Nos. 19-840 and 19-1019

In the Supreme Court of the United States

STATE OF CALIFORNIA, ET AL., PETITIONERS

v.

STATE OF TEXAS, ET AL.

STATE OF TEXAS, ET AL., PETITIONERS

v.

STATE OF CALIFORNIA, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the plaintiffs have standing to challenge the application of certain provisions of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119.

2. Whether, as a result of the elimination of the monetary penalty for noncompliance with the ACA's minimum-essential-coverage requirement, 26 U.S.C. 5000A(a), that requirement is no longer a valid exercise of Congress's legislative authority.

3. Whether, if the minimum-essential-coverage requirement is now invalid, the remainder of the ACA's provisions are inseverable from it.

PARTIES TO THE PROCEEDING

Petitioners in No. 19-840 are the States of California, Connecticut, Delaware, Hawaii, Illinois, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, the Commonwealth of Massachusetts, the District of Columbia, and Andy Beshear, the Governor of Kentucky, all of which intervened in the district court and were appellants in the court of appeals; and the States of Colorado, Iowa, Michigan, and Nevada, which intervened as defendants in the court of appeals. Respondents in No. 19-840 are the United States of America, the United States Department of Health and Human Services, the United States Internal Revenue Service, Alex Azar II, in his official capacity as Secretary of Health and Human Services, and Charles P. Rettig, in his official capacity as the Commissioner of the Internal Revenue Service, all of which were defendants in the district court and filed a notice of appeal but argued in defense of the district court's decision in the court of appeals; the United States House of Representatives, which intervened as a defendant in the court of appeals; and the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi by and through Governor Phil Bryant, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, and Neill Hurley and John Nantz, all of which were plaintiffs in the district court and appellees in the court of appeals.

Petitioners in No. 19-1019 are the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi by and through Governor Phil Bryant, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and

West Virginia, and Neill Hurley and John Nantz, all of which were plaintiffs in the district court and appellees in the court of appeals. Respondents in No. 19-1019 are the United States of America, the United States Department of Health and Human Services, the United States Internal Revenue Service, Alex Azar II, in his official capacity as Secretary of Health and Human Services, and Charles P. Rettig, in his official capacity as the Commissioner of the Internal Revenue Service, all of which were defendants in the district court and filed a notice of appeal but argued in defense of the district court's decision in the court of appeals; the States of California, Connecticut, Delaware, Hawaii, Illinois, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, the Commonwealth of Massachusetts, the District of Columbia, and Andy Beshear, the Governor of Kentucky, all of which intervened in the district court and were appellants in the court of appeals; and the States of Colorado, Iowa, Michigan, and Nevada, and the United States House of Representatives, which intervened as defendants in the court of appeals.

The State of Wisconsin was originally a plaintiff in the district court but later sought and was granted dismissal from the appeal.

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OPINIONS BELOW

The amended opinion of the court of appeals (J.A. 374-489) is reported at 945 F.3d 355. The memorandum opinion and order of the district court granting partial summary judgment (Pet. App. 163a-231a) is reported at 340 F. Supp. 3d 579.[1] The order of the district court granting a stay and partial final judgment (Pet. App. 117a-162a) is reported at 352 F. Supp. 3d 665.

[1] Unless otherwise indicated, this brief refers to the appendix to the petition for a writ of certiorari in No. 19-840.

JURISDICTION

The judgment of the court of appeals was entered on December 18, 2019. The petition for a writ of certiorari in No. 19-840 was filed on January 3, 2020, and the conditional cross-petition for a writ of certiorari in No. 19-1019 was filed on February 14, 2020. The petitions were granted on March 2, 2020. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are reproduced in the addendum to this brief. App., *infra*, 1a-24a.

STATEMENT

1. The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, established a framework of economic regulations and incentives that restructured the health-insurance and healthcare industries. See J.A. 376. Among many other provisions, Title I of the ACA, 124 Stat. 130, enacting 26 U.S.C. 5000A, see ACA § 1501(b), 124 Stat. 244, contains a "[r]equirement to maintain minimum essential coverage," 26 U.S.C. 5000A (emphasis omitted), which is colloquially known as the "individual mandate," *e.g.*, J.A. 375; see also ACA § 10106(b), 124 Stat. 909. Subsection (a) of Section 5000A provides that certain individuals "shall * * * ensure" they are "covered under minimum essential coverage." 26 U.S.C. 5000A(a). Subsection (b) imposes "a penalty," denominated as a "[s]hared responsibility payment," on certain taxpayers who "fail[] to meet the requirement of subsection (a)." 26 U.S.C. 5000A(b) (emphasis omitted). And subsection (c) specifies "[t]he amount of the penalty imposed" for noncompliance. 26 U.S.C. 5000A(c). As originally enacted, the

penalty was "calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 539 (2012) (*NFIB*); see ACA §§ 1501(b), 10106(b)(2) and (3), 124 Stat. 244, 909-910 (26 U.S.C. 5000A(c) (Supp. V 2011)).

In addition to the individual mandate, the ACA includes a number of other provisions addressing the health-insurance and healthcare sectors. For example, the "guaranteed-issue" provisions prohibit insurers from denying coverage because of an individual's medical condition or history. J.A. 376; see 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a). And the "community-rating" provisions prohibit insurers from charging higher premiums because of an individual's risk profile, including medical condition or history. J.A. 376; see 42 U.S.C. 300gg(a)(1), 300gg-4(b). Because the ACA prevented insurers from setting premiums based on risk, Congress expressly found that the individual mandate was "essential" to (among other things) the operation of the guaranteed-issue and community-rating provisions and that in tandem with other ACA provisions it would "broaden the health insurance risk pool." ACA §§ 1501(a)(2), 10106(a), 124 Stat. 243, 908 (42 U.S.C. 18091(2)(I)).

Other provisions enacted by Title I impose prohibitions on coverage limits, requirements to cover dependent children, and essential benefits packages for insurance plans. 42 U.S.C. 300gg-11, 300gg-14(a), 18022. Title I also created insurance exchanges to allow consumers to shop for insurance plans and provided subsidies and tax incentives. 42 U.S.C. 18031-18044 (creation of

insurance exchanges); 26 U.S.C. 36B, 45R, 4980H (tax changes). Other Titles of the ACA enacted a number of other changes, including expanding the Medicaid program (Title II, 124 Stat. 271), amending the Medicare program (Title III, 124 Stat. 353), enacting a range of prevention programs (Title IV, 124 Stat. 538), and imposing anti-fraud requirements (Title VI, 124 Stat. 684).

2. In *NFIB*, this Court addressed whether the individual mandate was a valid exercise of Congress's legislative authority. A majority of the Court concluded that the individual mandate could not be sustained as a valid exercise of Congress's authority under the Constitution's Commerce Clause, Art. I, § 8, Cl. 3, or Necessary and Proper Clause, Art. I, § 8, Cl. 18. *NFIB*, 567 U.S. at 547-561, 574 (opinion of Roberts, C.J.); *id.* at 649-660 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting (joint dissent)); see *id.* at 572 (opinion of the Court). As the Chief Justice explained, "the power to regulate" commerce "assumes there is already something to be regulated." *Id.* at 550 (opinion of Roberts, C.J.). But "[t]he individual mandate," he observed, "does not regulate existing commercial activity": it "compels individuals to *become* active in commerce by purchasing a product." *Id.* at 552; see *id.* at 548-558. And although the Court's "jurisprudence under the Necessary and Proper Clause * * * ha[s] been very deferential to Congress's determination that a regulation is 'necessary,'" the Chief Justice explained that the individual mandate could not be sustained under that Clause because it purported to "create the necessary predicate to the exercise of an enumerated power." *Id.* at 559-560; see *id.* at 558-561.

A different majority of the Court determined, however, that the individual mandate could be construed as

an exercise of Congress's taxing power to save the mandate from unconstitutionality. *NFIB*, 567 U.S. at 563-574. The Chief Justice noted that "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance." *Id.* at 562 (opinion of Roberts, C.J.). But in his opinion for the Court, the Chief Justice concluded that the shared-responsibility payment also could "reasonably be characterized as a tax" that the "Constitution permits." *Id.* at 574. The Court found that construction "reasonabl[e]" based on a "functional" analysis of the "'shared responsibility payment.'" *Id.* at 563, 565, 574 (brackets and citation omitted); see *id.* at 563-570. Among other things, the Court observed that the shared-responsibility payment "yield[ed] the essential feature of any tax: It produces at least some revenue for the Government." *Id.* at 564.

3. a. In December 2017, Congress enacted the Tax Cuts and Jobs Act (TCJA), Pub. L. No. 115-97, Tit. I, 131 Stat. 2054. Among other things, the TCJA eliminated the shared-responsibility payment as of January 1, 2019. § 11081, 131 Stat. 2092. It did so by reducing the amount of the required payment specified in Section 5000A(c) to zero. See *ibid.* (setting the percentage of income used to calculate the penalty at "Zero percent," setting the "applicable dollar amount" in 26 U.S.C. 5000A(c)(3)(A)—the figure used to calculate the minimum penalty—at "$0," *ibid.*, and eliminating the formula in 26 U.S.C. 5000A(c)(3)(D) (Supp. V 2017) for indexing that figure). The TCJA did not otherwise modify Section 5000A.

Following the TCJA's enactment, several plaintiffs, including Texas, 17 other States, and two individuals, brought this suit challenging the constitutionality of the

individual mandate and the enforceability of the remainder of the ACA. J.A. 383. Count I of their complaint alleged that Congress's elimination of the penalty abrogated the basis of *NFIB*'s saving construction of the individual mandate—as an exercise of Congress's taxing power—and they argued that the remainder of the ACA is inseverable from the mandate. *Ibid.*; see J.A. 61-63. Count I sought a declaratory judgment to that effect and a permanent injunction. J.A. 63. The other counts challenged the ACA and implementing regulations on other grounds and sought various declaratory and injunctive relief. J.A. 63-67. The plaintiffs also requested a preliminary injunction. Pet. App. 177a. The federal government agreed that the individual mandate is no longer constitutional and argued that the guaranteed-issue and community-rating requirements are inseverable from it. J.A. 383-384. California, 15 other States, and the District of Columbia intervened to defend the ACA. J.A. 384 & n.10.

b. The district court converted the plaintiffs' request for a preliminary injunction into a motion for partial summary judgment, over the intervenor States' objection. Pet. App. 165a; see J.A. 370-372. In an extensive opinion, the court denied the request for a preliminary injunction but granted the plaintiffs partial summary judgment on their claim (Count I) that the individual mandate is invalid and that all other ACA provisions are inseverable from it. Pet. App. 163a-231a. Following a detailed review of the ACA, *NFIB*, and the TCJA, *id.* at 165a-175a, the court held that the plaintiffs had standing to challenge the mandate, *id.* at 181a-185a, and that the mandate is no longer constitutional in light of the TCJA's elimination of the penalty, *id.* at 185a-204a. The court observed that *NFIB*'s reasoning

"compels the conclusion that the Individual Mandate may no longer be upheld under the Tax Power," and it "remains unsustainable under the Interstate Commerce Clause." *Id.* at 164a.

The district court additionally concluded that "the Individual Mandate is inseverable from the ACA's remaining provisions." Pet. App. 165a; see *id.* at 204a-231a. The court reasoned that "the 2010 Congress expressed through plain text an unambiguous intent that the Individual Mandate not be severed from" the rest of the ACA; that "this text-based conclusion is further compelled by two separate * * * decisions" from this Court—*NFIB* and *King* v. *Burwell*, 135 S. Ct. 2480 (2015); and that "the 2017 Congress had no intent with respect to the Individual Mandate's severability" that could displace that earlier intent. Pet. App. 208a, 214a, 228a; see *id.* at 208a-231a.

c. All parties agreed that the district court's decision should not take effect pending appeal. See D. Ct. Doc. 213-1, at 8-9 (Dec. 17, 2018); D. Ct. Doc. 216, at 6-8 (Dec. 21, 2018); D. Ct. Doc. 217, at 2 (Dec. 21, 2018). The court entered a partial final judgment as to Count I, declaring the individual mandate unconstitutional and inseverable from the remainder of the ACA, Pet. App. 116a, 120a-123a, but it stayed the judgment and further proceedings pending appeal, *id.* at 114a-115a, 120a, 123a-162a.[2]

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[2] In its brief addressing further proceedings, the federal government stated that issuance of a partial final judgment under Federal Rule of Civil Procedure 54(b) would be inappropriate in the case's then-current posture because no single claim had been completely resolved. D. Ct. Doc. 216, at 7-8, 13. The government understood the complaint's counts as asserting only a single claim under alternative legal theories and seeking various other forms of relief, which

4. a. The federal government and the intervenor States appealed. See J.A. 385. Several additional States moved unopposed in the court of appeals for permissive intervention, seeking to join California and the other States that had intervened in the district court to defend the ACA. Colorado et al. C.A. Mot. to Intervene 6-7 (Jan. 31, 2019); see J.A. 385 & n.12. The court of appeals granted their motion. 2/14/19 C.A. Order 2.

The United States House of Representatives also moved to intervene in the appeal as of right or, alternatively, for permissive intervention. House C.A. Mot. to Intervene 5-20 (Jan. 7, 2019); see J.A. 385. The court of appeals granted the House permissive intervention. 19-841 Pet. App. 113a-114a.

In addition, while the appeal was pending, the federal government notified the court of appeals that it had concluded that all of the ACA's remaining provisions are inseverable from the individual mandate. J.A. 385. The government advanced that position in the appeal. See Gov't C.A. Br. 36-49. The government, however, contended that any relief should be limited only to what is necessary to remedy the plaintiffs' own injuries. *Id.* at 26-29; see J.A. 385-386, 446-448.

b. A divided panel of the court of appeals affirmed in part and vacated in part. J.A. 374-448.

i. The court of appeals first concluded that at least the federal government and the intervenor States had

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the court had not addressed. *Ibid.* As the government explained in the court of appeals, however, the district court's issuance of a partial final judgment as to Count I "foreclosed any further remedial proceedings with respect to that count" and reflected a different view of the complaint's other counts as distinct claims. Gov't C.A. Br. 4 n.1. In light of that development, the government agreed that the court of appeals had jurisdiction. *Ibid.*

standing to appeal. J.A. 387-392. Turning to the district court's jurisdiction, the court of appeals determined that both the individual and State plaintiffs had standing to bring this lawsuit. J.A. 392-413. It agreed with the district court that "the undisputed evidence showed that the individual mandate caused" the individual plaintiffs two injuries—a "financial injury" of being forced to obtain insurance and an "increased regulatory burden"—which "a favorable judgment would redress." J.A. 396-397; see J.A. 396-406. The court of appeals additionally found that the State plaintiffs have standing because the ACA causes them "fiscal injuries as employers" subject to various ACA requirements. J.A. 406; see J.A. 406-413. But it observed that, "even if the state plaintiffs did not have standing, this case could still proceed because the individual plaintiffs have standing," J.A. 406 n.26, and vice versa, see J.A. 406 n.25.

On the merits, the court of appeals held that the individual mandate is no longer "a constitutional exercise of congressional power." J.A. 414; see J.A. 414-426. It observed that "[a] majority" of this Court in *NFIB* had held that the mandate could not be sustained under the Commerce or Necessary and Proper Clauses and had "save[d] the individual mandate from unconstitutionality" only by "[r]ead[ing]" the individual mandate "together with the shared responsibility payment * * * as a legitimate exercise of Congress' taxing power." J.A. 415, 417-418. "Now that the shared responsibility payment amount is set at zero" under the TCJA, the court of appeals reasoned, that "saving construction is no longer available." J.A. 419; see J.A. 419-426.

The court of appeals then turned to "whether, or how much of, the rest of the ACA is severable from" the individual mandate. J.A. 427. But the court did not decide that question. Instead, it "remand[ed] to the district court to undertake two tasks." *Ibid.*

First, the court of appeals determined that the district court had not undertaken the "analysis required by severability doctrine" under this Court's precedents. J.A. 430; see J.A. 444-445. The court explained that the severability inquiry here "involves a challenging legal doctrine applied to an extensive, complex, and oft-amended statutory scheme," and it was "not persuaded that the approach to the severability question set out in the district court opinion satisfie[d] that need." J.A. 434.

Second, the court of appeals directed the district court to consider the federal government's argument that relief should be confined to redressing the plaintiffs' injuries. J.A. 446-448. The court of appeals explained that "[t]he relief the plaintiffs sought in the district court was a universal nationwide injunction," and although the district court had not granted injunctive relief, it had entered "a judgment declaring the entire ACA 'invalid.'" J.A. 446. And the court of appeals asserted that "[t]he district court did not have the benefit of considering" the government's argument that "the declaratory judgment should only reach ACA provisions that injure the plaintiffs." J.A. 446-447. The court of appeals "agree[d]" with the federal government "that remand is appropriate for the district court to consider" that question "in the first instance." J.A. 447.

ii. Judge King dissented. J.A. 449-489.

Judge King concluded that none of the plaintiffs had standing to challenge the individual mandate. J.A.

452-467. She reasoned that the individual plaintiffs' asserted financial injury—the cost of obtaining health insurance—was "self-inflicted" because they could "disregard" the individual mandate "without consequence." J.A. 455, 461. She also concluded that the State plaintiffs lacked standing because the evidentiary record did not support their various alleged injuries. J.A. 462-467.

On the merits, Judge King concluded that the individual mandate remains constitutional. J.A. 467-474. "Now that Congress has zeroed out" the shared-responsibility payment, she reasoned, the individual mandate "does nothing," and merely "affords individuals the same choice individuals have had since the dawn of private health insurance, either purchase insurance or else pay zero dollars." J.A. 467-468.

As to severability, Judge King "agree[d] with much of" the majority's analysis but concluded that a remand was unnecessary. J.A. 474. She observed that "[s]everability is a question of law that [an appellate court] can review de novo," and, in her view, Congress's elimination of the shared-responsibility payment demonstrated that it "believed the ACA could stand in its entirety without the unenforceable coverage requirement." J.A. 474; see J.A. 474-488.

c. Following a request for a poll on whether to rehear the case en banc, the court of appeals denied rehearing. J.A. 490. Six of the 14 judges who voted would have granted rehearing en banc. J.A. 491.

SUMMARY OF ARGUMENT

I. The court of appeals correctly concluded that Article III jurisdiction exists over this case. The individual plaintiffs have shown that the ACA's insurance-reform provisions injure them by limiting their options with regard to insurance coverage and by raising their

costs. Accordingly, they have standing to challenge the enforcement of those provisions. And on the merits, they can claim that the reason those provisions cannot be enforced is because they are inseverable as a statutory matter from the individual mandate, which they contend is unconstitutional in light of the TCJA's elimination of the penalty. But the relief the Court orders should be limited to redressing the injury actually incurred—that is, the relief should reach only the enforcement of the ACA provisions that injure the individual plaintiffs.

II. The individual mandate no longer can be sustained as a valid exercise of Congress's Article I authority. A majority of this Court determined in *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012), that neither the Commerce Clause nor the Necessary and Proper Clause authorizes the mandate. The Court upheld the mandate only by adopting a saving construction of 26 U.S.C. 5000A, characterizing the mandate as the predicate to a tax. But Congress has now eliminated the tax, removing the basis for that construction.

The contrary arguments advanced by the intervenor States and House lack merit. Their contention that the mandate may still be viewed as the predicate to a tax of zero dollars is incorrect. Under *NFIB*'s functional approach, a statute that imposes no tax liability on anyone cannot be sustained as a tax. And the contention that the mandate may be upheld either because it is now simply precatory or because it still offers individuals a choice between obtaining insurance and refraining from doing so cannot be squared with the statutory text.

III. The individual mandate cannot be severed from the remainder of the ACA. Congressional findings incorporated into the ACA's text clearly indicate that Congress would not have adopted the guaranteed-issue and community-rating provisions absent the individual mandate's requirement to purchase insurance. This Court recognized the interrelatedness of these three provisions in *NFIB* and *King* v. *Burwell*, 135 S. Ct. 2480 (2015). And Congress's 2017 amendment does not alter the severability analysis because it left intact the critical statutory findings about the interconnectedness of these provisions—findings that were and remain the functional equivalent of an inseverability clause.

The ACA's remaining provisions are likewise inseverable, because it is evident that Congress would not have enacted them without the individual mandate and the guaranteed-issue and community-rating provisions. The *NFIB* joint dissent would have so held, and that conclusion is still equally valid today. Nothing the 2017 Congress did demonstrates it would have intended the rest of the ACA to continue to operate in the absence of these three integral provisions. The entire ACA thus must fall with the individual mandate, though the scope of relief entered in this case should be limited to provisions shown to injure the plaintiffs.

ARGUMENT

I. THIS COURT HAS JURISDICTION TO REACH THE QUESTIONS PRESENTED ADDRESSING THE MERITS AND SEVERABILITY

The court of appeals correctly concluded that this suit presents an Article III case or controversy. The individual plaintiffs have shown that they are injured by at least some ACA provisions—namely, various provisions regulating health-insurance plans that limit the

range and terms of plans the individual plaintiffs may obtain and that increase their costs of obtaining coverage. They thus have standing to challenge the enforcement of those provisions. And on the merits, they can argue that those insurance-reform provisions cannot be enforced because (1) those provisions (and indeed the entire ACA) are inseverable from the individual mandate, and (2) the mandate is now unconstitutional as a result of Congress's elimination in the TCJA of the penalty for noncompliance. The individual plaintiffs can make this merits argument regardless of whether they would have Article III standing to challenge the individual mandate by itself. But if successful, any remedy—whether a declaratory judgment or injunction—must be limited to enforcement of the insurance reforms and other ACA provisions that injure the individual plaintiffs.

A. The Plaintiffs Have Standing To Challenge Only Those ACA Provisions That Injure Them And May Seek Relief Only To Redress Their Own Cognizable Injuries

The plaintiffs bore the "burden of establishing their standing" by showing "'personal injury'" that is "'fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief.'" *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 342 (2006) (citation omitted). That showing must be claim-specific, because "standing is not dispensed in gross." *Town of Chester* v. *Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) (quoting *Davis* v. *FEC*, 554 U.S. 724, 734 (2008), in turn quoting *Lewis* v. *Casey*, 518 U.S. 343, 358 n.6 (1996)). "[A] plaintiff must demonstrate standing for each claim he seeks to press and for each form of relief that is sought." *Ibid.* (citation omitted).

So, too, any judicial "remedy must of course be limited to the inadequacy that produced the injury in fact that the plaintiff has established," *Cuno*, 547 U.S. at 353 (quoting *Lewis*, 518 U.S. at 357), and cannot go beyond redressing the plaintiff's own injury, see *Gill* v. *Whitford*, 138 S. Ct. 1916, 1929-1931 (2018); *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 494-497 (2009). "The actual-injury requirement would hardly serve [its] purpose . . . of preventing courts from undertaking tasks assigned to the political branches, if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy *all* inadequacies in that administration." *Cuno*, 547 U.S. at 353 (quoting *Lewis*, 518 U.S. at 357) (brackets omitted). Longstanding principles of equity likewise limit relief to what is needed to redress the plaintiff's own injuries. See *Lewis*, 518 U.S. at 359-360; *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979).

This Court's decisions accordingly make clear that a plaintiff injured by one action of a defendant—such as a particular practice, or a specific provision of law—may not seek redress against other actions that do not harm the plaintiff. For example, in *Lewis*—a suit by prisoners challenging various prison practices—this Court held that Article III permitted relief only to redress the one practice (regarding literacy services) that had been found to injure a named plaintiff. 518 U.S. at 358. The other practices the plaintiffs attacked "ha[d] not been found to have harmed any plaintiff in th[e] lawsuit." *Ibid.* The Court declined to consider the provisions allowing those practices and "eliminate[d] [them] from" the injunction the lower courts had issued. *Ibid.*

Similarly, in *Printz* v. *United States*, 521 U.S. 898 (1997), this Court held that certain provisions of a federal statute requiring state and local authorities to conduct background checks on prospective handgun purchasers were unconstitutional. *Id.* at 933-935. The plaintiffs—local officials required to conduct the background checks—attempted to leverage the invalidity of that requirement to challenge other provisions of the statute that did not apply to them, on the ground that they were inseverable from the background-check requirement. See *id.* at 934-935. The Court declined to consider that additional argument. *Id.* at 935. The plaintiffs' severability arguments concerning those other provisions raised "important questions," but the Court "ha[d] no business answering them" because those other provisions did not "burden" any plaintiff in the litigation. *Ibid.* The Court therefore "decline[d] to speculate regarding the rights and obligations of parties not before the Court." *Ibid.* The Court distinguished the situation before it from *New York* v. *United States*, 505 U.S. 144, 186-187 (1992), in which the Court, after holding invalid a statutory provision that affected the plaintiffs, then "address[ed] [the] severability" of other provisions of the statute that also "affected the plaintiffs." *Printz*, 521 U.S. at 935; see *Murphy* v. *NCAA*, 138 S. Ct. 1461, 1485-1487 (2018) (Thomas, J., concurring).

B. The Individual Plaintiffs May Challenge The ACA's Insurance-Reform Provisions As Inseverable From The Individual Mandate

The parties and courts below disputed the plaintiffs' standing to challenge the individual mandate. Compare, *e.g.*, J.A. 392-413 (court of appeals majority), Pet. App. 181a-185a (district court), with J.A. 452-467 (King,

J., dissenting). And neither court below comprehensively determined which if any other ACA provisions "actually injure the plaintiffs." J.A. 447 (remanding for the district court to consider the federal government's arguments addressing this issue). But at a minimum, as the government explained below, the individual plaintiffs have demonstrated standing to challenge certain interrelated insurance-reform provisions of the ACA that restrict their insurance options and raise their costs of obtaining coverage. See Gov't C.A. Br. 23-24. That is sufficient to establish Article III jurisdiction. And in pressing that challenge, the individual plaintiffs may advance, and this Court may consider, legal arguments that (1) the individual mandate is invalid and (2) all other ACA provisions, including the insurance-reform provisions that injure the individual plaintiffs, are inseverable from it.

1. The two individual plaintiffs presented evidence that they are injured by provisions of the ACA that preclude them from obtaining insurance plans they prefer and that increase their costs of obtaining coverage. The ACA contains a number of provisions that regulate the terms and premiums of health-insurance plans. Certain ACA provisions directly prescribe coverage requirements and essential benefits. See 42 U.S.C. 300gg-11, 300gg-14(a), 18022. And the guaranteed-issue and community-rating provisions, see 42 U.S.C. 300gg(a)(1), 300gg-1, 300gg-3, 300gg-4(a) and (b), limit insurers' ability to set premiums based on the health of the insured. Those requirements bar individuals from obtaining plans that do not meet the applicable criteria. And they operate to increase the cost of obtaining insurance for some individuals, such as relatively young and

healthy individuals, who otherwise could obtain less expensive coverage.

The individual plaintiffs are self-employed individuals who are subject to the ACA's insurance-reform provisions and are ineligible for subsidies to purchase health insurance. See J.A. 71, 75. One of the individuals, John Nantz, is the founder of a management-consulting business. J.A. 71. He averred in his sworn declaration that he is "young and in good health," has no dependents, and would prefer to obtain a high-deductible plan priced according to his actuarial risks—an option not available to him under the ACA. J.A. 73; see J.A. 71-73. The other individual, Neill Hurley, is the owner of a consulting business and is married with two dependent children. J.A. 75. He averred that, as a result of the ACA, his monthly premiums have increased dramatically, he has been unable to obtain a plan that would accept all of his family's health providers, and the quality of services from providers that accept his family's new plan is lower than it previously was. J.A. 76-77. Hurley stated that, were he "not limited to the plans provided through the federal health insurance marketplace," he "would purchase reasonably priced insurance coverage that allowed [him] to access care locally from [his] preferred service providers." J.A. 77.

The individual plaintiffs' factual averments of those financial and other consequences stemming from the ACA's insurance-reform provisions were considered in the district court, which adjudicated the plaintiffs' relevant claim in a summary-judgment posture without any conflicting evidence. And neither the evidence itself nor the district court's decision to resolve the case on summary judgment was challenged in the court of appeals or is challenged in this Court. See *Lujan* v. *Defenders*

of Wildlife, 504 U.S. 555, 561 (1992) ("[E]ach element" of standing "must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.*, with the manner and degree of evidence required at the successive stages of the litigation," including at the summary-judgment stage by "'set[ting] forth' by affidavit or other evidence 'specific facts.'") (citation omitted). The facts plaintiffs aver establish a cognizable injury traceable to the insurance-reform provisions. Because "[a]t least one plaintiff * * * ha[d] standing to seek * * * relief" from the application of the insurance-reform provisions, *Town of Chester*, 137 S. Ct. at 1651, the district court had jurisdiction over the plaintiffs' suit to that extent. And because "at least one" party in the appeal has standing to pursue that claim, neither the court of appeals nor this Court need examine whether the State plaintiffs may also seek the same relief. *Horne* v. *Flores*, 557 U.S. 433, 445 (2009). Although the court of appeals did not rely on that ground in holding that the district court had jurisdiction, that aspect of its judgment may be affirmed "on any ground permitted by the law and the record." *Dahda* v. *United States*, 138 S. Ct. 1491, 1498 (2018) (citation omitted).

2. In challenging the insurance-reform provisions, the individual plaintiffs may contend that (1) the individual mandate—which also applies to them—is now invalid and (2) all other provisions of the ACA are inseverable from it. Although those contentions also implicate other ACA provisions, they are the premises of the individual plaintiffs' challenge to the insurance-reform provisions that injure them. The relevant claim of their complaint alleged that the entire ACA "must be invalidated in whole" because the mandate is now "unconstitutional" and "[t]he remainder of the ACA," including

the insurance-reform provisions, is categorically "non-severable" from the mandate. J.A. 63; see J.A. 61-63. In making those arguments, the individual plaintiffs "seek[] to vindicate [their] own interests." *Phillips Petroleum Co.* v. *Shutts*, 472 U.S. 797, 805 (1985).

This case is effectively the inverse of *Printz*, where the Court declined to allow the plaintiffs to leverage the invalidity of a provision that did injure them to attack other provisions that did not injure them. 521 U.S. at 935; see p. 16, *supra*. Here, the plaintiffs challenge the insurance-reform provisions that do injure them, and the basis for their challenge is that the insurance-reform provisions are inseverable from the mandate, which is invalid. This case thus mirrors *Alaska Airlines, Inc.* v. *Brock*, 480 U.S. 678 (1987). In that case, several airlines contended that statutory provisions establishing certain protections for airline employees should be invalidated because the statute also contained an invalid legislative-veto provision, which the airlines contended was inseverable from the employee-protection provisions. *Id.* at 680-683. Although the Court did not expressly address the airlines' standing to make that argument, it considered and rejected the argument on the merits. *Id.* at 684-697.

Similarly, in the circumstances of this case, this Court can address both merits questions presented without determining whether the individual or State plaintiffs independently have standing to challenge the individual mandate. Regardless of whether the individual plaintiffs would have standing to challenge the mandate itself, the Court may pass upon their argument that the mandate is invalid because that is also a premise of their challenge to the insurance-reform provisions that injure

them.[3] Or, to put it differently, to enter judgment for the plaintiffs on that claim the district court necessarily had to conclude both that the mandate is invalid and that it is not severable from the remainder of the ACA. This Court may now review those conclusions.

To be sure, no plaintiff could obtain—and no federal court could issue—judicial *relief* against enforcement of any ACA provision that has not been shown to injure that plaintiff. See *Lewis*, 518 U.S. at 358. As the government explained in the court of appeals, although the logic of the plaintiffs' legal argument calls into doubt the enforceability of myriad other ACA provisions, they could not obtain a declaratory judgment or injunction directed to those provisions unless they demonstrated that such relief is necessary to redress their own cognizable injuries. See Gov't C.A. Br. 26-29. For example, if this Court accepts both premises of the individual plaintiffs' legal argument challenging the insurance-reform provisions, its *reasoning* would bear on the remainder of the ACA as a matter of precedent. But any *relief* issued as part of a judgment would be limited to enforcement of the provisions that have been shown to injure the individual plaintiffs.

For the same reasons, the Court may consider only arguments by the plaintiffs that implicate the insurance-reform provisions (and any other provisions that the Court finds injure the plaintiffs). The Court thus may consider the plaintiffs' categorical argument that all ACA provisions are inseverable from the individual mandate, because that argument directly bears on the

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[3] Similarly, the Court need not decide whether the same would be true of a plaintiff who is not subject to the individual mandate, because the individual plaintiffs here are subject to it.

insurance-reform provisions. In the lower courts, however, the plaintiffs also argued that various particular ACA provisions that do not appear to affect the individual plaintiffs are inseverable for more specific reasons that do not apply to the insurance-reform provisions. See, *e.g.*, State Plaintiffs C.A. Br. 49-50 (arguing that certain "minor" ACA provisions such as a medical-device tax are inseverable because they no longer serve their specific intended purposes without the mandate). As the government observed at the petition stage, the Court would have no occasion to consider such arguments unless it first determined that a plaintiff has standing to challenge those other provisions. See 19-840 Gov't Br. in Opp. 17.

3. The intervenor States' and House's arguments that the individual plaintiffs lack standing are substantially premised on their merits arguments that the individual mandate does not, in fact, impose any obligation on the individual plaintiffs. See Intervenor States Br. 18; House Br. 20-23. Thus, the intervenor States and the House do not actually contend that the Court must refrain from determining the central question whether, post-TCJA, the mandate must be construed to impose an obligation to purchase insurance. Rather, they merely contend that this Court must resolve the question under the label of "jurisdiction" rather than "merits." See *Bolivarian Republic of Venezuela* v. *Helmerich & Payne Int'l Drilling Co.*, 137 S. Ct. 1312, 1319 (2017) ("[M]erits and jurisdiction will sometimes come intertwined."); 13B Charles Alan Wright et al., *Federal Practice and Procedure*, § 3531.15 (3d ed. 2008) ("Despite the admonition that Article III standing issues must be resolved before approaching the merits," some circumstances "may justify a single inquiry, even if the conclusion that

standing must be denied is indistinguishable from a ruling on the merits."); see also House Br. 22 (agreeing that the Court can "determin[e] whether Section 5000A required the individual plaintiffs to purchase insurance"). Accordingly, this Court need not address hypotheticals regarding constitutional challenges to unrelated provisions that do not affect the plaintiffs. See House Br. 33. Instead, the Court can and should straightforwardly resolve the individual plaintiffs' claim that the mandate unconstitutionally requires them to purchase insurance and is inseverable from the ACA's insurance-reform provisions that prohibit them from obtaining the type of health insurance they would prefer at a cost they would prefer.[4]

II. THE INDIVIDUAL MANDATE IS NO LONGER A VALID EXERCISE OF CONGRESS'S AUTHORITY

On the merits, the district court and the court of appeals correctly determined that the individual mandate is no longer a valid exercise of Congress's legislative authority in light of Congress's elimination of the penalty for noncompliance. J.A. 414-426; Pet. App. 185a-204a. That conclusion follows from this Court's reasoning in *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012), which held that the mandate could be construed and sustained only as an exercise of Congress's taxing power based on a "functional" analysis of the penalty, its statutory context, and its practical

[4] For the same reasons, the individual plaintiffs have standing to obtain an injunction barring enforcement against them of the insurance reforms that injure them. The district court thus had authority to instead enter a declaratory judgment of that scope. Cf. Samuel L. Bray et al. Amicus Br. 2-4.

operation. *Id.* at 565; see *id.* at 563-570. The same functional analysis demonstrates that the *NFIB* Court's saving construction of the individual mandate as a tax is no longer tenable. The intervenor States' and House's contrary arguments in support of the mandate are incorrect.

A. The Individual Mandate No Longer Can Be Construed And Upheld As A Valid Exercise Of Congress's Taxing Power Because Congress Eliminated The Tax

1. In *NFIB*, this Court upheld the individual mandate imposed by 26 U.S.C. 5000A solely on the ground that the mandate, in combination with the shared-responsibility payment Congress imposed for noncompliance, was a valid exercise of Congress's power to "lay and collect Taxes," U.S. Const. Art. I, § 8, Cl. 1. See *NFIB*, 567 U.S. at 563-574. As the Chief Justice observed in his separate opinion, that is not "[t]he most straightforward reading of the mandate," which "reads more naturally as a command to buy insurance than as a tax." *Id.* at 562, 574 (opinion of Roberts, C.J.). "After all, it states that individuals 'shall' maintain health insurance." *Id.* at 562. But the Court adopted a saving construction of the mandate—as providing the predicate to a tax, see *id.* at 563-570 (opinion of the Court)—because a majority of the Court concluded that "Section 5000A would * * * be unconstitutional if read as a command." *Id.* at 575 (opinion of Roberts, C.J.); see *id.* at 547-561, 574; *id.* at 649-660 (joint dissent).

a. The Chief Justice explained that the Commerce Clause does not authorize a command to buy insurance because that Clause "grants Congress the power to '*regulate* Commerce,'" not the power "to *compel* it." *NFIB*, 567 U.S. at 550, 555 (opinion of Roberts, C.J.) (quoting U.S. Const. Art. I, § 8, Cl. 3); see *id.* at 548-558. The

Clause's "language," he observed, "reflects the natural understanding that the power to regulate assumes there is already something to be regulated," and thus "[t]he power to *regulate* commerce presupposes the existence of commercial activity." *Id.* at 550. The Chief Justice concluded that the individual mandate, if construed as a command, would exceed that authority because it "does not regulate existing commercial activity." *Id.* at 552. Instead, he observed, the individual mandate "compels individuals to *become* active in commerce by purchasing a product." *Ibid.* For this reason, the Chief Justice found inapposite the Court's precedents construing the Commerce Clause to authorize Congress to regulate existing "activities that 'have a substantial effect on interstate commerce.'" *Id.* at 549 (quoting *United States* v. *Darby*, 312 U.S. 100, 119 (1941)).

The Chief Justice further concluded that the Necessary and Proper Clause does not authorize Congress to enact a command that individuals buy insurance. *NFIB*, 567 U.S. at 558-561 (opinion of Roberts, C.J.). That Clause's grant of "power to 'make all Laws which shall be necessary and proper for carrying into Execution' the powers enumerated in the Constitution," *id.* at 559 (quoting U.S. Const. Art. I, § 8, Cl. 18), he observed, "vests Congress with authority to enact provisions 'incidental to the enumerated power, and conducive to its beneficial exercise,'" *ibid.* (quoting *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 418 (1819)) (brackets omitted). Although this Court's "jurisprudence under the Necessary and Proper Clause * * * ha[s] been very deferential to Congress's determination that a regulation is 'necessary,'" *ibid.*, the Chief Justice determined that the individual mandate exceeded even those broad

limits, *id.* at 560-561. Unlike enactments the Court had previously sustained under the Necessary and Proper Clause—which were all "exercises of authority derivative of, and in service to, a granted power"—he reasoned that "[t]he individual mandate * * * vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power." *Id.* at 560. The Chief Justice concluded that, "[e]ven if the individual mandate is 'necessary' to the Act's insurance reforms, such an expansion of federal power is not a 'proper' means for making those reforms effective." *Ibid.*

The four Justices who issued the joint dissent agreed with the Chief Justice that the individual mandate could not be sustained under the Commerce Clause or Necessary and Proper Clause. *NFIB*, 567 U.S. at 649-660 (joint dissent). A majority of the Court thus concluded that the mandate was not justified under either of those Clauses and would have upheld the Eleventh Circuit's judgment to that extent. See *id.* at 572 (opinion of the Court) ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity.").

b. A different majority of the Court determined that, to save the individual mandate from unconstitutionality, the mandate could be construed as an exercise of Congress's taxing power. *NFIB*, 567 U.S. at 563-574. As the Chief Justice observed, the federal government had argued in the alternative that the "mandate c[ould] be regarded as establishing a condition—not owning health insurance—that triggers a tax—the required payment to the" Internal Revenue Service (IRS). *Id.* at

563 (opinion of Roberts, C.J.). The government contended that, because the ACA imposed as a "consequence" for "not maintain[ing] health insurance" an obligation to "make an additional payment to the IRS when [a person] pays his taxes," the mandate could be viewed "not [as] a legal command to buy insurance" but as "in effect just a tax hike on certain taxpayers who do not have health insurance." *Id.* at 562-563. And because "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality," *id.* at 563 (quoting *Hooper* v. *California*, 155 U.S. 648, 657 (1895)), the Court considered that alternative reading, see *id.* at 563-574.

On that issue, the Court concluded (in an opinion by the Chief Justice) that the shared-responsibility payment for those who do not maintain coverage prescribed by the individual mandate could "reasonably be characterized as a tax." *NFIB*, 567 U.S. at 574; see *id.* at 563-574; 26 U.S.C. 5000A(b)(1) and (3), (c)(1) and (2). The Court acknowledged that the ACA "describe[d] the payment as a 'penalty,' not a 'tax.'" *NFIB*, 567 U.S. at 564. But it explained that the "label" alone was not dispositive and that the Court's precedents called for a "functional approach" that focuses on "practical characteristics" of an enactment to determine whether it can be sustained as a tax. *Id.* at 564-565. "The same analysis," the Court held, "suggests that the shared responsibility payment may for constitutional purposes be considered a tax" on those who lack insurance, not as a sanction for violating a command. *Id.* at 566; see *id.* at 563-570.

Applying that "functional approach," the *NFIB* Court explained that the shared-responsibility payment "looks like a tax in many respects." 567 U.S. at 563, 565.

Among other things, the Court observed that it was "paid into the Treasury by 'taxpayer[s]' when they file their tax returns"; "its amount [wa]s determined by such familiar factors as taxable income, number of dependents, and joint filing status"; it was "enforced by" the IRS, which "must assess and collect it 'in the same manner as taxes'"; and it "yield[ed] the essential feature of any tax," *i.e.*, "[i]t produce[d] at least some revenue for the Government," and was "expected to raise about $4 billion per year by 2017." *Id.* at 563-564 (citation omitted; first set of brackets in original). The Court also noted that the shared-responsibility payment resembled financial obligations the Court had previously upheld as taxes (rather than penalties) in other respects, including its size, the lack of a scienter requirement, and limitations on the means by which the IRS could enforce it. See *id.* at 566. Because of the nature and operation of the financial obligation Section 5000A imposed for noncompliance with the mandate, the Court held, "§ 5000A need not be read to do more than impose a tax," which "Congress had the power to impose." *Id.* at 570. The Court further concluded that the tax also comported with the Constitution's other limitations on taxes. *Id.* at 570-574.

2. As the courts below correctly determined, the saving construction of Section 5000A that the Court adopted in *NFIB* is no longer tenable in light of Congress's subsequent action in the TCJA. See J.A. 419-426, Pet. App. 139a-141a. Because it cannot reasonably be interpreted as a tax, the mandate in its current form exceeds Congress's enumerated powers.

As amended, Section 5000A preserves the "[r]equirement to maintain minimum essential coverage." 26 U.S.C. 5000A (emphasis omitted). And it continues to use the

language of legal command, specifying that covered individuals "shall * * * ensure" that they obtain "minimum essential coverage." 26 U.S.C. 5000A(a). In its current form, as when the Court considered the provision in *NFIB*, Section 5000A thus is most "naturally" read "as a command to buy insurance." *NFIB*, 567 U.S. at 574 (opinion of Roberts, C.J.); see *id.* at 562.

Critically, however, the linchpin of *NFIB*'s saving construction of the mandate as merely a predicate for tax liability, see 567 U.S. at 563-570, has been eliminated. Section 5000A cannot be read today as "establishing a condition—not owning health insurance—that triggers a tax," *id.* at 563 (opinion of Roberts, C.J.), because the tax no longer exists. In the TCJA, effective January 1, 2019, Congress replaced the existing percentage of income used to calculate the shared-responsibility payment with "Zero percent," and it set the figure used to calculate the minimum penalty (the "applicable dollar amount," 26 U.S.C. 5000A(c)(3)(A) and (D) (2012 & Supp. V 2017)) at "$0." TCJA § 11081, 131 Stat. 2092.

As the court of appeals explained, the same functional analysis that the Court applied in *NFIB* to conclude that the mandate could reasonably be interpreted as the basis for a tax therefore compels the opposite conclusion today. See J.A. 419-420. A penalty of zero does not "look[] like a tax" in *any* "respect[]." *NFIB*, 567 U.S. at 563. Under Section 5000A as it now stands, nothing is "paid into the Treasury by 'taxpayers' when they file their tax returns." *Ibid.* (brackets omitted). Nothing is "determined by such familiar factors as taxable income, number of dependents, and joint filing status," because the amount owed is always zero. *Ibid.* The mandate is no longer "enforced by" the IRS; it is

not "assess[ed] and collect[ed]" at all, much less "'in the same manner as taxes.'" *Id.* at 563-564 (citation omitted). And, perhaps most significantly, it does not "yield[] the *essential feature* of any tax," because it does not—indeed, under the current statute's terms, cannot—"produce[]" any "revenue for the Government." *Id.* at 564 (emphasis added).

Without any financial obligation imposed on those who do not maintain the "minimum essential coverage" that Section 5000A "[r]equire[s]," 26 U.S.C. 5000A (emphasis omitted), Section 5000A as it stands today cannot reasonably be construed as "impos[ing] a tax" for failing to do so. *NFIB*, 567 U.S. at 570. The mandate thus no longer can be upheld as the predicate to an "exaction" that "Congress had the power to impose * * * under the taxing power." *Ibid.* Instead, absent any tax for which it can serve as a trigger, the mandate's direction that a covered individual "shall * * * ensure that the individual * * * is covered under minimum essential coverage," 26 U.S.C. 5000A(a), can be understood only as a straightforward command to maintain such coverage. The statute thus must be "read to declare that failing to" maintain minimum essential coverage "is unlawful." *NFIB*, 567 U.S. at 568. As this Court held in *NFIB*, that command is unconstitutional. *Id.* at 572.

3. The intervenor States and House argue that *NFIB* definitively interpreted Section 5000A as affording a choice between maintaining insurance coverage and paying a tax—not as a freestanding command to maintain coverage—and that the TCJA did not abrogate that interpretation. Intervenor States Br. 26; House Br. 35. They observe that the only change the TCJA made to Section 5000A was to reduce the amount of the shared-responsibility payment to zero, leaving

the rest of the provision intact—including the text of the mandate and the text imposing a penalty on individuals who do not comply with the mandate's requirement. See Intervenor States Br. 28; House Br. 36. But that targeted amendment fundamentally changed the statute by removing the "essential feature" on which *NFIB*'s interpretation rested. 567 U.S. at 564. The Court's construction of the mandate as the predicate to a tax hinged critically on the existence of the "exaction" that produced "revenue." *Id.* at 564; see *id.* at 563-570.

Eliminating that exaction renders *NFIB*'s interpretation inapplicable. Under the "functional approach" that this Court's precedents prescribe and that *NFIB* applied, 567 U.S. at 565, reducing the shared-responsibility payment amount to zero for all individuals in all circumstances going forward is the equivalent of eliminating the payment altogether. Just as the Court determined that "practical" considerations supported classifying the shared-responsibility payment as a tax despite the statute's express description of that payment as a "penalty," *id.* at 564-565, so too the practical reality following the TCJA is that Section 5000A no longer imposes any tax on any individual.

The intervenor States nevertheless insist that Section 5000A can "still be upheld as a lawful exercise of Congress's taxing powers, albeit one whose practical application is currently suspended." Intervenor States Br. 32. They contend that the statute "retains many of the features that *NFIB* looked to in construing it as a tax," including "references to taxable income, number of dependents, and joint filing status" in the formula for calculating the payment. *Id.* at 33. But the TCJA eliminated entirely "the essential feature of any tax" that *NFIB* identified—the "produc[tion] [of] * * * revenue."

567 U.S. at 564. Indeed, the TCJA rendered parameters for calculating and enforcing the shared-responsibility payment irrelevant. The references to income, dependents, and filing status in the formula are immaterial because, regardless of those variables, the formula now calculates the same result—a payment of zero—for every individual.

The intervenor States also attempt to analogize Section 5000A sans penalty to taxes that yield no or little revenue. Intervenor States Br. 32-34. The intervenor States point to taxes that have delayed effective dates or are suspended temporarily and taxes that are in force but yield no revenue because no taxpayer engages in the conduct that triggers the tax (*e.g.*, because the tax itself deters the conduct, or the conduct is also a criminal offense). *Ibid.* Those analogies are inapt. Unlike delayed or suspended taxes that will fail to generate revenue in a particular period, Section 5000A permanently eliminates the duty to pay a penalty. It will never again generate tax revenue absent a further Act of Congress reinstating the penalty. And unlike taxes that produce no revenue because no taxpayer engages in the taxed conduct, Section 5000A generates no revenue regardless of how many individuals fail to maintain the insurance coverage required by the mandate.

In all events, the intervenor States' reading of Section 5000A as affording individuals a choice between maintaining insurance coverage and not maintaining coverage—with no tax liability either way—cannot justify upholding the mandate as an exercise of Congress's power to "lay and collect Taxes," U.S. Const. Art. I, § 8, Cl. 1. Similarly, the suggestion that "the greater power to enact a statute imposing a tax surely includes a lesser

power to reduce the tax to zero while leaving its structure in place," Intervenor States Br. 33-34, reduces to the illogical contention that Congress may exercise its taxing power without actually imposing any taxes.

B. The Individual Mandate Cannot Be Upheld As A Precatory Expression Of Congressional Sentiment Or As A Valid Exercise Of Congress's Authority Under The Necessary And Proper Clause Or The Commerce Clause

Tellingly, although they claim that the TCJA did not alter the constitutional analysis set out by this Court in *NFIB*, the intervenor States and House primarily defend the amended statute on grounds other than the power to impose taxes.

1. The intervenor States and House's lead argument is that the mandate is hortatory and thus need not rest on any source of lawmaking power. For example, the intervenor States argue that Congress enacted a "precatory provision" that is permissible "even where it addresses a subject on which Congress could not legislate with binding effect." Intervenor States Br. 32; see House Br. 35-36. The intervenor States and House thus interpret the mandate to lack any legal effect.

That characterization of the individual mandate cannot be squared with the statutory text. Section 5000A(a) states that "[a]n applicable individual *shall* * * * ensure that the individual * * * is covered under minimum essential coverage for such month," 26 U.S.C. 5000A(a) (emphasis added)—not that the individual "should" do so or that Congress would prefer that they do so. "[T]he word 'shall' usually connotes a requirement," *Kingdomware Techs., Inc.* v. *United States*, 136 S. Ct. 1969, 1977 (2016), and it "normally creates an obligation impervious to judicial discretion," *ibid.* (quoting *Lexecon Inc.* v. *Milberg Weiss Bershad Hynes &*

Lerach, 523 U.S. 26, 35 (1998)). Nothing in Section 5000A(a) indicates that Congress diverged from that ordinary understanding of the term, and "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.). Law-abiding citizens must comply with statutory commands whether or not any specific penalties are imposed for noncompliance.

Had Congress instead intended the mandate merely to encourage maintaining coverage or to convey Congress's own policy views, it easily could have done so—as illustrated by statutes the intervenor States and House cite, Intervenor States Br. 32; House Br. 35-36. In 4 U.S.C. 8, Congress provided that "[n]o disrespect should be shown to the flag of the United States of America," and it set forth more than a dozen specific practices that variously either "should" or "should never" be used in displaying the flag. *Ibid.* In 22 U.S.C. 7674, Congress stated that "[i]t is the sense of Congress that United States businesses should be encouraged to provide assistance to sub-Saharan African countries to prevent and reduce the incidence of HIV/AIDS in sub-Saharan Africa," and it identified one particular mechanism for providing such assistance that "United States businesses should be encouraged to consider." *Ibid.* And in 15 U.S.C. 7807, Congress provided that "States should enact the Uniform Athlete Agents Act of 2000." Each of those provisions contrasts starkly with Section 5000A(a), which states what covered individuals "shall" do.

At bottom, the contention of the intervenor States and House is that, without any enforceable sanction, the practical effect of Section 5000A is equivalent to a

sense-of-the-Congress resolution. But Section 5000A's text cannot fairly be construed as a suggestion. It most naturally conveys a "command." *NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.). And the reading of the mandate as a predicate to a tax that the Court adopted in *NFIB* based on context and the saving canon is no longer possible. See pp. 23-33, *supra*. As Section 5000A now stands, it must be read as creating a legal obligation that Congress lacks authority to impose.

2. The House alternatively argues that if the individual mandate "requires an enumerated power, the Court should still uphold it because it is necessary and proper to the exercise of Congress's power to lay and collect taxes," as "it retains the architecture of the tax upheld in *NFIB*." House Br. 37; see Intervenor States Br. 33. That theory—which permits the mandate's continued existence based solely on the hypothetical possibility that Congress might take *future action*—is incorrect. Retaining the individual mandate is unnecessary to enable Congress to reestablish a tax that currently does not exist. With or without the mandate, reinstating the tax would require future legislative action by Congress. And because this Court already found that the mandate would be unconstitutional if construed as a freestanding command, leaving the mandate in place purportedly to streamline hypothetical future legislation would be profoundly improper.

3. Finally, neither the intervenor States nor the House renews arguments made below that the individual mandate can be sustained under Congress's commerce power. See House C.A. Br. 40. That implicit concession is proper. This Court in *NFIB* held that neither the Commerce Clause nor the Necessary and Proper Clause authorized Congress to impose a legally binding

command to obtain health insurance as a freestanding regulation. See 567 U.S. at 547-561, 574 (opinion of Roberts, C.J.); *id.* at 649-660 (joint dissent). That conclusion rested on the nature and effects of what Congress sought to regulate—failure to maintain insurance coverage—not that the sanction it had imposed was too great or that the mandate would have been lawful with a smaller or no shared-responsibility payment. See *id.* at 572 (opinion of the Court) ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity.").

III. THE INDIVIDUAL MANDATE IS NOT SEVERABLE FROM THE REST OF THE ACT

Where a statutory provision is unconstitutional, determining whether the remainder of the statutory scheme should remain in effect requires an inquiry into legislative intent. The severability inquiry typically requires asking "whether Congress would have wanted the rest of [a statute] to stand, had it known that" one or more particular provisions of the statute would be held invalid. *NFIB*, 567 U.S. at 587 (opinion of Roberts, C.J.). While the "normal rule is that partial, rather than facial, invalidation is the required course," *Free Enter. Fund* v. *Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010) (citation and internal quotation marks omitted), courts must deem provisions inseverable where doing so implements Congress's evinced intent—for example, if the provisions' continued enforcement would result in "a scheme sharply different from what Congress contemplated," *Murphy*, 138 S. Ct. at 1482. After all, courts "cannot rewrite a statute and give it an effect altogether different from that sought by the measure viewed as a whole." *Ibid.* (citation omitted).

A. The Individual Mandate Is Inseverable From The Guaranteed-Issue And Community-Rating Provisions

1. Even though the guaranteed-issue and community-rating provisions are constitutionally valid when standing on their own, it is evident that Congress would not "have wanted" them to stand without the individual mandate. See *NFIB*, 567 U.S. at 587 (opinion of Roberts, C.J.).

a. That these provisions are inseverable is evident from the enacted text of the ACA, where Congress expressly found that the individual mandate is essential to the operation of the guaranteed-issue and community-rating provisions. See Pet. App. 209a ("Those findings are not mere legislative history—they are enacted text that underwent the Constitution's requirements of bicameralism and presentment."). "[I]f there were no requirement" to purchase insurance, Congress concluded, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. 18091(2)(I). But "[b]y significantly increasing health insurance coverage," the mandate, "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." *Ibid.* For that reason, Congress concluded, the individual mandate 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." *Ibid.* (emphasis added); see 42 U.S.C. 18091(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

In expressly finding a critical link between these three provisions, Congress looked to States' prior experiences in restructuring their health-insurance laws. Congress was well aware, in particular, that in some States guaranteed-issue and community-rating requirements "had an unintended consequence: They encouraged people to wait until they got sick to buy insurance." *King* v. *Burwell*, 135 S. Ct. 2480, 2485 (2015). The "adverse selection" of disproportionately ill people purchasing insurance forced insurers to raise premiums, which in turn resulted in "even more people wait[ing] until they became ill to buy it." *Id.* at 2485-2486. Congress was concerned about the resulting "economic 'death spiral,'" and thus looked to the experience of Massachusetts, which paired guaranteed-issue and community-rating provisions with tax credits and a requirement to purchase health insurance. *Id.* at 2486; see 42 U.S.C. 18091(2)(D) (explicitly relying on Massachusetts' experience).

b. This Court has repeatedly recognized that Congress viewed the guaranteed-issue and community-rating provisions as necessarily intertwined with the individual mandate. All nine Justices indicated as much in *NFIB*. See 567 U.S. at 548 (opinion of Roberts, C.J.) ("The guaranteed-issue and community-rating reforms * * * exacerbate" the "problem" of "healthy individuals who choose not to purchase insurance to cover potential health care needs," and "threaten to impose massive new costs on insurers. * * * The individual mandate was Congress's solution to these problems."); *id.* at 597-598 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("[T]hese two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. * * * [G]uaranteed-

issue and community-rating laws alone will not work."); *id.* at 698 (joint dissent) ("[I]mpos[ing] risks on insurance companies and their customers"—including the community-rating and guaranteed-issue provisions—"[w]ithout the Individual Mandate * * * would undermine Congress' scheme of shared responsibility.") (internal quotation marks omitted). Indeed, the government's briefing in *NFIB* agreed that both the guaranteed-issue and community-rating provisions were inseverable from the individual mandate. Gov't Br. on Severability at 44-55, *NFIB*, *supra* (Nos. 11-393 and 11-400).

And in *King*, this Court again acknowledged that "[t]hese three reforms are closely intertwined" and that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement." 135 S. Ct. at 2487.

c. The TCJA does not alter what Congress said in the ACA about how these three provisions are inextricably intertwined. While the TCJA eliminated the mandate's tax penalty, it did not eliminate the mandate itself, which still "[r]equire[s]" that individuals "shall" purchase health insurance. 26 U.S.C. 5000A(a) (emphasis omitted). And critically, the TCJA left in place Congress's findings that the mandate's "requirement" to purchase insurance is "essential" to the operation of the guaranteed-issue and community-rating provisions. 42 U.S.C. 18091(2)(I). By retaining the mandate (even without a penalty) and leaving undisturbed its prior express findings, Congress adhered to the view that the individual mandate and guaranteed-issue and community-rating provisions are interrelated. That indicates Congress's intent: Congress would not have "wanted" the guaranteed-issue and community-rating provisions "to

stand alone," either in 2010 or in 2017. *Murphy*, 138 S. Ct. at 1483.

2. The intervenor States and House push back, arguing that the 2017 Congress necessarily intended the guaranteed-issue and community-rating provisions to remain even if the mandate were invalidated because Congress left those provisions (and the rest of the ACA) intact while eliminating the mandate's penalty. See Intervenor States Br. 36-37; House Br. 40-42. But this argument overlooks that Congress retained the mandate itself, that Congress in 2017 did not expressly address what should happen if the mandate were later judicially invalidated, and that Congress instead left in place the 2010 findings that the mandate is essential to the guaranteed-issue and community-rating provisions. And although the intervenor States and House contend that Members of Congress would have been indifferent if the mandate were invalidated after the penalty was eliminated, they provide no evidence that Congress as a whole shared their pessimistic view that most American citizens would flout a mandatory requirement to purchase insurance simply because that legal duty is not backed by an enforcement penalty.

Even if that is what some Members of Congress would have wanted, it is not what Congress as a whole did. Congress left undisturbed the ACA's clear statement that the individual mandate is essential to the guaranteed-issue and community-rating provisions. Although the intervenor States and House do not label it this way, they are in effect arguing that Congress repealed its existing findings in Section 18091(2) by implication. But "repeals by implication are not favored and will not be presumed unless the intention of the legislature to repeal is clear and manifest," *National Ass'n of*

Home Builders v. *Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (brackets, citation, and internal quotation marks omitted), and "will only be found where provisions in two statutes are in irreconcilable conflict, or where the latter Act covers the whole subject of the earlier one and is clearly intended as a substitute," *Branch* v. *Smith*, 538 U.S. 254, 273 (2003) (opinion of Scalia, J.) (citation and internal quotation marks omitted). Here, Congress as a whole has nowhere demonstrated a clear and manifest intent to overturn its prior findings that the individual mandate and the guaranteed-issue and community-rating provisions must operate together. This is so because the elimination of the mandate's penalty neither conflicts with nor substitutes for the ACA's findings about the relationship between the mandate's requirement and the insurance-reform provisions. The presumption against implied repeals thus requires the Court to give effect to the ACA's statutory findings.

The intervenor States and House try to minimize the import of the statutory findings by suggesting that they were designed for a different purpose or that they have been superseded by subsequent events. Intervenor States Br. 41-44; House Br. 44-46. As to the first point, this Court should not ignore the factual findings simply because they were not specifically directed toward severability; as part of the ACA's text, they remain an important indicator of Congress's understanding of whether these various provisions are capable of functioning independently. As to the second point, neither the establishment and development of insurance marketplaces nor the change to the mandate's penalty sheds any light on Congress's intent regarding the interplay among the relevant provisions—especially given that Congress originally structured the mandate's penalty to change

over time, see 26 U.S.C. 5000A(c)(2)(B) and (3)(A)-(B) (2012).

More generally, the intervenor States and House contend that the intent of the 2010 Congress should be ignored because the constitutional infirmity did not arise until 2017. But as they properly recognize, the repeal of the tax was not itself unconstitutional; rather, it is the interaction between the ACA and TCJA that renders the individual mandate invalid. Thus, the focus is not exclusively on the 2010 Congress or the 2017 Congress, as the current statutory scheme is the product of enactments by both bodies. And the combined intent is clear: the 2010 Congress viewed the operation of the mandate as inextricably intertwined with the operation of the guaranteed-issue and community-rating provisions, and the 2017 Congress did not disturb that understanding—but rather ratified it—by retaining the findings while eliminating the penalty.

Ultimately, the findings in 42 U.S.C. 18091(2) are no different from a targeted inseverability clause. The government in *NFIB* recognized as much. See Gov't Br. on Severability at 52, *NFIB*, *supra* (Nos. 11-393 and 11-400) ("The question of severability is one of congressional intent, and Congress expressly found that the minimum coverage provision is 'essential' to the guaranteed-issue reforms. 42 U.S.C.A. 18091(a)(2)(I)."). If Congress had framed its findings as an inseverability clause, this Court would apply it—whether or not the Court independently believed that Congress's expression of intent made sense or achieved the wisest legislation. Cf. *Zobel* v. *Williams*, 457 U.S. 55, 64-65 (1982) (explaining the Court "need not consider" other alternatives that the legislature could have adopted where

"the legislation expressly provides that invalidation of any portion of the statute renders the whole invalid").

Here, Congress did not speak in general terms about the severability of provisions or applications. It instead addressed a specific issue that is directly relevant to severability: that the individual mandate is essential to the guaranteed-issue and community-rating provisions. That only makes Congress's intent *more* clear. Giving effect to Congress's statutorily codified expression of its intent may or may not achieve what its Members expected in 2017 when they amended the ACA—depending on whether they perceived the issue and wanted the findings to control—and there were likely Members on all sides. But this Court would not pause over Members' subjective intentions in applying an express inseverability clause, and the result should be no different when Congress expresses its intent with respect to a specific issue that is directly relevant to severability and then leaves that intent undisturbed during subsequent amendments.

B. The ACA's Remaining Provisions Are Inseverable

1. Once the individual mandate and the guaranteed-issue and community-rating provisions are invalidated, the remainder of the ACA should not be allowed to remain in effect. As noted above, this Court may consider the inseverability of, and award relief concerning, other ACA provisions only insofar as such provisions injure the plaintiffs. But the government will address the whole Act here, both because at least some other insurance reforms do injure the individual plaintiffs, see pp. 16-19, *supra*, and because an argument for the inseverability of those provisions likewise applies to other ACA provisions. And the Court may benefit from a complete

analysis should it conclude that additional discrete provisions of the ACA injure any of the plaintiffs.

As explained by the joint dissenters in *NFIB*—the only Justices to reach the issue of whether the rest of the Act could be severed from the individual mandate and the guaranteed-issue and community-rating provisions—the ACA's interlocking web of provisions cannot function as Congress intended absent that core triad. 567 U.S. at 691-707 (joint dissent). Eliminating those three provisions would in turn "rewrite [the] statute," *Murphy*, 138 S. Ct. at 1482 (citation omitted), by fundamentally altering the ACA's other insurance reforms, which were premised on the availability of uniform plans to all potential purchasers of insurance in the individual and small-group markets. As even the amicus curiae appointed in *NFIB* to argue *in favor of* severability acknowledged, "the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited to just those provisions." Court-Appointed Amicus Br. Supporting Complete Severability at 46, *NFIB*, *supra* (Nos. 11-393 and 11-400).

For example, the ACA created insurance "exchanges" where individuals could purchase insurance. "A key purpose of an exchange is to provide a marketplace of insurance options where prices are standardized regardless of the buyer's pre-existing conditions." *NFIB*, 567 U.S. at 702 (joint dissent). Without the community-rating provisions, which generally prohibit altering the price of insurance based on the buyer's health condition, "[t]he prices would vary from person to person," and "the exchanges cannot operate in the manner Congress intended." *Id.* at 702-703. And without the insurance

exchanges, there would be no basis for requiring employers to make a payment to the federal government if they do not offer insurance to employees and those employees then purchase insurance on the exchange. See 26 U.S.C. 4980H; *NFIB*, 567 U.S. at 703 (joint dissent).

The ACA's tax credits suffer a similar fate absent the three central provisions. As *King* recognized, "the guaranteed issue and community rating requirements * * * only work when combined with the coverage requirement and the tax credits." 135 S. Ct. at 2494. "Without the community-rating insurance regulation, * * * the average federal subsidy could be much higher; for community rating greatly lowers the enormous premiums unhealthy individuals would otherwise pay." *NFIB*, 567 U.S. at 701 (joint dissent). "The result would be an unintended boon to insurance companies, an unintended harm to the federal fisc, and a corresponding breakdown of the 'shared responsibility' * * * that Congress intended." *Id.* at 702.

Similarly, the ACA included a panoply of other insurance regulations and taxes, such as coverage limits, requirements to cover dependent children, and restrictions on high-cost insurance plans. See *NFIB*, 567 U.S. at 698 (joint dissent) (citing 26 U.S.C. 4980I; 42 U.S.C. 300gg-11, 300gg-14(a)). These regulations all indisputably impose "higher costs for insurance companies." *Ibid.* The ACA's design contemplated that these costs would be offset in part by the individual mandate, which would increase the number of individuals enrolled in insurance, and by federal subsidies. See *id.* at 698-699. Allowing these provisions to continue in effect without the interdependent provisions already discussed would create a potentially unstable insurance market—unlike anything that Congress intended. *Id.* at 699.

As the joint dissent also explained, the ACA's cost-saving measures are linked to provisions that reduce uncompensated care. The ACA "reduces payments by the Federal Government to hospitals by more than $200 billion over 10 years." *NFIB*, 567 U.S. at 699 (joint dissent). These reductions were palatable only because other provisions in the ACA were expected to lead to "[n]ear-universal coverage" that would "offset the government's reductions in Medicare and Medicaid reimbursements to hospitals." *Ibid.* There is no indication that Congress would have cut payments without providing hospitals with an opportunity to receive offsetting revenue, particularly where doing so could have dramatic effects—including raising the costs of care and insurance premiums borne by consumers—and contravene the Act's goals. See *id.* at 699-700.

These reductions in federal payments were in turn designed to "offset the $434-billion cost of the Medicaid Expansion," *NFIB*, 567 U.S. at 700 (joint dissent), and there is no indication that Congress would have enacted legislation that greatly increased the federal deficit if the reductions in federal spending were invalidated. There is no tension between this conclusion and the *NFIB* majority's conclusion that the Medicaid expansion should be allowed to take effect even if it could not be a condition on the remainder of a State's Medicaid allotment. A less extensive expansion of Medicaid than Congress intended does not contravene Congress's objectives in the same way as would the system-wide rebalancing of costs and benefits that the intervenor States and House urge here.

That leaves the ACA's comparatively "minor," ancillary provisions. *NFIB*, 567 U.S. at 704 (joint dissent).

Some of those provisions interact with the major provisions just discussed, and thus would not act in the manner that Congress intended once the major provisions are invalidated. See *id.* at 705 (discussing tax increases that offset costs imposed by health-insurance reforms). There are other provisions that might be able to operate in the manner that Congress intended when viewed in isolation, but the question of congressional intent as to those provisions is complicated by the sprawling nature of the ACA. In this unique context, comparatively "minor," ancillary provisions that were tacked on to the bill should be held inoperative once the core provisions have been struck down because "[t]here is no reason to believe that Congress would have enacted them independently." *NFIB*, 567 U.S. at 705 (joint dissent).[5]

2. The court of appeals criticized the district court for failing to engage in a sufficiently detailed inquiry into the various aspects of the statute. J.A. 441-445. But in *NFIB* four Justices of this Court determined that a similar inquiry was sufficient. No further analysis is necessary; once the individual mandate and the guaranteed-issue and community-rating provisions are invalidated, the remainder of the ACA cannot survive.

For their part, the intervenor States and House emphasize that Congress declined to repeal additional provisions of the ACA before eliminating the mandate's penalty. See Intervenor States Br. 46-47; House Br. 41-42. But this history does not speak to the relevant

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[5] The House asserts that "[t]he United States made a diametrically opposed argument" in *Seila Law LLC* v. *CFPB*, No. 19-7 (argued Mar. 3, 2020). House Br. 49 n.11. But that is clearly incorrect because Congress in the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376, included an *express severability clause*, 12 U.S.C. 5302.

question here—namely, what Congress would have wanted if the mandate itself were invalidated *as well as* the guaranteed-issue and community-rating provisions. On that question, the best guides for this Court's analysis are the substantive connections between the various provisions of the ACA as recognized by the joint dissenters in *NFIB*. If this Court concludes that, notwithstanding the legislative background invoked by the intervenor States and House, Congress's statutory findings tie the invalid mandate to the guaranteed-issue and community-rating provisions, then it necessarily follows that the rest of the ACA must also fall—which is a text- and structure-based conclusion that the invoked legislative background cannot undermine.

CONCLUSION

The judgment of the court of appeals should be affirmed insofar as it held that the individual mandate is unconstitutional, and this Court should further hold that the insurance provisions injuring the individual plaintiffs are inseverable from the mandate and the remainder of the Act. This case should then be remanded for consideration of the scope of appropriate relief redressing plaintiffs' injuries.

Respectfully submitted.

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APPENDIX

1. U.S. Const. Art. I, § 8, Cl. 1 provides:

The Congress shall have Power 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; but all Duties, Imposts and Excises shall be uniform throughout the United States;

2. U.S. Const. Art. I, § 8, Cl. 3 provides:

To regulate Commerce with foreign Nations, and among several States, and with Indian Tribes;

3. U.S. Const. Art. I, § 8, Cl. 18 provides:

To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

4. 26 U.S.C. 5000A provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual,

is covered under minimum essential coverage for such month.

(b) Shared responsibility payment

(1) In general

If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return

Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty

If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) Zero percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1)—

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $0.

(B) Phase in

The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the

applicable dollar amount for the calendar year in which the month occurs.

(4) Terms relating to income and families

For purposes of this section—

(A) Family size

The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income

The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) Applicable individual

For purposes of this section—

(1) In general

The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemptions

(i) In general

Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that—

(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section; or

(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

(ii) Special rules

(I) Medical health services defined

For purposes of this subparagraph, the term "medical health services" does not include routine dental, vision and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(II) Attestation required

Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.

(B) Health care sharing ministry

(i) In general

Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry

The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present

Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals

Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions

No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage

(A) In general

Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution

For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual

(without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing

In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the per-

[1] So in original. Probably should be followed by "the".

centage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold

Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes

Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps

(A) In general

Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules

For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no

exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships

Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage

For purposes of this section—

(1) In general

The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs

Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act),

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers);[3] or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan

Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market

Coverage under a health plan offered in the individual market within a State.

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[2] So in original. The semicolon probably should be a comma.

[3] So in original. The semicolon probably should be a comma.

(D) Grandfathered health plan

Coverage under a grandfathered health plan.

(E) Other coverage

Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan

The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage

The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories

Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms

Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure

(1) In general

The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules

Notwithstanding any other provision of law—

(A) Waiver of criminal penalties

In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies

The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

5. 42 U.S.C. 18091 provides:

Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement

has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The

requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg-3, 300gg-4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

6. Pub. L. No. 115-97, Tit. I, 131 Stat. 2054 provides in pertinent part:

* * * * *

SEC. 11081. ELIMINATION OF SHARED RESPONSIBILITY PAYMENT FOR INDIVIDUALS FAILING TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) IN GENERAL.—Section 5000A(c) is amended—

(1) in paragraph (2)(B)(iii), by striking "2.5 percent" and inserting "Zero percent", and

(2) in paragraph (3)—

(A) by striking "$695" in subparagraph (A) and inserting "$0", and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2018.

* * * * *

7. 26 U.S.C. 5000A (2012) provides in pertinent part:

Requirement to maintain minimum essential coverage

* * * * *

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1)—

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in

The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount

In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

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

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

(4) Terms relating to income and families

For purposes of this section—

(A) Family size

The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income

The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

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