65 n.8 (noting state petitioner Washington's concession that the Act's reauthorization of the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, was severable from the minimum coverage provision).

Moreover, many of the Act's provisions are already in effect. See HHS, *Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights* 1-13 (Sept. 23, 2011). For example, more than 20 sections of the Act made changes to Medicare payment rates for 2011. Those revi-

sions have been incorporated through notice-and-comment rulemaking into Medicare payment regulations and implemented through changes to nearly every major Medicare claims processing system. See 75 Fed. Reg. 73,170 (Nov. 29, 2010); 75 Fed. Reg. 71,800 (Nov. 24, 2010); 75 Fed. Reg. 50,042 (Aug. 16, 2010). In addition, the Act already requires insurers that provide coverage for adult children to continue making such coverage available until the young adult turns 26. 42 U.S.C.A. 300gg-14; see Office of the Asst. Sec'y for Planning & Evaluation, HHS, *ASPE Issue Brief: One Million Adults Gain Health Insurance in 2011 Because of the Affordable Care Act* 1 (Sept. 21, 2011) (One million additional young adults had health insurance in the first quarter of 2011 after this provision of the Act took effect.). Petitioners cannot meet their burden of establishing that it is "evident" (*Free Enterprise Fund*, 130 S. Ct. at 3161 (citation omitted)) that, absent the minimum coverage provision, Congress would not have enacted those already-effective provisions. Congress clearly contemplated that they would properly work independently of the minimum coverage provision because they took effect three years before that provision.

In addition, many of the Act's provisions are subject to special statutory review procedures, such as the Medicare Act's special review provision, see *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), and the Anti-Injunction Act, 26 U.S.C. 7421(a), which bars review of the Act's many tax provisions outside the context of a suit for refund. Such exclusive review provisions would preclude judicial review and invalidation of the provisions to which they apply in the context of a severability analysis in this case.

b. Absent petitioners' request for wholesale invalidation of the Act, a proper severability analysis would focus on the Act's individual provisions, and a particular provision would not be invalidated on inseverability grounds unless it was evident that Congress would not have enacted it without a minimum coverage provision. Petitioners did not attempt to make such a provision-by-provision showing before the district court or the court of appeals. Nor do they identify any such provisions (other than the guaranteed-issue and community-rating provisions discussed below) in the questions presented or bodies of their certiorari petitions.

Moreover, petitioners must demonstrate that each of the Act's provisions they contend is inseverable from the minimum coverage provision "burden[s]" them. *Printz*, 521 U.S. at 935. But the vast majority of those provisions do not regulate petitioners, instead affecting "the rights and obligations of parties not before the Court." *Ibid.* (declining to address severability where party challenging constitutionality of federal statutes was unaffected by additional provisions claimed to be inseverable); see *Davis* v. *Federal Election Comm'n*, 554 U.S. 724, 733-734 (2008) ("'[S]tanding is not dispensed in gross.' Rather, 'a plaintiff must demonstrate standing for each claim he seeks to press' and 'for each form of relief' that is sought.") (brackets in original; citations omitted).[12]

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[12] Petitioner NFIB's bald assertion that "countless provisions of the Act aggrieve NFIB and its members," Pet. 15, does not establish its ability to challenge unspecified provisions on behalf of unidentified members. See *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 498 (2009). NFIB has never demonstrated that any of its members is burdened by any provision in the Act other than the minimum coverage provision.

c. Although the state petitioners are affected by the expansion of Medicaid eligibility and thus may properly raise in this case the contention that it is inseverable from the minimum coverage provision, that contention is incorrect on the merits. The Medicaid eligibility expansion plainly could function independently of the minimum coverage provision, and petitioners fail to demonstrate that it is "evident" that Congress would not have enacted it without the minimum coverage provision. As noted, that expansion is expected to provide health insurance for more than 16 million individuals. See p. 16, *supra*. Moreover, Congress has on several occasions expanded eligibility for Medicaid without enacting a minimum coverage provision, see p. 13, *supra*, demonstrating that the two provisions need not stand or fall together. See *New York*, 505 U.S. at 186 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated.").

The state petitioners also have a stake in whether the employer responsibility provision is inseverable from the minimum coverage provision because it applies to them. *Printz*, 521 U.S. at 935. But they cannot press that contention as part of this pre-enforcement challenge because of the Anti-Injunction Act. See pp. 18-21, *supra*. In any event, there is no basis to conclude that the employer responsibility provision could not function without the minimum coverage provision. Congress has long used the tax code to encourage employers to provide health insurance benefits for their employees, see p. 25, *supra*, and petitioners fail to demonstrate that it is evi-

dent that Congress would not have done so in this instance absent a minimum coverage provision.

d. The court of appeals separately considered the severability of the Act's guaranteed-issue and community-rating provisions from the minimum coverage provision. App. 176a-186a. As an initial matter, petitioners (none of which is an insurance company) did not demonstrate that they were burdened by those provisions. See *Printz*, 521 U.S. at 935.[13] The court of appeals therefore should not have reached the question of the severability of those provisions at petitioners' behest, and the court of appeals' ruling that those provisions can be severed therefore should at least be vacated.

Assuming *arguendo* that the court of appeals properly reached the merits of the severability of the guaranteed-issue and community-rating provisions, it erred in finding them severable from the minimum coverage provision. Beginning in 2014, the guaranteed-issue and community-rating provisions will bar insurers from refusing to issue health insurance coverage to a person because of a pre-existing medical condition, 42 U.S.C.A. 300gg-1(a), 300gg-3(a), and from charging higher premiums based on a person's medical history, 42 U.S.C.A. 300gg. The experience of state insurance regulators demonstrated that this system of guaranteed issue and community rating would not effectively achieve afford-

[13] Before the court of appeals, the federal government explained that the guaranteed-issue and community-rating provisions were "integral[ly]" related to the minimum coverage provision but argued that a finding of inseverability could not be made in this case because "even when particular provisions are integrally related, a court may not address provisions that do not burden parties to the litigation." Fed. Gov't C.A. Br. 59 (citing *Printz*, 521 U.S. at 935); see Fed. Gov't C.A. Reply Br. 59.

able coverage without a minimum coverage provision that prevents individuals from exploiting the new guarantees by delaying their purchase of insurance until their medical costs outstrip the cost of health insurance premiums.

For example, citing New Jersey's experience, Professor Uwe Reinhardt of Princeton University explained that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 111th Cong., 1st Sess. 10 (Mar. 17, 2009). In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 91-92 (2000). Likewise, when Maine enacted similar legislation, most insurers withdrew from the State. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways and Means*, 111th Cong., 1st Sess. 117 (2009) (statement of Phil Caper, M.D., and Joe Lendvai).

Against that background, Congress expressly found that the minimum coverage provision is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C.A. 18091(a)(2)(I). The decision of the court below in this case to reject that empirical judgment of Congress—like its decision to reject Congress's empirical judgments that provide the constitu-

tional foundation for its enactment of the minimum coverage provision—reflects an extraordinary disregard for the "traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy," *Turner Broad. Sys. Inc.* v. *FCC*, 520 U.S. 180, 196 (1997).

CONCLUSION

The Court should, in conjunction with a grant of the federal government's petition in No. 11-398, grant the petition in No. 11-400, limited to the third question presented. The petition in No. 11-400 should otherwise be denied. The Court should grant the petition in No. 11-393.

Respectfully submitted.

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OCTOBER 2011