No. 19-10011

**UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

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

Intervenor Defendants-Appellants.

On Appeal from the United States District
Court for the Northern District of Texas
(No. 4:18-cv-00167-O)

**OPENING BRIEF OF INTERVENOR THE
U.S. HOUSE OF REPRESENTATIVES**

Douglas N. Letter
General Counsel
Todd B. Tatelman
Deputy General Counsel
Kristin A. Shapiro
Assistant General Counsel
Brooks M. Hanner
Assistant General Counsel

OFFICE OF GENERAL COUNSEL
U.S. HOUSE OF REPRESENTATIVES
219 Cannon House Office Building
Washington, D.C. 20515
Tel: (202) 225-9700
Douglas.Letter@mail.house.gov

Donald B. Verrilli, Jr.
Elaine J. Goldenberg
Ginger D. Anders
Jonathan S. Meltzer
Rachel G. Miller-Ziegler
Jeremy S. Kreisberg
MUNGER, TOLLES & OLSON LLP
1155 F Street N.W., 7th Floor
Washington, D.C. 20004-1361
Tel: (202) 220-1100
Fax: (202) 220-2300
Donald.Verrilli@mto.com

Elizabeth B. Wydra
Brianne J. Gorod
Brian R. Frazelle
Ashwin P. Phatak
CONSTITUTIONAL
ACCOUNTABILITY CENTER
1200 18th Street N.W., Suite 501
Washington, D.C. 20036-2513
Tel: (202) 296-6889
elizabeth@theusconstitution.org
brianne@theusconstitution.org

Counsel for the U.S. House of Representatives

CERTIFICATE OF INTERESTED PERSONS

Because the U.S. House of Representatives is a government entity, a certificate of interested persons is not required. 5th Cir. R. 28.2.1.

Dated: March 25, 2019

Respectfully submitted,

/s/ Donald B. Verrilli, Jr.
Donald B. Verrilli, Jr.

STATEMENT REGARDING ORAL ARGUMENT

This is an appeal from a district court order striking down as unconstitutional an exceptionally important Act of Congress affecting millions of Americans. Oral argument is warranted.

TABLE OF CONTENTS

Page

CERTIFICATE OF INTERESTED PERSONS i

STATEMENT REGARDING ORAL ARGUMENT ii

TABLE OF CONTENTS.. iii

TABLE OF AUTHORITIES v

JURISDICTIONAL STATEMENT 1

PERTINENT STATUTES..1

STATEMENT OF ISSUES 1

INTRODUCTION 1

STATEMENT OF THE CASE...5

SUMMARY OF ARGUMENT 9

STANDARD OF REVIEW 12

ARGUMENT 12

I. THE SUPREME COURT AUTHORITATIVELY CONSTRUED SECTION 5000A AS OFFERING INDIVIDUALS A CHOICE BETWEEN TWO LAWFUL OPTIONS, AND NOTHING IN THE 2017 AMENDMENT CHANGES THAT...12

A. In *NFIB*, the Supreme Court held that Section 5000A did not impose a legal requirement to buy insurance, but instead offered a "lawful choice" between buying insurance and paying a tax. 13

B. The reduction of the shared-responsibility payment to zero does not change the Supreme Court's construction of Section 5000A.......16

II. THE PLAINTIFFS LACK STANDING..20

A. The individual plaintiffs lack standing...21

1. The individual plaintiffs lack standing to complain about an entirely voluntary choice..21

2. Even if the Act did obligate the individual plaintiffs to purchase insurance, such a mandate would inflict no legally cognizable injury because it lacks any enforcement mechanism. 24

TABLE OF CONTENTS
(Continued)

Page

B. The state plaintiffs lack standing......28

III. CONGRESS HAS THE CONSTITUTIONAL AUTHORITY TO PROVIDE THE CHOICE OFFERED IN SECTION 5000A. 35

IV. IF THE COURT DEEMS THE MANDATE UNCONSTITUTIONAL, IT MUST BE SEVERED FROM THE REMAINDER OF THE ACT......41

A. Congress's decision to leave the rest of the Act in place when it eliminated the shared-responsibility payment in 2017 answers the severability question......43

B. The *Booker* factors also compel severance of the mandate from the rest of the Act. 47

CONCLUSION......57

CERTIFICATE OF SERVICE 58

CERTIFICATE OF COMPLIANCE......59

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Alaska Airlines, Inc. v. Brock,
480 U.S. 678 (1987) 42, 46, 48, 49

Allen v. Wright,
468 U.S. 737 (1984) 27, 29

Ayotte v. Planned Parenthood of N. New England,
546 U.S. 320 (2006) .... *passim*

Babbitt v. United Farm Workers Nat'l Union,
442 U.S. 289 (1979) 25

Barber v. Bryant,
860 F.3d 345 (5th Cir. 2017) 27

Bauer v. Marmara,
774 F.3d 1026 (D.C. Cir. 2014) 23

Blodgett v. Holden,
275 U.S. 142 (1927) 3

Bolivarian Republic of Venezuela v. Helmerich & Payne Int'l Drilling Co.,
137 S. Ct. 1312 (2017) 23

Bowsher v. Synar,
478 U.S. 714 (1986) 37

Cent. & S. W. Servs., Inc. v. EPA,
220 F.3d 683 (5th Cir. 2000) 33

Clapper v. Amnesty Int'l USA,
568 U.S. 398 (2013) .... *passim*

Clark v. Martinez,
543 U.S. 371 (2005) 18

TABLE OF AUTHORITIES
(Continued)

Page(s)

Crane v. Johnson,
783 F.3d 244 (5th Cir. 2015) 32

DaimlerChrysler Corp. v. Cuno,
547 U.S. 332 (2006)..34

Davis v. FEC,
554 U.S. 724 (2008)..34

Dimmitt v. City of Clearwater,
985 F.2d 1565 (11th Cir. 1993) 37

Florida ex rel. Att'y Gen. v. U.S. Dep't of Health and Human Servs.,
648 F.3d 1235 (11th Cir. 2011) 5, 49, 51

Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.,
561 U.S. 477 (2010)..42, 47

Glass v. Paxton,
900 F.3d 233 (5th Cir. 2018) 22

I.N.S. v. Chadha,
462 U.S. 919 (1983)..37

Kimble v. Marvel Entm't, LLC,
135 S. Ct. 2401 (2015)..16

King v. Burwell,
135 S. Ct. 2480 (2015)..51, 56

Lance v. Coffman,
549 U.S. 437 (2007)..26

Leavitt v. Jane L.,
518 U.S. 137 (1996)..41

Lexmark Int'l, Inc. v. Static Control Components, Inc.,
572 U.S. 118 (2014)..20

TABLE OF AUTHORITIES
(Continued)

Page(s)

Lujan v. Defs. of Wildlife,
504 U.S. 555 (1992)....................10, 29, 31

McCulloch v. Maryland,
17 U.S. (4 Wheat.) 316 (1819) 38

Meese v. Keene,
481 U.S. 465 (1987)....................24

Moore v. Bryant,
853 F.3d 245 (5th Cir. 2017) 27

Murphy v. Nat'l Collegiate Athletic Ass'n,
138 S. Ct. 1461 (2018)....................45, 46

Nat'l Fed'n of Indep. Business v. Sebelius,
567 U.S. 519 (2012)....................*passim*

Nat'l Fed'n of the Blind of Texas, Inc. v. Abbott,
647 F.3d 202 (5th Cir. 2011) 34

New York v. United States,
505 U.S. 144 (1992)....................15, 36

Nixon v. United States,
506 U.S. 224 (1993)....................43

Pennsylvania v. New Jersey,
426 U.S. 660 (1976)....................33

Poe v. Ullman,
367 U.S. 497 (1961)....................10, 25, 26, 27

Raines v. Byrd,
521 U.S. 811 (1997)....................20

Regan v. Time, Inc.,
468 U.S. 641 (1984)....................41

TABLE OF AUTHORITIES
(Continued)

Page(s)

Rust v. Sullivan,
500 U.S. 173 (1991)....................3

Seals v. McBee,
898 F.3d 587 (5th Cir. 2018)....................31

Smith v. Reg'l Transit Auth.,
827 F.3d 412 (5th Cir. 2016)....................12

Steel Co. v. Citizens for a Better Env't,
523 U.S. 83 (1998)....................23

Susan B. Anthony List v. Driehaus,
573 U.S. 149 (2014)....................25

TC Heartland LLC v. Kraft Foods Grp. Brands LLC,
137 S. Ct. 1514 (2017)....................16

Texas v. United States,
809 F.3d 134 (5th Cir. 2015)....................32, 33

United States v. Booker,
543 U.S. 220 (2005)....................42, 47

United States v. Comstock,
560 U.S. 126 (2010)....................38, 39, 40

Virginia v. Am. Booksellers Ass'n, Inc.,
484 U.S. 383 (1988)....................26

Warth v. Seldin,
422 U.S. 490 (1975)....................20

FEDERAL STATUTES

7 U.S.C. § 2901....................40

15 U.S.C. § 7807....................37

TABLE OF AUTHORITIES
(Continued)

Page(s)

26 U.S.C. § 36B 6

26 U.S.C. § 4980H 6

26 U.S.C. § 4980H(a) 5, 47

26 U.S.C. § 5000A .... *passim*

26 U.S.C. § 5000A(a) .... *passim*

26 U.S.C. § 5000A(b) .... *passim*

26 U.S.C. § 5000A(c) .... *passim*

26 U.S.C. § 5000A(d) 7

26 U.S.C. § 5000A(e) 7, 15, 19

28 U.S.C. § 1291 1

28 U.S.C. § 1331 1

29 U.S.C. § 207(r) 5, 48

29 U.S.C. § 218A 6

36 U.S.C. § 135 37

42 U.S.C. § 300gg(a) 6

42 U.S.C. § 300gg-1 6

42 U.S.C. § 300gg-3 .... 6, 48

42 U.S.C. § 300gg-4 6

42 U.S.C. § 300gg-4(b) 6

42 U.S.C. § 300gg-11 .... 6, 48

TABLE OF AUTHORITIES
(Continued)

Page(s)

42 U.S.C. § 300gg-12 .... 6, 48

42 U.S.C. § 300gg-13 6

42 U.S.C. § 300gg-14 .... 6, 48

42 U.S.C. § 300hh-31 48

42 U.S.C. § 710 5

42 U.S.C. § 1303 55

42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) 5, 47

42 U.S.C. § 18031(b)(1) 5, 6

42 U.S.C. § 18071 6

42 U.S.C. § 18091(1) 53

42 U.S.C. § 18091(2)(A) 53

42 U.S.C. § 18091(2)(C) 52

42 U.S.C. § 18091(2)(H) 52, 53

42 U.S.C. § 18091(2)(I) 52

Pub. L. No. 100-418, Title V, § 5003(d),
102 Stat. 1107 (Aug. 23, 1988) 37

Pub. L. No. 115-97, § 11081, 131 Stat. 2054 (2017) 8, 16, 43

FEDERAL RULES

Fed. R. Civ. P. 54(b) 1

CONSTITUTIONAL PROVISIONS

U.S. Const. art. I, § 8, cl. 18 38

TABLE OF AUTHORITIES
(Continued)

Page(s)

LEGISLATIVE MATERIALS

163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) 17

163 Cong. Rec. S7665 (daily ed. Dec. 1, 2017) 17

163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017) 17, 44

Constitution, *Jefferson's Manual, and Rules of the House of Representatives*, 112th Cong., H.R. Doc. No. 111-157 (2011) 36

Continuation of the Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" Before the Senate Comm. on Fin., 115th Cong. (Nov. 15, 2017) 17, 44

H.R. Rep. No. 111-299, pt. 3 (2009) 51

H.R. Rep. No. 111-443, pt. 2 (2010) 51

S. Rep. No. 54-1335 (1897) 37

OTHER AUTHORITIES

Bernadette Fernandez et al., Cong. Research Serv., R40517, *Health Care Reform: An Introduction* (Aug. 31, 2009) 5

Bob Bryan & Zachary Tracer, *The Newest Obamacare Enrollment Numbers Prove the Health Law Is 'Far From Dead' Despite Repeated Attacks from Trump and the GOP*, Business Insider (Dec. 20, 2018), https://www.businessinsider.com/obamacare-open-enrollment-sign-ups-down-4-after-gop-trump-changes-2018-12 50

C. Stephen Readhead & Janet Kinzer, Cong. Research Serv., R43289, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act* (Feb. 7, 2017) 8

TABLE OF AUTHORITIES
(Continued)

Page(s)

Christine Eibner & Sarah A. Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, The Commonwealth Fund (July 2018), https://www.commonwealthfund.org/sites/default/files/2018-07/Eibner_individual_mandate_repeal.pdf 31

Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Dec. 2008), https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf 30

Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017) ....*passim*

John G. Roberts, Jr., *Article III Limits on Statutory Standing*, 42 Duke L.J. 1219 (1993) 20

Kevin C. Walsh, *The Ghost That Slayed the Mandate*, 64 Stan. L. Rev. 55 (2012) 34

Michelle M. Doty et al., *Failure To Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund (July 2009), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf 50, 51

Rachel Roubein, *TIMELINE: The GOP's Failed Effort to Repeal ObamaCare*, The Hill (Sept. 26, 2017) 8, 46

JURISDICTIONAL STATEMENT

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

PERTINENT STATUTES

Pertinent statutes are reproduced in the Addendum.

STATEMENT OF ISSUES

1. Whether plaintiffs lack standing to challenge 26 U.S.C. § 5000A, which has no effect on them.

2. Whether Section 5000A, as amended by the Tax Cuts and Jobs Act, is constitutional.

3. Whether, if this Court concludes that Section 5000A is unconstitutional, the provision is severable from the remainder of the Affordable Care Act.

INTRODUCTION

In 2010, the elected representatives of the People of the United States enacted the Patient Protection and Affordable Care Act (the "Act"). In 2012, the Supreme Court upheld the Act's insurance-market reforms, which ensure that persons with preexisting conditions can obtain affordable care, and left in place an option for States to participate in the Act's Medicaid expansion. *Nat'l Fed'n of Indep. Business v. Sebelius* ("*NFIB*"), 567 U.S. 519 (2012). Since then, the Act has made it possible

for tens of millions of Americans to enjoy quality health care that has enabled them to live happier and more productive lives; to care for their children, spouses, and parents; and to contribute more fully to their communities and their country.

Despite all the Act has achieved, its political opponents have made repeated efforts to repeal it or to disable it through litigation. Those efforts all have failed. Meanwhile, most States and the federal government have invested substantial resources to build the infrastructure needed to provide the historic gains in health coverage that Congress intended.

The case now before this Court is the latest chapter in this ongoing political controversy. Several States and two individual plaintiffs have asked the judiciary to step in and do what Congress would not: wipe the Act off the books. Their challenge focuses on a decision by the 2017 Congress—the same Congress that voted down a repeal bill—to amend the Act in one modest respect by reducing to zero the shared-responsibility tax payment that is an alternative to maintaining health coverage. Plaintiffs assert that Section 5000A injures them even though it does not require them to do anything; that the Act's so-called individual mandate now violates the Constitution because it is no longer backed by a tax incentive; and that the entire Act must be invalidated as a result. And the district court accepted all of those remarkable assertions.

The district court's decision does violence to multiple precepts that govern the use of judicial power. This dispute should not be before the Court at all because plaintiffs do not satisfy the requirements of Article III standing, which ensure that judicial power is properly constrained in a democratic society. The two individual plaintiffs have not been injured. They can lawfully make whatever choice they want about health insurance, and will face no adverse consequence if they choose to forgo it. The plaintiff States have not suffered any injury either. Section 5000A does not apply to them, and their claim that reducing the tax to zero will cause their citizens to sign up in greater numbers for Medicaid or Children's Health Insurance Program ("CHIP") coverage relies on an attenuated chain of speculative and improbable inferences, unsupported by any record evidence.

The district court's ruling on the merits reflects a similar lack of appreciation for the limits on the judicial role. Striking down an Act of Congress "is the gravest and most delicate duty that [a] Court is called on to perform," and courts therefore have a duty to adopt any reasonable construction of a challenged law that will enable it to be upheld. *Rust v. Sullivan*, 500 U.S. 173, 191 (1991) (quoting *Blodgett v. Holden*, 275 U.S. 142, 148 (1927) (opinion of Holmes, J.)); *see NFIB*, 567 U.S. at 562. Section 5000A is plainly susceptible to a saving construction. Because the provision no longer alters any individual's rights or obligations, it no longer needs an enumerated power to support it. And even if it is incorrectly interpreted as having

concrete effects, it can be justified as necessary and proper to Congress's exercise of its enumerated powers.

Finally, even if Section 5000A were unconstitutional, the district court disregarded established limits on judicial power when it struck down the Act *in toto*—all 10 titles, spanning 974 pages—rather than severing the mandate from the remainder of the Act. As the Supreme Court often has held, the "touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature." *NFIB*, 567 U.S. at 586 (citation omitted). Here, the enacted statutory text establishes that Congress specifically intended for the Act's insurance-market reforms to operate even in the absence of any effective mandate to purchase insurance. That is precisely the statute Congress created with its 2017 amendment. And the amended Act has in fact operated as Congress intended. Millions of people obtained coverage for 2019 even absent the tax incentive, and insurance markets remained stable—just as the Congressional Budget Office ("CBO") predicted in advance of the 2017 amendment.

If the district court's stunning ruling invalidating the entire Act—or even just its protections for people with preexisting conditions—is upheld, the consequences will be devastating. Millions of Americans will be denied affordable health care. Insurance costs will skyrocket. Medicare recipients will face steep increases in the price of drugs and other services. And the Nation's healthcare system will be thrown

into chaos. The severity of such consequences calls for the utmost caution, and plaintiffs' arguments do not come close to justifying such massive harm. This Court should reverse.

STATEMENT OF THE CASE

1. In 2010, Congress passed the Act to increase access to quality health insurance for all Americans. At the time, over 45 million Americans lacked health insurance, and millions more had difficulty obtaining coverage because of preexisting conditions. Bernadette Fernandez et al., Cong. Research Serv., R40517, *Health Care Reform: An Introduction* 1 (Aug. 31, 2009); *see Florida ex rel. Att'y Gen. v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1245 (11th Cir. 2011).

To address these and other problems, the Act included hundreds of provisions. It expanded Medicaid to millions of lower-income Americans, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), altered the rules governing employer-provided coverage, *see, e.g.*, 26 U.S.C. § 4980H(a), and reformed the individual insurance market, *see, e.g.*, 42 U.S.C. § 18031(b)(1). It also included myriad other provisions unrelated to insurance markets, such as restoring funding for abstinence education, 42 U.S.C. § 710, and requiring break time for nursing mothers, 29 U.S.C. § 207(r).

Critical among the Act's market reforms were important protections for individuals with preexisting conditions. The "'guaranteed issue' requirement ... bars

insurers from denying coverage to any person on account of that person's medical condition or history." *NFIB*, 567 U.S. at 597; *see* 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4. The "community rating" provision prohibits charging higher premiums because of a medical condition. 42 U.S.C. §§ 300gg(a), 300gg-4(b).

The Act also encourages individuals to enter the health-insurance market. It creates "exchanges" where individuals can shop online for insurance. *Id.* § 18031(b)(1). It provides federal subsidies for the purchase of insurance on those exchanges, 26 U.S.C. § 36B, and offers additional assistance to certain low-income individuals, 42 U.S.C. § 18071. It makes insurance more attractive through consumer protections, such as by prohibiting insurers from imposing lifetime dollar limits and from rescinding coverage except in the case of fraud, *id.* §§ 300gg-11, 300gg-12; requiring health plans to cover preventive services without cost sharing, *id.* § 300gg-13; and ensuring that children can stay on their parents' plans until age 26, *id.* § 300gg-14. It also takes steps to encourage employees to enroll in employer-provided plans. *See, e.g.*, 26 U.S.C. § 4980H; 29 U.S.C. § 218A.

As initially enacted, the law provided in 26 U.S.C. § 5000A an incentive to purchase insurance. This section has three central components. Subsection (a)—which has been referred to as the "individual mandate"—states that certain individuals "shall ... ensure" that they and their dependents are "covered under minimum essential coverage." Subsection (b) provides that individuals to whom

subsection (a) applies who do not obtain such coverage must make a "[s]hared responsibility payment" as part of their tax return. Finally, subsection (c) sets the amount of that payment. The Act also identifies certain groups of people who are exempt from subsection (a), *id.* § 5000A(d), and others who are exempt from subsection (b), *id.* § 5000A(e).

2. Since the Act's passage, it has been the subject of litigation. Most pertinent here, in *NFIB*, the Supreme Court considered a challenge to the constitutionality of Section 5000A. A majority of the Court concluded that the mandate could not be upheld under the Commerce Clause, 567 U.S. at 547-61 (opinion of Roberts, C.J.); *id.* at 649-61 (joint dissent), but a separate majority concluded that it was a permissible exercise of Congress's taxing power, *id.* at 563-75 (majority opinion); *see* p. 14, *infra*.

3. Many unsuccessful attempts have been made to repeal the Act. In the 112th, 113th, and 114th Congresses, the House of Representatives passed numerous bills that would have repealed the law in whole or in part, defunded it, or blocked its

implementation. Those attempts all failed.[1] The 115th Congress also repeatedly considered and rejected legislation repealing the Act.[2]

In December 2017, Congress passed the Tax Cuts and Jobs Act, which amended the Act in one respect. It eliminated one of the Act's incentives to purchase insurance by setting the "shared responsibility payment" in Section 5000A(c) at zero. Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092. But, tellingly, Congress deliberately left the rest of the Act intact. Numerous legislators made clear that their support for the 2017 amendment was contingent on their understanding that all other provisions of the Act, including the protections for individuals with preexisting conditions, would remain in force. *See* p. 44, *infra*.

4. In 2018, two individuals and a group of States filed this suit, alleging that, following the 2017 amendment, Section 5000A is unconstitutional and the entire Act must be stricken. *See* ROA.68-104, ROA.503-537.

The district court ruled in favor of plaintiffs, holding that the individual plaintiffs had standing, ROA.2627-2628, and that Section 5000A is unconstitutional,

---

[1] C. Stephen Readhead & Janet Kinzer, Cong. Research Serv., R43289, *Legislative Actions in the 112th, 113th, and 114th Congresses to Repeal, Defund, or Delay the Affordable Care Act* (Feb. 7, 2017).

[2] *See* Rachel Roubein, *TIMELINE: The GOP's Failed Effort to Repeal ObamaCare*, The Hill (Sept. 26, 2017), https://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare.

ROA.2629-2644. The court also held that the remainder of the Act was inseverable from Section 5000A. ROA.2645-2665.

SUMMARY OF ARGUMENT

I. Plaintiffs' arguments that they have standing and that the Act is unconstitutional both depend on a critical premise: that Section 5000A(a) requires individuals to purchase insurance. That premise is wrong. In *NFIB*, the Supreme Court authoritatively ruled that "the mandate is not a legal command to buy insurance." 567 U.S. at 563. Instead, the Supreme Court concluded, Section 5000A provides a choice between two lawful options: buying health insurance or making a "shared responsibility payment." *Id.* at 574. That definitive construction is binding, absent clear congressional intent to override it. Far from evincing such intent, the 2017 amendment confirms beyond doubt that Section 5000A is not a legal command to buy insurance because it removes any consequence for failing to purchase insurance.

II. Neither the individual plaintiffs nor the state plaintiffs have standing to challenge Section 5000A.

A. The individual plaintiffs lack standing because Section 5000A does not require them to purchase insurance. They could have declined to purchase insurance without breaking the law, and they cannot manufacture standing based on self-inflicted harm. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 402 (2013).

Even if the statute were wrongly construed to require the individual plaintiffs to purchase insurance, they would still lack standing because they would suffer no cognizable injury from failing to comply. Because the tax has now been set at zero, the federal government has no means to "enforce" the mandate. The impossibility of enforcement is fatal to plaintiffs' case, as a generalized legal obligation is insufficient to support standing. *Poe v. Ullman*, 367 U.S. 497, 507 (1961) (plurality opinion). Nor can plaintiffs rely on "stigmatic" harm. The mere feeling that a law expresses disapproval of one's conduct is insufficient to confer standing, and in any event there is no stigma here.

B. The state plaintiffs also lack standing. They argue that many individuals will feel compelled by Section 5000A to buy insurance (despite the lack of any such requirement), that those same individuals will be eligible for CHIP and Medicaid and will enroll in those programs because of Section 5000A, and that sufficient enrollment will occur to burden the States' finances. That chain of speculative inferences about "the unfettered choices made by independent actors not before the courts" cannot support standing. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 562 (1992) (citation omitted). In all events, the state plaintiffs have failed to support that fanciful theory with a shred of evidence.

III. Plaintiffs' contention that Section 5000A exceeds Congress's enumerated powers fails for the same reason that plaintiffs lack standing: as

amended, Section 5000A no longer alters rights and duties. Its continued existence in the U.S. Code therefore need not be grounded in an enumerated power. Even if this Court concludes that an enumerated power is necessary, Section 5000A is necessary and proper to Congress's exercise of its tax power and its commerce power.

IV. Should this Court conclude that plaintiffs have standing and that Section 5000A is unconstitutional, the Court should sever Section 5000A from the remainder of the Act. The "touchstone for any decision about remedy is legislative intent," *NFIB*, 567 U.S. at 586, and here Congress's intent could not be clearer. By leaving the rest of the Act intact when it reduced the shared-responsibility payment to zero, the 2017 Congress unambiguously established that it intended the rest of the law to function in the absence of an enforceable mandate. Even without that direct evidence of congressional intent, there can be no doubt that all of the Act's other provisions—including its protections for individuals with preexisting conditions—are valid and can function independently of the mandate.

In striking down the entire Act, the district court disregarded the clearly expressed intent of the democratically elected representatives of the People. That novel and unprecedented ruling is wholly insupportable. This Court should reverse.

STANDARD OF REVIEW

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

ARGUMENT

I. THE SUPREME COURT AUTHORITATIVELY CONSTRUED SECTION 5000A AS OFFERING INDIVIDUALS A CHOICE BETWEEN TWO LAWFUL OPTIONS, AND NOTHING IN THE 2017 AMENDMENT CHANGES THAT.

Plaintiffs' arguments on standing and the merits both depend on a critical premise: Section 5000A(a) imposes a legal mandate that individuals purchase insurance. Plaintiffs' claimed injury-in-fact is that they are required to purchase insurance they would prefer to decline, and their contention on the merits is that Section 5000A(a) is a legal command that exceeds Congress's authority. Plaintiffs' contentions therefore require resolution of an antecedent question of statutory construction: whether Section 5000A(a), as amended, requires the purchase of insurance.

The Supreme Court definitively resolved that question in *NFIB*, holding unequivocally that "the mandate is not a legal command to buy insurance." 567 U.S. at 563. Rather, the Court held, Section 5000A gives individuals a choice between two *lawful* options: purchasing insurance or making a "shared responsibility payment" to the federal government. *Id*. at 574. That definitive construction is

binding, absent subsequent congressional action reflecting a clear intent to override it.

The 2017 amendment provides nothing like that necessary clear intent—just the opposite. The amendment leaves Section 5000A's operative text untouched, and it *eliminates* any means of enforcing compliance with the individual mandate. Now, as then, Section 5000A provides individuals with two options. They may obtain health insurance as directed in Section 5000A(a), which provides that "[a]n applicable individual shall" maintain insurance. 26 U.S.C. § 5000A(a). Alternatively, they may make the "shared responsibility payment" specified in Section 5000A(b), which states that, subject to certain exceptions, any individual who fails to maintain insurance must pay the amount set forth in Section 5000A(c). *Id.* § 5000A(b). The sole change effected by the 2017 amendment was to amend Section 5000A(c) to reduce the amount of the shared-responsibility payment to zero. The statute thus continues to operate in precisely the way the Supreme Court construed it in *NFIB*: Section 5000A commands nothing and allows individuals to make the choice not to purchase health insurance.

A. In *NFIB*, the Supreme Court held that Section 5000A did not impose a legal requirement to buy insurance, but instead offered a "lawful choice" between buying insurance and paying a tax.

In *NFIB*, to determine whether Section 5000A was a valid exercise of Congress's taxing power, the Supreme Court first answered an antecedent question

of statutory construction: did that provision "declare that failing to [purchase insurance] is unlawful" and impose a penalty for that "unlawful act or omission," 567 U.S. at 567-68, or did it instead permit individuals to lawfully choose not to purchase insurance, subject to a tax on that choice?

The Court first concluded that the shared-responsibility payment set forth in Section 5000A(b) had the characteristics of a tax that Congress has the Article I authority to enact. 567 U.S. at 564-66. The Court acknowledged that the payment could not be considered a tax if it operated as a penalty, however, and therefore addressed whether the payment was "punishment for an unlawful act or omission." *Id*. at 567. That question turned on the proper construction of Section 5000A(a): if it imposed a legal requirement to buy insurance, such that failing to do so was unlawful, then the shared-responsibility payment would represent "punishment for an unlawful act." *Id*. The Court concluded that Section 5000A(a) imposed no legal requirement, stating that "[w]hile [it] clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful." *Id*. at 567-68. Thus, Section 5000A(b) did not impose a penalty.

That conclusion rested on two aspects of Section 5000A(a). First, "[n]either the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS." *Id.* at 567-68. The government therefore "has no power to compel or punish individuals subject to" the mandate so

long as "a tax is properly paid." *Id.* at 574. Second, Congress had anticipated that "four million people each year" would decline to buy insurance. *Id*. at 568. As the Court observed, "[t]hat Congress apparently regards such extensive failure to comply with the mandate as tolerable suggests that Congress did not think it was creating four million outlaws." *Id.*

The Court therefore concluded that Section 5000A(a)'s provision that "[a]n applicable individual *shall*" maintain "minimum essential coverage," 26 U.S.C. § 5000A(a) (emphasis added), need not be read as a mandatory command, but instead could be interpreted "to impose" one of "'a series of incentives.'" 567 U.S. at 569 (quoting *New York v. United States*, 505 U.S. 144, 170 (1992)). Taken as a whole, Section 5000A provided individuals with a "lawful choice": "[t]hose subject to the individual mandate may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes. The only thing they may not lawfully do is not buy health insurance and not pay the resulting tax." *Id.* at 574 & n.11.

Notably, at the time the Court adopted that construction in *NFIB*, certain classes of individuals were subject to the mandate but exempted from the shared-responsibility payment. *See* 26 U.S.C. § 5000A(e) (exempting, *inter alia*, members of Indian tribes). Those individuals were subject to Section 5000A(a), but they could choose to forgo purchasing insurance without paying anything to the government. The Court did not suggest that those individuals were breaking the law by not

purchasing insurance simply because they were not required to pay Section 5000A(b)'s tax, or that the mandate somehow operated differently as to them.

B. The reduction of the shared-responsibility payment to zero does not change the Supreme Court's construction of Section 5000A.

Once the Supreme Court has authoritatively construed a statutory provision, that construction becomes "part of the statutory scheme." *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2409 (2015). "When Congress intends to effect a change" in the Supreme Court's "definitive[]" construction, "it ordinarily provides a relatively clear indication of its intent in the text of the amended provision." *TC Heartland LLC v. Kraft Foods Grp. Brands LLC*, 137 S. Ct. 1514, 1520 (2017). Far from providing any "clear indication" of intent to alter *NFIB*'s authoritative interpretation of Section 5000A(a), the 2017 amendment left untouched every aspect of the statutory scheme on which *NFIB* relied.

1. The 2017 amendment made a single change to Section 5000A: it reduced the amount of the payment provided in Section 5000A(c) to zero. *See* Pub. L. No. 115-97 § 11081, 131 Stat. 2054, 2092. The amendment did not alter the text of the mandate or shared-responsibility subsections—*i.e.*, the statutory text that the Court construed in *NFIB*. Nor did the amendment alter the provision's structure. Section 5000A(a) remains the "mandate"; Section 5000A(b) continues to require a "shared responsibility payment" in the amount prescribed in Section 5000A(c); and Section 5000A(c) continues to prescribe the amount of that payment (now zero). Thus,

Section 5000A still provides the same two choices that the Supreme Court construed in *NFIB*, expressed in unchanged statutory language.

The 2017 amendment's sole purpose and effect was thus to remove any coercive force the mandate might have had. After the amendment, Section 5000A retains the characteristic on which the Supreme Court relied in concluding that the provision is not mandatory: it does not impose any legal consequences for failing to purchase insurance. Further, the amendment eliminates any practical effect that the shared-responsibility payment previously imposed. The provision now has no consequences. Indeed, numerous Members of Congress stated that they intended to *eliminate* obligations on relevant individuals, not increase them. For instance, Senator Hatch emphasized that the 2017 amendment would allow individuals to "cho[o]se not to enroll in health coverage once the penalty for not doing so is no longer in effect." *Continuation of the Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" Before the Senate Committee on Finance*, 115th Cong. 106 (Nov. 15, 2017) (statement of Senator Orrin G. Hatch, Chairman); *see also* 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) (Capito); *id*. at S7666 (daily ed. Dec. 1, 2017) (Scott); *id.* at S7665 (Collins).

Any doubt on that score is removed by the fact that Congress knew in December 2017 that the 2017 amendment's enactment would increase the number of people declining to purchase insurance. Cong. Budget Office, *Repealing the*

Individual Health Insurance Mandate: An Updated Estimate 1 (Nov. 2017) ("CBO Report") (by 2027, 13 million fewer people will maintain insurance). Just as Congress did not mean to "creat[e] four million outlaws" in 2010, 567 U.S. at 568, it surely did not mean to create 13 million "outlaws" in 2017. *See* p. 15, *supra*.

2. The district court believed that it was free to disregard *NFIB*'s construction of Section 5000A(a) because the Supreme Court adopted that construction pursuant to constitutional-avoidance principles. ROA.2642-2643. But when the Court has adopted a "limiting construction" to avoid constitutional questions, that construction controls as to *all* applications of the statute, regardless of whether the original constitutional implications are present. *Clark v. Martinez*, 543 U.S. 371, 380, 382 (2005). Any other rule would "render every statute a chameleon, its meaning subject to change depending on the presence or absence of constitutional concerns in each individual case." *Id.* at 382. The district court therefore was not free to hold that Section 5000A(a) acts as a command because the "plain meaning" of "shall" is mandatory. ROA.2641. *NFIB* already resolved that question, and Congress in 2017 acted against the backdrop of the Supreme Court's definitive construction.

The district court also incorrectly believed that the pre-amendment mandate was optional only in the sense that it was one prong of a two-pronged mandatory choice—all individuals had to either buy insurance or pay the tax—and the amendment eliminated the tax prong, thereby leaving the mandate as a "standalone

command." ROA.2643-2644. That is incorrect. The amendment did not eliminate Section 5000A(b)'s payment option; it simply set the amount of that payment to zero. And *NFIB* already construed the statutory text *not* to command individuals to purchase insurance. Now, as in 2012, Section 5000A continues to offer individuals two options, either of which is a lawful choice.

Equally to the point, *NFIB* interpreted Section 5000A this way despite the fact that Section 5000A(e) provided that millions of persons theoretically subject to the mandate were exempted from any shared-responsibility payment, just as the individual plaintiffs (and all other persons) are now. Under the district court's logic, those individuals would have been breaking the law from the moment Section 5000A went into effect, because it would have functioned as a standalone command as to them. *NFIB* forecloses that conclusion. For those reasons, the choice identified in *NFIB* remains intact. It cannot be, as the district court apparently believed, that if the payment amount were set at $1 the choice in Section 5000A would remain effective and the mandate would remain optional—but setting the payment to zero transforms the mandate into a command.

* * *

The conclusion that Section 5000A does not command anyone to purchase insurance makes this a straightforward case, for the reasons discussed below. Because plaintiffs could have lawfully declined to buy insurance, any injury is self-

inflicted, and they therefore lack standing. And because Section 5000A now lacks legal effect, its continued existence does not exceed Congress's constitutional authority.

II. THE PLAINTIFFS LACK STANDING.

To establish standing, a plaintiff must demonstrate that it has "suffered or [is] imminently threatened with a concrete and particularized 'injury in fact' that is fairly traceable to the challenged action of the defendant and likely to be redressed by a favorable judicial decision." *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 125 (2014). Faithful adherence to those requirements is essential to maintaining "the proper—and properly limited—role of the courts in a democratic society," *Warth v. Seldin*, 422 U.S. 490, 498 (1975), and "prevent[ing] the judicial process from being used to usurp the powers of the political branches," *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013); *see* John G. Roberts, Jr., *Article III Limits on Statutory Standing*, 42 Duke L.J. 1219, 1230-31 (1993) ("Standing is an apolitical limitation on judicial power."). The standing inquiry must therefore be "especially rigorous when reaching the merits of the dispute would force [the court] to decide whether an action taken by one of the other two branches of the Federal Government was unconstitutional." *Raines v. Byrd*, 521 U.S. 811, 819-20 (1997).

Plaintiffs fail to satisfy those requirements. The individual plaintiffs are not obligated to purchase health insurance, and they cannot manufacture standing by

claiming injury based on their own voluntary purchasing decisions. And even if Section 5000A were wrongly construed to "require" them to purchase insurance, they would still lack standing because they would suffer no cognizable injury from failing to comply. The state plaintiffs complain that they are injured because their costs will increase as a result of some individuals misconstruing Section 5000A(a) as a requirement to have insurance coverage, but that assertion rests on a chain of speculative inferences and lacks factual support. Nor can the state plaintiffs establish standing to challenge Section 5000A by claiming injury from other provisions that they are not challenging.

A. The individual plaintiffs lack standing.

1. The individual plaintiffs lack standing to complain about an entirely voluntary choice.

a. The individual plaintiffs claim that they are injured because they have purchased health insurance that meets the Act's minimum-coverage standard, despite the fact that they prefer not to have such insurance. *See, e.g.*, ROA.529. But because—as *NFIB* unequivocally held, and the 2017 Amendment reinforced—the Act imposes no legal requirement to obtain insurance, individual plaintiffs could have declined to purchase insurance without breaking the law. Having voluntarily elected to buy insurance, plaintiffs do not have standing to complain that they were injured by that decision.

The governing precedent is clear: plaintiffs "cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending." *Clapper*, 568 U.S. at 416. When plaintiffs inflict injury on themselves because they desire to challenge a statute, rather than because the statute actually injures them, any "ongoing injuries that [they] are suffering are not fairly traceable to" the statute. *Id.*; *see, e.g.*, *Glass v. Paxton*, 900 F.3d 233, 242 (5th Cir. 2018) (plaintiff "cannot manufacture standing by self-censoring her speech").

That precisely describes the individual plaintiffs' circumstances. If those plaintiffs voluntarily choose to purchase health insurance, such a self-inflicted "injury" cannot establish Article III standing. Adjudicating claims based on that alleged harm improperly "risk[s] disregarding [federal courts'] constitutional mandate to limit their jurisdiction to actual cases and controversies and thereby avoid the issuance of advisory opinions." *Glass*, 900 F.3d at 242.

b. The district court incorrectly rejected that reasoning, concluding that determining whether the individual plaintiffs were, in fact, required to purchase insurance would improperly "conflate" standing with the "merits analysis." ROA.2767-2768.

But adjudicating the individual plaintiffs' standing is not possible without first determining the legal effect of Section 5000A because their claimed injury-in-fact is

that Section 5000A required them to purchase insurance. Their theory of standing thus rests on a legal assertion that Section 5000A must be construed as a command. The district court could not assure itself of its Article III jurisdiction, as it was required to do, without first addressing that legal question. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 99 (1998); *Bauer v. Marmara*, 774 F.3d 1026, 1029 (D.C. Cir. 2014) ("when a plaintiff's alleged injury arises solely from a statute, questions concerning standing and the" merits "may be intertwined"); *see also Bolivarian Republic of Venezuela v. Helmerich & Payne Int'l Drilling Co.*, 137 S. Ct. 1312, 1319 (2017) (court must answer jurisdictional question, even "[i]f to do so, it must inevitably decide some, or all, of the merits issues"). Particularly given that the plaintiffs' position contradicts *NFIB*'s authoritative statutory construction and the plain terms of the 2017 amendment, there was not even an arguable basis for plaintiffs' claim that the statute injures them. The district court therefore erred in accepting the plaintiffs' legal assertions.

Indeed, were addressing the jurisdictional question impermissible because of overlap with the merits, parties could manufacture standing to bring a statutory challenge merely by alleging that a statute imposes some obligation on them—no matter what the statute actually says—and that the obligation is unconstitutional. That would invite exactly the expansion of the judicial role that standing doctrine is designed to foreclose.

None of the cases cited by the district court supports a contrary conclusion. The court asserted that *Meese v. Keene*, 481 U.S. 465 (1987), states that any question relevant to the merits is "'irrelevant to the standing analysis.'" ROA.2768 & n.24 (quoting *Keene*, 481 U.S. at 473). But it does no such thing. *Keene* deemed it "irrelevant" whether the statute in question "abridge[d] ... the plaintiff's freedom of speech" because that was not the injury alleged. 481 U.S. at 473. *Keene* does not "hold[] or even suggest[] that plaintiffs can establish standing simply by claiming that they experienced a 'chilling effect' that resulted from a governmental policy that does not regulate, constrain, or compel any action on their part," *Clapper*, 568 U.S. at 419, let alone that a court is foreclosed from examining whether such a policy actually involves those consequences. Neither do the decisions of this Court to which the district court pointed. *See* ROA.2768 n.25.

2. Even if the Act did obligate the individual plaintiffs to purchase insurance, such a mandate would inflict no legally cognizable injury because it lacks any enforcement mechanism.

a. Even accepting the incorrect premise that the Act requires the individual plaintiffs to buy insurance, they still lack standing because no consequence follows from the failure to purchase that insurance. After all, failing to maintain insurance triggers only the tax payment of Section 5000A(b), *see NFIB*, 567 U.S. at 574 & n.11, and the tax amount is now zero. The federal government therefore has no

means to "enforce" the mandate—and the individual plaintiffs suffer no harm by failing to comply with it.

The district court believed that the individual plaintiffs sufficiently demonstrated an injury by alleging that "Congress legislated in a way the Constitution does not allow and the Individual Plaintiffs are the direct object of that legislation." ROA.2765. But the "mere existence" of a generalized legal obligation is "insufficient grounds to support a federal court's adjudication of its constitutionality." *Poe*, 367 U.S. at 507 (plurality opinion). Otherwise, the federal courts would be forced to resolve "debates concerning harmless, empty shadows." *Id.* at 508.

The district court did correctly observe that "individuals need not" always "disobey a law to earn standing to challenge it." ROA.2763. But a plaintiff cannot establish injury based only on an allegation that he wishes "to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute." *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298-99 (1979). Instead, he must show such intent "*and* ... a credible threat of prosecution thereunder." *Id.* (emphasis added); *see Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 161-67 (2014).

Those cases establish that if a plaintiff can engage in prohibited conduct without fearing enforcement then he faces no actual constraint and therefore has not

suffered a concrete injury. A plaintiff cannot claim that the law itself, sitting on the books, chills his conduct or injures him merely because he believes—along with millions of other citizens—that obeying the law is important. *See Lance v. Coffman*, 549 U.S. 437, 442 (2007) ("The only injury plaintiffs allege is that the [Elections Clause of the Constitution] ... has not been followed. This injury is precisely the kind of undifferentiated, generalized grievance about the conduct of government that we have refused to countenance in the past."). Because the individual plaintiffs may disregard the mandate without fearing any consequence, it causes them no injury.

Here, an additional consideration makes the absence of any realistic threat of enforcement—and hence of any injury sufficient to support standing—particularly clear. Not only is there no mechanism by which the federal government could "enforce" the mandate, but plaintiffs can be doubly assured that no enforcement action will occur because the Executive Branch has taken the position that Section 5000A is unconstitutional. *See Virginia v. Am. Booksellers Ass'n, Inc.*, 484 U.S. 383, 393 (1988) (suggesting that plaintiffs would not have injury if State indicated it would not enforce the challenged statute); *Poe*, 367 U.S. at 507 ("If the prosecutor expressly agrees not to prosecute, a suit against him ... is not such an adversary case as will be reviewed here.").

b. The district court also suggested that the injury to the individual plaintiffs was stigmatic—that is, distress or disgrace of some kind associated with simply being a "lawbreaker." ROA.2765-2769. That suggestion is simply wrong.

The "fear of enforcement" cases described above foreclose any argument that purely stigmatic harm is sufficient to show standing. The premise of those cases is that no sufficiently concrete injury arises from being a "lawbreaker," absent a concrete legal consequence. *E.g.*, *Poe*, 367 U.S. at 508 (suggesting that doctor could violate anti-contraceptive law without fear of enforcement, and dismissing alleged coercive effect of doctor's "standing as a physician" and "sensitiveness"). Indeed, even in situations in which some stigmatic harm is a recognized component of injury in fact, a plaintiff must always allege concrete legal injury as well—for instance, discriminatory treatment in the Equal Protection context. *See Moore v. Bryant*, 853 F.3d 245, 250 (5th Cir. 2017); *Barber v. Bryant*, 860 F.3d 345, 357 (5th Cir. 2017); *see also Allen v. Wright*, 468 U.S. 737, 755 (1984). A plaintiff's mere feeling that a law expresses disapproval of his conduct or status is not enough to justify the federal courts' encroachment into the legislature's sphere.

In any event, no stigma exists here. The CBO predicted that millions of people would forgo insurance when the consequence was having to pay hundreds of dollars in taxes. *See NFIB*, 567 U.S. at 568. Now that there is no legal consequence, even more individuals will decline to buy insurance. *See* p. 17, *supra*. There is no legally

cognizable "stigma" in being one of many millions of people who choose that course. *See NFIB*, 567 U.S. at 568 ("Congress did not think it was creating" millions of "outlaws"). And Congress's removal of any legal consequence for failing to purchase insurance demonstrates that Congress itself does not disapprove of that choice.

B. The state plaintiffs lack standing.

The state plaintiffs also lack standing to challenge Section 5000A. They contend that their costs will increase because some citizens will misinterpret Section 5000A as a legal requirement to maintain insurance coverage and will respond by enrolling in Medicaid and CHIP. ROA.623. But that contention depends on a chain of speculative inferences unsupported by evidence and is insufficient to give rise to standing in any event. They also contend that they are injured by portions of the Act *other* than Section 5000A, ROA.624-625, but standing to challenge Section 5000A cannot be established on that basis.

1. a. The state plaintiffs' assertion of increased costs does not establish the existence of a threatened injury that is certainly impending and traceable to Section 5000A. Whether the state plaintiffs' costs will increase because of the unenforceable mandate turns on whether individuals who are already eligible for Medicaid and CHIP under existing law would enroll in those programs solely because of the mandate. That "depends on the unfettered choices made by independent actors not

before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or to predict." *Lujan*, 504 U.S. at 562 (citation omitted). In such a case, standing is "'substantially more difficult' to establish." *Id.* (quoting *Allen*, 468 U.S. at 758); *see Clapper*, 568 U.S. at 414 (same).

The state plaintiffs have not met that difficult burden because they posit only a highly attenuated chain of possibilities that defies logic and common sense. *See Clapper*, 568 U.S. at 410-11. First, they surmise that—despite the absence of any tax consequence for failing to buy insurance—a significant number of individuals will misinterpret Section 5000A as requiring them to maintain insurance and will therefore feel compelled to obtain insurance when they otherwise would not have done so. Second, they hypothesize that those individuals are eligible for CHIP and Medicaid, will enroll in those programs for the first time because of Section 5000A, and will do so in sufficient numbers to inflict financial injury on the States.

Each link in that chain is flawed. The state plaintiffs' assertion that people will seek insurance because of Section 5000A is far-fetched. "In the case of a mandate to have health insurance, individuals would generally weigh the benefits of that coverage against [the] expected costs [of noncompliance] when determining

whether to comply."[3] Accordingly, "[t]he degree to which individuals who are subject to a mandate believe that their noncompliance would be detected, and that fines would be levied as a result ... greatly affects a mandate's impact on coverage."[4] When, as here, the consequence of failing to obtain insurance is to pay nothing, a "mandate" is highly unlikely to affect behavior. That is even more true when the non-existent payment is not, in fact, a penalty for noncompliance, but itself a way to satisfy the law's requirements. *See* pp. 14-15, *supra*.

The state plaintiffs have nonetheless contended that "some people obtain health insurance solely out of a 'willingness to comply with the law.'" ROA.623 (quoting CBO Report at 1). But the source on which plaintiffs rely actually explains that, at best, "with no penalty at all, only a small number of people" would obtain insurance "solely because" of a desire to comply with what they wrongly perceive to be a legal obligation. CBO Report at 1.

The state plaintiffs' next inferential leap—that the "small number of people" in question are eligible for and would enroll in Medicaid and CHIP, and would consequently cause those States financial harm—is equally flawed. Section 5000A

---

[3] Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 49 (Dec. 2008), https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-keyissues.pdf.

[4] *Id.* at 51.

does not expand eligibility for CHIP or Medicaid, and those who are eligible have long had compelling reasons to enroll that have nothing to do with Section 5000A. Those programs enable financially needy people to pay little to nothing for extremely valuable healthcare coverage.[5] People who are eligible and have thus far not enrolled in those programs are exceedingly unlikely to enroll now because of a legally unenforceable mandate.[6]

In short, the state plaintiffs' claimed injury rests on exactly the "highly attenuated chain of possibilities" that the Supreme Court has held cannot support Article III standing. *Clapper*, 568 U.S. at 410-11. That is reason enough to reject the state plaintiffs' argument for standing based on allegedly increased costs.

b. Even assuming that such speculation could have supported standing at an earlier stage of the litigation, it cannot do so now. Because this appeal arises from a grant of summary judgment in plaintiffs' favor, the state plaintiffs had to establish that no genuine issues of material fact would prevent the court from concluding that they had standing. *See Lujan*, 504 U.S. at 561; *Seals v. McBee*, 898 F.3d 587, 591 (5th Cir. 2018). But there is no evidence in the summary-judgment record

---

[5] Christine Eibner & Sarah A. Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, The Commonwealth Fund 6 (July 2018), https://www.commonwealthfund.org/sites/default/files/2018-07/Eibner_individual_mandate_repeal.pdf.

[6] *Id.* at 7.

suggesting that the States' "chain of possibilities" has occurred since the 2017 amendment or will likely occur in the future. Although plaintiffs submitted two insurance-purchaser declarations, *see* ROA.634-641, those individuals are not eligible for CHIP or Medicaid, and therefore the declarations do not address enrollment in those programs.[7]

This Court previously ruled that a State failed "to establish standing" when its "claim of injury" based on purported increases in state expenses was "not supported by any facts." *Crane v. Johnson*, 783 F.3d 244, 252 (5th Cir. 2015). The same is true here. And, as in *Crane*, no remand is appropriate, both because the state plaintiffs' theory fails at the threshold as overly attenuated and because they failed to submit evidence in support of the theory—which presumably would be in their hands if it existed at all—despite having had every opportunity to do so. *Id.* ("Mississippi submitted no evidence" of DACA-eligible residents or resulting costs). The state plaintiffs' "subjective concern," unmoored from any factual support, that Section 5000A might lead some individuals to enroll in particular

[7] Nor have the state plaintiffs shown that increased enrollment in CHIP or Medicaid would actually cost them money. Enrolling more people could lead to early detection of relatively minor conditions that would otherwise develop into serious and expensive conditions, thereby saving the States money. State plaintiffs submitted no evidence to the contrary. To the extent that *Texas v. United States*, 809 F.3d 134, 155-56 (5th Cir. 2015), suggests that they need not do so, that decision should be overruled.

benefits programs "cannot serve as the basis for ... standing." *Cent. & S. W. Servs., Inc. v. EPA*, 220 F.3d 683, 700 (5th Cir. 2000).

c. Finally, even if the state plaintiffs' cost theory had any plausibility or support, they still could not show a cognizable injury traceable to Section 5000A. The Supreme Court has long held that "[n]o State can be heard to complain about damage inflicted by its own hand." *Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976). The alleged injury here arises from individuals enrolling in Medicaid and CHIP—two benefit programs that the state plaintiffs have voluntarily chosen to offer their citizens. Any financial "damage" the States claim as a result of those choices is self-inflicted and therefore not cognizable under Article III. *See* p. 22, *supra*.

This Court has held that a State has standing to challenge a federal policy that *itself* expands the pool of beneficiaries eligible for a state benefit. *See Texas v. United States*, 809 F.3d 134, 155-56 (5th Cir. 2015). But this case is different: Section 5000A did not make new individuals eligible for Medicaid or CHIP, or otherwise change States' responsibilities in administering those programs. A State does not suffer a cognizable injury from a federal statute that at most encourages people to take advantage of a state benefit already being offered to them. Otherwise, States could challenge nearly any federal action on the theory that such action incidentally changes the composition of a state benefit pool.

2. The state plaintiffs also claim that they have standing to challenge Section 5000A because—under a severability analysis like the district court's—such a challenge could result in the invalidation of other provisions that allegedly injure them.

But standing to challenge one portion of a statute does not support standing to challenge another. *See, e.g.*, *Davis v. FEC*, 554 U.S. 724, 733-34 (2008). Article III's requirements must be met with respect to "each claim" a plaintiff "seeks to press." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 352 (2006). The state plaintiffs therefore can challenge Section 5000A only if they are injured by that provision. *See Clapper*, 568 U.S. at 411. And the threshold jurisdictional inquiry must take place without considering whether, after the merits are adjudicated, the challenged provisions might be inseverable from other provisions that do cause a plaintiff harm. *See Nat'l Fed'n of the Blind of Texas, Inc. v. Abbott*, 647 F.3d 202, 211 (5th Cir. 2011); *see also, e.g.*, Kevin C. Walsh, *The Ghost That Slayed the Mandate*, 64 Stan. L. Rev. 55, 76-77 (2012).

The state plaintiffs' argument cannot be reconciled with those principles. Accepting their argument would dramatically weaken Article III's requirements in any case involving a challenge to a complex statute and would therefore dramatically expand the use of "the judicial process ... to usurp the powers of the political branches." *Clapper*, 568 U.S. at 408.

In sum, because neither the individual plaintiffs nor the state plaintiffs have standing, this case must be dismissed.

III. CONGRESS HAS THE CONSTITUTIONAL AUTHORITY TO PROVIDE THE CHOICE OFFERED IN SECTION 5000A.

Plaintiffs' contention that Section 5000A exceeds Congress's authority fails for the same reason that plaintiffs lack standing: Section 5000A imposes no consequences on individuals who fail to purchase insurance. The provision can therefore be read in a manner that renders it constitutional—as permitting individuals to choose whether to purchase health insurance. Because it can be read in a constitutional manner, it must be. *NFIB*, 567 U.S. at 574-75.

1. Congress's original enactment of Section 5000A was a valid exercise of its taxing power. *NFIB*, 567 U.S. at 575. Congress's decision to reduce the tax amount in Section 5000A(c) to zero was similarly valid. The question here is whether, after the 2017 amendment, the "mandate" of Section 5000A(a) remains constitutional. The answer is yes.

After the 2017 amendment, the Act continues to offer individuals a choice. They can choose to maintain insurance coverage or they can choose not to do so and instead face the tax consequences that Section 5000A prescribes. Congress has simply decided that the tax shall now be nothing. There can be no reasonable argument that Congress lacked constitutional authority to reduce the tax payment to zero. Because Congress had the authority to take that step (just as it had the authority

to prescribe a tax based on a percentage of income in the original Act), Section 5000A(a) remains constitutional for the same reason it was upheld in *NFIB*. Now as before, Section 5000A(a) compels nothing. It merely "establish[es] a condition—not owning health insurance—that triggers a tax." 567 U.S. at 563. In other words, the choice offered to individuals after the 2017 amendment is the same choice they faced before the amendment. The only difference is that the choice to forgo insurance now triggers no tax liability. Section 5000A thus imposes no obligation that Congress lacks the Article I power to impose. *Id.*; *see New York*, 505 U.S. at 169-74.

2. Indeed, because Section 5000A as amended has no binding effect or enforcement mechanism, and therefore does not alter anyone's legal rights and duties, its validity no longer depends on an enumerated power. Congress unquestionably possesses authority to express its views in that non-binding manner. Congress may, for instance, use a concurrent resolution—not signed by the President and therefore not a law—to "express[] fact, principles, opinions, and purposes of the two Houses." *Constitution*, *Jefferson's Manual, and Rules of the House of Representatives*, 112th Cong., H.R. Doc. No. 111-157, at 202 (2011). Because a concurrent resolution "makes no binding policy" that would alter legal rights and duties, Congress need not exercise its constitutional legislative power to pass such

resolutions. *Bowsher v. Synar*, 478 U.S. 714, 756 (1986) (Stevens, J., concurring); *accord I.N.S. v. Chadha*, 462 U.S. 919, 952 (1983).

Those principles apply equally when Congress enacts through bicameralism and presentment a provision that creates no legal duties. The constraints on Congress depend "not on ... form but upon 'whether [the action] contain[s] matter which is properly to be regarded as legislative in its character and effect.'" *Chadha*, 462 U.S. at 952 (quoting S. Rep. No. 54-1335, at 8 (1897)). Congress thus routinely enacts statutes that are no more binding than a concurrent resolution, in that they urge particular behavior but permit people to choose whether or not to comply—even when such statutes cannot be premised on an enumerated power. Some concern local, noncommercial individual behavior. *See, e.g.*, 36 U.S.C. § 135 ("All private citizens ... are encouraged to recognize Parents' Day through" activities "supporting the role of parents"). Other laws would contravene limits on Congress's authority if they directed the actions in question. 15 U.S.C. § 7807 ("States should enact the Uniform Athlete Agents Act of 2000"); Pub. L. No. 100-418, title V, § 5003(d), 102 Stat. 1107, 1424 (Aug. 23, 1988) ("the President should pursue the negotiation" of a particular treaty); *Dimmitt v. City of Clearwater*, 985 F.2d 1565, 1573 (11th Cir. 1993) (4 U.S.C. § 8 directs the manner of handling the United States flag, but "was not intended to proscribe conduct"). Those laws do not "alter[] the legal rights, duties and relations of persons." *Chadha*, 462 U.S. at 952. Individuals remain free

to choose to act in whatever manner they prefer. In enacting such laws, Congress is not constrained by the limitations on congressional authority that would otherwise apply.

Section 5000A, as amended, is constitutional for the same reason. It tells individuals that they may choose to obtain insurance or they may subject themselves to a zero-dollar tax liability. Because individuals may choose not to have insurance without breaking the law or suffering consequences, Section 5000A does not affect legal rights and duties. Thus, even though Congress originally enacted the provision using an enumerated power, it can be upheld now without reference to one.

3. Even if this Court concludes that Section 5000A, while not a command, nonetheless requires an enumerated power, the Court should still uphold it because it is necessary and proper to the exercise of Congress's powers.

The Necessary and Proper Clause grants Congress the power "[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers." U.S. Const. art. I, § 8, cl. 18. The Clause "makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 560 U.S. 126, 133-34 (2010) (quoting *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 413, 418 (1819)).

The Supreme Court has "been very deferential to Congress's determination that a regulation is 'necessary,'" *NFIB*, 567 U.S. at 559, requiring only a rational relationship to an enumerated power, *Comstock*, 560 U.S. at 134. The Court has also deferred to Congress's judgment that a law is "proper"; it has invalidated statutes as not "proper" only when they "undermine the structure of government established by the Constitution." *NFIB*, 567 U.S. at 559.

a. As amended, Section 5000A is necessary and proper to the exercise of Congress's taxing power. It is "necessary" because Section 5000A retains the architecture of the tax upheld in *NFIB*, even though Congress has now made a policy choice to reduce the amount of the tax to zero. No one disputes that it would have been permissible under the tax power for Congress to set the amount of the tax to one cent. Congress's decision to instead lower the amount of the tax to zero is "rationally related" to its choice to levy the tax in the first place and to its ability to raise revenue in the future. *Comstock*, 560 U.S. at 134. It is "convenient or useful" to Congress to retain the option to later reinstate a higher payment into the existing statutory structure. *McCulloch*, 4 Wheat. at 413. And Congress's decision to set the amount of the tax at zero is "proper" too, as it neither expands "the sphere of federal regulation," *NFIB*, 567 U.S. at 560 (opinion of Roberts, C.J.), nor compels any action by anyone; indeed, it eliminates any coercion. It is therefore constitutional.

b. Even if Section 5000A were erroneously construed as imposing some form of obligation, it would remain constitutional as necessary and proper to the exercise of Congress's commerce power. In *NFIB*, the Court held that the mandate, if construed as a command to purchase insurance, was not "proper." *Id*. at 560. Unlike previous laws that were "incidental" to an enumerated power, the mandate "would work a substantial expansion of federal authority" by compelling individual economic activity. *Id*.; *accord id*. at 654 (joint dissent).

The current version of Section 5000A does not present those difficulties. Section 5000A at most offers encouragement to buy insurance, which is "necessary" because it is rationally related to other insurance reforms like the guaranteed-issue and community-rating provisions that are unquestionably valid exercises of the commerce power. *Comstock*, 560 U.S. at 134.[8] The mandate is now also "proper," as the provision is "narrow in scope" and "incidental" to its regulation of the interstate insurance market. *NFIB*, 567 U.S. at 560. It is firmly in line with laws that encourage people to consume products when Congress desires to expand the relevant market. *See, e.g*., 7 U.S.C. § 2901 (encouraging consumption of beef to "expand" that market).

---

[8] As discussed below, the Act will continue to function effectively even if this Court invalidates the mandate. But that does not suggest that the mandate is not "necessary" for purposes of the Necessary and Proper Clause, *i.e.*, rationally related to an enumerated power.

IV. IF THE COURT DEEMS THE MANDATE UNCONSTITUTIONAL, IT MUST BE SEVERED FROM THE REMAINDER OF THE ACT.

If this Court reaches the merits and invalidates Section 5000A, the Court should sever it and uphold the remainder of the Act. That is the only result that respects the intent of Congress (as definitively established by the actual statute Congress enacted in 2017) and the Supreme Court's binding instructions.

Severability principles are not mere technicalities. They perform a vital role in preserving the separation of powers. That is why the Supreme Court has been emphatic that courts must limit themselves to striking down only as much of a statute as is necessary to cure a constitutional violation. The "touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature." *NFIB*, 567 U.S. at 586 (quoting *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006)). A court therefore must ask whether "the legislature [would] have preferred what is left of its statute to no statute at all." *Ayotte*, 546 U.S. at 330; *see Leavitt v. Jane L.*, 518 U.S. 137, 143 (1996) (explaining that "relevant question" for severability is "not whether the legislature would prefer (A+B) to B" but "whether the legislature would prefer not to have B if it could not have A as well").

Relatedly, courts must apply a presumption of severability. *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984). A court should not strike down valid provisions "[u]nless it is *evident* that the Legislature would not have enacted those provisions

... independently of that which is ... invalid." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (emphasis added) (citation omitted); *see Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010) ("when confronting a constitutional flaw in a statute, [courts] try to limit the solution to the problem" (citation omitted)). Thus, courts must "retain those portions of [an] Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 258-59 (2005) (citations omitted).

Those principles yield a clear and straightforward answer in this case: the individual mandate must be severed from the rest of the Act. The 2017 Congress reduced the shared-responsibility payment to zero but otherwise left the Act intact and fully operative. That enactment is dispositive evidence of Congress's intent to retain the rest of the Act even without an enforceable mandate. And even if it were not so clear, the remainder of the Act must be severed under the Supreme Court's controlling test because it is valid, functions independently of the mandate, and carries out Congress's objectives of increasing insurance coverage and decreasing healthcare costs.

In disregarding binding severability precedents and striking down all 974 pages of the Act, the district court countermanded the unambiguously expressed "intent of the elected representatives of the people." *Ayotte*, 546 U.S. at 329 (citation

omitted). That meant invalidating significant statutory protections, including provisions mandating coverage for preexisting medical conditions; federal insurance premium tax credits; disclosure requirements on insurer plans; penalties for employers who decline to offer insurance; and automatic enrollment of employees in employer-sponsored health plans. The district court did not identify a single case from this Court or the Supreme Court—or any court, for that matter—that invalidated an entire statute with as many diverse provisions as the Act based on the unconstitutionality of one discrete provision. That is because, so far as we are aware, no such case exists. This Court should hold that the rest of the Act is severable from the mandate.

A. Congress's decision to leave the rest of the Act in place when it eliminated the shared-responsibility payment in 2017 answers the severability question.

1. The plain text of the 2017 amendment to the Act is irrefutable proof that Congress intended the Act to remain in place even if the mandate were subsequently held unconstitutional. *See Nixon v. United States*, 506 U.S. 224, 232 (1993).

In 2017, Congress surgically targeted the "shared responsibility" payment, amending Section 5000A(c) to reduce the payment to zero. Pub. L. No. 115-97, § 11081. By removing the tax incentive, Congress eliminated any practical force the mandate previously had. But Congress left the rest of the Act untouched. Congress thus made clear, in the primary way that body operates, its intent that the

rest of the Act should continue to function without a mandate—by eliminating through statute the only means by which the mandate could be enforced but leaving the remainder of the Act unchanged and fully operative.

The history of the 2017 amendment's passage confirms what the statutory text establishes. During the Senate Finance Committee's consideration, Chairman Hatch insisted that "[t]he bill does nothing to alter Title I of Obamacare, which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits."[9] Senator Toomey similarly insisted that there would be "no cuts to Medicaid," "no cuts to Medicare," and that "[n]obody is disqualified from insurance."[10] And Senator Scott insisted that reducing the tax to zero "take[s] nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage," and that the bill "does not have a single letter in there about preexisting conditions or any actual health feature." 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017).

This case therefore presents the unusual circumstance in which there is no need to hypothesize about whether Congress would "have preferred what is left of [the Act] to no statute at all." *Ayotte*, 546 U.S. at 330. Through enacted legislation,

---

[9] *Continuation of the Open Executive Session to Consider an Original Bill Entitled the "Tax Cuts and Jobs Act" Before the Senate Comm. on Fin.*, 115th Cong. 286 (Nov. 15, 2017).

[10] *Id.* at 71.

Congress has demonstrated that it would prefer that the remainder of the Act continue to function. Severing the rest of the Act from the mandate thus does not produce an "effect altogether different from that sought by the measure viewed as a whole," *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018) (citation omitted); rather, it produces exactly the "effect" that Congress "sought" under the 2017 amendment. The district court's conclusion to the contrary flouts the will of Congress.

2. The district court disregarded the 2017 statutory text and looked instead to what it believed to be the intent of the Congress that originally passed the Act in 2010 because, in its view, the 2017 Congress eliminated only the tax payment while retaining the 2010 language of the mandate. *See* ROA.2647-2662. But that misapprehends what Congress did in 2017. By reducing the tax to zero, Congress eliminated the only mechanism by which the government could enforce the mandate. For that reason, as the CBO contemporaneously noted, reducing the tax to zero would have "very similar" effects to repealing both the mandate and the tax payment. CBO Report at 1. Members understood that, in practical terms, Congress was eliminating the mandate by reducing the tax to zero. *See* p. 17, *supra*.

At the very least, then, the 2017 Congress intended the remainder of the Act to function even after it eliminated the only means by which the mandate could be enforced. It is manifestly not "evident" that Congress would have wanted the entire

Act to fall simply because a court held that the intentionally unenforceable mandate was *also* unenforceable because it was unconstitutional. *Alaska Airlines*, 480 U.S. at 684.

The district court also thought it significant that Congress amended the law "by a majority vote under the restrictive reconciliation process" and "could not have revoked the guaranteed-issue or community-rating provisions through reconciliation." ROA.1577, 2662-2663. But what matters for purposes of discerning Congress's intent is what is "enshrined in a text that makes it through the constitutional processes of bicameralism and presentment," not the technical method by which Congress chose to proceed. *Murphy*, 138 S. Ct. at 1487 (Thomas, J., concurring). Here, the text that both Houses of Congress passed and the President signed eliminated the tax payment while leaving the rest of the Act intact.

The inference the district court drew from Congress's use of the reconciliation process also fails to account for what *else* happened in the same congressional session: Congress voted on a bill to repeal the Act in its entirety, and that bill failed because a majority of Senators opposed it.[11] Moreover, Congress amended the Act *outside* the reconciliation process "on numerous occasions" after the 2017 amendment, but never repealed the guaranteed-issue and community-rating

[11] *See* Roubein, *supra* note 2.

protections (or the entire Act). ROA.1579. Given that history, and the respect owed to the legislation Congress actually enacted, it is difficult to imagine a greater disregard for the democratically expressed will of the People than the argument adopted by the district court.

B. The *Booker* factors also compel severance of the mandate from the rest of the Act.

Even if the intent of the 2017 Congress were not so clear, this Court would still be obligated "to limit the solution to the problem." *Free Enter. Fund*, 561 U.S. at 508 (quoting *Ayotte*, 546 U.S. at 328-29). The Court must "retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *Booker*, 543 U.S. at 258-59 (citations omitted). The Act's provisions (other than the mandate itself) easily satisfy those criteria and must be retained.

1. Numerous provisions that are unrelated to the mandate or that predated it are capable of functioning independently of the mandate and are consistent with Congress's basic objectives in enacting the Act.

The mandate addresses only individuals' purchase of insurance—and most of the Act has nothing to do with that issue, or with the individual health-insurance market more generally. For example, the Act (among many other things) expands Medicaid, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); reforms the employer-provided insurance market, *see, e.g.*, 26 U.S.C. § 4980H(a); requires break time for nursing

mothers, 29 U.S.C. § 207(r); and establishes epidemiology and laboratory capacity grants, 42 U.S.C. § 300hh-31.

In addition, many provisions became operative years before the mandate took effect in 2014. For instance, between 2010 and 2011, provisions took force that prohibited insurers from imposing lifetime dollar limits on coverage, 42 U.S.C. § 300gg-11; prohibited insurers from denying children coverage based on preexisting conditions, *id.* § 300gg-3 & note; regulated rescission of coverage, *id.* § 300gg-12; and allowed children to stay on their parents' insurance until age 26, *id.* § 300gg-14.

All of these provisions, and others like them, self-evidently satisfy the *Booker* factors and are thus severable. In concluding otherwise, the district court said that it was "impossible to know which minor provisions Congress would have passed absent the Individual Mandate." ROA.2898. But that approach disrespects the democratically expressed judgments of Congress in precisely the way that severability law prohibits. Statutory provisions are to be struck only when it is *evident* that Congress would *not* have enacted them. *Alaska Airlines*, 480 U.S. at 684. If forced to guess about Congress's intent, a court must presume severability and leave in place what the political branches have done.

2. While agreeing that the vast majority of the Act's provisions are severable from the mandate, the Federal Defendants have argued that the guaranteed-issue and

community-rating provisions, which protect people with preexisting conditions, cannot be severed. That too is wrong under the *Booker* analysis.

First, the guaranteed-issue and community-rating provisions are plainly constitutional. No one has argued otherwise.

Second, whatever may have been the case when those provisions first took effect in 2014, they are now fully operative without an enforceable mandate. They do not "contain any cross-reference to the individual mandate or make their implementation dependent on the mandate's continued existence." *Florida*, 648 F.3d at 1324; *see Alaska Airlines*, 480 U.S. at 688-89. And as a practical matter, they are effective without the mandate because the Act includes many other provisions that induce healthy individuals to obtain insurance. Those provisions include extensive health-insurance reforms, new exchanges, the employer mandate, federal premium tax credits subsidizing insurance purchases, and automatic enrollment in certain employer-sponsored plans. *See Florida*, 648 F.3d at 1325; p. 6, *supra*.

Real-world experience since the 2017 amendment conclusively demonstrates that the protections for people with preexisting conditions function independently of the mandate. In 2017, the CBO predicted that the individual markets "would continue to be stable in almost all areas of the country throughout the coming decade" without a mandate. CBO Report at 1. That prediction has proven correct.

Over eight million Americans enrolled on the "healthcare.gov" website for 2019—only a small decrease from 2018.[12] Individual health-insurance markets thus continue to function effectively following elimination of the tax payment, even though protections for individuals with preexisting conditions remain in effect.

Third, the guaranteed-issue and community-rating provisions are consistent with Congress's basic objectives in enacting the statute. As the Supreme Court explained, "[t]he Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 538. Protection of individuals with preexisting provisions directly furthers those objectives, with or without the mandate, by preventing insurers from denying coverage or charging higher prices. That is especially important because, before the Act's passage, more than a third of adults who attempted to purchase coverage in the individual insurance market were denied or charged higher rates because of a preexisting condition.[13]

---

[12] Bob Bryan & Zachary Tracer, *The Newest Obamacare Enrollment Numbers Prove the Health Law Is 'Far From Dead' Despite Repeated Attacks from Trump and the GOP*, Business Insider (Dec. 20, 2018), https://www.businessinsider.com/obamacare-open-enrollment-sign-ups-down-4-after-gop-trump-changes-2018-12. The only source the district court cited for the proposition that eliminating the mandate would undermine other provisions of the Act is a book published before the mandate even went into effect. *See* ROA.2657 (citing Josh Blackman, *Unprecedented: The Constitutional Challenge to Obamacare* 147 (2013)).

[13] Michelle M. Doty et al., *Failure To Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund 2 (July 2009), https://www.commonwealthfund.org/sites/default/files/documents/

Congress was well aware of that problem. A House Report recognized that "health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy," including denying coverage or charging higher rates. H.R. Rep. No. 111-299, Pt. 3, at 92 (2009); *see* H.R. Rep. No. 111-443, Pt. 2, at 975-76 (2010) ("To protect families struggling with health care costs and inadequate coverage, the bill ensures that health insurance companies can no longer compete based on risk selection.").

In short, the continued applicability of protections for those with preexisting conditions vindicates Congress's objectives, even absent the mandate. Those protections therefore are severable.

3. The district court failed to respect the limits on its authority when it disregarded the clear intention of the 2017 Congress and instead gave controlling weight to certain congressional findings in the original 2010 Act and to statements in *NFIB* and *King v. Burwell*, 135 S. Ct. 2480 (2015). *See* ROA.2648-2656.

a. The 2010 findings do not support the district court's conclusion that the Act's insurance market reforms are now inseverable from Section 5000A. The

___media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf; *see Florida*, 648 F.3d at 1245.

district court focused on Congress's statement in 2010 that the mandate is "essential to creating effective health insurance markets," ROA.2650 (quoting 42 U.S.C. § 18091(2)(I)). But the very language of those findings makes clear that they were about "*creating* effective health insurance markets," 42 U.S.C. § 18091(2)(I) (emphasis added). They shed little light on what Congress would have believed about the need for the mandate now that insurance marketplaces are fully up and running. As demonstrated, the 2017 Congress was well aware when it amended Section 5000A(c) that these established markets could continue to function effectively even if individuals faced no tax consequences for failing to maintain insurance. The understanding of the 2017 Congress is what governs the severability analysis.

Even putting that dispositive consideration aside, the congressional findings on which the district court relied do not support its conclusion. The court pointed, for example, to 2010 findings that "[t]he [mandate] requirement, *together* with the other provisions of this Act," would "add millions of new customers to the health insurance market," ROA.2649 (quoting 42 U.S.C. § 18091(2)(C)), and that "the absence [of the mandate] would *undercut* Federal regulation of the health insurance market,'" ROA.2649 (quoting 42 U.S.C. § 18091(2)(H)). But those findings do no more than state the obvious: Congress intended the pieces of the law to work together and believed the law would function best with the mandate. The findings

do not suggest that Congress would have preferred no law at all to one that worked differently or even somewhat less effectively. They also reflected Congress's view that the commerce power supported the mandate. *See, e.g.*, 42 U.S.C. § 18091(1); *id.* § 18091(2)(A); *id.* § 18091(2)(H). They likewise do not suggest that Congress would have preferred *no statute at all*—or no protection for people with preexisting conditions—if the mandate were later deemed unconstitutional.

In addition, the district court's flawed reliance on the 2010 findings proves too much. One of the other 2010 findings on which the district court relied, *id.* § 18091(2)(H), stated that the mandate was "essential" to the "larger regulation of economic activity" under ERISA and the Public Health Service Act. Thus, the court's analysis would suggest that those statutes are also inseverable and must be invalidated. That is obviously wrong.

In the end, the findings to which the district court pointed do not address severability, or suggest anything about the 2010 Congress's views in the situation now presented—one in which the individual marketplaces have been up and running for years, a subsequent Congress eliminated the tax payment (after receiving a CBO report that the individual insurance market would continue to operate effectively without the tax), and a court later held unconstitutional the unenforceable mandate that remained. Congress has not even hinted that it would prefer the rest of the law to fall in that circumstance.

b. The district court also relied on *NFIB* and *King v. Burwell*. But here, too, the court erred. The court asserted that "[a]ll nine Justices [in *NFIB*] ... agreed the Individual Mandate is inseverable from at least the preexisting-condition prohibitions." ROA.2651-2652. That statement is simply wrong. A majority of the Court never addressed the mandate's severability because five Justices held that the mandate was constitutional. *NFIB*, 567 U.S. at 574.

The isolated quotations that the district court extracted from *NFIB* do not support the court's severability analysis. The various *NFIB* opinions all noted, correctly, that the mandate was a key part of Congress's design for creating insurance marketplaces. But it does not follow that Congress would have preferred no statute at all, years after the marketplaces were established and could operate effectively even without a tax incentive to purchase insurance.

Notably, the only actual severability holding in *NFIB* came out the other way. The Supreme Court concluded that the requirement that States expand Medicaid, another critical aspect of healthcare reform that the Court invalidated, *was* severable. The Court acknowledged that Congress "assumed that every State would participate in the Medicaid expansion," made "Medicaid a means for satisfying the [individual] mandate," and "enacted no other plan for providing coverage to many low-income individuals." *NFIB*, 567 U.S. at 587. Despite the interdependence between the Medicaid expansion and the rest of the Act, however, the Court explained that "[t]he

other reforms ... will remain fully operative as a law ... and will still function in a way consistent with Congress' basic objectives in enacting the statute." *Id.* at 587-88 (citation omitted).

The district court discounted the relevance of the Medicaid severability holding because, according to the court, "Congress included a severability clause." ROA.2650-2651 n.26. That statement too is wrong. The severability clause did not address the Medicaid expansion's severability from the Act; it addressed the Medicaid expansion's severability from the rest of Medicaid. *See* 42 U.S.C. § 1303 ("If any provision of *this chapter* ... is held invalid, the remainder of *the chapter* ... shall not be affected thereby." (emphasis added)); *NFIB*, 567 U.S. at 586. In fact, when the Supreme Court went on to consider "whether [its] holding [on Medicaid expansion] affects other provisions of the Affordable Care Act," 567 U.S. at 586, the Court did not even mention the severability clause. Applying routine severability analysis, the Court concluded that Congress intended the rest of the Act to stand, notwithstanding the importance of the Medicaid expansion to Congress's design.

The district court's reliance on *King* is misplaced for the same reason. There, the Supreme Court described three key reforms in the Act—the mandate, tax credits to purchase insurance, and protections for people with preexisting conditions—as being "closely intertwined," suggesting in dicta that "the guaranteed issue and community rating requirements would not work without the coverage requirement."

135 S. Ct. at 2487. But, again, it is one thing to say that Congress preferred all three provisions to act together in order to create effective insurance markets; it is quite another to say that Congress would not have chosen to maintain fully operative markets with protections for individuals with preexisting conditions unless it could also maintain an enforceable mandate. *King* never said that.

* * *

In sum, nothing in the district court's opinion supports the conclusion that Congress evidently would want the entire Act—or even just the guaranteed-issue and community-rating provisions—to fall if the mandate were held unconstitutional. Indeed, just two years ago, Congress essentially repealed the mandate by making it legally unenforceable and yet left the rest of the law untouched. "[L]egislative intent" is the "touchstone for any decision about remedy" because "a court cannot use its remedial powers to circumvent the intent of the legislature." *NFIB*, 567 U.S. at 586 (quoting *Ayotte*, 546 U.S. at 330). This Court should respect that intent here.

CONCLUSION

The district court's judgment should be reversed.

Dated: March 25, 2019

Respectfully submitted,

/s/ *Donald B. Verrilli, Jr.*
Donald B. Verrilli, Jr.
Elaine J. Goldenberg
Ginger D. Anders
Jonathan S. Meltzer
Rachel G. Miller-Ziegler
Jeremy S. Kreisberg
MUNGER, TOLLES & OLSON LLP
1155 F Street N.W., 7th Floor
Washington, D.C. 20004-1361
Tel: (202) 220-1100
Fax: (202) 220-2300
Donald.Verrilli@mto.com

Elizabeth B. Wydra
Brianne J. Gorod
Brian R. Frazelle
Ashwin P. Phatak
CONSTITUTIONAL
ACCOUNTABILITY CENTER
1200 18th Street N.W., Suite 501
Washington, D.C. 20036-2513
Tel: (202) 296-6889
elizabeth@theusconstitution.org
brianne@theusconstitution.org

Douglas N. Letter
General Counsel
Todd B. Tatelman
Deputy General Counsel
Kristin A. Shapiro
Assistant General Counsel
Brooks M. Hanner
Assistant General Counsel

OFFICE OF GENERAL COUNSEL
U.S. HOUSE OF REPRESENTATIVES
219 Cannon House Office Building
Washington, D.C. 20515
Tel: (202) 225-9700
Douglas.Letter@mail.house.gov

Counsel for the U.S. House of Representatives

CERTIFICATE OF SERVICE

I hereby certify that on March 25, 2019, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel of record.

Dated: March 25, 2019

Respectfully submitted,

/s/ *Donald B. Verrilli, Jr.*
Donald B. Verrilli, Jr.

CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 32(a)(7)(B), because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 12,966 words.

2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point, Times New Roman.

Dated: March 25, 2019

Respectfully submitted,

/s/ *Donald B. Verrilli, Jr.*
Donald B. Verrilli, Jr.

ADDENDUM

TABLE OF CONTENTS

26 U.S.C.A. § 5000A (current) A-1

26 U.S.C.A. § 5000A (effective 2010-2017) A-9

26 U.S.C.A. § 5000A, CURRENT

§ 5000A. 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.

[**(D) Repealed.** Pub.L. 115-97, Title I, § 11081(a)(2)(B), Dec. 22, 2017, 131 Stat. 2092]

(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) Repealed. Pub.L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(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 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 percentage 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;

(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); 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.

(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.

26 U.S.C.A. § 5000A, 2010-2017 VERSION

§ 5000A. 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) 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.

[(D) Repealed. Pub.L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(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 exemption.--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 such individual is--

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(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 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 percentage 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,

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

(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); 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.

(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.