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Florida v. HHS - Amicus Brief of Chamber of Commerce

United States Chamber of Commerce

Nos. 11-11021-HH, 11-11067-HH

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Pam Bondi Attorney General,
STATE OF SOUTH CAROLINA, by and through Alan Wilson Attorney General,
et al.,

Plaintiffs-Appellees/Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
KATHLEEN SEBELIUS, in her official capacity as the Secretary of the United States Department of Health and Human Services, et al.,

Defendants-Appellants/Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

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State of Florida, et al. v. United States Dep't of Health & Human Servs., et al.
Nos. 11-11021-HH, 11-11067-HH

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, undersigned counsel certifies that *amicus* is not a publicly held corporation and that no corporation or other publicly held entity owns more than 10% of its stock. Pursuant to 11th Circuit Rule 26.1-1, undersigned counsel for *amicus* certifies that, to the best of his knowledge, the list of persons or entities that have or may have an interest in the outcome of this case is adequately set forth in the Appellants' opening brief and the subsequently filed briefs of the other *amici* in this case, except for the following additions:

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INTERESTS OF *AMICUS CURIAE*[1]

The Chamber of Commerce of the United States of America (the Chamber) is the world's largest business federation, representing 300,000 direct members and indirectly representing an underlying membership of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. At least 98 percent of the Chamber's members are small businesses with one hundred or fewer employees. The Chamber advocates on issues of vital concern to the nation's business community and has frequently participated as *amicus curiae* before this Court and other courts. The provision of health insurance is of considerable interest to Chamber members, since many of them are employers who provide health insurance to their employees. Indeed, employers are the country's largest providers of health insurance, providing coverage for more than 160 million people and more than 60 percent of nonelderly Americans.

[1] The parties have consented to the filing of this brief. Fed. R. App. P. 25(a). No counsel for a party authored this brief in whole or in part, and no such counsel or any party made a monetary contribution intended to fund the preparation or submission of this brief. Fed. R. App. P. 29(c)(5)(A)–(B). No person or entity—other than *amicus*, its members, or its counsel—made a monetary contribution intended to fund this brief's preparation or submission. Fed. R. App. P. 29(c)(5)(C).

INTRODUCTION AND SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act (PPACA or the Act) contains an extensive set of reforms primarily intended to make health insurance available to and affordable for millions of uninsured Americans and increase the quality of health insurance for all Americans. *See* President Barack Obama, Remarks to a Joint Session of Congress on Health Care (Sept. 9, 2009), *available at* http://www.whitehouse.gov/the_press_office/remarks-by-the-president-to-a-joint-session-of-congress-on-health-care ("[I]f you're one of the tens of millions of Americans who don't currently have health insurance … this plan will finally offer you quality, affordable choices."). The Act's insurance reforms are interdependent and built upon one central provision: the minimum coverage mandate in Section 1501. PPACA, Pub. L. No. 111-148 § 1501(a), 26 U.S.C. § 5000A(a).

The individual mandate is central to the health insurance reforms because Congress understood that it could not simply prohibit insurers from denying coverage or increasing the costs of coverage to the unhealthiest subscribers. Standing alone, those restrictions (the core of which is known as the guaranteed-issue and community-rating reforms) would make health insurance ***less*** affordable because individuals would wait to purchase health insurance until they absolutely needed it, forcing insurers to raise premiums for everyone else. To prevent this,

Congress's solution was to include a minimum coverage requirement in the PPACA—the so-called individual mandate.

By requiring individuals to maintain a minimum level of health insurance coverage, the individual mandate prevents the type of adverse selection that would otherwise undermine the PPACA's insurance market reforms. The individual mandate makes it possible for the guaranteed-issue, community-rating, and other insurance reforms to function as Congress intended. As Congress explained, the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that … do not exclude coverage of preexisting conditions can be sold." 42 U.S.C. § 18091(a)(2)(I).

This Court has received substantial briefing on the question of whether the individual mandate represents a valid exercise of Congress's constitutional powers. *Amicus* does not address this issue and takes no position on the constitutionality of the individual mandate, but instead submits this brief to address a secondary question—*viz.*, if the individual mandate were held to exceed Congress's powers, which additional provisions of the PPACA should be considered non-severable from the individual mandate and thus fall with it.

The district court below concluded that it was impossible to sever the individual mandate from the PPACA, and it therefore struck down the entire Act upon finding the mandate unconstitutional. Record Excerpts (RE) 2074-75. That

court correctly emphasized the centrality of the mandate to the PPACA, concluded that the mandate was essential to the operation of the PPACA's health insurance market reforms, and determined that those reforms could not survive without the mandate. RE 2072-74. That court further reasoned that the PPACA's health insurance reforms comprise the core of the Act, and that any effort to engage in a line-by-line analysis of the 2,700 page Act to identify discrete provisions that should remain standing independently of the mandate would amount to a judicial reconstruction of the Act. RE 2074-75. Therefore, that court struck down the entirety of the Act, reasoning that any effort to implement health care reform absent the individual mandate is a task best left to Congress. RE 2075.

If this Court agrees with the district court that the individual mandate is unconstitutional, the Court will then need to consider whether, as the district court determined, invalidation of the mandate requires setting aside the PPACA in its entirety. If the Court disagrees with the district court's severability analysis, the prudent course is to remand to the district court for close scrutiny of the PPACA provisions to assess which of the remaining provisions Congress would have enacted in the absence of the individual mandate. Such an assessment would require examining whether the remaining provisions and insurance reform requirements would function as intended without the individual mandate. Applying those standards here, this Court must conclude that, at a minimum, the

health insurance reform provisions in the PPACA are non-severable from the individual mandate and would necessarily fall with it. If the PPACA's remaining insurance reform provisions were left standing in the absence of the mandate, individuals and employers who sponsor health insurance coverage for their employees would surely encounter significant market disruption. Health care costs would rise and fewer individuals would obtain coverage—precisely the opposite of Congress's intentions.

For instance, the United States has explained that two of the principal health insurance reforms enacted by the PPACA—the guaranteed-issue and community-rating reforms—would necessarily fall with the minimum coverage mandate. *See* U.S. Br. at 59; RE 1765 ("As defendants have made clear . . . the guaranteed issue and community insurance industry reforms in Section 1201 will stand or fall with the minimum coverage mandate."). In the absence of the mandate, individuals would be encouraged to forgo purchasing insurance until they become sick, thereby causing an increase in insurance premiums for the remaining consumers. The increase in premiums would in turn cause healthy individuals to relinquish (or refrain from obtaining) health insurance, causing premiums to rise still further. This "premium spiral" has been experienced in various states that have enacted similar health insurance reforms without an accompanying minimum coverage mandate (such as New York, Kentucky, and Washington). The legislative record

confirms that Congress understood this dynamic and would not have enacted guaranteed-issue and community-rating reforms in the absence of the individual mandate.

But the severability inquiry does not—and cannot—end with the guaranteed-issue and community-rating reforms alone. Rather, other insurance reforms in the PPACA, beyond guaranteed-issue and community-rating, are also dependent on the individual mandate. As one example, the Act's risk adjustment mechanism would not function properly without the individual mandate and the associated community-rating and guaranteed-issue reforms. PPACA § 1343, 42 U.S.C. § 18063. Risk adjustment provisions are necessary to counterbalance the incentive created by guaranteed issue and community rating for insurers to seek out healthy subscribers, in lieu of unhealthy subscribers. This incentive exists because guaranteed issue and community rating prevent insurers from underwriting and pricing products based on the risk presented. The PPACA's risk adjustment mechanism counteracts those incentives by reallocating premium revenues among insurers so that each insurer receives an amount proportional to its actual risk exposure. But if the mandate, guaranteed-issue, and community-rating provisions were invalidated and the risk adjustment mechanism remained, gross inefficiencies in the health insurance markets would exist, allowing insurers to pass off to others the consequences of flawed underwriting and poor management of health care

costs. This would lead to an increase in health insurance costs, undermining one of the primary aims of the PPACA.

Amicus does not purport to catalog here the full complement of provisions in the Act that should be deemed non-severable from the individual mandate. Instead, the principal purpose of this brief is to demonstrate that basic severability principles would dictate that many provisions of the Act are non-severable from the individual mandate. If this Court is not inclined to invalidate the Act in its entirety, the prudent course would be to remand the case to the district court with instructions to conduct further analysis on this issue. A remand would enable the district court to supplement the record and obtain additional briefing and evidence on the interrelationship of the minimum coverage mandate and the health insurance reform provisions in the PPACA.

ARGUMENT

I. IF THE MINIMUM COVERAGE MANDATE IS HELD TO EXCEED CONGRESS'S CONSTITUTIONAL POWERS, HEALTH INSURANCE REFORM PROVISIONS IN THE PPACA SHOULD ALSO BE INVALIDATED AS NON-SEVERABLE FROM THE MANDATE

A. Applying Severability Analysis to the PPACA

As the Supreme Court has explained, when a court strikes down a particular statutory provision on the grounds that it exceeds Congress's constitutional powers, the remaining provisions in the act will remain standing "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (quotation marks omitted); *see also Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010). In short, the question is whether Congress would have enacted the remaining provisions in the absence of the invalid one. *See Alaska Airlines*, 480 U.S. at 685 ("The final test" for severability holds that "the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted."). That overarching question turns on an assessment of whether the remaining provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the invalidated provision. *Id.*

Congress can "ease[]" the inquiry by enacting a severability clause that expressly dictates that if any provision is invalidated, it should be considered

severable from the remainder of the statute. *Id.* at 686. In that case, there is a "presumption" that the "objectionable provision can be excised from the remainder of the statute," leaving the remaining provisions intact. *Id.* This presumption does not apply to the PPACA, however, because Congress chose not to include a severability clause in the Act. Indeed, Congress considered one version of the legislation that would ultimately become the PPACA that contained a severability clause. *See* H.R. 3962, 111th Cong. § 255 (as passed by House, Nov. 7, 2009) ("If any provision of this Act … is held to be unconstitutional, the remainder of the provisions of this Act … shall not be affected."). Congress elected to pass the bill without a severability clause.

Thus far, two district courts have found the mandate unconstitutional and have applied severability analysis to the PPACA, reaching divergent conclusions. In *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010), the court effectively bypassed the required severability analysis after observing that, "without the benefit of extensive expert testimony and significant supplementation of the record, this Court cannot determine what, if any, portion of the bill would not be able to survive independently." *Id.* at 789. Rather than supplement the record and hear expert testimony, however, the court mechanically and without explanation ruled that other PPACA provisions were non-severable from the mandate only if they explicitly cross-reference the mandate. *Id.* at 790. That unprecedented and

formalistic approach to severability implicates an arbitrary handful of the PPACA provisions without regard to the basic question of which provisions Congress would have enacted in the absence of the mandate.[2] Indeed, that approach would even leave intact the PPACA's guaranteed-issue and community-rating reforms, 42 U.S.C. §§ 300gg–300gg-4, which the United States has rightly explained could not survive without the mandate but do not explicitly cross-reference it.

The district court below, by contrast, correctly emphasized Congress's findings that the individual mandate is essential to the guaranteed-issue and community-rating provisions. RE 2071-72. The court concluded that those provisions of the Act, as the United States has recognized, could not survive without the mandate. RE 2071-72. As the court explained, "the individual mandate is indisputably necessary to the Act's insurance market reforms, which are, in turn, indisputably necessary to the purpose of the Act." RE 2072. For that reason—and because the PPACA lacks a severability clause—the Court struck down the Act in its entirety as non-severable from the mandate. RE 2075. Any other conclusion, the court explained, would call for a line-by-line, judicial

[2] The court made no effort to identify which provisions of the PPACA—if any—specifically reference the mandate. Thirteen statutory provisions include one or more references to 26 U.S.C. § 5000A, the provision codifying the mandate. *See* PPACA §§ 1001, 1251, 1302, 1311, 1312, 1331, 1332, 1401, 1411, 1512, 1514, 9001, and 9014.

rewriting of a complex and interwoven congressional enactment, a quasi-legislative function best left to Congress in the first instance. RE 2075.

The district court's approach allows Congress, rather than the courts in the first instance, to decide what elements of the PPACA should remain the law of the land absent the mandate. However, if this Court were to disagree with this approach and decline to invalidate the PPACA in its entirety, applicable severability principles at least would require careful examination of the interrelationship between the mandate and the PPACA's health insurance reforms. In particular, there are compelling reasons for recognizing the non-severability of health insurance reform provisions beyond those that the United States has expressly identified as non-severable from the mandate—the guaranteed-issue and community-rating provisions.

Amicus does not attempt in this brief to compile an exhaustive catalog of the particular PPACA health insurance reforms that must fall with the mandate under an appropriate severability analysis. Instead, it first explains why the community-rating and guaranteed-issue reforms are non-severable from the mandate, and further illustrates why the list of non-severable provisions cannot end there. An examination of several health insurance reforms in the PPACA illustrates the interconnection between the individual mandate and various PPACA provisions.

B. A Proper Approach to Severability Compels the Conclusion that the PPACA's Guaranteed-Issue and Community-Rating Provisions Are Non-Severable from the Individual Mandate

In this case and in related litigation, the United States has explained that the PPACA's guaranteed-issue and community-rating provisions cannot survive without the individual mandate. RE 1765 ("Because Congress would not have intended this result, these reforms cannot be severed from the minimum coverage provision."). Those reforms prohibit denying coverage or raising premiums based on preexisting conditions, and in the absence of the mandate, they would not "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. Congress explained the interrelationship between those reforms and the mandate in the express terms of the Act:

> [I]f there were no [minimum coverage] requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

PPACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I). In light of Congress's own explanation of its intent, the guaranteed-issue and community-rating provisions plainly should be deemed non-severable from the mandate.

The PPACA's guaranteed-issue provisions bar health insurers from denying coverage based on a subscriber's preexisting conditions or medical history. *See, e.g.*, 42 U.S.C. § 300gg-4(a) ("A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors…."). The PPACA's community-rating provisions prescribe that insurers may not charge higher premiums based on preexisting conditions and certain other factors. *See, e.g.*, 42 U.S.C. § 300gg(a)(1). Those provisions thus preclude health insurers from raising premiums based on any condition other than age, geography, and tobacco use. The provisions also establish limits on the extent of permissible variations in premiums based on those three factors. 42 U.S.C. § 300gg(a)(1)(A)(ii) – (iv).[3]

Congress understood that, in the absence of the individual mandate, the guaranteed-issue and community-rating provisions would disrupt the health insurance market due to adverse selection. If health insurance companies may not adjust premiums or deny coverage based on preexisting conditions, healthy individuals would have little incentive to obtain insurance until they become sick

[3] Both the guaranteed-issue and community-rating provisions are found in Title I, Section 1201 of the PPACA. PPACA § 1201, codified at 42 U.S.C. §§ 300gg – 300gg-7.

and need coverage, because they know full well that they will be able to obtain insurance at the same price at such a time. Therefore, healthy persons would opt out of the insurance market, which would leave health insurers little choice but to raise premiums to account for the diminished health (on average) of their subscribers. This increase in premiums will cause more healthy individuals to forgo health insurance, further increasing premiums, and so on. As the United States has starkly explained, "[a]bsent a minimum coverage provision, the guaranteed-issue and community-rating reforms in Section 1201 would incentivize many to drop coverage, leading to a spiral of increased premiums and a shrinking risk pool—the insurance market will 'implode.'" RE 1765; *see also* Making Health Care Work for American Families: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce, 111th Cong. 11 (Mar. 17, 2009), *available at* http://democrats.energycommerce.house.gov/Press_111/20090317/testimony_reinhardt.pdf (testimony of Prof. Uwe E. Reinhardt) ("It is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance.").[4]

[4] Experts in the health care field share the view that the individual mandate is essential to the intended operation of the PPACA's guaranteed-issue and community-rating provisions. *See, e.g.*, Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the PPACA*, 364 New Eng. J. Med. 16e (Mar. 10, 2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMpv1101519?ssource=hcrc ("Although they are politically popular, these community-rating and guaranteed-issue provisions can reduce the stability of

Congress's concerns about an "implosion" of the health insurance market are reinforced by the experience that various states have had when implementing comparable community-rating and guaranteed-issue provisions without an individual mandate. Seven states have enacted guaranteed-issue laws without an accompanying mandate. Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (1994) (repealed); Me. Rev. Stat. tit. 24-A, § 2736-C(3); N.H. Rev. Stat. § 420-G:6 (1994); N.J. Stat. § 17B:27A-22; N.Y. Ins. L. §§ 3231, 3232; Vt. Stat. Ann. tit. 8, § 4080B(d)(1); Wash. Code § 48.43.012(1). Studies in those states reveal precisely the type of adverse selection problems that Congress sought to avoid in the PPACA. *See* Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 97 (2000) ("Following reform, the overall percentage of the population with insurance has worsened…."); Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 Suffolk U. L. Rev. 1271, 1291 (1993)

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private health insurance markets.… The primary purpose of the individual mandate is to mitigate this adverse selection…."); Anthony T. Lasso, National Institute for Health Care Management Foundation, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market,* at 2 (Jan. 2011), *available at* http://nihcm.org/pdf/EV-LoSassoFINAL.pdf (stressing the "distortions that can result from community rating and guaranteed issue regulations in the non-group market when there are no provisions in place to keep people enrolled in coverage"); Jonathan Gruber, Center for American Progress, *Why We Need the Individual Mandate*, at 1 (Apr. 8, 2010), *available at* http://www.americanprogress .org /issues/ 2010/04/pdf/individual_mandate.pdf ("Without the individual mandate, the entire structure of reform would fail.").

(New York's community rating requirement "has led to an increase in rates for young, healthy insureds" and "many of them have dropped their health insurance coverage"). Indeed, the Kentucky market reforms were repealed because they destabilized the health insurance market. *Cf.* Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol., Pol'y & L. 133, 151 (2000) ("The Kentucky reform experience has become notorious for the mass exit of insurers from its market.").

For those reasons, there is no basis to doubt Congress's express understanding that the individual mandate is "essential" to the proper functioning of a health insurance market that includes the PPACA's guaranteed-issue and community-rating provisions. 42 U.S.C. § 18091(a)(2)(I). The mandate and those reforms are a tightly interwoven group, which presumably stands or falls together. *Cf. Carter v. Carter Coal Co.*, 298 U.S. 238, 315-16 (1936) ("These two sets of requirements are not like a collection of bricks, some of which may be taken away without disturbing the others, but rather are like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole.").

C. Health Insurance Reforms Beyond the Guaranteed-Issue and Community-Rating Provisions Are Similarly Intertwined With the Individual Mandate for Severability Purposes

While explaining that the guaranteed-issue and community-rating provisions would necessarily fall if the individual mandate were to be invalidated, the United States thus far has deferred any comprehensive effort to identify or assess which additional provisions in the PPACA it would deem non-severable from the mandate. U.S. Br. 55-60. If this Court disagrees with the district court below and declines to invalidate the PPACA in its entirety, there are compelling reasons for recognizing the non-severability of other health insurance reform provisions.

1. The PPACA's risk-adjustment provision

The risk adjustment provision in Section 1343 of the PPACA, 42 U.S.C. § 18063, would not function as Congress intended without the individual mandate and its associated guaranteed-issue and community-rating provisions. Under a community-rating system, health plans generally obtain the same premium per subscriber, regardless of a subscriber's health status, gender, or other demographic factors. Health plans with healthier members may receive a windfall because they earn an identical premium (per subscriber) to plans that must pay more in claims. *See* Robert Kuttner, *The Risk-Adjustment Debate*, 339 New Eng. J. Med. 1952, 1952 (Dec. 24, 1998) ("If plans receive the same unadjusted premium for each subscriber, then the plan with healthier members reaps an unearned windfall.").

This system rewards so-called "cream skimming," *i.e.*, efforts to attract healthier subscribers and discourage riskier individuals, instead of rewarding the provision of quality service. *Id.* at 1952.

The PPACA's risk adjustment provision in Section 1343 counteracts those incentives by reallocating premiums in a manner proportional to the actuarial risk of each health insurer's subscribers. Under the risk adjustment provision, states must levy a charge on insurers whose level of actuarial risk falls below the statewide average. 42 U.S.C. § 18063. States then transfer those funds to health insurers carrying an actuarial risk exceeding the statewide average. By aligning premium revenues with actuarial risk, the risk-adjustment mechanism diminishes the incentive to target healthier populations. *See* General Accounting Office, *Health Care Reform: Considerations for Risk Adjustment under Community Rating*, GAO/HEHS 94-173, at 1 (Sept. 22, 1994), *available at* http://archive.gao.gov/t2pbat2/152795.pdf (risk adjustment is meant to "reduce the undesirable effects of community rating on insurers' incentives").

If the individual mandate and the associated community-rating reforms were invalidated, the risk-adjustment provision would not function as Congress intended. Without community rating, health insurers would apply traditional underwriting principles, varying premium rates based on health risk and other relevant factors. In such market conditions, a health insurer's premiums should

already reflect the actuarial risk of its subscribers. Thus, imposing a risk-adjustment mechanism under these market conditions would transfer premium dollars from health insurers, who accurately assessed the actuarial risk of their subscribers, to other insurers who misjudged their risk pools. In fact, it could create a disincentive for insurers to appropriately manage health care costs; instead, insurers may choose to forgo expending resources to appropriately manage health care costs, relying instead on the risk adjustment mechanism to recoup any losses they may have sustained. That, in turn, would create gross inefficiencies unintended by Congress and contrary to one of the central aims of the PPACA: promoting affordable health care. The risk-adjustment provision in Section 1343 thus is non-severable from the individual mandate and community-rating reforms.

2. The PPACA's bar on annual limits for benefits

Section 1001 of the PPACA severely restricts, and eventually prohibits, health insurers from imposing annual limits on the benefits paid to subscribers. PPACA § 1001; 42 U.S.C. § 300gg-11. These restrictions currently dictate that annual limits may not be less than $750,000 per person. Interim Final Rule, 75 Fed. Reg. 37,188-01 (June 28, 2010). That floor increases to $1.25 million per person in September, 2011, to $2 million per person in September, 2012, and plans with annual limits will be phased out entirely by 2014. *Id.* This reform provision will eliminate plans with low annual limits, including so called "mini-med" or

"limited benefit" plans, often the most affordable plans for individuals with limited income.

This prohibition against annual limits only functions as intended when considered alongside the individual mandate and guaranteed-issue reforms. As previously noted, the primary purpose of the individual mandate is to avoid the potential premium spiral of continually deteriorating risk pools and escalating premiums. Congress appreciated that the mandate was critical to minimizing "adverse selection and broaden[ing] the health insurance risk pool to include healthy individuals … [in order to] lower health insurance premiums." PPACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I). But if the bar on annual limits were enforced in the absence of the individual mandate and guaranteed-issue reforms, it would eliminate one of the most affordable health insurance options for lower income individuals and thereby expand the pool of uninsured individuals contrary to Congress's intent.

While the PPACA's restrictions on low annual limits have technically already taken effect, the Department of Health and Human Services has liberally granted waivers to enable low-cost plans to continue operating until the mandate and guaranteed-issue provisions become effective. *See* Hearing of the Oversight & Investigations Subcomm. of the H. Energy & Commerce Comm. (Feb. 16, 2011) (testimony of Steven Larsen) ("[I]n establishing the waiver process … we did want

to make sure that people who have that coverage … can continue that coverage"). To date, the Department has granted approximately one thousand waivers to plans with annual limits below the current $750,000 threshold, exempting them from the Act's annual limit requirements. *See* Robert Pear, *Four States Get Waivers to Carry Out Health Law*, N.Y. Times, Feb. 17, 2011, at A22. The Department has also granted waivers to four states, exempting all plans operating within their borders from PPACA's annual limit requirements. *Id*. The Department's decisions to grant waivers to these plans demonstrate that the regulation of annual limits cannot function as intended without the individual mandate and guaranteed-issue reforms.

3. The PPACA's Medical Loss Ratio provision

The PPACA's Medical Loss Ratio (MLR) requirement, also contained in Section 1001 of the PPACA, 42 U.S.C. § 300gg-18, is another example of a provision that is inextricably linked to the individual mandate. "Medical Loss Ratio" refers to the percentage of each premium dollar expended by an insurer on the provision of health care to its subscribers, as opposed to other expenses such as administrative costs, salaries, advertising, and profits. The PPACA establishes a minimum MLR of eighty percent for individual and small group coverage, and eighty-five percent for large group coverage. PPACA § 1001, 42 U.S.C. § 300gg-18.

Congress predicated the MLR provision on the reduction in administrative costs that would accompany the individual mandate and guaranteed-issue reforms. 42 U.S.C. § 18091(a)(2)(J) ("By significantly increasing health insurance coverage and the size of purchasing pools … [PPACA] will significantly reduce administrative costs and lower health insurance premiums."). Conversely, absent the mandate's expanded risk pool and community-rating provisions (provisions which have the effect of drastically reducing underwriting costs), administrative costs are necessarily higher. *See* 42 U.S.C. § 18901(a)(2)(J) (pre-PPACA, "[a]dministrative costs for private health insurance … are 26 to 30 percent of premiums in the current individual and small group markets," an amount greater than the administrative costs contemplated under applicable MLR caps). Therefore, the MLR provision assumes the existence of the individual mandate.

The MLR provision also works in tandem with the individual mandate because the mandate increases the total number of subscribers in the risk pool, which in turn facilitates the estimation of costs in any given year. To function as intended, the MLR provision requires health insurers to price their premiums based on the expected amount of claims they will have to pay each year. With a sufficiently sizable risk pool, health insurers can make those predictions with a fair degree of accuracy. But if the individual mandate falls, insurers (particularly those in locations with smaller risk pools) could be subject to extreme variations in MLR

ratios year-over-year, which are only exacerbated by the ability of individuals to move in and out of the risk pool on the basis of their current health status (*i.e.*, sick people will move in and healthy people will move out).

Those fluctuations could be accommodated over time if health insurers were permitted to make long-term predictions based on the knowledge that any fluctuations in MLR would eventually even out over a number of years. But the PPACA's MLR requirements prevent health insurers from insulating themselves against such fluctuations by requiring plans to refund excess profits in each profitable year.[5] This prevents insurers from protecting themselves against lean years. In other words, the MLR provision can only function as Congress intended if health insurers can accurately predict their costs year by year, and those predictions in turn rest on the increased risk pool that the individual mandate would produce.

Therefore, it is no surprise that a number of states have requested exemptions from the MLR requirements in the PPACA until the mandate takes effect. For instance, Kentucky has asked that the MLR requirement remain at Kentucky's present MLR requirement of sixty-five percent for 2011, with five

[5] After the individual mandate takes effect in 2014, any refund owed under the MLR provision will be calculated based on the three-year period preceding the MLR deficiency, rather than being calculated based only on the prior year. 42 U.S.C. § 300gg-18(b)(1)(B)(ii).

percent increases each year until it reaches eighty percent in 2014. Letter from Sharon P. Clark, Ky. Ins. Comm'r, to Sec. Kathleen Sebelius (Feb. 16, 2011). New Hampshire has requested that the MLR requirement remain at seventy percent until 2014 and noted that, without this exemption, "[t]he loss of carriers providing individual insurance in New Hampshire will have a destabilizing effect on the market." Letter from Roger A. Sevigny, N.H. Ins. Comm'r, to Sec. Kathleen Sebelius, (Jan. 6, 2011), *available at* http://www.hhs.gov/ociio/regulations/mlr_adj_req_01062010.pdf. Maine, Georgia, Florida, Nevada, Louisiana, Iowa, and North Dakota have also requested an exemption from the PPACA's MLR requirements and many other states have signaled their intent to do the same in the coming months. *See* Dep't of Health and Human Servs., Medical Loss Ratio, *available at* http://cciio.cms.gov/programs/marketreforms/mlr/index.html; *Scoreboard*, Politico, Apr. 1, 2011, *available at* http://www.politico.com/politicopulse/0411/politicopulse469.html (reporting that six additional states are leaning toward filing a request for an exemption).

The Department of Health and Human Services has issued one ruling on these waiver requests so far, granting Maine an exemption from the Act's MLR requirements and adjusting Maine's individual health insurance market MLR rate to sixty-five percent through 2013. Letter from Steven B. Larsen to Mila Kofman, Me. Superintendent of Ins. (Mar. 8, 2011), *available at* http://cciio.cms.gov/

programs/marketreforms/mlr/states/maine/maine_decision_letter_3_8_11.pdf. The ruling that granted Maine's waiver request explicitly noted that "there is a reasonable likelihood" that insurers "would exit the Maine individual market in the absence of an adjustment to the 80 percent MLR standard." *Id.* at 16. This waiver, along with those that are sure to be granted in the near future, demonstrates that the Act's MLR provision is predicated on the individual mandate, and cannot function as intended without the mandate.

* * * * *

These examples generally illustrate the need, under settled severability principles, to closely examine the interrelationships between the PPACA's individual mandate and the statute's health insurance reforms. The examples are only illustrative: experts have identified additional provisions that Congress may not have implemented in the absence of the mandate and associated community-rating and guaranteed-issue reforms. *See* Herring, *supra*, New Eng. J. Med. (discussing additional provisions that may not function as intended without the mandate). Congress clearly contemplated the operation of the PPACA's health insurance reforms in conjunction with the individual mandate, not in its absence.[6] RE 2071-75.

[6] The PPACA contains a host of health insurance reform provisions beyond those discussed in this brief that require close scrutiny to determine if they are severable from the mandate. The "rate review" provision, PPACA § 1003, 42 U.S.C.

II. IF THIS COURT AFFIRMS THE INVALIDATION OF THE INDIVIDUAL MANDATE BUT DOES NOT INVALIDATE THE ENTIRE ACT, IT SHOULD REMAND TO THE DISTRICT COURT TO CONDUCT A PROPER SEVERABILITY ANALYSIS IN THE FIRST INSTANCE

If this Court concludes that the individual mandate exceeds Congress's constitutional authority, then it must determine whether to affirm the district court's conclusion that the mandate is so central to the PPACA that the entire statute must be invalidated. In the event that this Court does not invalidate the PPACA in its entirety (or the Act's full package of insurance reforms), the court should rely on established severability principles and remand the issue to the district court to assess which PPACA provisions should be invalidated as non-severable from the individual mandate.

The scope of severability—if indeed severability is found to be warranted at all—would be best determined by the district court after the parties have an opportunity to supplement the evidentiary record. A remand would properly enable the district court to expand and supplement the record to facilitate a meaningful inquiry into the interrelationship between the mandate and the PPACA's various health insurance reforms.

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§ 300gg-94, the health insurance exchanges, PPACA § 1311, 42 U.S.C. § 18031, and the health insurance provider tax, PPACA § 9010, 26 U.S.C. § 4001, are further examples of insurance reforms that were calibrated to function alongside the mandate. While the PPACA's insurance reforms are primarily located in Title I, they are interspersed throughout the Act.

As a general matter, "severability disputes usually turn on fact-intensive inquiries best left to the trial court in the first instance." *Ackerley Commc'ns of Mass., Inc. v. City of Cambridge*, 135 F.3d 210, 214−15 (1st Cir. 1998). As a result, even when confronting severability questions of substantially lesser complexity than those presented here, the courts of appeals frequently remand to allow the district court to conduct the analysis in the first instance. *See Chesapeake B&M, Inc. v. Harford County, Md.*, 58 F.3d 1005, 1012−13 (4th Cir. 1995) ("[W]e remand to the district court to determine whether and to what extent the licensing scheme is severable from the remainder of the Licensing Law."); *see also Long Beach Area Peace Network v. City of Long Beach*, 574 F.3d 1011, 1016 (9th Cir. 2009) ("We remand to allow the district court to determine whether the unconstitutional provisions are severable from the remainder."); *Am. Banker's Ass'n v. Gould*, 412 F.3d 1081, 1083 (9th Cir. 2005) ("Because there is a possibility that some part of these provisions may survive preemption, we remand to the district court."); *Vt. Right of Life Comm., Inc. v. Sorrell*, 211 F.3d 376, 389 (2d Cir. 2000) (directing "the district court, on remand, to analyze the issue of severability in the first instance").

In the event the Court declines to invalidate the entire Act, additional considerations compel a remand in this case. The United States did not fully brief severability questions before the district court, but instead took the position that

"[w]orking through the complex permutations presented by the issue of severability is an effort best undertaken in separate briefing if this case reaches that stage." RE 1763. Thus, the United States has yet to fully address its views regarding the proper scope of severability if the individual mandate is stricken. In addition, even if the Court were inclined to limit a finding of non-severability to those provisions that the United States has itself acknowledged must fall (*i.e.*, the guaranteed-issue and community-rating reforms), it is not clear which precise statutory provisions would be stricken. There is no single provision of the Act that embodies all of the guaranteed-issue reforms, nor is there a single provision that constitutes the community-rating reforms. Rather, elements of these reforms are contained within multiple statutory provisions. *See* 42 U.S.C. §§ 300gg, 300gg-1−300gg-4. Therefore, even a narrow severability ruling would be difficult to implement at the appellate level and would be better suited to the determination of a district court on remand after receipt of additional briefing. Also, as explained above, there is a need for a close examination of the other health insurance reforms contained in the PPACA. The district court is better positioned to receive evidence and consider full briefing devoted to these issues, along with expert testimony and expansion of the record as needed.

CONCLUSION

If this Court determines that the minimum coverage mandate is unconstitutional and declines to invalidate the entire Act, it should remand the case to the district court to receive evidence and briefing from the parties to determine which other health insurance reforms in the PPACA must fall with the mandate.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Under Federal Rule of Appellate Procedure 32(a)(7)(C) and Eleventh Circuit Rule 28-1(m), I hereby certify that the foregoing brief of Chamber of Commerce of the United States of America as *amicus curiae* in support of neither party complies with (1) the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5)(A) because it was written in Times New Roman, 14-point font and (2) the type-volume limitations contained in Fed. R. of App. P. 28.1(e)(2)(C), because it contains 6,351 words, excluding those parts of the brief excluded from the word count under 11th Circuit Rule 32-4. The text of the hard copy of this brief and the text of the PDF version of the brief filed electronically are identical. A virus check was performed on the E-brief using Symantec Endpoint Detection and no virus was detected.

/s/ Joshua Deahl
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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing brief of Chamber of Commerce of the United States of America as *amicus curiae* in support of neither party has been served by FedEx, a third-party commercial carrier, for delivery within three business days on this 9th day of April, 2011, to the following counsel of record:

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