No. 19-840

In the Supreme Court of the United States

THE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON, ANDY BESHEAR, THE GOVERNOR OF KENTUCKY, AND THE DISTRICT OF COLUMBIA,

Petitioners,

v.

THE STATE OF TEXAS, *et al.*,

Respondents.

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

OPENING BRIEF FOR THE PETITIONERS

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QUESTIONS PRESENTED

In 2010, Congress adopted 26 U.S.C. § 5000A as part of the Patient Protection and Affordable Care Act (ACA). Section 5000A provided that "applicable individual[s] shall" ensure that they are "covered under minimum essential coverage," 26 U.S.C. § 5000A(a); required any "taxpayer" who did not obtain such coverage to make a "[s]hared responsibility payment," *id.* § 5000A(b); and set the amount of that payment, *id.* § 5000A(c). In *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 574 (2012), this Court held that Congress lacked the power to impose a command to purchase health insurance but upheld Section 5000A as a whole as an exercise of Congress's taxing power, concluding that it affords individuals a "lawful choice" between buying health insurance or paying an alternative tax in the amount specified in Section 5000A(c). In 2017, Congress set that amount to zero but retained the remaining provisions of the ACA. The questions presented in No. 19-840 are:

1. Whether the state and individual plaintiffs in this case have established Article III standing to challenge the minimum coverage provision in Section 5000A(a).

2. Whether reducing the amount specified in Section 5000A(c) to zero rendered the minimum coverage provision unconstitutional.

3. If so, whether the minimum coverage provision is severable from the rest of the ACA.

PARTIES TO THE PROCEEDING

Petitioners and cross-respondents the States of California, Connecticut, Delaware, Hawaii, Illinois, Massachusetts, Minnesota (by and through its Department of Commerce), New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, Andy Beshear (the Governor of Kentucky), and the District of Columbia intervened as defendants in the district court and were appellants in the court of appeals. Petitioners the States of Colorado, Iowa, Michigan, and Nevada intervened as defendants in the court of appeals.

Respondent and cross-respondent the United States House of Representatives intervened as a defendant in the court of appeals.

Respondents and cross-respondents the United States of America, the United States Department of Health and Human Services, Alex M. Azar II, Secretary of Health and Human Services, the United States Internal Revenue Service, and Charles P. Rettig, the Commissioner of Internal Revenue, were defendants in the district court and filed a notice of appeal. They remained appellants in the court of appeals, but ultimately filed their appellate brief on the appellees' schedule and defended the district court's judgment.

Respondents and cross-petitioners the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi (by and through Governor Phil Bryant), Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, and individuals Neill Hurley and John Nantz were plaintiffs in the district court and were appellees in the court of appeals.

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INTRODUCTION

Congress transformed our Nation's healthcare system when it enacted the Patient Protection and Affordable Care Act (ACA). The ACA has allowed tens of millions of Americans to obtain high-quality healthcare coverage; slowed the growth of healthcare costs; conferred substantial savings on States, local governments, and hospitals; improved health outcomes; and funded responses to emerging public health crises. Many of its reforms have proven indispensable in the context of the current pandemic.

Since its enactment, the ACA has also been a centerpiece of the Nation's political debates. Congress has considered numerous proposals to repeal the Act or to eliminate its core reforms. Every one of those proposals has failed, including a series of bills in 2017. The 2017 Congress instead made a focused change to the Act by reducing to zero the amount of the tax imposed by 26 U.S.C. § 5000A on Americans who choose not to buy health insurance. That amendment retained every other provision of the ACA while eliminating the only legal consequence for individuals who decide to forgo health insurance.

Based on that single change, opponents of the ACA now seek from the courts what they failed to accomplish through the political process: invalidation of the entire Act. They argue that the 2017 amendment transformed Section 5000A into a command to buy insurance—a command that would be unconstitutional under *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) (*NFIB*). And they contend that this purported defect requires the courts to strike down every other provision of the ACA as well—despite the fact that Congress left each of those

provisions in place at the same time that it rendered Section 5000A effectively unenforceable by reducing the tax amount to zero. Those arguments have no basis in law or in congressional intent. This Court should decline respondents' invitation to impose a breathtakingly broad national policy change under the guise of constitutional adjudication.

OPINIONS BELOW

The opinion of the court of appeals is reported at 945 F.3d 355 (J.A. 374-489).[1] The order denying rehearing en banc (J.A. 490-491) is unreported. The relevant orders of the district court are reported at 340 F. Supp. 3d 579 (Pet. App. 163a-231a) and 352 F. Supp. 3d 665 (Pet. App. 117a-162a).

JURISDICTION

The court of appeals had jurisdiction over petitioners' appeal of the district court's partial final judgment under 28 U.S.C. § 1291. The judgment of the court of appeals was entered on December 18, 2019. J.A. 492. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Relevant constitutional and statutory provisions are reproduced in the appendix to this brief.

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[1] After petitioners filed their petition, the court of appeals issued a revised opinion containing technical changes. The revised opinion is included in the joint appendix.

STATEMENT

A. Legal Background

1. The Affordable Care Act

In 2010, Congress adopted the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119. "The Act's 10 titles stretch over 900 pages and contain hundreds of provisions." *NFIB*, 567 US. at 538-539. They address, among other things, the market for private health insurance (Title I), public health insurance programs (Title II), the quality and efficiency of healthcare systems (Title III), chronic disease and other public health issues (Title IV), the healthcare workforce (Title V), transparency in healthcare (Title VI), access to innovative therapies (Title VII), community living assistance services (Title VIII), revenue provisions (Title IX), and other matters, including Indian healthcare (Title X).

a. One of the ACA's central goals was "to increase the number of Americans covered by health insurance." *NFIB*, 567 U.S. at 538. Congress pursued that goal in several ways. First, it allowed States to expand the number of people eligible for Medicaid, with the federal government covering most of the increased cost. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14)(I)(i), 1396d(y)(1); *NFIB*, 567 U.S. at 575-586 (plurality opinion).

Second, it expanded access to employer-based health insurance. For example, the ACA requires companies with more than a certain number of full-time-equivalent employees to provide health coverage or pay a penalty. 26 U.S.C. § 4980H. And it requires insurers to allow young adults to stay on their parents' plans until age 26. 42 U.S.C. § 300gg-14.

Third, Congress made a series of reforms intended primarily "to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). The ACA prohibits insurers from denying coverage for pre-existing conditions and requires them to cover conditions that were diagnosed before an individual's enrollment date (the "guaranteed-issue requirement"). 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a). It also bars them from charging individuals higher premiums because of their health status (the "community-rating requirement"). *Id.* §§ 300gg, 300gg-4(b).[2]

At the time the ACA was enacted, States with guaranteed-issue and community-rating requirements had experienced that those reforms, standing alone, had an "unintended consequence: They encouraged people to wait until they got sick to buy insurance." *King*, 135 S. Ct. at 2485. "This consequence—known as 'adverse selection'—led to a second: Insurers were forced to increase premiums to account for the fact that, more and more, it was the sick rather than the healthy who were buying insurance." *Id.* To address that concern, the ACA included provisions designed to encourage healthy individuals to purchase insurance. It provided billions of dollars in subsidies to offset the cost of health insurance for low- and middle-income Americans. *Id.* at 2487, 2489 (citing 26

[2] The ACA adopted other consumer protections as well, including requiring that plans cover essential health benefits such as prescription drugs and maternity care, 42 U.S.C. §§ 18021(a)(1)(B), 18022, and prohibiting yearly or life-time benefit limits, *id.* § 300gg-11. It applied many protections to the "small-group" health insurance market, *see, e.g.*, *id.* §§ 300gg(a)(1), 300gg-3(a), 300gg-4(a), and strengthened existing protections in the "large-group" market, *see, e.g.*, *id.* § 18022(c) (capping out-of-pocket costs).

U.S.C. § 36B and 42 U.S.C. §§ 18081, 18082). It created government-run health insurance marketplaces, known as Exchanges, that allow consumers to "compare and purchase insurance plans." *Id.* at 2485; *see also* 42 U.S.C. § 18031. It established fixed open-enrollment periods, which "prevent[] consumers from purchasing health insurance only when they need it." J.A. 477-478 (King, J., dissenting) (citing 42 U.S.C. § 18031(c)(6)). And it adopted the provision at issue here, 26 U.S.C. § 5000A.

As originally enacted, Section 5000A "generally require[d] individuals to maintain health insurance coverage or make a payment to the IRS." *King*, 135 S. Ct. at 2486. Subsection (a) stated that "applicable individual[s] shall" ensure that they are "covered under minimum essential coverage." Subsection (b) required any "taxpayer" who did not obtain such coverage to make a "[s]hared responsibility payment" to the IRS. And subsection (c) set the amount of that alternative payment.

b. Congress included hundreds of other provisions in the ACA, many of which "are unrelated to the private insurance market," and some of which "are only tangentially related to health insurance at all." J.A. 478 (King, J., dissenting). For example, the Act reformed the way Medicare payments are made, encouraging healthcare providers to deliver higher-quality and more cost-efficient care. J.A. 217-220, 227-228; *see* 42 U.S.C. § 1395ww. It created the Prevention and Public Health Fund, which has funded state and local responses to emerging public health risks like the opioid epidemic and infectious diseases. J.A. 223-224, 228; *see, e.g.*, 42 U.S.C. § 300u-11. It enabled States to strengthen their Medicaid programs through initiatives like the Community First Choice

Option, which covers in-home and community-based care for persons with disabilities. J.A. 216; *see* 42 U.S.C. § 1396n(k). It also invested billions of dollars in local community health programs, J.A. 224-227; *see, e.g.*, 42 U.S.C. § 254b-2, created a student-loan repayment assistance program for members of the public health workforce, 42 U.S.C. § 295f-1, and strengthened criminal laws against healthcare fraud, *see, e.g.*, 18 U.S.C. § 1347(b).

c. The ACA has achieved many of its goals. Among other accomplishments, the Nation's uninsured rate dropped by 43 percent shortly after the Act's major reforms took effect. J.A. 194. Thirty-six States—including eight of the state respondents—and the District of Columbia have expanded their Medicaid programs; nearly twelve million individuals received healthcare coverage in 2016 as a result of Medicaid expansions. D.Ct. Dkt. 15-2 at 10-11.[3] In 2017, 10.3 million people received coverage through the Exchanges, with over 8 million receiving tax credits to help them pay their premiums. J.A. 207.

The Act has also been instrumental in our Nation's response to the COVID-19 pandemic. Among many other things, the Act's Prevention and Public Health Fund is supporting state and local efforts to track the spread of coronavirus, enhance laboratory capacity, and expand diagnostic testing.[4] Its investment in

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[3] *Status of State Medicaid Expansion Decisions: Interactive Map*, Kaiser Family Found., https://bit.ly/3b9rCv2 (last visited May 5, 2020).

[4] *See, e.g.*, *CDC Coronavirus Funding to Jurisdictions*, Dep't of Health & Human Servs. (Apr. 23, 2020), https://bit.ly/3c4Yiax (summarizing Epidemiology and Laboratory Capacity Program

community health centers is helping to prevent, detect, and treat the disease.[5] Its "essential health benefits" provision is requiring insurers to cover the costs of diagnosis and treatment—and will require them to cover the cost of an approved vaccine. 42 U.S.C. § 18022(b)(1).[6] And the ACA is allowing Americans who have lost their jobs and their employer-based health insurance to purchase coverage through the Exchanges and to obtain subsidies for that coverage. *See* 45 C.F.R. § 155.420(d)(1)(i).

2. *NFIB v. Sebelius*

Since "the day the President signed the Act into law," the ACA has been the subject of legal challenges. *NFIB*, 567 U.S. at 540. In *NFIB*, this Court addressed the constitutionality of Section 5000A and upheld the requirement that individuals either maintain minimum coverage or make a payment to the IRS.

The Court's decision was composed of shifting majorities. Chief Justice Roberts first concluded that Section 5000A would exceed Congress's authority under the Commerce Clause if it were construed as imposing a requirement that individuals purchase health insurance. *NFIB*, 567 U.S. at 547-558 (Roberts, C.J.). He reasoned that the Commerce Clause authorizes Congress to "*regulate* Commerce," not to require individuals to "*become* active in commerce by

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awards).

[5] *See, e.g.*, *Coronavirus Disease 2019 (COVID-19) Frequently Asked Questions*, HRSA, https://bit.ly/2Y3aS5Q (last visited May 5, 2020).

[6] *See* Ctr. for Consumer Info. & Ins. Oversight, *FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)* at 1-2 (Mar. 12, 2020), https://go.cms.gov/3afO0SZ.

purchasing a product." *Id.* at 550, 552. Four dissenting Justices reached the same conclusion. *See id.* at 657 (joint dissent).

The Chief Justice next considered whether Section 5000A could be upheld under Congress's power to "'lay and collect Taxes.'" *NFIB*, 567 U.S. at 561 (Roberts, C.J.). He observed that the "most straightforward" understanding of Section 5000A(a), read in isolation, was that it "command[ed] individuals to purchase insurance." *Id.* at 562. But he explained "that if a statute has two possible meanings, one of which violates the Constitution," the Court has a "plain duty" to adopt the meaning that saves the statute. *Id.* Construing Section 5000A as a whole, it was "'fairly possible'" to read the provision as imposing "a tax hike on certain taxpayers who do not have health insurance." *Id.* at 563.

The Chief Justice then announced the judgment of a majority of the Court that Section 5000A was a lawful exercise of the taxing power. *NFIB*, 567 U.S. at 574.[7] The Court pointed to several features of Section 5000A, including that it was found in the Internal Revenue Code; any amount due was "determined by such familiar factors as taxable income, number of dependents, and joint filing status"; and it "yield[ed] the essential feature of any tax: It produce[d] at least some revenue for the Government." *Id.* at 563, 564. Section 5000A offered individuals a "lawful choice": they could "forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes." *Id.* at 574 & n.11. Construed that way, Section 5000A(a)'s statement that individuals "shall" obtain

[7] Four other Justices joined Part III-C of the Chief Justice's opinion. *See* 567 U.S. at 589 (opinion of Ginsburg, J.).

health insurance "is not a legal command to buy insurance," but instead "establish[es] a condition—not owning health insurance—that triggers a tax." *Id.* at 563 (Roberts, C.J.).

Four dissenting Justices would have held that both Section 5000A and the Act's Medicaid expansion were unconstitutional, and that those provisions could not be severed from the rest of the ACA. *See NFIB*, 567 U.S. at 646-707 (joint dissent).

3. Efforts to repeal the ACA

"Between 2010 and 2016, Congress considered several bills to repeal, defund, delay, or amend the ACA." J.A. 380. Except for a few adjustments that attracted bipartisan support, those efforts failed. *See id.*

In 2017, opponents of the Act renewed their efforts to repeal many of its most important reforms. J.A. 380. House leaders cancelled a floor vote on a bill to repeal core provisions of the ACA in March. *Id.* Two months later, the House approved a revised version of that bill. *See* H.R. 1628, 115th Cong. (2017). The Senate, however, did not approve any corresponding legislation. In July, the Senate voted on three additional proposals to repeal central parts of the ACA; each one failed.[8] In September, several Senators introduced another repeal bill. *See* S. Amendment 1030 to H.R. 1628, 115th Cong. (2017). Senate leaders ultimately chose not to bring that bill to the floor. *See* Kaplan & Pear, *Senate Republicans Say They Will Not Vote on Health Bill*, N.Y. Times, Sept. 26, 2017.

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[8] *See* S. Amendment 270 to H.R. 1628, 115th Cong. (2017); S. Amendment 271 to H.R. 1628, 115th Cong. (2017); S. Amendment 667 to H.R. 1628, 115th Cong. (2017).

4. The Tax Cuts and Jobs Act

While efforts to repeal the ACA's major provisions failed, Congress did make a focused change to the Act in December 2017. As part of the Tax Cuts and Jobs Act (TCJA), Congress reduced to zero the amount of the alternative tax imposed by Section 5000A(c), effective January 1, 2019. Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).[9]

Congressional supporters of that amendment emphasized that it was limited to Section 5000A and would not affect any other aspect of the ACA. For example, Senator Toomey explained that "zero[ing] out the penalty" was "equivalent to repeal[ing]" Section 5000A, 163 Cong. Rec. S8115 (daily ed. Dec. 19, 2017), and that "[w]e don't change anything" in the ACA "except one thing," 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017). Before the vote on the TCJA, the Congressional Budget Office told Congress that the effect of setting the tax amount to zero "would be very similar to" that of "repealing" the minimum coverage provision altogether—and that even if that provision were repealed, the individual insurance markets "would continue to be stable in almost all areas of the country throughout the coming decade." J.A. 307.

B. Proceedings Below

1. District court proceedings

a. After Congress enacted the TCJA, two private individuals and a group of States (respondents here) sued the federal government. J.A. 29-35. Their complaint alleged that by reducing the amount of the

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[9] Except for a temporary reduction in the "medical expense deduction floor," § 11027, 131 Stat. at 2077, the TCJA made no other change to the ACA.

alternative tax in Section 5000A(c) to zero, Congress transformed Section 5000A(a) into an unconstitutional command to buy health insurance. *Id.* at 45-47. They further argued that the rest of the ACA must be struck down as well, because the minimum coverage provision was "essential to" and "non-severable from" the balance of the Act. *Id.* at 63-64. They sought declaratory relief and preliminary and permanent injunctions forbidding enforcement of any provision of the ACA. *Id.* at 67.

The federal defendants (also respondents here) agreed with the plaintiffs that the minimum coverage provision now exceeded Congress's constitutional authority. J.A. 324-327. Initially, the federal defendants argued that the minimum coverage provision was inseverable from the guaranteed-issue and community-rating requirements, but that those three provisions could be severed from the rest of the ACA. *Id.* at 327-336. And they opposed the plaintiffs' request for "immediate relief" on the ground that Section 5000A's alternative tax would not be reduced to zero for another six months. *Id.* at 337. They instead asked the district court to construe the motion for a preliminary injunction as a request for summary judgment, and to declare the minimum coverage, community-rating, and guaranteed-issue provisions invalid. *Id.* Sixteen States and the District of Columbia (petitioners here) intervened to defend the ACA. *Id.* at 384.

b. The district court denied the motion for a preliminary injunction but granted partial summary judgment on the claim for declaratory relief. Pet. App. 163a-231a. The court first held that the individual respondents had established standing to challenge Section 5000A(a) because it "requires them to pur-

chase and maintain certain health-insurance coverage." *Id.* at 182a. On the merits, the court held that the 2017 amendment converted Section 5000A(a) into a "standalone command" to purchase health insurance, which exceeded Congress's powers. *Id.* at 203a-204a.

The district court then held that this construction of Section 5000A required it to strike down the entire ACA. Although the purported constitutional defect was the product of a 2017 amendment, the court focused on the 2010 Congress, asking whether it would have adopted the rest of the original ACA had it known that it could not include Section 5000A(a). Pet. App. 208a-226a. The court relied on legislative findings made in 2010 and on this Court's opinions in *NFIB* and *King*, which it read as establishing that "all nine Justices" agreed that the minimum coverage provision was "inseverable from at least" the guaranteed-issue and community-rating provisions. *Id.* at 214a. It then concluded that the same considerations established that the "Individual Mandate is inseverable from the *entirety* of the ACA." *Id.* at 218a; *see id.* at 218a-224a. The court asserted that it was "unhelpful" to consider the intent of the 2017 Congress, *id.* at 227a, and concluded in any event that the 2017 Congress either "had no intent with respect to the Individual Mandate's severability," *id.* at 228a, or "must have agreed" that the minimum coverage provision was "essential to the ACA," *id.* at 229a.

c. In a separate order, the district court entered a partial final judgment under Federal Rule of Civil Procedure 54(b), but stayed the effect of that judgment pending appeal. Pet. App. 116a-162a.

2. Fifth Circuit proceedings

a. Petitioners and the federal respondents filed separate notices of appeal. J.A. 387. The United States House of Representatives and the States of Colorado, Iowa, Michigan, and Nevada intervened on appeal to defend the ACA. *Id.* at 385 n.12.

On the day their opening brief would have been due, the federal respondents "changed their litigation position," J.A. 385, indicating that they would now argue that "no ACA provision was severable" from the minimum coverage provision and the district court's judgment should be affirmed in its entirety, *id.* at 446; *see* U.S. C.A. Letter (Mar. 25, 2019). When they later filed their brief, they changed positions again, arguing that the district court's judgment should be reversed "insofar as it purports to extend relief to ACA provisions that are unnecessary to remedy plaintiffs'" purported injuries. J.A. 386.

b. A divided panel of the Fifth Circuit affirmed in part. J.A. 374-489. The court first held that the individual and state respondents had established standing to challenge the minimum coverage provision. *Id.* at 392-413.[10] Because the individual respondents "feel compelled by the individual mandate to buy insurance," and bought insurance "solely for that reason," *id.* at 403, the court concluded that they had established a "concrete, particularized injury," *id.* at 400. As to the state respondents, the court reasoned that the States as employers are "required by the ACA to issue forms verifying which employees are covered by minimum essential coverage," *id.* at 407 (citing 26 U.S.C. §§ 6055(a), 6056(a)), and that the minimum

[10] It also held that both petitioners and the federal respondents had standing to appeal. J.A. 387-392.

coverage provision has "increased the cost of printing and processing these forms and of updating the state employers' in-house management systems," *id.*

On the merits, the court held that the minimum coverage provision was no longer a "constitutional exercise of congressional power." J.A. 414. It concluded that the saving construction adopted in *NFIB* was "no longer available," because the "central attributes" this Court relied on in interpreting Section 5000A as a tax "no longer exist" after the TCJA. *Id.* at 419. It reasoned that the "only reading available" of Section 5000A(a) was as an unconstitutional "command to purchase insurance." *Id.* at 420.

As to remedy, however, the court vacated the district court's judgment and remanded for further consideration. J.A. 427-448. It explained that the district court's severability analysis was "incomplete in two ways." *Id.* at 440. First, the district court gave "relatively little attention to the intent of the 2017 Congress, which appear[ed] in the analysis only as an afterthought." *Id.* at 441. Second, it failed to "explain[] how particular segments" of the ACA were "inextricably linked to the individual mandate." *Id.*[11]

c. Judge King dissented. J.A. 449-489. She would have held that the individual and state respondents lacked standing to sue. *Id.* at 451-467. As a result of the 2017 amendment, Section 5000A now "does nothing more than require individuals to pay zero dollars to the IRS if they do not purchase health insurance, which is to say that it does nothing at all." *Id.* at 451. Because the individual respondents would be "no

[11] The court noted that, on remand, the district court could also consider the federal respondents' "new arguments as to the proper scope of relief." J.A. 446.

worse off by any conceivable measure if they choose not to purchase health insurance," any injury they incurred by purchasing health insurance was "entirely self-inflicted." *Id.* at 455. As to the state respondents, the record contained "no actual evidence tying any costs the state [respondents] have incurred to the unenforceable coverage requirement." *Id.* at 467.

On the merits, Judge King concluded that Section 5000A is "constitutional, albeit unenforceable." J.A. 450. Because Congress zeroed-out the only "'negative legal consequence[]'" of not buying health insurance, Section 5000A now "affords individuals the same choice individuals have had since the dawn of private health insurance, either purchase insurance or else pay zero dollars." *Id.* at 467. Congress does not "exceed[] its enumerated powers when it passes a law that does nothing." *Id.* at 467-468. Responding to the majority's conclusion that Section 5000A(a) now imposes an invalid command, Judge King observed that "it boggles the mind to suggest that Congress intended to turn a nonmandatory provision into a mandatory provision by doing away with the only means of incentivizing compliance with that provision." *Id.* at 472-473.

Finally, Judge King explained that the severability question was "quite simple." J.A. 474. When it enacted the TCJA, Congress "declawed the coverage requirement without repealing any other part of the ACA." *Id.* As a result, "little guesswork is needed to determine that Congress believed the ACA could stand without the unenforceable coverage requirement." *Id.*

SUMMARY OF ARGUMENT

This Court addressed a constitutional challenge to 26 U.S.C. § 5000A in *NFIB*, and ruled that the provision did not command anyone to buy insurance. Rather, it presented Americans with a "lawful choice": buy insurance or pay a tax. 567 U.S. at 574 & n.11. Congress was aware of that construction when, in the Tax Cuts and Jobs Act of 2017, it reduced the amount of the alternative tax to zero. Individuals still have a choice: buy insurance or don't.

None of the respondents has established standing to challenge Section 5000A as amended by the TCJA. The individual respondents are not harmed by a statute that does not require them to do anything. But even if Section 5000A(a) were treated as imposing a "command" for purposes of the jurisdictional analysis, they would still lack standing because they would face no adverse legal consequence for disobeying it. And while States can undoubtedly establish standing if a federal law causes them to sustain a fiscal injury, the state respondents here utterly failed to introduce evidence showing that the amended Section 5000A inflicts any such injury on them.

In any event, there is no constitutional problem. After considering and rejecting efforts to repeal the ACA or its major provisions, Congress passed a narrow amendment that modified the terms of the choice presented by Section 5000A—by allowing individuals to freely decide whether to buy health insurance without facing any tax assessment if they do not. The effect of the amendment was to render Section 5000A nugatory: it may encourage Americans to buy insurance, but it does not require anyone to do anything. Congress does not exceed its constitutional authority by creating such a provision. It is sustainable either

as a merely precatory provision or as a suspended exercise of the taxing power. The contrary judgment of the lower court rests on the remarkable premise that when Congress enacted the TCJA, it transformed Section 5000A(a) into the very command that *NFIB* had already held to be unconstitutional. Every relevant interpretive principle confirms that Congress did no such thing.

Finally, any question of severability in this case requires no extended analysis. Severability turns on the intent of Congress, and here Congress eliminated the minimum coverage provision's "only enforcement mechanism but left the rest of the Affordable Care Act in place." J.A. 449 (King, J., dissenting). If that amendment somehow introduced a constitutional defect, then it is plain that Congress would have wanted the remainder of the Act to stand without an enforceable requirement to maintain coverage—because that is precisely the arrangement that Congress itself created.

ARGUMENT

I. RESPONDENTS HAVE NOT ESTABLISHED STANDING

Article III requires "an injury in fact" that is "fairly traceable to the challenged conduct of the defendant" and "likely to be redressed by a favorable judicial decision." *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1547 (2016). Plaintiffs carry the burden of supporting each element of standing "in the same way as any other matter on which the plaintiff bears the burden of proof." *Lujan v. Dfs. of Wildlife*, 504 U.S. 555, 561 (1992). Where standing is addressed "at the summary judgment stage," as here, a plaintiff cannot "rest on mere allegations, but must set forth by affidavit or

other evidence specific facts." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 412 (2013) (internal quotation marks and alterations omitted). None of the plaintiffs in this case carried that burden.

A. The Individual Respondents Lack Standing

1. The individual respondents submitted declarations asserting that they "value compliance with [their] legal obligations" and continue to purchase health insurance because Section 5000A "obligate[s]" them to do so. J.A. 73-74, 77; *see also id.* at 60. That is insufficient to establish standing.

First, Section 5000A does not require the individual respondents (or anyone else) to buy insurance. Under the statutory construction this Court adopted in *NFIB*, Section 5000A offers individuals a choice between obtaining insurance and paying a tax of a specified amount. *See* 567 U.S. at 574 & n.11. With full knowledge of that construction, Congress reduced the amount of that tax to zero. Section 5000A now allows individuals to choose between buying insurance and doing nothing. *See infra* pp. 26-31. The individual respondents cannot show a "concrete" injury that "actually exist[s]" and is "fairly traceable" to the challenged statute, *Spokeo*, 136 S. Ct. at 1547, 1548, by asserting that they "feel compelled" to buy insurance (J.A. 403) when nothing in Section 5000A actually compels them to do anything.

Second, even if the Court assumed for purposes of analyzing standing that Section 5000A(a) was now "a command to purchase insurance," J.A. 404, the individual respondents would still lack standing because they would face no adverse legal consequence for disobeying the command. "A plaintiff who challenges

a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979). In *NFIB*, the Court recognized that the only "negative legal consequence[]" of going without health insurance is the requirement to make a "payment to the IRS." 567 U.S. at 568. By setting the amount of that payment to zero, Congress has rendered any requirement imposed by Section 5000A(a) effectively unenforceable. Because it is now "impossible for the individual [respondents] to ever be prosecuted (or face any other consequences) for violating it," J.A. 459 (King, J., dissenting), the individual respondents do not "allege a dispute susceptible to resolution by a federal court," *Babbitt*, 442 U.S. at 299; *cf. Poe v. Ullman*, 367 U.S. 497, 508 (1961) (plurality opinion) ("This Court cannot be umpire to debates concerning harmless, empty shadows.").

2. The court below held that the individual respondents established standing by asserting that they "feel compelled" by Section 5000A(a) to buy insurance and "bought insurance solely for that reason." J.A. 403. But whatever their subjective perceptions, it is legally clear that "absolutely nothing" will happen to them if they choose to go without coverage. *Id.* at 455 (King, J., dissenting). If they instead choose to continue "spending money" on insurance that they "do not want or need," J.A. 399-400 (majority opinion), any resulting financial harm would be "entirely self-inflicted," *id.* at 455 (King, J., dissenting). Respondents cannot "manufacture standing" based on "hypothetical" fears when there is no possible prospect—let alone a "certainly impending" threat—of any supposed command in Section 5000A(a) being enforced against them. *Clapper*, 568 U.S. at 416.

In these circumstances, it is immaterial whether the individual respondents are viewed as "the objects of the individual mandate." J.A. 397. This Court has observed that where a "plaintiff is himself an object of" a governmental action, "there is ordinarily little question that the action . . . has caused him injury, and that a judgment preventing . . . the action will redress it." *Lujan*, 504 U.S. at 561-562. But that observation reflects the commonsense point that if the government is taking action against an individual—or, at the very least, has the legal power to take action—then there is likely to be actual or imminent harm to that individual, traceable to the government and redressable by a legal judgment. Here, the government no longer has the authority to take any action against the individual respondents for choosing to forgo healthcare coverage. *Cf. NFIB*, 567 U.S. at 568 ("Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS.").

The court below also reasoned that it was required to "defer" to the district court's "factual finding" that the individual respondents "bought health insurance because they are obligated to." J.A. 398. But the question of whether Section 5000A inflicts any cognizable injury on the individual respondents is not a factual one. Respondents seek to invoke the jurisdiction of the federal courts on the theory that they have a "legal obligation[]" to purchase health insurance. J.A. 73, 77. In this context, assessing whether Section 5000A "actually" imposes any "concrete" consequence for choosing not to purchase health insurance, *e.g.*, *Spokeo*, 136 S. Ct. at 1548, requires a legal analysis of the meaning and effect of the statute, not a factual inquiry into respondents' subjective perceptions.

B. The State Respondents Have Not Established Standing

The state respondents assert that Section 5000A(a) inflicts a "pocketbook injury" on them by "forc[ing]" third parties to obtain health insurance. Texas C.A. Br. 20. A fiscal injury resulting from the effects of a federal policy on choices by third parties can of course be a proper basis for state standing. *See, e.g.*, *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2565-2566 (2019). But when a State seeks to rely on such a theory at the summary judgment stage, it carries "the burden . . . to adduce facts showing that those choices have been or will be made in such manner as to produce causation and permit redressability of injury." *Lujan*, 504 U.S. at 562. The state respondents here failed to do so.

1. The state respondents have advanced two theories of fiscal injury. First, in the lower courts, they argued that the minimum coverage provision increases their Medicaid and Children's Health Insurance Program (CHIP) spending because it "forces individuals" to enroll in those programs, for which "the States share coverage expenses for enrollees." Texas C.A. Br. 20, 21. The district court did not address the state respondents' standing at all, *see* Pet. App. 184a-185a; the court of appeals did not adopt this theory of standing, *see* J.A. 406-413; and the state respondents did not renew the argument in their certiorari-stage briefing, *see* Texas Opp. 16-22.

Second, the state respondents have lately argued that Section 5000A(a) increases their "administrative costs . . . to report, manage, and track the insurance coverage of their employees." J.A. 413. These costs, they contend, "'are created in part by the individual

mandate's practical *interaction* with other ACA provisions.'" Texas Opp. 18. They reason that the amended Section 5000A causes some state employees to purchase health insurance, and that "[e]very time an individual gets that insurance through a state employer, the state employer must send the individual a form certifying that he or she is covered and otherwise process that information through in-house management systems." J.A. 410.

To establish standing under either theory, the state respondents were required to introduce evidence showing a "likelihood" or "substantial risk" that more people will enroll in their Medicaid, CHIP, or state employer health plans because of the amended Section 5000A. *Dep't of Commerce*, 139 S. Ct. at 2565. The state respondents had ample opportunity to try to provide that kind of evidence.[12] But the evidence they actually introduced consists primarily of declarations from state officials describing costs and burdens arising from the ACA generally. J.A. 79-191, 339-363. It does not establish that Section 5000A in particular will likely inflict any concrete fiscal injury on the state respondents now that the alternative tax is set to zero.

The state respondents' theory of standing is not only unsupported, it is implausible. As Judge King

[12] In the district court, the American Medical Association filed an amicus brief challenging the state respondents' standing. *See* Pet. App. 181a n.6. Thereafter, the state respondents did not attempt to introduce any further evidence in support of their standing theory; did not oppose the district court moving directly to summary judgment, *see* J.A. 365-366; and asserted that "[d]iscovery and further factual development of the record" were "unnecessary," *id.* at 367. (Petitioners opposed proceeding to summary judgment, and requested an opportunity to brief "all of the legal and factual issues" before the Court, J.A. 372, but the district court ignored that request.)

explained in her dissent, the notion that Section 5000A (as amended) increases the number of individuals on Medicaid, CHIP, or state employer plans is "dubious." J.A. 463. Because CHIP and Medicaid are "available to eligible recipients at little to no cost, it is especially unlikely that the unenforceable coverage requirement would play any significant part in anyone's decision to enroll." *Id.* at 466. If a person "would otherwise pass on the significant benefits" offered by these programs, it "belies common sense to conclude that" she "would be motivated to enroll solely because of an unenforceable law." *Id.* For similar reasons, it is unlikely that a state employee who would not otherwise avail herself of an employer-subsidized health plan would do so because of a provision that now imposes no legal consequences for choosing to forgo insurance. *See id.* at 464-465.

2. The court below concluded that the record was "replete" with evidence "that the individual mandate itself has increased" the state respondents' reporting costs. J.A. 407. It quoted declarations from state officials about the costs of "track[ing] and report[ing] ACA eligible employees," "complet[ing] mandatory IRS Form 1095" reports, and complying with other ACA requirements. *Id.* at 407-408; *cf. id.* at 409 (costs of enhanced "management systems" related to Medicaid). But none of the referenced declarations establishes that the amended Section 5000A "predictably causes" (*id.* at 413) more individuals in the respondent states to enroll in state healthcare programs—or even remotely addresses that issue. *See* J.A. 79-87, 124-129, 138-144, 156-170, 185-191, 344-352.

The court also invoked two Congressional Budget Office reports, one issued 15 months before the ACA became law and the second a month before Congress

enacted the TCJA. *See* J.A. 398, 408 n.27, 413 n.31. The first report predicted that "[m]any individuals . . . would comply with a mandate, even in the absence of penalties." Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 53 (2008). The second predicted that "[i]f the individual mandate penalty was eliminated but the mandate itself was not repealed . . . only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law." J.A. 307. Neither report quantified those predictions or offered any survey data or other direct support for them. And even if the reports were sufficient to support the general premise that "some people will buy insurance" after the TCJA "solely because of a desire to comply with the law," J.A. 413 n.31, they do not establish a substantial risk that any of the state respondents' employees or prospective Medicaid or CHIP beneficiaries are "among this 'small number of people,'" *id.* at 465 n.9 (King, J., dissenting).[13]

Finally, the legal authorities discussed by the court of appeals (J.A. 412-413) do not support its holding. As this Court recognized in *Department of Commerce*, a State may establish standing by showing that "third parties will likely react" in ways that cause the State harm. 139 S. Ct. at 2566. But the state plaintiffs in that case supported their standing theory with specific evidence—including expert testimony, comprehensive

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[13] The state respondents were not required to identify any "specific" individual who would enroll because of the amended Section 5000A. J.A. 411 n.30. They were, however, required to show a "substantial risk" that at least one such person would make that choice, causing them cognizable fiscal harm. *E.g.*, *Dep't of Commerce*, 139 S. Ct. at 2565.

studies, and detailed government memoranda—demonstrating that a citizenship question would "result in noncitizen households responding to the census at lower rates than other groups, which in turn would cause them to be undercounted and lead to" fewer congressional seats and lost federal funding. *Id.* at 2565; *see* 18-966 Pet. App. 141a-184a. The record here contains nothing similar.

The Fifth Circuit's ruling in the challenge to the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) policy is inapposite for the same reason. *See Texas v. United States*, 809 F.3d 134 (5th Cir. 2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016). It was "undisputed" there that DAPA would "enable beneficiaries to apply for driver's licenses"; that at least 500,000 potential beneficiaries lived in Texas; that Texas "would lose a minimum of $130.89" on each license issued; and that there were "strong incentives" for beneficiaries to get licenses. *Id.* at 155-156, 160. The DAPA case illustrates that the state respondents are capable of introducing evidence of a concrete fiscal injury when it is available to them. They did not do so here.

II. SECTION 5000A DOES NOT VIOLATE THE CONSTITUTION

Even if respondents had standing, their constitutional challenge would fail on the merits. Respondents argue that Section 5000A can only be read as an unconstitutional command to purchase health insurance. But this Court reviewed Section 5000A in *NFIB* and construed it differently: as presenting individuals with a choice between buying health insurance and paying an alternative tax. *See* 567 U.S. at 574 & n.11. Congress was aware of that authoritative construction when it reduced the amount of the alternative tax to

zero in 2017. The intent of that amendment was to allow Americans to freely choose whether to buy insurance without facing any tax liability if they decide to forgo it; the effect was to render Section 5000A inoperative, at least for the time being. As amended, Section 5000A may encourage or exhort Americans to buy health insurance, but it does not require anyone to do anything. Congress does not exceed its constitutional authority by creating such a provision.

A. Section 5000A Does Not Command Americans to Purchase Health Insurance

This Court normally "assume[s]" that Congress "legislates in the light of constitutional limitations," *Rust v. Sullivan*, 500 U.S. 173, 191 (1991); that congressional amendments to a statute are made with "full cognizance" of the Court's prior construction of that statute, *Ankenbrandt v. Richards*, 504 U.S. 689, 700 (1992); and that Congress does not intend to change a prior construction "unless an intent to make such changes is clearly expressed," *id.* (internal quotation marks omitted). The court of appeals rested its holding on the conclusion that when Congress enacted the TCJA, it transformed Section 5000A(a) into "a command to purchase insurance," J.A. 426—a command that would plainly be unconstitutional under *NFIB*. Every relevant interpretive principle confirms that Congress did no such thing.

1. *NFIB* addressed the constitutionality of Section 5000A as originally enacted. *See* 567 U.S. at 546-575. The Court began with the statutory text, *id.* at 538-540, which commences by stating that "[a]n applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage," 26 U.S.C. § 5000A(a). The Chief Justice noted that the "most

natural interpretation" of that language, read in isolation, is "that it commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562, 563 (Roberts, C.J.). Four dissenting Justices would have adopted that interpretation. *See, e.g.*, *id.* at 649, 652, 663 (joint dissent). And if the minimum coverage provision were read in that way, the Chief Justice and the four dissenting Justices would have held that it exceeded Congress's powers. *See id.* at 547-561 (Roberts, C.J.); *id*. at 650-660 (joint dissent). But the Court rejected that reading.

Instead, a different majority held that Section 5000A as a whole should be construed as "merely impos[ing] a tax citizens may lawfully choose to pay in lieu of buying health insurance." *NFIB*, 567 U.S. at 568. In other words, Section 5000A offered individuals a "lawful choice to do or not do a certain act," so long as they were "willing to pay a tax levied on that choice." *Id.* at 574. As interpreted in *NFIB*, therefore, the statement in Section 5000A(a) that individuals "shall" maintain health coverage imposed no legal obligations on them. Read together with subsections (b) and (c), it required only that individuals either obtain insurance or pay a tax.

When Congress amended Section 5000A in 2017, it acted with "full cognizance" of *NFIB*'s construction of that provision. *Ankenbrandt*, 504 U.S. at 700; *cf. Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2409 (2015). It was likewise aware of the "constitutional limitations" clarified by that decision, *Rust*, 500 U.S. at 191—specifically, that a command to purchase insurance would be unconstitutional, *see NFIB*, 567 U.S. at 558 (Roberts, C.J.); *id*. at 657 (joint dissent). Under those circumstances, it would have been astonishing if the 2017 Congress had amended the statute

to do exactly what this Court had forbidden just a few years earlier.

And the text of the amendment makes clear that Congress did not. The TCJA changed Section 5000A in a single respect: it reduced the amount of the alternative tax specified in Section 5000A(c) to zero. That amendment modified the terms of the lawful choice presented to Americans. Section 5000A still allows individuals to choose whether or not to purchase health insurance; but the alternative tax imposed on those who do not purchase insurance is currently set at "zero dollars, which means that the coverage requirement now does nothing." J.A. 468-469 (King, J., dissenting). In other words, there are presently "no consequences *at all*" for choosing to forgo health insurance, *id.* at 473; the TCJA has rendered Section 5000A effectively inoperative. And Section 5000A(a) now "functions as an expression of national policy or words of encouragement, at most." *Id.* at 473-474. It may exhort Americans to buy health insurance, but it does not command them to do anything.

Interpreting Section 5000A(a) in this way is not only faithful to the statutory text and this Court's precedent, it is consistent with the other indications of legislative intent surrounding the TCJA's enactment. The Speaker of the House, for example, announced that the TCJA would "repeal[] the individual mandate." 163 Cong. Rec. H10,212 (daily ed. Dec. 19, 2017). The Senate Majority Leader said that the TCJA would "repeal Obamacare's individual mandate tax so that low- and middle-income families *are not* forced to purchase something they either don't want or can't afford." 163 Cong. Rec. S8153 (daily ed. Dec. 20, 2017) (emphasis added). The Chairman of the Finance Committee similarly explained that the TCJA "simply

repeals an extremely regressive tax." *Continuation of the Open Executive Session to Consider an Original Bill Entitled the Tax Cuts and Jobs Act Before the S. Comm. on Fin.*, 115th Cong. 106 (2017) (Finance Comm. Hearing). Senator Toomey said that the legislation "effectively repeals the individual mandate of ObamaCare," 163 Cong. Rec. S8115 (daily ed. Dec. 19, 2017), and "eliminate[s] that coercion, which force[d] people to buy" insurance, 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017). Congressional supporters of the TCJA could hardly have been clearer that Congress intended to make the minimum coverage provision nugatory.

2. The lower courts instead concluded that the only possible reading of Section 5000A(a) after the TCJA is as a "command to purchase insurance." J.A. 426. They noted that "§ 5000A was originally cognizable as either a command or a tax," *id.*, and reasoned that it must now be construed as a command because it can no longer be justified under the taxing power, *see id.* at 419-420. That conclusion is doubly wrong. As explained below, *infra* pp. 32-34, Section 5000A may be upheld as a suspended exercise of the taxing power. But in any event, now that Congress has reduced the amount of the tax payment to zero, the two alternatives identified by the lower courts are not the only possible interpretations. The better reading is that Section 5000A now at most encourages Americans to purchase health insurance, but does not require them to do so or impose any legal consequence if they do not. *Supra* pp. 27-28.

In support of their contrary conclusion that Section 5000A now imposes a command, the lower courts focused on the word "shall" in Section 5000A(a). J.A. 422-423; Pet. App. 200a-201a. There is no doubt that

the text of Section 5000A(a), in isolation, *can* be read as a command. *See NFIB*, 567 U.S. at 562-563 (Roberts, C.J.). But a necessary premise of *NFIB* is that Congress's use of "shall" in Section 5000A(a) need not be read that way. *See, e.g.*, 567 U.S. at 570 ("§ 5000A need not be read to do more than impose a tax."). Congress was aware of the *NFIB* interpretation when it amended Section 5000A, and it "boggles the mind to suggest that Congress intended to turn a non-mandatory provision into a mandatory provision by doing away with the only means of incentivizing compliance with that provision." J.A. 472-473 (King, J., dissenting).

Even apart from *NFIB*, it is simply incorrect that the word "'shall'" is "only cognizable as a command." J.A. 425-426. While it "usually connotes a requirement," *Me. Cmty. Health Options v. United States*, 590 U.S. ___, slip op. at 12 (2020) (internal quotation marks omitted), legal writers sometimes use "'shall' to mean 'should,'" *Gutierrez de Martinez v. Lamagno*, 515 U.S. 417, 432 n.9 (1995). As the district court recognized, dictionary definitions establish that the word can be "used to express a command *or exhortation*." Pet. App. 200a (emphasis added) (quoting Webster's Third New International Dictionary 2085 (1986)); *see, e.g.*, Black's Law Dictionary 1499 (9th ed. 2009) ("shall *vb*. . . . 2. Should (as often interpreted by courts)").

And Congress has used the word "shall" as an exhortation in a number of other statutes. For example, severability clauses routinely direct that, "[i]f any provision . . . is held invalid, the remainder of the chapter shall not be affected thereby." *E.g.*, 15 U.S.C. § 719n. This Court has repeatedly instructed that such a clause is "'an aid merely; not an inexorable command.'" *Reno v. Am. Civil Liberties Union*, 521

U.S. 844, 884 n.49 (1997). Similarly, in *New York v. United States*, the Court considered an Act providing that "'[e]ach State shall be responsible for providing . . . for the disposal of . . . low-level radioactive waste'" generated within the State. 505 U.S. 144, 169 (1992) (quoting 42 U.S.C. § 2021c(a)(1)(A)). To avoid constitutional difficulties, the Court construed the statute as offering States a series of incentives to take responsibility for their waste—even though the "shall" clause, viewed "alone and in isolation," could "plausibly be understood" as "a command." *Id.* at 170.

Indeed, this Court recognized in *King v. Burwell* that Congress used "shall" as something short of a command in another provision of the ACA. The Court considered 42 U.S.C. § 18031(b)(1), which "provides that '[e]ach State shall . . . establish an American Health Benefit Exchange . . . for the State.'" *King*, 135 S. Ct. at 2489. Although that provision is "phrased as a requirement," the Court did not construe it as a command. *Id.* Instead, it read the statutory scheme as a whole as affording "each State the opportunity to establish its own Exchange" while directing that the federal government would "establish the Exchange if the State does not." *Id.* at 2485; *see also id.* at 2487 (discussing 42 U.S.C. § 18041(c)(1)). This Court's precedents thus foreclose any argument that the "only" available interpretation of Section 5000A(a) is as an unconstitutional command.

B. Section 5000A Does Not Exceed Congress's Constitutional Authority

Understood in light of *NFIB* and the TCJA amendment, Section 5000A now at most encourages Americans to purchase health insurance—without commanding them to do so or imposing any legal consequences on those who choose to forgo it. Such a

provision does not exceed Congress's constitutional authority.

1. Congress routinely adopts provisions that encourage or exhort but do not impose any enforceable requirement or mandatory duty. For example, 4 U.S.C. § 8 provides that "[n]o disrespect should be shown to the flag of the United States," and that the flag "should not be dipped to any person or thing." Other parts of the U.S. Code "encourage the domestic consumption of nutritious agricultural commodities," 42 U.S.C. § 1751, direct that "United States businesses should be encouraged to provide assistance to sub-Saharan African countries," 22 U.S.C. § 7674, and state that "[a]ll private citizens . . . are encouraged to recognize Parents' Day," 36 U.S.C. § 135(b). No one has ever seriously questioned the constitutionality of this type of precatory provision, even where it addresses a subject on which Congress could not legislate with binding effect.[14]

By enacting the TCJA and reducing the alternative tax to zero, Congress turned Section 5000A into an unobjectionable provision along the same lines. *Supra* pp. 27-28. And there can be no remaining concern that Section 5000A(a) violates the Commerce Clause by "compel[ling] individuals not engaged in commerce to purchase an unwanted product," *NFIB*, 567 U.S. at 549 (Roberts, C.J.), now that Congress has eliminated the only possible form of compulsion.

2. Section 5000A may also still be upheld as a lawful exercise of Congress's taxing powers, albeit one whose practical application is currently suspended.

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[14] To be sure, Congress could not adopt even a precatory provision if it violated one of the Constitution's express prohibitions. But Section 5000A does not contravene any such prohibition.

After the TCJA, Section 5000A retains many of the features that *NFIB* looked to in construing it as a tax. 567 U.S. at 563-564. It is still set out in the Internal Revenue Code; it still includes references to taxable income, number of dependents, and joint filing status, 26 U.S.C. § 5000A(b)(3), (c)(2), (c)(4); by its terms, it still does not apply to individuals whose household income is less than the filing threshold in the Internal Revenue Code, *id.* § 5000A(e)(2); and it still provides a statutory structure through which future "taxpayer[s]" could be directed to pay a tax, *id.* § 5000A(b).

Of course, *NFIB* also observed that "the essential feature of any tax" is that "[i]t produces at least some revenue for the Government." 567 U.S. at 564. The court below relied on that observation in holding that Section 5000A can no longer be justified under the taxing power because it does not generate revenue in current tax years. J.A. 419-420. But it did not identify any sound reason why the Constitution prohibits Congress from reducing the amount of a valid tax to zero while leaving the statutory structure for that tax on the books. That approach enables Congress to readily employ the same framework to generate revenue in future years if it chooses to do so. Preserving that option would seem to be the most sensible and efficient course, particularly in light of the budget procedures under which Congress frequently acts.[15] And the greater power to enact a statute imposing a tax

[15] For example, a future Congress could increase the amount of the tax in Section 5000A(c) using reconciliation procedures, through which the Senate may pass measures with a simple majority vote. *See generally* Heniff, Cong. Research Serv., *The Budget Reconciliation Process: The Senate's "Byrd Rule"* (Nov. 22, 2016).

surely includes a lesser power to reduce the tax to zero while leaving its structure in place.

The lower court's reasoning also ignores standard congressional practice in the tax arena. Congress routinely adopts taxes with delayed start dates or temporarily suspends the collection of certain taxes. For example, in 2010 Congress imposed a 2.3 percent excise tax on medical devices that did not become effective until the end of 2012, was collected from 2013 through 2015, suspended from 2016 through 2019, and then eliminated.[16] No one has ever contended that the tax was unconstitutional, rather than simply immaterial, in the years when it was not generating revenue. Congress also routinely imposes taxes to discourage a particular activity. *See, e.g.*, *NFIB*, 567 U.S. at 567; *United States v. Sanchez*, 340 U.S. 42, 44 (1950). And it is "beyond serious question that a tax does not cease to be valid merely because it regulates, discourages, or even *definitively deters* the activities taxed." *Sanchez*, 340 U.S. at 44 (emphasis added). Under the logic of the courts below, however, delayed or suspended taxes would be "unconstitutional" for the period they were not in effect—and a tax that succeeded in deterring an undesirable activity would become unconstitutional the moment it achieved that goal.

3. Instead of upholding Section 5000A on either of these available grounds, the courts below construed it as a command to purchase health insurance and struck it down on that basis. J.A. 426. That ignores not just the statutory construction adopted in *NFIB*,

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[16] Pub. L. No. 111-152, § 1405, 124 Stat. 1029, 1064-1065 (2010); Pub. L. No. 114-113, § 174, 129 Stat. 2242, 3071-3072 (2015); Pub. L. No. 115-120, § 4001, 132 Stat. 28, 38 (2018); Pub. L. No. 116-94, § 501, 133 Stat. 2534, 3118-3119 (2019).

but also the central lesson of that case. Courts have a "duty to construe a statute to save it, if fairly possible." *NFIB*, 567 U.S. at 574 (Roberts, C.J.). If "a statute has two possible meanings, one of which violates the Constitution, courts should adopt the meaning that does not do so." *Id.* at 562. That principle reflects a "'[p]roper respect for a coordinate branch of the government.'" *Id.* at 538; *see also Rust*, 500 U.S. at 190-191. If Section 5000A is read as presenting Americans with a choice between buying health insurance or paying a tax of zero dollars, it may be upheld either as a precatory provision or as a suspended exercise of the taxing power. That is a perfectly reasonable interpretation in light of *NFIB*—and certainly "a 'fairly possible' one." *NFIB*, 567 U.S. at 563 (Roberts, C.J.) (quoting *Crowell v. Benson*, 285 U.S. 22, 62 (1932)). The lower courts erred by instead adopting the interpretation that would render Section 5000A unconstitutional.

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

Finally, even if the TCJA had turned Section 5000A(a) into an unconstitutional command to buy health insurance, the only appropriate remedy would be the one that Congress itself effectively selected in the TCJA: making Section 5000A(a)—and only that provision—unenforceable.

Perhaps the only common ground among the participants in this case is that severability "is ultimately a question of legislative intent." 19-1019 Pet. 11; *see* U.S. C.A. Br. 36; J.A. 427 (majority opinion); *id.* at 474 (dissent); Pet. App. 208a (district court order). In some cases that question is complicated, even "nebulous." J.A. 431. Here it is simple. Congress actively debated

proposals to repeal the entire ACA or substantial parts of it; considered the costs of such a policy change to the Nation, the States, the economy, and our public health system; and rejected those proposals. Instead, it enacted a law that rendered Section 5000A(a) unenforceable by reducing the alternative tax to zero, while leaving every other provision of the ACA in place. The resulting statutory scheme establishes beyond any reasonable debate that Congress "believed the ACA could stand"—and *intended* it to stand—"in its entirety without the unenforceable coverage requirement." J.A. 474 (King, J., dissenting).

A. Congress Plainly Intended That the Rest of the ACA Would Remain in Place Even Without the Minimum Coverage Provision

"[T]he touchstone for any decision about remedy is legislative intent, for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'" *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006); *accord NFIB*, 567 U.S. at 586 (plurality opinion). Courts must "refrain from invalidating more of [a] statute than is necessary." *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion); *see also id.* at 653 ("[T]he presumption is in favor of severability."). If a court holds a statutory provision unconstitutional, it 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. Here, Congress plainly expressed its preference for an ACA without an enforceable minimum coverage provision over no ACA at all.

1. In assessing congressional intent on the question of severability, the best way to "determine[] what Congress would have done" is "by examining what it did." *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533,

560 (2001) (Scalia, J., dissenting). Examining the statutory scheme that Congress created when it amended the ACA makes this a straightforward case. The TCJA reduced to zero the amount of the alternative tax imposed by Section 5000A. That amendment "declawed the coverage requirement without repealing any other part of the ACA." J.A. 474 (King, J., dissenting). In other words, the statutory scheme currently in effect—which was adopted by both Houses of Congress and signed into law by the President—makes the minimum coverage provision effectively unenforceable while preserving the rest of the ACA.

The statutory text thus gives us "unusual insight into Congress's thinking." J.A. 481 (King, J., dissenting). It manifests "Congress' intent that" the balance of the ACA "should survive in the absence" of an enforceable minimum coverage provision, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 687 (1987), because that is precisely the way Congress arranged things. Indeed, if Congress had viewed the minimum coverage provision "as so essential to the rest of the ACA that it intended the entire statute to rise and fall" with that provision, it is "inconceivable that Congress would have" made the minimum coverage provision unenforceable while leaving the rest of the Act in place. J.A. 481 (King, J., dissenting).

2. This Court has articulated several different formulations of the severability test over the years. Under any of those formulations, the balance of the Affordable Care Act must stand following the TCJA.

Most recently, the Court framed the severability inquiry as whether it is "'evident that Congress would not have enacted those provisions which are within its

power, independently of those which are not.'" *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (brackets omitted) (quoting *Alaska Airlines*, 480 U.S. at 684); *accord NFIB*, 567 U.S. at 587 (plurality opinion). As just discussed, here it is abundantly clear that Congress wanted to keep the hundreds of other ACA provisions that are within its power without an enforceable minimum coverage provision, because that is the scheme Congress created. The Court also noted in *Murphy* that "we ask whether the law remains 'fully operative' without the invalid provisions." *Murphy*, 138 S. Ct. at 1482 (quoting *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010)). In the years since the TCJA rendered Section 5000A(a) toothless, the remaining provisions of the ACA have continued to operate as Congress intended, as petitioners and numerous amici from across the healthcare sector can attest.

Elsewhere, the Court has asked whether the remainder of a statute "will function in a *manner* consistent with the intent of Congress," explaining that "the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." *Alaska Airlines*, 480 U.S. at 685. Here, the statutory scheme that would be created in the absence of an enforceable Section 5000A(a) is functionally the same as the one that Congress *did* enact when it adopted the TCJA.

In other cases, the Court has described the severability inquiry as a three-part inquiry under which it "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." *United States v.*

Booker, 543 U.S. 220, 258-259 (2005) (internal quotation marks and citations omitted). Each part of that inquiry is satisfied here. No party contends that any provision of the ACA other than Section 5000A(a) is unconstitutional. As noted, the balance of the ACA is already functioning independently. And leaving the remaining provisions in place was the evident intent of the TCJA—which harmonizes with the ACA's basic objectives of "increas[ing] the number of Americans covered by health insurance and decreas[ing] the cost of health care." *NFIB*, 567 U.S. at 538.

Even for those who have worried that the Court's "modern severability precedents" sometimes "require[] courts to make 'a nebulous inquiry into hypothetical congressional intent,'" *Murphy*, 138 S. Ct. at 1485, 1486 (Thomas, J., concurring), this case presents no similar concern. There was nothing hypothetical about the choice that Congress made when it enacted the TCJA. After considering and rejecting several proposals that would have repealed the entire ACA or substantial parts of it, Congress instead chose to make Section 5000A unenforceable while leaving the rest of the ACA intact. The resulting statutory scheme—created through the "constitutional processes of bicameralism and presentment," *id.* at 1487—plainly establishes Congress's intent that the rest of the ACA would stand even if the minimum coverage provision fell.

B. The District Court's Severability Analysis Is Wrong in Every Respect

The district court found it "'unthinkable' and 'impossible'" that Congress would have wanted any part of the ACA to remain in place if Section 5000A(a) were invalid, Pet. App. 226a, asserting that the statutory text "unequivocal[ly]" supported that conclusion,

id. at 213a. Its analysis was flawed at every step. It focused on the intent of the wrong Congress; relied on statutory findings that have been rendered irrelevant by intervening events; misconstrued this Court's precedents; and incorrectly concluded that the Congress that zeroed out the alternative tax "had no intent with respect to" whether the rest of the ACA would remain in place if the minimum coverage provision were unenforceable. *Id.* at 228a.

1. The district court focused its analysis on the intent of the 2010 Congress that enacted the ACA in its original form. Pet. App. 208a-226a. As all three members of the panel below acknowledged, however, that approach was flawed. *See* J.A. 441 (majority opinion); *id.* at 481-482 (dissent).

When a court strikes down part of a statute that has not changed since it was first adopted, the severability inquiry focuses on the intent of the enacting Congress. *See, e.g.*, *Free Enter. Fund*, 561 U.S. at 508-510. But that is not the relevant inquiry when the original statute is held to be constitutional and a later Congress amends the statute in a way that makes a particular provision constitutionally infirm. In that situation, it makes no sense to ask what the original Congress would have preferred as a remedy had it known what the later Congress would do. The question is the intent of the Congress that created the constitutional problem—because that is the Congress that would have been confronted with the hypothetical choice of enacting "what is left of" the statutory scheme its amendment created or having "no statute at all." *Ayotte*, 546 U.S. at 330; *see, e.g.*, *Regan*, 468 U.S. at 652-655 (plurality opinion) (focusing on intent of 1958 Congress that amended provision in existing

statutory scheme regulating photographic reproductions of currency).

2. The district court's inquiry into the intent of the 2010 Congress focused on legislative findings adopted as part of the original ACA. Pet. App. 209a-213a. Those findings began by pronouncing that the minimum coverage provision "is commercial and economic in nature, and substantially affects interstate commerce." 42 U.S.C. § 18091(1); *accord* § 1501(a)(1), 124 Stat. at 242. They stated, among other things, that the provision was "essential to creating effective health insurance markets." 42 U.S.C. § 18091(2)(I); *see also id.* § 18091(2)(H), (J). The district court reasoned that those findings provided "unequivocal" evidence of the intent of the 2010 Congress on the question of severability. Pet. App. 213a. But that misunderstands the nature and purpose of the findings.

Congress frequently adopts statutory findings "to support and justify the action taken as a constitutional exertion of the legislative power." *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 (1938). Often, as here, it uses them to memorialize its judgment that a statute is within the scope of its Commerce Clause powers because the statute regulates activity that "substantially affect[s] interstate commerce." *United States v. Morrison*, 529 U.S. 598, 612 (2000). This type of finding "does not govern, and is not particularly relevant to, the different question of severability." *Florida v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1326 (11th Cir. 2011), *aff'd in part, rev'd in part on other grounds sub nom. NFIB*, 567 U.S. 519.

And whatever these findings tell us about the intent of the Congress that adopted them in 2010—before the ACA took effect and thus before it began

"creating effective health insurance markets," 42 U.S.C. § 18091(2)(I)—they tell us nothing about what a different Congress intended when it reduced the alternative tax to zero seven years later. Statutory findings "aid[] informed judicial review, as do the reports of legislative committees, by revealing the rationale of the legislation" as expressed contemporaneously by the enacting Congress. *Carolene Prods.*, 304 U.S. at 152. They do not reflect the intent of a later Congress. That is particularly so here: Each of the findings that the district court relied on explicitly referred to the "individual responsibility requirement *provided for in this section*"—*i.e.*, Section 1501 of the ACA as originally enacted. § 1501(a)(1), 124 Stat. at 242 (emphasis added). By their terms, those findings have no application to the amended Section 5000A that Congress created seven years later. What is more, this Court rendered the findings irrelevant when it held in *NFIB* that the minimum coverage provision as it was originally codified could not be sustained under the Commerce Clause. *Supra* pp. 7-8.

3. The district court also asserted that this "Court's decisions in *NFIB* and *King* . . . make clear the Individual Mandate is inseverable from the ACA." Pet. App. 220a; *see id.* at 214a-220a. That badly misreads the Court's decisions. The only opinion in *NFIB* to address the severability of the minimum coverage provision was the joint dissent. *See* 567 U.S. at 691-706 (joint dissent). The Court had no occasion to reach that issue because a majority held that the provision could be justified as part of a lawful exercise of the taxing power. In *King*, neither the majority nor the dissent had anything to say about the severability of the minimum coverage provision. *See* 135 S. Ct. at 2485-2496 (majority); *id.* at 2496-2507 (Scalia, J., dissenting).

The district court reasoned, to the contrary, that "[a]ll nine Justices to address the issue . . . agreed the Individual Mandate is inseverable from at least" the guaranteed-issue and community-rating provisions. Pet. App. 214a. It quoted extensively from portions of opinions in *NFIB* and *King* discussing the connection between the minimum coverage provision and the community-rating and guaranteed-issue requirements. *See id.* at 214a-217a. But those opinions were discussing the significance of an *enforceable* minimum coverage provision—requiring those who chose to forgo insurance to pay a substantial tax—to the *original* statutory scheme adopted by the 2010 Congress. *See, e.g.*, *King*, 135 S. Ct. at 2485-2487; *NFIB*, 567 U.S. at 547-548 (Roberts, C.J.); *id.* at 596-599 (opinion of Ginsburg, J.); *id.* at 695-696 (joint dissent). They did not address the different statutory scheme created by the 2017 Congress, which reduced the alternative tax to zero after years of observing how the healthcare markets created by the ACA actually functioned. *See infra* pp. 44-45 & n.18.

4. When it finally turned to the intent of the Congress that enacted the TCJA, the district court posited that "the 2017 Congress had no intent with respect to . . . severability." Pet. App. 228a. It then asserted that "[i]f the 2017 Congress had any relevant intent," it "must have agreed" that the minimum coverage provision was "essential to the ACA." *Id.* at 229a. Both positions are incompatible with the statutory scheme created by the TCJA—and both are contrary to every piece of historical evidence surrounding the TCJA's enactment.

The district court reasoned that the 2017 Congress must have considered the minimum coverage provision indispensable because it did not repeal Section

5000A(a), did not eliminate the legislative findings in Section 18091, and did not "repudiate or otherwise supersede" *NFIB* or *King*. Pet. App. 228a. But that litany of things that "Congress did *not* do in 2017," *id.* at 227a, provides no support for the court's severability holding. There was no need for Congress to formally strike Section 5000A(a) from the statutory text, because it understood that the TCJA "effectively repeal[ed] the individual mandate" by reducing the alternative tax to zero. 163 Cong. Rec. S8115 (daily ed. Dec. 19, 2017) (statement of Sen. Toomey). There was no need to "repeal 42 U.S.C. § 18091," Pet. App. 228a, because that section contained findings related to Congress's power under the Commerce Clause to enact the original Section 5000A, and this Court rendered those findings irrelevant when it held that Section 5000A could not be sustained on that basis, *supra* pp. 7-8, 42.[17] And there was no need to "repudiate" *NFIB* or *King*, because those cases interpreted the prior statutory scheme and did not, in any event, address the severability of the minimum coverage provision, *supra* pp. 42-43. In contrast, what Congress actually *did* do in 2017 offers dispositive evidence of its intent regarding severability: it made the minimum coverage provision unenforceable and left every other provision of the ACA in place.

The history and context surrounding the enactment of the TCJA provide further confirmation that Congress intended the minimum coverage provision to

[17] Precisely because legislative findings are understood to reflect the intent of the enacting Congress, it is not uncommon for Congress not to repeal findings that are no longer relevant. *See, e.g.*, 15 U.S.C. § 6601(a) (findings about dangers posed by "year 2000 computer date-change problems").

be severable. By 2017, Congress had been "able to observe the ACA's actual implementation" for years. J.A. 441 (King, J., dissenting). That experience had lessened any concern that, in the absence of an enforceable minimum coverage provision, "adverse selection" would undermine the functioning of the individual health insurance markets. Pet. App. 211a. And just a month before Congress adopted the TCJA, the Congressional Budget Office advised that the individual markets would "continue to be stable in almost all areas of the country throughout the coming decade" without either the "individual mandate" or its "penalty." J.A. 307.[18]

Congress was also aware by 2017 of the profound benefits produced by other provisions of the ACA. It knew, for example, that almost twelve million Americans were receiving healthcare coverage through the ACA's expansion of Medicaid and another eight million were using ACA-funded tax credits to purchase insurance through the Act's Exchanges. D.Ct. Dkt. 15-2 at 10-11; J.A. 207. It knew that the Act was directing billions of dollars to state and local governments, which used the funds to expand access to healthcare and fight emerging public health threats.

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[18] That prediction has been confirmed by experience. Individual health insurance markets have continued to function following the enactment of the TCJA. In 2019, for example, premiums for the "benchmark" plans offered through the ACA's Exchanges either fell or increased by less than five percent in most parts of the country, and overall enrollment dipped by only three percent. Bipartisan Econ. Scholars Br. 21 (Jan. 15, 2020). The ACA's other individual market reforms have proven "far more important" to the functioning of those markets than the minimum coverage provision. Council of Econ. Advisers, *Deregulating Health Insurance Markets: Value to Market Participants* at 5 (2019).

J.A. 221-227, 230-277. And it knew that more than 100 million Americans with pre-existing health conditions were benefitting from the provisions forbidding insurers from denying them coverage or charging them excessive premiums. *Id.* at 202.

To be sure, the ACA remained controversial in 2017, and many members of Congress wanted to repeal it in whole or in substantial part. Congress actively considered a number of bills that would have rescinded major provisions of the ACA. The debate over those bills was informed by evidence of the costs and benefits of the ACA. One report from the Congressional Budget Office concluded that even a partial repeal would have swelled the ranks of uninsured Americans by 32 million by 2026 and doubled premiums in the individual markets.[19] Other reports forecast that repealing the ACA would lead to thousands of additional premature deaths each year, a trillion-dollar increase in uncompensated care costs over the course of a decade, and the loss of at least 2.6 million jobs.[20] Ultimately, Congress rejected each one of the repeal proposals—sometimes in close and dramatic votes. *Supra* p. 9.

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[19] Cong. Budget Office, *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017* at 1 (2017).

[20] Pa. Budget & Policy Ctr., *Devastation, Death, and Deficits: The Impact of ACA Repeal on Pennsylvania* at 1 (2017) (rescinding Medicaid expansion and tax credits would result in 3,425 more premature deaths annually in Pennsylvania); J.A. 197 (Council of Economic Advisers estimate that ACA prevents 24,000 deaths annually); Blumberg et al., Urban Inst., *Implications of Partial Repeal of the ACA through Reconciliation* at 2 (2016) (describing increase in uncompensated care costs); Ku et al., Commonwealth Fund, *Repealing Federal Health Reform* at 4 (2017) (job-loss estimate).

When it later passed the TCJA and reduced the alternative tax to zero, Congress made abundantly clear that it did not intend to incur the profound costs that would have resulted from repealing other provisions of the ACA. That is why the text of the TCJA effectively rendered the minimum coverage provision unenforceable while preserving every other provision of the ACA. And congressional supporters repeatedly disclaimed any intent to alter any other provision, emphasizing that the TCJA would not "change any of the subsidies," 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017) (statement of Sen. Toomey); that it would "take nothing at all away from anyone who needs a subsidy, anyone who wants to continue their coverage," 163 Cong. Rec. S7666 (daily ed. Dec. 1, 2017) (statement of Sen. Scott); that "[n]o one" would be "forced off of Medicaid or a private health insurance plan," 163 Cong. Rec. S7383 (daily ed. Nov. 29, 2017) (statement of Sen. Capito); and that it would do "nothing to alter Title [I]" of the ACA, "which includes all of the insurance mandates and requirements related to preexisting conditions and essential health benefits," Finance Comm. Hearing at 106, 286 (statement of Chairman Hatch).

Had "Congress wanted to repeal the ACA through the deliberative legislative process, it could have done so." J.A. 482 (King, J., dissenting). But the circumstances here make it inconceivable that Congress would have "want[ed] a statute on which millions of people rely for their healthcare and livelihoods to disappear overnight with the wave of a judicial wand." *Id.* The district court's contrary holding makes a mockery of the legislative process through which the people's elected representatives deliberated, refused to repeal the ACA, and instead made a focused amendment to the Act. It contravenes the rule that courts

"should refrain from invalidating more of [a] statute than is necessary." *Regan*, 468 U.S. at 652 (plurality opinion). It is a "textbook" example of "judicial overreach." J.A. 489 (King, J., dissenting).

There is no need in this case for the judicial branch to reach the question of remedy at all. *Supra* pp. 17-35. But even if there were, the only remedy that would respect congressional intent would be an order making the minimum coverage provision unenforceable while leaving the rest of the Affordable Care Act in place.

CONCLUSION

The judgment of the court of appeals should be reversed.

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APPENDIX

1. U.S. Const. art. I § 8, cl. 1 provides:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States;

2. U.S. Const. art. I § 8, cl. 3 provides:

The Congress shall have Power . . . To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes;

3. 26 U.S.C. § 5000A provides:

(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.