IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
HATTIESBURG DIVISION

LT. GOV. PHIL BRYANT et al., Plaintiffs, v. ERIC H. HOLDER, JR., in his official capacity as Attorney General of the United States, et al., Defendants.	)	Civil Action No. 2:10-cv-76-KS-MTP

MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Beginning in 2014, the Patient Protection and Affordable Care Act will prohibit insurance companies from taking into account any individual's medical status or medical history when making enrollment decisions or when setting the cost of premiums. Despite that future prohibition, plaintiffs here speculate that another provision of the Affordable Care Act – the minimum coverage provision, 26 U.S.C. § 5000A, which will also go into effect in 2014 – will violate an asserted constitutional right to medical privacy, under a theory that, if plaintiffs were to comply with the provision, plaintiffs would be unable to obtain health coverage without disclosing private medical information.

Plaintiffs' claim fails as a matter of law. The minimum coverage provision will require all nonexempt individuals either to maintain a certain level of health coverage, whether through employer-sponsored plans or government programs or through individual plans, or to pay a tax penalty. Nothing in the text of the provision requires individuals to disclose private medical information to prospective insurers (or, for that matter, to obtain insurance at all rather than pay the penalty). Nor have plaintiffs established that, despite the absence of any textual basis for their claim, all sources from which they might obtain qualifying health coverage for 2014 or later years would in fact require them to disclose private medical information as a condition of their enrollment. Plaintiffs simply assume that all insurers offering coverage for 2014 or later years will require such disclosures as a condition of enrollment even though the Act will place new prohibitions on those same insurers, beginning that same year, which will prevent the insurers from considering such information when enrolling people in their plans or setting rates.

Plaintiffs cannot prevail in their claim based on nothing more than an unsupported

assumption. And because none of the relevant statutory provisions will go into effect until 2014, plaintiffs cannot even hope to muster evidence in support of that assumption – to show that they will in fact be unable to obtain new coverage or maintain existing coverage for 2014 without disclosing private medical information – until shortly before 2014, when enrollment in a 2014 plan will become possible. As a result, plaintiffs have failed to establish an injury-in-fact caused by the minimum coverage provision, much less one that stems from the actions of defendants rather than the independent (and as-yet unknown) decisions of third party insurers not before the Court. For similar reasons, plaintiffs' medical privacy claim is unripe.

Moreover, should the Court reach the merits, plaintiffs' medical privacy claim would fail there as well. Even if the uncertainties described above do not create jurisdictional problems, they at least make clear that, if an insurance company were to require potential enrollees to disclose private medical information as a condition of enrollment, the requirement would not derive from the Affordable Care Act, which – far from requiring that medical information be collected – in fact prohibits insurers from taking such information into account when making enrollment decisions. An insurance company's independent decision to collect private medical information at enrollment, despite the statutory prohibitions on what any such information could be used for, could not be fairly attributed to the government and thus would not qualify as government action at all. In addition, existing precedent makes clear that any constitutional right to informational privacy would not be violated by routine disclosures of medical information to insurers, particularly where another federal statute – the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") – imposes safeguards on insurers' use or further dissemination of private health information. Because plaintiffs cannot prevail as a matter of law,

defendants request that this Court enter summary judgment in defendants' favor.

STATUTORY BACKGROUND

Prior to Congress's enactment of the Affordable Care Act in 2010, economists had concluded that "[t]he market for health insurance . . . is not a well-functioning market." COUNCIL OF ECONOMIC ADVISERS ("CEA"), THE ECONOMIC CASE FOR HEALTH CARE REFORM (2009) ("THE ECONOMIC CASE"), at 16 (submitted into the record for *The Economic Case for Health Reform: Hearing Before the H. Comm. on the Budget*, 111th Cong. 5 (2009), and attached hereto as Exhibit A). One reason that the insurance market has become increasingly dysfunctional is that, because medical procedures are expensive, insurers in the individual and small-group markets, absent regulation, have a strong market incentive to exclude those they deem most likely to incur expenses. *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 51-52 (2008) (statement of Mark Hall, Professor of Law and Public Health, Wake Forest University) (attached hereto as Exhibit B). Insurers thus adopted measures designed – albeit imperfectly – to "cherry-pick healthy people and to weed out those who are not as healthy," H.R. REP. NO. 111-443, pt. II, at 990 (internal quotation omitted), in an individualized review of insurance applicants' health status, a process known as "medical underwriting." The result of such practices is that individuals who cannot afford the health care services they need without insurance may be priced out of the insurance market, or denied coverage entirely, at the time they most need health care.

The Affordable Care Act includes a component designed to ensure that individuals will not be denied health coverage, or charged unaffordable rates, based on their preexisting conditions. The Act's guaranteed issue and community rating provisions prohibit insurance

companies from denying coverage to an individual or raising the individual's premiums based on the individual's medical condition or medical history. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4. These provisions first take effect for plan years on or after January 1, 2014. *See id.* § 300gg (Effective and Applicability Provisions set forth as note following statutory text).

Another provision of the Affordable Care Act requires nonexempt individuals, beginning in 2014, to maintain a minimum level of health coverage during a year or else to pay a penalty with their income taxes for that year. *See* 26 U.S.C. § 5000A. Individuals can satisfy the minimum coverage requirement through enrollment in an employer-sponsored health plan; an individual plan obtained directly from an insurance company or through new health insurance exchanges that are to be established pursuant to the Act; a grandfathered health plan; certain government-sponsored programs such as Medicare, Medicaid, or TRICARE; or similar coverage recognized by the Secretary of Health and Human Services in coordination with the Secretary of the Treasury. *Id.* § 5000A(f). In enacting the minimum coverage provision, Congress found that, among other positive effects, the provision would reduce cost-shifting by the uninsured, 42 U.S.C. § 18091(a)(2)(F), and was also "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," *id.* § 18091(a)(2)(I). Like the guaranteed issue and community rating provisions, the minimum coverage provision first takes effect in 2014. 26 U.S.C. § 5000A(a).

Nothing in the text of the minimum coverage provision, or in any of the Act's other provisions, requires individuals to provide information about their current medical condition or their medical history to insurance companies as a condition of acquiring or maintaining coverage,

nor is there any provision that requires insurance companies to collect such information. It has long been common procedure for individuals to enroll in their employer's health plan, or in a government-sponsored program such as Medicare, without providing any details about medical status or medical history. The Act brings individual plans in line with those employer- and government-sponsored options through the guaranteed issue and community rating provisions, discussed above, that prohibit insurance companies from denying coverage to an individual or raising the individual's premiums based on the individual's medical condition or medical history. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4. Coverage that conforms with these provisions will not be offered, on an individual basis or through the exchanges that the Affordable Care Act also establishes, *see* 42 U.S.C. § 18031, until the enrollment period for the 2014 plan year begins.[1]

PROCEDURAL HISTORY

Plaintiffs originally filed this action on April 2, 2010, asserting a number of constitutional challenges to the minimum coverage provision. The Court dismissed the claims asserted in plaintiffs' First Amended Petition for lack of standing. Order of Feb. 3, 2011 (ECF No. 26). Plaintiffs filed a Second Amended Petition on March 4, 2011. In their Second Amended Petition, plaintiffs assert that they "have no intention whatsoever of . . . purchasing health insurance now or in the future" and that they "intend[] to disobey the [Affordable Care Act] by failing to purchase health insurance despite the Individual Mandate." Second Am. Pet'n ¶¶ 5-6. They further assert that, although they do not intend to purchase health insurance, they are nevertheless

[1]The enrollment period for exchanges will begin, for the 2014 plan year, on October 1, 2013. 45 C.F.R. § 155.410(b) (effective May 29, 2012).

"currently arranging [their] financial affairs differently" and "making decisions to forego certain spending today, so that [they] will have the funds to pay for the penalties" set forth in 26 U.S.C. § 5000A. Second Am. Pet'n ¶ 7. Because the allegations in the Second Amended Petition are vague and internally inconsistent (among other things, plaintiffs asserted that none of them had health insurance and at the same time acknowledged that Governor Bryant actually did have health insurance), defendants sought jurisdictional discovery in regard to all plaintiffs other than Governor Bryant, and moved to dismiss certain claims on jurisdictional grounds, including all claims asserted by Governor Bryant as well as the claim that the minimum coverage provision violates plaintiffs' right to medical privacy.

The Court granted in part defendants' motion to dismiss but held that plaintiffs' assertions were sufficient to satisfy jurisdictional requirements at the pleading stage for certain claims, including plaintiffs' medical privacy claim. *See* Order of Aug. 29, 2011, at 11 (noting that this ruling "was largely determined by the standard of review and the assumption that there are, in fact, constitutional privacy issues at play here") (ECF No. 42). The Court thus allowed those claims to proceed to discovery. While discovery was underway in this case, the Supreme Court granted certiorari in another case challenging the minimum coverage provision, and this Court accordingly stayed proceedings in this action except with respect to plaintiffs' medical privacy claim, which is not raised in the case before the Supreme Court. Order of Nov. 23, 2011 (ECF No. 47).

At the time of the Court's November 23, 2011 Order, plaintiffs had not yet responded to defendants' pending discovery requests. Four plaintiffs responded shortly before the discovery deadline, but those responses were inadequate. Defendants therefore sought and were granted an

extension of the discovery deadline and, after conferring with plaintiffs, filed a motion to compel. Magistrate Judge Parker granted defendants' motion in part and ordered plaintiffs to comply with his rulings no later than April 18, 2012, indicating that failure to comply by any plaintiff could result in sanctions or the dismissal of that particular plaintiff's claims. Order of Apr. 11, 2012, at 1 (ECF No. 62). Only four of the eleven plaintiffs provided additional discovery responses.[2] There is no question that the nonresponding plaintiffs have failed to establish standing. Moreover, the four responding plaintiffs' responses are still deficient. Because plaintiffs have failed to establish the Court's jurisdiction, and because defendants are entitled to judgment as a matter of law on the merits, defendants now seek summary judgment with respect to plaintiffs' medical privacy claim.

STANDARD OF REVIEW

Summary judgment is appropriate where "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Celotex Corp. v. Catrett,* 477 U.S. 317, 322 (1986) (Rule 56 "mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a sufficient showing to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial"). Conclusory allegations, speculation, and unsubstantiated assertions are insufficient to defeat summary judgment or create a genuine issue for trial. *TIG Ins. Co. v. Sedgwick James,* 276 F.3d 754, 759 (5th Cir. 2002).

[2]Defendants are today filing a separate Motion to Dismiss pursuant to Fed. R. Civ. P. 41(b) with respect to the seven plaintiffs who, despite the Court's Order, failed to produce any responses at all.

ARGUMENT

I. PLAINTIFFS HAVE NOT MET THEIR HEIGHTENED BURDEN AT THE SUMMARY JUDGMENT STAGE TO ESTABLISH STANDING

Now that plaintiffs can no longer rely solely on the allegations pled in their Petition, they fail to meet their burden to establish subject matter jurisdiction. A plaintiff seeking to invoke a court's jurisdiction under Article III must establish (1) "an injury in fact – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical," (2) "a causal connection between the injury and the conduct complained of," and (3) that the injury is redressable by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (internal quotation omitted). A plaintiff "'must demonstrate standing for each claim he seeks to press' and 'for each form of relief' that is sought." *Davis v. FEC*, 554 U.S. 724, 734 (2008) (quoting *DaimlerChrysler Corp. v. Cuno,* 547 U.S. 332, 352 (2006)). Here, the only claim at issue – relating to plaintiffs' asserted right to medical privacy – appears in a single paragraph of plaintiffs' Second Amended Petition, where plaintiffs allege that, "by requiring Petitioners to abide by the [Affordable Care Act]'s Individual Mandate, Congress is also compelling Petitioners to fully disclose past medical conditions, habits and behaviors," and that "Congress's Individual Mandate will, by necessity, allow the compelled insurer access to Petitioners' present and future medical information of a confidential nature." Second Am. Pet'n ¶ 99. Thus, plaintiffs must establish a concrete and particularized, actual or imminent invasion of their asserted medical privacy interests, and they also must establish that any such invasion is caused by the minimum coverage provision and would be redressed if the provision were declared invalid.

This Court previously concluded that plaintiffs made sufficient allegations in their Second Amended Petition to pursue their medical privacy claim at the pleading stage, but at the same time the Court cautioned that its ruling "was largely determined by the standard of review and the assumption that there are, in fact, constitutional privacy issues at play here." Order of Aug. 19, 2011, at 11. Now at the summary judgment stage, plaintiffs "'can no longer rest on . . . mere allegations, but must set forth by affidavit or other evidence *specific facts*'" establishing that all three Article III requirements of standing are satisfied. *Ford v. NYLCare Health Plans of Gulf Coast, Inc.*, 301 F.3d 329, 332 (5th Cir. 2002) (emphasis added) (quoting *Lujan,* 504 U.S. at 561).

Defendants' repeated efforts, in discovery, to uncover any such "specific facts" that could support plaintiffs' standing have been unavailing. Given plaintiffs' steadfast refusal to support the allegations in their Second Amended Petition with actual evidence, they cannot meet their burden to establish either the injury-in-fact or the causation prong of standing at the summary judgment stage. As this Court has previously recognized, plaintiffs' theory of standing relies on two factual premises: (1) that plaintiffs will face a choice, in 2014, between either disclosing private medical information to insurance companies or paying a penalty pursuant to 26 U.S.C. § 5000A, and (2) that plaintiffs are currently rearranging their financial affairs in anticipation of paying such a penalty when it comes due, at the earliest, on April 15, 2015. *See* Order of Aug. 19, 2011, at 10-11. Plaintiffs have provided no evidence to support the first premise, and only insufficient assertions in their attempt to support the second, rendering both premises nothing more than pure speculation.

In order to establish the first premise, plaintiffs would have to prove that they could not

obtain qualifying coverage in 2014 without disclosing private medical information as a condition of enrollment. In other words, they would have to prove that, in 2014 when the minimum coverage provision goes into effect, *every* insurer that was otherwise accessible would require plaintiffs to divulge private medical information as a condition of signing up for a qualifying plan. Plaintiffs have not only failed to make this showing, but they have also failed to raise any genuine dispute of material fact on this issue. And this is so even assuming that plaintiffs' options will be limited to the individual- or small-group plan market – a fact that plaintiffs also have not established and that two plaintiffs have admitted is untrue with respect to them.[3] After all, nothing in the statutory text of the minimum coverage provision requires private insurance companies to collect confidential medical information from individuals when offering qualifying coverage, nor does it require individuals to provide such information to insurance companies as a prerequisite to plan enrollment. *See* 26 U.S.C. § 5000A.

And not only does the provision not require the disclosure of such information, but other provisions of the Act eliminate the justification that insurance companies had relied upon for requesting such information in the individual-plan market in the past. Specifically, as described

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[3]Specifically, both Governor Bryant and Richard Conrad have admitted that they and their wives currently have health coverage through their respective employers. *See* Governor Bryant's Response to Interrogatory No. 2, exhibit C, attached hereto, at 4-5; Richard Conrad's Supplemental Response to Interrogatory No. 2, exhibit D, attached hereto, at 3. These two plaintiffs therefore clearly cannot establish standing to challenge the minimum coverage provision on any ground. With respect to medical privacy in particular, these two plaintiffs cannot possibly claim that they face any "unwarranted disclosure" – which is the "injury-in-fact" relevant to medical privacy, *NASA v. Nelson*, 131 S. Ct. 746, 755 (2011) (recognizing that, to the extent any privacy interest might be deemed of constitutional significance, the interest at issue is the interest in "avoid[ing] unwarranted disclosures" of private information (internal quotation omitted)) – as a result of a provision that is not yet in effect when they have already enrolled in their health coverage independent of any requirement set forth in the Affordable Care Act.

above, the Affordable Care Act actually *prohibits* insurers, as of 2014 when the guaranteed issue and community rating requirements first go into effect, from taking into account an individual's medical status or medical history when making enrollment decisions or setting premium rates. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4.[4] Plaintiffs face a heavy burden to establish that, despite those prohibitions, *every* insurer from which they could possibly obtain health coverage in 2014 would nevertheless require information about an individual's medical status or medical history as a condition of enrollment, and that any such requirement would be, in any way, "fairly traceable" to § 5000A. Not only have they failed to meet that burden, but plaintiffs have not even established that a single insurer will require such information as a condition of enrollment for the 2014 plan year.[5] Given these uncertainties, another court has held that individuals such as plaintiffs lack standing to challenge the minimum coverage provision on this ground because they "do[] not, nor can [they] at this time, allege that [they] ha[ve] been compelled by the [Affordable Care Act] to provide personal information." *Baldwin v. Sebelius*, No. 10-1033, 2010 WL 3418436, at *4 (S.D. Cal. Aug. 27, 2010), *aff'd without specific discussion by* 654 F.3d 877

[4]It is, of course, no coincidence that the guaranteed issue and community rating requirements are scheduled to go into effect at the same time as the minimum coverage provision. As indicated above, the minimum coverage provision is itself a tool designed to help these provisions succeed. *See* 42 U.S.C. § 18091(a)(2)(I) (explaining that § 5000A, "together with the other provisions of this Act," will minimize the adverse selection that guaranteed issue and community rating would otherwise cause).

[5]In particular, in response to Requests for Production, plaintiffs failed to produce any documents that support their assertion on this point. *See* Governor Bryant's Response to Request for Production ("RFP") No. 3, ex. C at 14; Richard Conrad's Supplemental Response to RFP No. 3, ex. D at 9; Michael Shotwell's Supplemental Response to RFP No. 3, exhibit E attached hereto, at 9; Ryan Walters's Supplemental Response to RFP No. 3, exhibit F attached hereto, at 17 (indicating that Walters claims to have responsive documents but failing to produce any such documents to defendants).

(9th Cir. 2011).

Plaintiffs do no better with respect to the second premise. Indeed, Governor Bryant admits that because he has health insurance already, "he has not taken any actions to alter his finances and/or begin saving money as a result of the [minimum coverage] provision's enactment." Governor Bryant's Response to Interrogatory No. 7, ex. C at 8. While the other three responding plaintiffs claim that they have attempted to save money or decrease spending, their assertions do not satisfy their burden here to establish that they must set aside money now specifically for the purpose of paying the § 5000A penalty when it comes due, at the earliest, on April 15, 2015, and that they are in fact setting money aside for that purpose. For example, Conrad claims that he and his wife have "decreased spending, trying to save money to meet the financial burdens," but Conrad does not indicate when this effort began or how it has been implemented, nor does he identify a specific amount that he thinks he must save if he were to incur the § 5000A penalty.[6] *See* Conrad's Supplemental Response to Interrogatory No. 7, ex. D at 6. Shotwell claims that he has "set aside $200-$400" but claims it is "impossible for Plaintiff to know how much, precisely, to set aside." *See* Shotwell's Supplemental Response to Interrogatory

[6]Conrad's assertions are particularly implausible because Conrad, like Governor Bryant, already has coverage, as noted above, for which he pays approximately $2632 per year. *See* ex. D at 3. If Conrad were to stop paying his premiums, and assuming that his household income in 2014 is approximately $93,000 (the approximate combined salaries of Conrad and his wife in 2011, according to his discovery responses) and the return filing threshold for married taxpayers filing joint returns is the same in 2014 as it is in 2011 ($19,000), the penalty Conrad would owe on April 15, 2015, for the 2014 year would be approximately $740 (the greater of the flat dollar amount or a percentage of income). *See* 26 U.S.C. § 5000A(c). Thus, if it were simply a choice between the penalty and health coverage (without taking into account the risk of high health care costs that Conrad would face if he were to stop participating in his employer's plan), Conrad would pay less in 2014 without health coverage. His assertion that he must save money to pay the penalty is completely at odds with that fact.

No. 7, ex. E, at 6. Walters claims to have cut back on certain expenses but does not identify an amount he is seeking to save. *See* Walters's Supplemental Response to Interrogatory No. 7, ex. F at 10. No plaintiff has produced any documents that establish that any asserted nonspending that might have occurred was actually in anticipation of the § 5000A penalty.[7]

Without documentation, plaintiffs' contentions are at best improbable. Under the phase-in contemplated by the ACA, the annual penalty amount per nonexempt individual could be as low as $95 in 2014, $325 in 2015, and $695 in following years, depending on the taxpayer's household income and whether the taxpayer fails to maintain minimum essential coverage for himself only, or for a spouse and dependents as well. *See* 26 U.S.C. § 5000A(c).[8] At the same time, plaintiffs undoubtedly face, or can reasonably anticipate, many other expenses that exceed those amounts. For example, given that all plaintiffs except Governor Bryant claim that they will lack health coverage in 2014, they may have good reason to anticipate medical expenses that far exceed the amount of any penalty that might be assessed under § 5000A. Even if plaintiffs had established (and they have not) that their budgets are such that, while allegedly ineligible for any

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[7]*See* Governor Bryant's Response to RFP No. 2, ex. C at 13-14; Conrad's Supplemental Response to RFP No. 2, ex. D at 8; Shotwell's Supplemental Response to RFP No. 2, ex. E at 8; Walters's Supplemental Response to RFP No. 2, ex. F at 17 (indicating that Walters claims to have responsive documents but failing to produce any such documents to defendants).

[8]The amount of the potential penalty that any given plaintiff might incur in 2014, assuming that the plaintiff failed to comply with the minimum coverage provision for the duration of the year, would be the greater of the applicable "flat dollar amount" – which in 2014 would be $95 if only the plaintiff failed to maintain minimum essential coverage, up to $190 if two members of the plaintiff's household failed to comply, or up to $285 if three or more members of a plaintiff's household failed to comply – or 1% of the amount of the plaintiff's household income that exceeds the filing threshold amount for that year. In no event can the penalty exceed the amount of the national average premium for a qualified health plan with bronze level of coverage for the applicable family size involved. 26 U.S.C. § 5000A(c).

hardship exemption under the Act, they could not pay the § 5000A penalty in 2015 unless they start saving money now, they would be hard-pressed to prove that their savings will go toward a § 5000A penalty rather than toward some other expense. After all, if plaintiffs' regular income is insufficient, on its own, to cover the § 5000A penalty in 2015, it seems certain that that income is also insufficient to cover any number of other expenses. And even if plaintiffs had established that they are actually saving money, and *claimed* that this savings is intended for the penalty, such a claim, standing alone, would be tantamount to allowing plaintiffs to manufacture their own standing, which the Fifth Circuit has specifically disapproved. *See Ass'n of Cmty. Orgs. for Reform Now v. Fowler*, 178 F.3d 350, 359 (5th Cir. 1999) (holding an association could not "manufacture" its own standing by spending resources on litigation). Other courts, too, have recognized – even with respect to past actions and not something as nebulous as the situation here, where plaintiffs claim to be saving money that has not yet been spent – that "uncorroborated oral evidence" of this kind, where a plaintiff describes his own purported reasons for acting, is insufficient. *Sanner v. Bd. of Trade*, 62 F.3d 918, 924 (7th Cir. 1995) (quoting *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 746 (1975)). Defendants are therefore entitled to summary judgment because plaintiffs lack standing to pursue their claims in this action.

II. PLAINTIFFS' MEDICAL PRIVACY CLAIM IS ALSO UNRIPE

Plaintiffs have also failed to meet their burden to establish that their medical privacy claim is ripe. "'[T]he ripeness doctrine seeks to separate matters that are premature for review because the injury is speculative and may never occur, from those cases that are appropriate for federal court action.'" *Roark & Hardee LP*, 522 F.3d 533, 544 n.12 (5th Cir. 2008) (quoting

Erwin Chemerinsky, *Federal Jurisdiction* § 2.4.1 (5th ed. 2007)). As explained above, plaintiffs have not established that *every* insurer that could offer them qualifying insurance in 2014 will require the disclosure of private medical information as a condition of enrollment. Such a showing is clearly essential to plaintiffs' medical privacy claim because, if plaintiffs will be able to obtain qualifying insurance without disclosing private medical information, no disclosure – much less any conceivable invasion of medical privacy – is at issue.

But even if plaintiffs had made a genuine attempt to establish specific facts in support of their assertion on this point, they would simply be unable to do so at the present time. For, as has also been explained above, the entire framework under which insurance companies will offer individual plans for 2014 and later years, under the Affordable Care Act, will be fundamentally different from the framework that exists today. Again, the Affordable Care Act's guaranteed issue and community rating provisions, which first go into effect in 2014, will prohibit insurance companies from denying insurance to individuals or setting individual rates based on the individual's medical status or medical history. Those changes cast considerable doubt on the proposition that insurers will request medical information during the enrollment process. Certainly, nothing in the Act will require them to request such information. Simply put, plaintiffs cannot establish that all third parties in a certain category (insurance companies offering qualifying plans in the individual market) will in the future adopt policies for which there is no statutory requirement when the only certainty now is that the entire context in which those third parties operate is about to change. Plaintiffs bear the burden to establish the Court's jurisdiction, but they cannot meet that burden in the face of the uncertainties that underlie their central premise. Indeed, the Act's guaranteed issue and community rating provisions are sufficient to

establish that plaintiffs' premise, at this point, is pure speculation. This Court should therefore grant summary judgment in favor of defendants on the ground that plaintiffs' claim is unripe.

III. PLAINTIFFS' ASSERTION THAT THE MINIMUM COVERAGE PROVISION VIOLATES A CONSTITUTIONAL RIGHT TO MEDICAL PRIVACY FAILS AS A MATTER OF LAW

A. Plaintiffs Identify No Government Action that Requires Disclosure of Private Medical Information

Even if the Court determines that it has jurisdiction to consider plaintiffs' medical privacy claim, plaintiffs cannot establish a constitutional violation. Plaintiffs assert that the minimum coverage provision implicates an individual privacy right in "private and confidential medical details" because it will allegedly compel them "to fully disclose past medical conditions, habits and behaviors" and provide insurers with "access to Petitioners' present and future medical information of a confidential nature." Second Am. Pet'n. ¶ 99. As discussed above, however, the minimum coverage provision does not compel any such disclosures. Nowhere in the text of the provision is there any requirement that individuals disclose information about their medical status or history to insurance companies as a condition of enrollment, nor that insurance companies collect such information when enrolling individuals in plans. *See* 26 U.S.C. § 5000A.

Indeed, far from requiring such disclosures, the Affordable Care Act will actually bar insurance companies from denying coverage or setting premiums on the basis of an individual's medical condition or history. *See* 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4. That bar will go into effect in 2014, the very same year the minimum coverage provision goes into effect. *See id.* Given that the Act will prohibit insurance companies from using such information in order to make enrollment decisions or set premium rates, there is no reason to assume that these

companies will collect such information in the first place, and even if they were to do so, the practice certainly could not be attributed to the minimum coverage provision or any other provision of the Act. Plaintiffs' medical privacy challenge thus fails at the outset because they do not identify any government action as violating their alleged privacy interests. *See Priester v. Lowndes County*, 354 F.3d 414, 421 (5th Cir. 2004) (recognizing, in the parallel Fourteenth Amendment context, that a plaintiff "alleging the deprivation of Due Process . . . must also show that state action caused his injury"); *see also Blum v. Yaretsky*, 457 U.S. 991, 1005 (1982) (no state action where state was not responsible for nursing home decisions under challenge); *Citizens for Health v. Leavitt*, 428 F.3d 167, 182 (3d Cir. 2005) (disclosures of medical information for routine uses by private insurers did not constitute government action).

Plaintiffs nevertheless insist that insurance companies will require such disclosures. Yet their insistence is nothing more than speculation. They provide no evidence that *any* insurance company will require individuals to disclose information about their medical condition or history as a condition of enrollment in a health plan for 2014 or later plan years – much less that *all* insurance companies will do so as a result of the minimum coverage provision.[9] Thus, plaintiffs'

[9]As discussed above in connection with jurisdiction, because the statutory text is silent, and other statutory (guaranteed issue and community rating) provisions cast considerable doubt on plaintiffs' premise, the burden here is squarely on plaintiffs to establish that *all* insurance companies that would otherwise offer accessible health coverage will require disclosure of information about an individual's medical condition and medical history as a condition of enrollment. After all, the possibility that one insurance company might request such information would clearly be insufficient because, in that event, an individual could simply seek insurance from a different company. Plaintiffs' theory depends on the notion that it will be impossible to obtain health insurance in 2014 without making such disclosures. Of course, as noted above, that notion is not true even in the present context, where many individuals do obtain health coverage, through their employment or through government programs, without first providing any information about their medical condition or history. It certainly cannot be established as true in 2014, when, as described, even private individual policies cannot be denied or priced based on

apparent assumption that they will be unable to acquire or maintain health insurance in 2014 without disclosing such information has no plausible basis, much less one that they could prove by a preponderance of the evidence. *Cf. U.S. Citizens Ass'n v. Sebelius*, 754 F. Supp. 2d 903, 910 (N.D. Ohio 2010) (dismissing challenge to minimum coverage provision on privacy grounds for failure to meet plausibility standard of *Bell Atlantic Corp. v. Twombly,* 550 U.S. 544 (2007), and *Ashcroft v. Iqbal,* 129 S. Ct. 1937 (2009)), *appeal pending*, No. 11-3327 (6th Cir.). Certainly, they cannot establish government action based on a speculative possibility of something that a private actor may never do in the first place. *Cf. Blum*, 457 U.S. at 1004-05 (government action requirement is meant "to assure that constitutional standards are invoked only when it can be said that the [government] is *responsible* for the specific conduct of which the plaintiff complains. . . . a State normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State"); *Cornish v. Corr. Serv. Corp.*, 402 F.3d 545, 549 (5th Cir. 2005) (private acts may qualify as government action if government has "exert[ed] coercive power over" or significantly encouraged private entity to take such acts).

B. Even if Plaintiffs Could Establish Government Action, the Minimum Coverage Provision Meets the Supreme Court's Reasonableness Standard

Even if plaintiffs could establish that they will be forced to disclose medical information to insurers as a condition of obtaining or maintaining health insurance for 2014 and later years, and that such a disclosure will be fairly attributable to the government, their claim would still lack merit. Plaintiffs evidently seek to reference what the Fifth Circuit has called a "right to

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the individual's medical status or history.

confidentiality." *Nat'l Treasury Employees Union ("NTEU") v. U.S. Dep't of Treasury*, 25 F.3d 237, 242 (5th Cir. 1994). Under the Fifth Circuit's "right to confidentiality" analysis,"a court must weigh the government's interest in disclosure against the individual's privacy interest." *NTEU*, 25 F.3d at 242. Under the Supreme Court's recent decision in *NASA*, the government need not show that a disclosure is "necessary" or the "least restrictive means" to achieve its interest; rather, a "reasonableness" standard applies. *NASA*, 131 S. Ct. at 760-61.[10]

The Supreme Court also emphasized in *NASA* that the context of a disclosure matters. *See id.* at 757. In this regard, the Court identified two factors that it has repeatedly emphasized in its overall determination of reasonableness – (1) whether a disclosure was public or not, and (2) whether there were safeguards in place to protect any confidential information from unwarranted disclosures or use. *See id.* at 755-56 (discussing *Whalen v. Roe*, 429 U.S. 589 (1977), and *Nixon v. Adm'r of Gen. Servs.,* 433 U.S. 425 (1977)); *id.* at 761-63 (applying *Whalen* and *Nixon* to facts at hand). Here, both factors demonstrate that any disclosures at issue here would qualify as reasonable.

First, plaintiffs have not identified any specific medical information that, in their view, will be disclosed, so the contours of their alleged privacy interest remain undefined. However, one thing is certain: As this Court has already recognized, plaintiffs' claim concerns only the potential disclosure of information to insurance companies themselves. *See* Order of Aug. 29, 2011, at 11. This case therefore does not involve any complaint about *public* disclosure of

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[10]In *NASA*, the Supreme Court "assume[d], without deciding," that the challenged government conduct "implicate[s] a privacy interest of constitutional significance." *NASA*, 131 S. Ct. at 756; *see id.* at 764 (Scalia, J., concurring in judgment) (indicating that "[a] federal constitutional right to 'informational privacy' does not exist").

allegedly private information. That fact alone weighs against plaintiffs' claim.[11] Indeed, in *Whalen*, the Supreme Court specifically recognized that disclosures of medical information "to doctors, to hospital personnel, to insurance companies, and to public health agencies," are "often an essential part of modern medical practice," and thus do not constitute an impermissible invasion of privacy. *Whalen*, 429 U.S. at 602; *Fadjo v. Coon*, 633 F.2d 1172,1176 (5th Cir. 1981) (recognizing that Supreme Court in *Whalen* rejected confidentiality claim where "chances of public disclosure were minimal"); *see also Gutierrez v. Lynch*, 826 F.2d 1534, 1539 (6th Cir. 1987) (rejecting challenge to city ordinance requiring certain medical disclosures because, under *Whalen*, "legitimate requests for medical information do not constitute an invasion of the right to privacy"). The routine nature of such disclosures is highlighted by the fact that plaintiffs acknowledge that at least some of them have themselves, in the past, enrolled in health coverage and have submitted claims to insurers.[12]

Second, any private medical information that plaintiffs might provide to insurance companies would be subject to another federal law – HIPAA – that imposes strict limits on how insurance companies may use or disclose such information. *See* 42 U.S.C. §§ 1320d *et seq.*; 45 C.F.R. § 164.502; *Acara v. Banks*, 470 F.3d 569, 570-71 (5th Cir. 2006).[13] Thus, even assuming

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[11]Of course, the Fifth Circuit has recognized that even public disclosure requirements may be justified in some circumstances. *See Plante v. Gonzalez*, 575 F.2d 1119, 1133 (5th Cir. 1978) (upholding mandatory public disclosures of elected officials' financial information).

[12]*See* Bryant Response to Interrogatory No. 5, ex. C at 7; Conrad Supp. Response to Interrogatory No. 5, ex. D at 5.

[13]In addition to HIPAA, new regulations promulgated by the Department of Health and Human Services restrict information that potential enrollees would be required to provide to any exchanges established within a state, *see* 45 C.F.R. § 155.315(i) (effective May 29, 2012), and impose additional security requirements on any information that is collected, *id.* § 155.260.

insurance companies might collect private medical information during enrollment, this case would be similar to *NASA*, where the Supreme Court upheld government employee background investigations because the Privacy Act protects any private information that was gathered through these investigations from unwarranted further disclosure. *NASA*, 131 S. Ct. at 761-63 (holding that neither "[t]he 'remote possibility' of public disclosure created by these narrow [statutory] 'routine use[s],'" nor "the mere possibility that security measures [designed to protect electronically-stored information] will fail," undermined the Privacy Act's protections); *see also Nixon,* 433 U.S. at 458-59 (government archivists' review of the plaintiff's Presidential papers did not violate his privacy interests where Presidential Recordings and Materials Preservation Act "mandate[d] regulations" against "undue dissemination" and required immediate return of any "purely private" materials); *Whalen*, 429 U.S. at 600-02 (no privacy interest was implicated by a New York statute requiring the creation of an electronic state database with information about prescription drug recipients because the database did not make the information publicly available and the statute included "security provisions" intended to prevent public disclosure).

In sum, even if plaintiffs could establish that a government-compelled disclosure will take place, there is no dispute that the disclosure at issue would not be public disclosure, but would at most involve a disclosure to insurance companies that are indisputably subject to HIPAA. Thus, there would be no significant risk that the information at issue would be publicly disclosed, or that the information would be used other than for the routine and familiar uses necessary to process individuals' health insurance enrollments. On the other side of the balance, the minimum coverage provision serves undeniably legitimate government interests. *See* 42 U.S.C. § 18091(a)(2). Among other things, as discussed above, the provision was designed as a

tool that would help the Act's nondiscrimination requirements – the guaranteed issue and community rating provisions that prohibit insurance companies from denying coverage or setting rates based on an individual's medical history or current medical status – succeed. *Id.* § 18091(a)(2)(I). By requiring all nonexempt individuals to maintain health coverage, the minimum coverage provision also prevents cost-shifting by the uninsured, who as a group receive billions of dollars of health care services that they do not pay for. *Id.* § 18091(a)(2)(F). On balance, the minimum coverage provision thus qualifies as reasonable, and plaintiffs' medical privacy claim fails as a matter of law.

CONCLUSION

For the foregoing reasons, defendants therefore respectfully request that this Court grant summary judgment in their favor with respect to plaintiffs' medical privacy claim.

DATED this 1st day of May, 2012.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was served via ECF on counsel of record for plaintiffs in the above-captioned case.

Dated: May 1, 2012

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