132 S.Ct. 2566
Supreme Court of the United States
NATIONAL FEDERATION OF INDEPENDENT BUSINESS et al., Petitioners,
v.
SEBELIUS, Secretary of Health and Human Services, et al.
Department of Health and Human Services, et al., Petitioners,
v.
Florida, et al.
Florida, et al., Petitioners,
v.
Department of Health and Human Services et al.
Nos. 11–393, 11–398, 11–400.
Argued March 26, 27, 28, 2012.Decided June 28, 2012.

* * *

2666-2677 (joint dissent)

F

Seven Members of the Court agree that the Medicaid Expansion, as enacted by **2667 Congress, is unconstitutional. See Parts IV–A to IV–E, *supra*, ; Part IV–A, *ante*, at 2598 – 2607 (opinion of ROBERTS, C.J., joined by BREYER and KAGAN, JJ.). Because the Medicaid Expansion is unconstitutional, the question of remedy arises. The most natural remedy would be to invalidate the Medicaid Expansion. However, the Government proposes—in two cursory sentences at the very end of its brief—preserving the Expansion. Under its proposal, States would receive the additional Medicaid funds if they expand eligibility, but States would keep their pre-existing Medicaid funds if they do not expand eligibility. We cannot accept the Government's suggestion.

The reality that States were given no real choice but to expand Medicaid was not an accident. Congress assumed States would have no choice, and the ACA depends on States' having no choice, because its Mandate requires low-income individuals to obtain insurance many of them can afford only through the Medicaid Expansion. Furthermore, a State's withdrawal might subject everyone in the State to much higher insurance premiums. That is because the Medicaid Expansion will no longer offset the cost to the insurance *690 industry imposed by the ACA's insurance regulations and taxes, a point that is explained in more detail in the severability section below. To make the Medicaid Expansion optional despite the ACA's structure and design " 'would be to make a new law, not to enforce an old one. This is no part of our duty.' " *Trade–Mark Cases*, 100 U.S. 82, 99, 25 L.Ed. 550 (1879).

Worse, the Government's proposed remedy introduces a new dynamic: States must choose between expanding Medicaid or paying huge tax sums to the federal fisc for the sole benefit of expanding Medicaid in other States. If this divisive dynamic between and among States can be introduced at all, it should be by conscious congressional choice, not by Court-invented interpretation. We do not doubt that States are capable of making decisions when put in a tight spot. We do doubt the authority of this Court to put them there.

The Government cites a severability clause codified with Medicaid in Chapter 7 of the United States Code stating that if "any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such

provision to other persons or circumstances shall not be affected thereby." 42 U.S.C. § 1303. But that clause tells us only that other provisions in Chapter 7 should not be invalidated if § 1396c, the authorization for the cut-off of all Medicaid funds, is unconstitutional. It does not tell us that § 1396c can be judicially revised, to say what it does not say. Such a judicial power would not be called the doctrine of severability but perhaps the doctrine of amendatory invalidation—similar to the amendatory veto that permits the Governors of some States to reduce the amounts appropriated in legislation. The proof that such a power does not exist is the fact that it would not preserve other congressional dispositions, but would leave it up to the Court what the "validated" legislation will contain. The Court today opts for permitting the cut-off of only incremental Medicaid funding, but it might just as well have permitted, say, the cut-off of funds that represent *691 no more than *x* percent of the State's budget. The Court severs nothing, but simply revises § 1396c to read as the Court would desire.

We should not accept the Government's invitation to attempt to solve a constitutional problem by rewriting the Medicaid Expansion so as to allow States that reject it to retain their pre-existing Medicaid funds. Worse, the Government's remedy, **2668 now adopted by the Court, takes the ACA and this Nation in a new direction and charts a course for federalism that the Court, not the Congress, has chosen; but under the Constitution, that power and authority do not rest with this Court.

V

Severability

The Affordable Care Act seeks to achieve "near-universal" health insurance coverage. § 18091(2)(D) (2006 ed., Supp. IV). The two pillars of the Act are the Individual Mandate and the expansion of coverage under Medicaid. In our view, both these central provisions of the Act—the Individual Mandate and Medicaid Expansion—are invalid. It follows, as some of the parties urge, that all other provisions of the Act must fall as well. The following section explains the severability principles that require this conclusion. This analysis also shows how closely interrelated the Act is, and this is all the more reason why it is judicial usurpation to impose an entirely new mechanism for withdrawal of Medicaid funding, see Part IV–F, *supra,* which is one of many examples of how rewriting the Act alters its dynamics.

A

When an unconstitutional provision is but a part of a more comprehensive statute, the question arises as to the validity of the remaining provisions. The Court's authority to declare a statute partially unconstitutional has been well established since *Marbury v. Madison,* 1 Cranch 137, 2 L.Ed. 60 (1803), when the Court severed an unconstitutional provision from the Judiciary *692 Act of 1789. And while the Court has sometimes applied "at least a modest presumption in favor of ... severability," C. Nelson, Statutory Interpretation 144 (2011), it has not always done so, see, *e.g.*, *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 190–195, 119 S.Ct. 1187, 143 L.Ed.2d 270 (1999).

An automatic or too cursory severance of statutory provisions risks "rewrit [ing] a statute and giv[ing] it an effect altogether different from that sought by the measure viewed as a whole." *Railroad Retirement Bd. v. Alton R. Co.*, 295 U.S. 330, 362, 55 S.Ct. 758, 79 L.Ed. 1468 (1935). The Judiciary, if it orders uncritical severance, then assumes the legislative function; for it imposes on the Nation, by the Court's decree, its own new statutory regime, consisting of policies, risks, and duties that Congress did not enact. That can be a more extreme exercise of the judicial power than striking the whole statute and allowing Congress to address the conditions that pertained when the statute was considered at the outset.

The Court has applied a two-part guide as the framework for severability analysis. The test has been deemed "well established." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684, 107 S.Ct. 1476, 94 L.Ed.2d 661 (1987). First, if the Court holds a statutory provision unconstitutional, it then determines whether the now truncated statute will operate in the manner Congress intended. If not, the remaining provisions must be invalidated. See *id.*, at 685, 107 S.Ct. 1476. In *Alaska Airlines*, the Court clarified that this first inquiry requires more than asking whether "the balance of the legislation is incapable of functioning independently." *Id.*, at 684, 107 S.Ct. 1476. Even if the remaining provisions will operate in some coherent way, that alone does not save the statute. The question is whether the provisions will work as Congress intended. The "relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Id.*, at 685, 107 S.Ct. 1476 (emphasis **2669 in original). See also *Free Enterprise Fund v. Public Company Accounting Oversight Bd.*, 561 U.S. 477, 509, 130 S.Ct. 3138, 3161, 177 L.Ed.2d 706 (2010) (the Act "remains fully operative as a law with these tenure *693 restrictions excised" (internal quotation marks omitted)); *United States v. Booker*, 543 U.S. 220, 227, 125 S.Ct. 738, 160 L.Ed.2d 621 (2005) ("[T]wo provisions ... must be invalidated in order to allow the statute to operate in a manner consistent with congressional intent"); *Mille Lacs*, *supra*, at 194, 119 S.Ct. 1187 ("[E]mbodying as it did one coherent policy, [the entire order] is inseverable").

Second, even if the remaining provisions can operate as Congress designed them to operate, the Court must determine if Congress would have enacted them standing alone and without the unconstitutional portion. If Congress would not, those provisions, too, must be invalidated. See *Alaska Airlines*, *supra*, at 685, 107 S.Ct. 1476 ("[T]he unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted"); see also *Free Enterprise Fund*, *supra*, at 509, 130 S.Ct., at 3162 ("[N]othing in the statute's text or historical context makes it 'evident' that Congress, faced with the limitations imposed by the Constitution, would have preferred no Board at all to a Board whose members are removable at will"); *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 330, 126 S.Ct. 961, 163 L.Ed.2d 812 (2006) ("Would the legislature have preferred what is left of its statute to no statute at all"); *Denver Area Ed. Telecommunications Consortium, Inc. v. FCC*, 518 U.S. 727, 767, 116 S.Ct. 2374, 135 L.Ed.2d 888 (1996) (plurality opinion) ("Would Congress still have passed § 10(a) had it known that the remaining provisions were invalid" (internal quotation marks and brackets omitted)).

The two inquiries—whether the remaining provisions will operate as Congress designed them, and whether Congress would have enacted the remaining provisions standing alone—often are interrelated. In the ordinary course, if the remaining provisions cannot operate according to the congressional design (the first inquiry), it almost necessarily follows that Congress would not have enacted them (the second inquiry). This close interaction may explain why the Court has not always been precise in distinguishing between the *694 two. There are, however, occasions in which the severability standard's first inquiry (statutory functionality) is not a proxy for the second inquiry (whether the Legislature intended the remaining provisions to stand alone).

B

The Act was passed to enable affordable, "near-universal" health insurance coverage. 42 U.S.C. § 18091(2)(D). The resulting, complex statute consists of mandates and other requirements; comprehensive regulation and penalties; some undoubted taxes; and increases in some governmental expenditures, decreases in others. Under the severability test set out above, it must be determined if those provisions function in a coherent way and as Congress would have

intended, even when the major provisions establishing the Individual Mandate and Medicaid Expansion are themselves invalid.

Congress did not intend to establish the goal of near-universal coverage without regard to fiscal consequences. See, *e.g.*, ACA § 1563, 124 Stat. 270 ("[T]his Act will reduce the Federal deficit between 2010 and 2019"). And it did not intend to impose the inevitable costs on any one industry or group of individuals. The whole design of the Act is to balance the costs and benefits affecting each set of regulated **2670 parties. Thus, individuals are required to obtain health insurance. See 26 U.S.C. § 5000A(a). Insurance companies are required to sell them insurance regardless of patients' pre-existing conditions and to comply with a host of other regulations. And the companies must pay new taxes. See § 4980I (high-cost insurance plans); 42 U.S.C. §§ 300gg(a)(1), 300gg–4(b) (community rating); §§ 300gg–1, 300gg–3, 300gg–4(a) (guaranteed issue); § 300gg–11 (elimination of coverage limits); § 300gg–14(a) (dependent children up to age 26); ACA §§ 9010, 10905, 124 Stat. 865, 1017 (excise tax); Health Care and Education Reconciliation Act of 2010 (HCERA) § 1401, 124 Stat. 1059 (excise tax). States are expected to expand Medicaid eligibility and to create regulated marketplaces *695 called exchanges where individuals can purchase insurance. See 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII) (2006 ed., Supp. IV) (Medicaid Expansion), 18031 (exchanges). Some persons who cannot afford insurance are provided it through the Medicaid Expansion, and others are aided in their purchase of insurance through federal subsidies available on health-insurance exchanges. See 26 U.S.C. § 36B (2006 ed., Supp. IV), 42 U.S.C. § 18071 (2006 ed., Supp. IV) (federal subsidies). The Federal Government's increased spending is offset by new taxes and cuts in other federal expenditures, including reductions in Medicare and in federal payments to hospitals. See, *e.g.*, § 1395ww(r) (Medicare cuts); ACA Title IX, Subtitle A, 124 Stat. 847 ("Revenue Offset Provisions"). Employers with at least 50 employees must either provide employees with adequate health benefits or pay a financial exaction if an employee who qualifies for federal subsidies purchases insurance through an exchange. See 26 U.S.C. § 4980H (2006 ed., Supp. IV).

In short, the Act attempts to achieve near-universal health insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers—while, at the same time, offsetting significant portions of those costs with new benefits to each group. For example, the Federal Government bears the burden of paying billions for the new entitlements mandated by the Medicaid Expansion and federal subsidies for insurance purchases on the exchanges; but it benefits from reductions in the reimbursements it pays to hospitals. Hospitals lose those reimbursements; but they benefit from the decrease in uncompensated care, for under the insurance regulations it is easier for individuals with pre-existing conditions to purchase coverage that increases payments to hospitals. Insurance companies bear new costs imposed by a collection of insurance regulations and taxes, including "guaranteed issue" and "community rating" requirements to give coverage regardless of the insured's pre-existing conditions; but the insurers benefit from the *696 new, healthy purchasers who are forced by the Individual Mandate to buy the insurers' product and from the new low-income Medicaid recipients who will enroll in insurance companies' Medicaid-funded managed care programs. In summary, the Individual Mandate and Medicaid Expansion offset insurance regulations and taxes, which offset reduced reimbursements to hospitals, which offset increases in federal spending. So, the Act's major provisions are interdependent.

The Act then refers to these interdependencies as "shared responsibility." See ACA Subtitle F, Part I, 124 Stat. 242 ("Shared Responsibility"); ACA § 1501, *ibid.* (same); ACA § 1513, *id.*, at 253 (same); ACA § 4980H, *ibid.* (same). In at least six places, the Act describes the Individual

Mandate as working "together with the other provisions of this Act." 42 U.S.C. § 18091(2)(C) (2006 ed., Supp. IV) **2671 (working "together" to "add millions of new consumers to the health insurance market"); § 18091(2)(E) (working "together" to "significantly reduce" the economic cost of the poorer health and shorter lifespan of the uninsured); § 18091(2)(F) (working "together" to "lower health insurance premiums"); § 18091(2)(G) (working "together" to "improve financial security for families"); § 18091(2)(I) (working "together" to minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals"); § 18091(2)(J) (working "together" to "significantly reduce administrative costs and lower health insurance premiums"). The Act calls the Individual Mandate "an essential part" of federal regulation of health insurance and warns that "the absence of the requirement would undercut Federal regulation of the health insurance market." § 18091(2)(H).

C

One preliminary point should be noted before applying severability principles to the Act. To be sure, an argument can be made that those portions of the Act that none of the *697 parties has standing to challenge cannot be held nonseverable. The response to this argument is that our cases do not support it. See, *e.g.*, *Williams v. Standard Oil Co. of La.*, 278 U.S. 235, 242–244, 49 S.Ct. 115, 73 L.Ed. 287 (1929) (holding nonseverable statutory provisions that did not burden the parties). It would be particularly destructive of sound government to apply such a rule with regard to a multifaceted piece of legislation like the ACA. It would take years, perhaps decades, for each of its provisions to be adjudicated separately—and for some of them (those simply expending federal funds) no one may have separate standing. The Federal Government, the States, and private parties ought to know at once whether the entire legislation fails.

The opinion now explains in Part V–C–1, *infra*, why the Act's major provisions are not severable from the Mandate and Medicaid Expansion. It proceeds from the insurance regulations and taxes (C–1–a), to the reductions in reimbursements to hospitals and other Medicare reductions (C–1–b), the exchanges and their federal subsidies (C–1–c), and the employer responsibility assessment (C–1–d). Part V–C–2, *infra*, explains why the Act's minor provisions also are not severable.

1

The Act's Major Provisions

Major provisions of the Affordable Care Act—*i.e.*, the insurance regulations and taxes, the reductions in federal reimbursements to hospitals and other Medicare spending reductions, the exchanges and their federal subsidies, and the employer responsibility assessment—cannot remain once the Individual Mandate and Medicaid Expansion are invalid. That result follows from the undoubted inability of the other major provisions to operate as Congress intended without the Individual Mandate and Medicaid Expansion. Absent the invalid portions, the other major provisions could impose enormous risks of unexpected burdens on patients, the *698 health-care community, and the federal budget. That consequence would be in absolute conflict with the ACA's design of "shared responsibility," and would pose a threat to the Nation that Congress did not intend.

a

Insurance Regulations and Taxes

Without the Individual Mandate and Medicaid Expansion, the Affordable Care Act's insurance regulations and insurance taxes impose risks on insurance companies and their customers that this Court cannot measure. Those risks would undermine Congress' scheme of "shared responsibility." **2672 See 26 U.S.C. § 4980I (2006 ed., Supp. IV) (high-cost insurance plans);

42 U.S.C. §§ 300gg(a)(1) (2006 ed., Supp. IV), 300gg–4(b) (community rating); §§ 300gg–1, 300gg–3, 300gg–4(a) (guaranteed issue); § 300gg–11 (elimination of coverage limits); § 300gg–14(a) (dependent children up to age 26); ACA §§ 9010, 10905, 124 Stat. 865, 1017 (excise tax); HCERA § 1401, 124 Stat. 1059 (excise tax).

The Court has been informed by distinguished economists that the Act's Individual Mandate and Medicaid Expansion would each increase revenues to the insurance industry by about $350 billion over 10 years; that this combined figure of $700 billion is necessary to offset the approximately $700 billion in new costs to the insurance industry imposed by the Act's insurance regulations and taxes; and that the new $700–billion burden would otherwise dwarf the industry's current profit margin. See Brief for Economists as *Amici Curiae* in No. 11–393 etc. (Severability), pp. 9–16, 10a.

If that analysis is correct, the regulations and taxes will mean higher costs for insurance companies. Higher costs may mean higher premiums for consumers, despite the Act's goal of "lower[ing] health insurance premiums." 42 U.S.C. § 18091(2)(F) (2006 ed., Supp. IV). Higher costs also could threaten the survival of health-insurance companies, despite *699 the Act's goal of " effective health insurance markets." § 18091(2)(J).

The actual cost of the regulations and taxes may be more or less than predicted. What is known, however, is that severing other provisions from the Individual Mandate and Medicaid Expansion necessarily would impose significant risks and real uncertainties on insurance companies, their customers, all other major actors in the system, and the government treasury. And what also is known is this: Unnecessary risks and avoidable uncertainties are hostile to economic progress and fiscal stability and thus to the safety and welfare of the Nation and the Nation's freedom. If those risks and uncertainties are to be imposed, it must not be by the Judiciary.

b

Reductions in Reimbursements to Hospitals and Other Reductions in Medicare Expenditures

The Affordable Care Act reduces payments by the Federal Government to hospitals by more than $200 billion over 10 years. See 42 U.S.C. §§ 1395ww(b)(3)(B)(xi)-(xii) (2006 ed., Supp. IV); § 1395ww(q); § 1395ww(r); § 1396r–4(f)(7).

The concept is straightforward: Near-universal coverage will reduce uncompensated care, which will increase hospitals' revenues, which will offset the government's reductions in Medicare and Medicaid reimbursements to hospitals. Responsibility will be shared, as burdens and benefits balance each other. This is typical of the whole dynamic of the Act.

Invalidating the key mechanisms for expanding insurance coverage, such as community rating and the Medicaid Expansion, without invalidating the reductions in Medicare and Medicaid, distorts the ACA's design of "shared responsibility." Some hospitals may be forced to raise the cost of care in order to offset the reductions in reimbursements, which could raise the cost of insurance premiums, in contravention of the Act's goal of "lower[ing] health insurance premiums." *700 42 U.S.C. § 18091(2)(F) (2006 ed., Supp. IV). See also § 18091(2)(I) (goal of "lower[ing] health insurance premiums"); § 18091(2)(J) (same). Other hospitals, particularly safety-net hospitals that serve a large number of uninsured patients, may be forced to shut down. Cf. Nat. Assn. of Public **2673 Hospitals, 2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times 5–6 (Feb. 2011). Like the effect of preserving the insurance regulations and taxes, the precise degree of risk to hospitals is unknowable. It is not the proper role of the Court, by severing part of a statute and allowing the rest to stand, to impose unknowable risks that Congress could neither measure nor predict. And Congress could not have intended that result in any event.

There is a second, independent reason why the reductions in reimbursements to hospitals and the ACA's other Medicare cuts must be invalidated. The ACA's $455 billion in Medicare and Medicaid savings offset the $434–billion cost of the Medicaid Expansion. See CBO Estimate, Table 2 (Mar. 20, 2010). The reductions allowed Congress to find that the ACA "will reduce the Federal deficit between 2010 and 2019" and "will continue to reduce budget deficits after 2019." ACA §§ 1563(a)(1), (2), 124 Stat. 270.

That finding was critical to the ACA. The Act's "shared responsibility" concept extends to the federal budget. Congress chose to offset new federal expenditures with budget cuts and tax increases. That is why the United States has explained in the course of this litigation that "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions." Memorandum in Support of Government's Motion for Summary Judgment in No. 3–10–cv–91 (DC ND Fla.), p. 41.

If the Medicare and Medicaid reductions would no longer be needed to offset the costs of the Medicaid Expansion, the reductions would no longer operate in the manner Congress *701 intended. They would lose their justification and foundation. In addition, to preserve them would be "to eliminate a significant *quid pro quo* of the legislative compromise" and create a statute Congress did not enact. *Legal Services Corporation v. Velazquez*, 531 U.S. 533, 561, 121 S.Ct. 1043, 149 L.Ed.2d 63 (2001) (SCALIA, J., dissenting). It is no secret that cutting Medicare is unpopular; and it is most improbable Congress would have done so without at least the assurance that it would render the ACA deficit-neutral. See ACA §§ 1563(a)(1), (2), 124 Stat. 270.

c

Health Insurance Exchanges and Their Federal Subsidies

The ACA requires each State to establish a health-insurance "exchange." Each exchange is a one-stop marketplace for individuals and small businesses to compare community-rated health insurance and purchase the policy of their choice. The exchanges cannot operate in the manner Congress intended if the Individual Mandate, Medicaid Expansion, and insurance regulations cannot remain in force.

The Act's design is to allocate billions of federal dollars to subsidize individuals' purchases on the exchanges. Individuals with incomes between 100% and 400% of the poverty level receive tax credits to offset the cost of insurance to the individual purchaser. 26 U.S.C. § 36B (2006 ed., Supp. IV); 42 U.S.C. § 18071 (2006 ed., Supp. IV). By 2019, 20 million of the 24 million people who will obtain insurance through an exchange are expected to receive an average federal subsidy of $6,460 per person. See CBO, Analysis of the Major Health Care Legislation Enacted in March 2010, pp. 18–19 (Mar. 30, 2011). Without the community-rating insurance regulation, however, the average federal subsidy could be much higher; for community rating greatly lowers the enormous **2674 premiums unhealthy individuals would otherwise pay. Federal subsidies would make up much of the difference.

*702 The result would be an unintended boon to insurance companies, an unintended harm to the federal fisc, and a corresponding breakdown of the " shared responsibility" between the industry and the federal budget that Congress intended. Thus, the federal subsidies must be invalidated. In the absence of federal subsidies to purchasers, insurance companies will have little incentive to sell insurance on the exchanges. Under the ACA's scheme, few, if any, individuals would want to buy individual insurance policies outside of an exchange, because federal subsidies would be unavailable outside of an exchange. Difficulty in attracting individuals outside of the exchange would in turn motivate insurers to enter exchanges, despite the exchanges' onerous regulations.

See 42 U.S.C. § 18031. That system of incentives collapses if the federal subsidies are invalidated. Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all.

There is a second reason why, if community rating is invalidated by the Mandate and Medicaid Expansion's invalidity, exchanges cannot be implemented in a manner consistent with the Act's design. A key purpose of an exchange is to provide a marketplace of insurance options where prices are standardized regardless of the buyer's pre-existing conditions. See *ibid*. An individual who shops for insurance through an exchange will evaluate different insurance products. The products will offer different benefits and prices. Congress designed the exchanges so the shopper can compare benefits and prices. But the comparison cannot be made in the way Congress designed if the prices depend on the shopper's pre-existing health conditions. The prices would vary from person to person. So without community rating—which prohibits insurers from basing the price of insurance *703 on pre-existing conditions—the exchanges cannot operate in the manner Congress intended.

d

Employer–Responsibility Assessment

The employer responsibility assessment provides an incentive for employers with at least 50 employees to provide their employees with health insurance options that meet minimum criteria. See 26 U.S.C. § 4980H (2006 ed., Supp. IV). Unlike the Individual Mandate, the employer-responsibility assessment does not require employers to provide an insurance option. Instead, it requires them to make a payment to the Federal Government if they do not offer insurance to employees and if insurance is bought on an exchange by an employee who qualifies for the exchange's federal subsidies. See *ibid.*

For two reasons, the employer-responsibility assessment must be invalidated. First, the ACA makes a direct link between the employer-responsibility assessment and the exchanges. The financial assessment against employers occurs only under certain conditions. One of them is the purchase of insurance by an employee on an exchange. With no exchanges, there are no purchases on the exchanges; and with no purchases on the exchanges, there is nothing to trigger the employer-responsibility assessment.

Second, after the invalidation of burdens on individuals (the Individual Mandate), insurers (the insurance regulations and taxes), States (the Medicaid Expansion), the Federal Government (the federal subsidies **2675 for exchanges and for the Medicaid Expansion), and hospitals (the reductions in reimbursements), the preservation of the employer-responsibility assessment would upset the ACA's design of “shared responsibility.” It would leave employers as the only parties bearing any significant responsibility. That was not the congressional intent.

2

***704 The Act's Minor Provisions**

The next question is whether the invalidation of the ACA's major provisions requires the Court to invalidate the ACA's other provisions. It does.

The ACA is over 900 pages long. Its regulations include requirements ranging from a break time and secluded place at work for nursing mothers, see 29 U.S.C. § 207(r)(1) (2006 ed., Supp. IV), to displays of nutritional content at chain restaurants, see 21 U.S.C. § 343(q)(5)(H) (2006 ed., Supp. IV). The Act raises billions of dollars in taxes and fees, including exactions imposed on high-income taxpayers, see ACA §§ 9015, 10906, 124 Stat. 870, 1020; HCERA § 1402, medical

devices, see 26 U.S.C. § 4191 (2006 ed., Supp. IV), and tanning booths, see § 5000B. It spends government money on, among other things, the study of how to spend less government money. 42 U.S.C. § 1315a (2006 ed., Supp. IV). And it includes a number of provisions that provide benefits to the State of a particular legislator. For example, § 10323, 124 Stat. 954, extends Medicare coverage to individuals exposed to asbestos from a mine in Libby, Montana. Another provision, § 2006, *id.*, at 284, increases Medicaid payments only in Louisiana.

Such provisions validate the Senate Majority Leader's statement, " 'I don't know if there is a senator that doesn't have something in this bill that was important to them.... [And] if they don't have something in it important to them, then it doesn't speak well of them. That's what this legislation is all about: It's the art of compromise.' " Pear, In Health Bill for Everyone, Provisions for a Few, N.Y. Times, Jan. 4, 2010, p. A10 (quoting Sen. Reid). Often, a minor provision will be the price paid for support of a major provision. So, if the major provision were unconstitutional, Congress would not have passed the minor one.

*705 Without the ACA's major provisions, many of these minor provisions will not operate in the manner Congress intended. For example, the tax increases are "Revenue Offset Provisions" designed to help offset the cost to the Federal Government of programs like the Medicaid Expansion and the exchanges' federal subsidies. See Title IX, Subtitle A—Revenue Offset Provisions, 124 Stat. 847. With the Medicaid Expansion and the exchanges invalidated, the tax increases no longer operate to offset costs, and they no longer serve the purpose in the Act's scheme of "shared responsibility" that Congress intended.

Some provisions, such as requiring chain restaurants to display nutritional content, appear likely to operate as Congress intended, but they fail the second test for severability. There is no reason to believe that Congress would have enacted them independently. The Court has not previously had occasion to consider severability in the context of an omnibus enactment like the ACA, which includes not only many provisions that are ancillary to its central provisions but also many that are entirely unrelated—hitched on because it was a quick way to get them passed despite opposition, or because their proponents could exact their enactment as the *quid pro quo* for their needed support. When we are confronted with such a so-called "Christmas tree," a law to which many nongermane ornaments have been attached, we think the proper rule must be **2676 that when the tree no longer exists the ornaments are superfluous. We have no reliable basis for knowing which pieces of the Act would have passed on their own. It is certain that many of them would not have, and it is not a proper function of this Court to guess which. To sever the statute in that manner " 'would be to make a new law, not to enforce an old one. This is not part of our duty.' " *Trade–Mark Cases*, 100 U.S., at 99.

This Court must not impose risks unintended by Congress or produce legislation Congress may have lacked the support *706 to enact. For those reasons, the unconstitutionality of both the Individual Mandate and the Medicaid Expansion requires the invalidation of the Affordable Care Act's other provisions.

* * *