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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Nick Coons; et al., Plaintiffs, vs. Timothy Geithner; et al., Defendants	Case No.: CV-10-1714-PHX-GMS **DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND CROSS-MOTION FOR SUMMARY JUDGMENT**

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INTRODUCTION

Plaintiffs—an individual, a doctor who alleges he participates in the Medicare program, and two United States Representatives—seek to invalidate the Patient Protection and Affordable Care Act ("ACA" or "Act"). They claim that the minimum coverage provision of the ACA—which requires all non-exempt Americans to maintain a minimum level of health insurance or pay a penalty—exceeds Congress's Commerce Clause authority. And they contend that the Independent Payment Advisory Board ("IPAB")—which is tasked with finding ways to reduce Medicare costs—is also unconstitutional. Plaintiffs are wrong on both accounts.

As an initial matter, plaintiffs lack standing to raise their claims.[1] And plaintiffs' arguments as to the Act's alleged unconstitutionality fail as a matter of law. As the Sixth Circuit recently concluded, the minimum coverage provision, which regulates the timing and method of payment for health care services, falls well within Congress's Commerce

[1] Under Local Rule 7.1(d)(2), defendants incorporate by reference the background, standing, and merits arguments addressing plaintiffs' IPAB, substantive due process, personal medical autonomy, and preemption claims contained in their response to plaintiffs' motion for preliminary injunction, *see* Defs.' Resp. Pls.' Mot. Prelim. Inj. at 2-20 ECF No. 27, and defendants' motion to dismiss and reply in support of that motion, *see* Defs.' Mot. Dismiss at 5-54 ECF No. 42; Defs.' Reply at 2-6, 23-30 ECF No. 59. The government's position is that every count of the complaint is subject to dismissal on its face for lack of jurisdiction. If this Court concludes that the complaint alleges facts sufficient to support standing, however, defendants respectfully request that the Court "defer considering the" motions for summary judgment or "allow time . . . to take discovery." Fed. R. Civ. P. 56(d)(1), (2).

In addition to moving for summary judgment on Counts I, II, III, and VII of the Second Amended Complaint, defendants move for summary judgment on plaintiffs' remaining claims -- Count IV (personal medical autonomy), Count V (substantive due process), and Count VIII (alternative preemption). Plaintiffs voluntarily dismissed Count VI of their Second Amended Complaint, *see* Pls.' Mem. at 1, ECF No. 51.

Clause power. *See Thomas More Law Center v. Obama*, __ F.3d __ (6th Cir. June 29, 2011), 2011 WL 2556039. Indeed, to uphold the provision, the Court need not make new law or alter the established allocation of authority between state and federal government; it need only apply longstanding principles recognizing congressional authority to regulate economic conduct that substantially affects interstate commerce.

Plaintiffs' claim that the IPAB violates the non-delegation doctrine is equally without merit given the detailed statutory requirements concerning its operation. The Supreme Court has upheld far broader delegations couched in far more subjective terms. Plaintiffs' other attempts to overturn the ACA—their substantive due process, personal medical autonomy, and preemption claims—are unavailing for the reasons set forth in defendants' prior briefing, *see* Mot. to Dismiss at 41-45, 53-54, ECF No. 42; *see also* Reply Mem. in Supp. of Mot. to Dismiss at 23-26, ECF No. 59.

Plaintiffs may dispute the policy judgments that Congress made in enacting the Affordable Care Act. But those judgments are reserved to the legislators elected to make them. In our democratic system, there is a strong presumption that those judgments are constitutional. Plaintiffs do not and cannot overcome that presumption. The government is therefore entitled to summary judgment.

BACKGROUND

The Affordable Care Act is a comprehensive reform of our national health care system. The Act seeks to ameliorate the crisis in the interstate market for health care services that accounts for more than 17% of the nation's gross domestic product. SMF ¶

1. Millions of people without health insurance consume many billions of dollars worth of health care services each year. *Id.* ¶ 12. They fail to pay the full cost of those services and shift the uncompensated costs of their care—totaling $43 billion in 2008—to health care providers regularly engaged in interstate commerce. *Id.* ¶ 21. Providers pass on much of this cost to insurance companies, which also operate interstate. *Id.* ¶ 23. The result is higher premiums that, in turn, make insurance unaffordable to even more people. *Id.* At the same time, insurers use restrictive underwriting practices to deny coverage or charge higher premiums to millions because they have pre-existing medical conditions. *Id.* ¶ 16. The Affordable Care Act addresses these national problems through measures designed to make affordable health care coverage widely available, protect consumers from restrictive underwriting practices, and reduce the uncompensated care that is obtained by the uninsured and paid for by other participants in the health care market.

First, the Act builds upon the existing nationwide system of employer-based health insurance, the principal private mechanism for health care financing. Congress established tax incentives for small businesses to purchase health insurance for their employees. 26 U.S.C. § 45R. It also prescribed tax penalties for large employers if the employer does not offer full-time employees adequate coverage and at least one full-time employee receives a tax credit to assist with the purchase of coverage in a health insurance exchange established under the Act. *Id.* § 4980H.

Second, the Act provides for the creation of health insurance exchanges to allow individuals, families, and small businesses to use their collective buying power to obtain

prices competitive with those of large-employer group plans. 42 U.S.C. § 18031.

Third, for individuals and families with household income between 133% and 400% of the federal poverty line who purchase health insurance through an exchange, Congress offered federal tax credits to defray the cost of premiums. 26 U.S.C. § 36B(a), (b). Congress also authorized federal payments to help cover out-of-pocket expenses such as co-payments or deductibles for eligible individuals who purchase coverage through an exchange. 42 U.S.C. § 18071. In addition, Congress expanded eligibility for Medicaid to cover individuals with income up to 133% of the federal poverty line. *Id.* § 1396a(a)(10)(A)(i)(VIII).

Fourth, the Act regulates insurers to prohibit industry practices that have prevented people from obtaining and maintaining health insurance. The Act bars insurers from refusing coverage because of pre-existing medical conditions, canceling insurance absent fraud or intentional misrepresentation of material fact, charging higher premiums based on a person's medical history, and placing lifetime dollar caps on benefits. *Id.* §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a), 300gg-11, 300gg-12.

Fifth, the minimum coverage provision at issue here will require, beginning in 2014, that non-exempted individuals maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C. § 5000A. The requirement may be satisfied through enrollment in an eligible employer-sponsored plan; an individual market plan, including one offered through a health insurance exchange; a grandfathered plan; government-sponsored programs such as Medicare, Medicaid, or TRICARE; or similar coverage as

recognized by the Secretary of Health and Human Services ("HHS") in coordination with the Treasury Secretary. *Id.* § 5000A(f)(1). Congress exempted certain groups, *id.* § 5000A(d), and made the tax penalty inapplicable to individuals whose household income is too low to require them to file a federal income tax return, whose premium payments would exceed 8% of household income, or who establish (under standards set by the HHS Secretary) that they have suffered a hardship with respect to the capacity to obtain coverage. *Id.* § 5000A(e).

In enacting the minimum coverage provision, Congress made detailed findings that establish the foundation for the exercise of its commerce power. Congress found that the minimum coverage provision "regulates activity that is commercial and economic in nature"—how people pay for services in the interstate health care market. 42 U.S.C. § 18091(a)(2)(A). Congress found that, as a class, people who "forego health insurance coverage and attempt to self-insure" fail to pay for the medical services that they consume, and shift substantial costs to providers and insured consumers, raising average family premiums by more than $1,000 a year. *Id.* § 18091(a)(2)(A), (F). In addition, Congress found that the minimum coverage requirement is "essential" to the Act's guaranteed issue and community rating reforms that will prevent insurers from relying on medical condition or history to deny coverage or set premiums. *Id.* § 18091(a)(2)(I). Congress found that, without the minimum coverage requirement, many people would exploit these new consumer protections by waiting to purchase health insurance until they needed care, which would undermine the effective functioning of insurance markets. *Id.*

The ACA also establishes an Independent Payment Advisory Board. Composed of fifteen members appointed by the President and confirmed by the Senate, the Board will be responsible for finding ways to "reduce the per capita rate of growth in Medicare spending[.]" 42 U.S.C. § 1395kkk(b). The Secretary of Health and Human Services will be required to implement the Board's recommendations on a yearly basis unless Congress passes legislation to supersede the Board's proposals. *See* 42 U.S.C. § 1395kkk(e)(3)(A).

ARGUMENT

A court should grant summary judgment 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); *see Szajer v. City of Los Angeles*, 632 F.3d 607, 610 (9th Cir. 2011). This case presents pure questions of law—primarily, whether Congress acted within its Article I powers in enacting the Affordable Care Act's minimum coverage provision and the IPAB-related provisions. Congressional acts are entitled to a "presumption of constitutionality," and will be invalidated only upon a "plain showing that Congress has exceeded its constitutional bounds." *United States v. Morrison*, 529 U.S. 598, 607 (2000). This presumption is "not a mere polite gesture" but reflects the substantial deference that a court owes the "deliberate judgment by constitutional majorities of the two Houses of Congress that an Act is within their delegated power." *United States v. Five Gambling Devices*, 346 U.S. 441, 449 (1953).

Moreover, plaintiffs bring a facial challenge to the minimum coverage provision. To prevail, plaintiffs must establish that "'no set of circumstances exists'" under which

the provision would be valid, "'*i.e.*, that the law is unconstitutional in all of its applications.'" *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (internal citation and quotation marks omitted). Unless plaintiffs can meet this heavy burden, defendants are entitled to summary judgment.

I. THE MINIMUM COVERAGE PROVISION IS A PROPER EXERCISE OF CONGRESS'S CONSTITUTIONAL AUTHORITY TO REGULATE INTERSTATE COMMERCE

A. The Minimum Coverage Provision Regulates Payment for Health Care Services, a Class of Economic Activity That Substantially Affects Interstate Commerce

The Constitution grants Congress the power to "regulate Commerce . . . among the several States," U.S. CONST. art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. This grant of authority allows Congress not only to regulate the channels and instrumentalities of interstate commerce, but also to address other conduct that "substantially affect[s] interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005). In assessing those substantial effects, Congress's focus is necessarily on the aggregate impact of a particular class of conduct. Congress need not predict whether and to what extent a particular individual in the class will contribute to that aggregate effect. *Id.* at 22; *Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942); *see also United States v. Serang*, 156 F.3d 910, 913 (9th Cir. 1998).

A Court's task in reviewing the validity of legislation enacted under the commerce power "is a modest one." *Raich*, 545 U.S. at 22. The Court "need not determine" whether the regulated activities, "taken in the aggregate, substantially affect interstate

commerce in fact, but only whether a 'rational basis' exists for so concluding." *Id.* This deferential standard reflects both Congress's superior capacity to make empirical judgments and operational choices and the appropriate structural separation between the judicial and legislative powers. The courts owe "Congress' findings deference in part because the institution is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions." *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195 (1997) (internal quotation omitted). "This is not the sum of the matter, however." *Id*. The courts "owe Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power," lest a court "infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Id*. Accordingly, in the context of a Commerce Clause challenge, this Court's task is to conduct a "narrow" inquiry into whether Congress had a "'rational basis'" for concluding that the activity it was regulating affects interstate commerce. *State of Nevada v. Skinner*, 884 F.2d 445, 450 (9th Cir. 1989).

The record supports Congress's express findings that the minimum coverage provision "regulates activity that is commercial and economic in nature," 42 U.S.C. § 18091(a)(2)(A), and has an enormous impact on interstate commerce. First, the provision addresses the consumption of health care services without paying for them, an activity that shifts billions of dollars of costs annually to other participants in the interstate health care market. 42 U.S.C. § 18091(a)(2)(F). These shifted expenses spread across state lines because many insurance companies operate in multiple states. 42

U.S.C. § 18091(a)(2)(B); *see* SMF ¶ 28. Second, the provision is instrumental to the ACA's guaranteed issue and community rating reforms that take effect in 2014. These reforms guarantee that individuals will not be denied insurance because of illness or accident, and will not have to pay higher premiums based on their health or medical history. 42 U.S.C. § 18091(a)(2)(I), (J); *see* SMF ¶¶ 37-43.

1. The minimum coverage provision regulates the practice of obtaining health care without insurance, a practice that shifts health care costs to other participants in the health care market

Without question, the market for health care services is an interstate market. *See* SMF ¶¶ 1, 3, 19-29, 37, 43. "[H]ealth-related spending amounted to 17.6% of the national economy, or $2.5 trillion, in 2009. . . . Virtually all of this market affects interstate commerce, and many aspects of it---medical supplies, drugs, and equipment---are directly linked to interstate commerce." *Thomas More Law Ctr. v. Obama*, No. 10-2388, 2011 WL 2556039, at *24 (6th Cir. June 29, 2011) (Sutton, J.), *petition for cert. filed*, (U.S. July 26, 2011) (No. 11-117); *see* SMF ¶¶ 1, 28. Moreover, "[t]he medical insurance market is large . . . and is inextricably linked to interstate commerce." *Thomas More Law Ctr.*, 2011 WL 2556039, at *24 (Sutton, J.).

There is also no doubt that Americans, whether or not they have health insurance, visit doctors and seek medical treatment. *See* SMF ¶¶ 3-4, 7, 12-15, 19. Indeed, "[f]ew people escape the need to obtain health care at some point in their lives, and most need it regularly." *Thomas More*, 2011 WL 2556039, at *24 (Sutton, J.). Because health care is so expensive that most uninsured individuals cannot afford to pay for all the care they

receive, however, the uninsured, as a class, do not bear the full cost of their participation in the health care market, instead passing significant costs on to others. SMF ¶¶ 12-15, 19-24, 28. Congress's express statutory findings quantify the effect of this cost-shifting on interstate commerce: The uninsured received $43 billion in medical care that they did not pay for in 2008 alone. 42 U.S.C. § 18091(a)(2)(F); *see* SMF ¶ 21. Congress's findings also describe how this activity affects the interstate health care market; the costs of care that the uninsured receive are passed from providers "to private insurers, which pass on the cost to families" in a direct way, by inflating their insurance premiums "by on average over $1,000 a year." *Id.*; *see also* FAMILIES USA, HIDDEN HEALTH TAX, at 2, 6. *See Mead v. Holder*, 766 F. Supp. 2d 16, 34 n.10 (D.D.C. 2011), *appeal pending*, No. 11-5047 (D.C. Cir.) ("In short, those who choose not to purchase health insurance will ultimately get a 'free ride' on the backs of those Americans who have made responsible choices to provide for the illness we all must face at some point in our lives."); *see also* SMF ¶¶ 19-24, 27.

"The minimum coverage provision regulates activity that is decidedly economic." *Thomas More*, 2011 WL 2556039, at *11 (Martin, J.). "By requiring individuals to maintain a certain level of coverage, the minimum coverage provision regulates the financing of health care services, and specifically the practice of self-insuring for the cost of care." *Id.* "The activity of foregoing health insurance and attempting to cover the cost of health care needs by self-insuring is no less economic than the activity of purchasing an insurance plan." *Id.*

To be sure, not every uninsured person will shift health care costs to others in any given year. But millions will do so each year, and the cumulative impact of such cost-shifting is to impose a multi-billion dollar annual burden on interstate commerce. *See Thomas More*, 2011 WL 2556039, at *12 (Martin, J.) (observing that "[t]he uninsured cannot avoid the need for health care, and [] consume over $100 billion in health care services annually"); *see also* SMF ¶¶ 19-24. Supreme Court precedent makes clear that the validity of a regulation under the Commerce Clause does not turn on a specific person's actual conduct or circumstance. Nor does Congress have to wait until an individual engages in particular conduct and then try to deal with the consequences. Rather, Congress can exercise its commerce power to address the aggregate effect of a class of conduct, taking into account the "likelihood" that a particular activity will impact the relevant interstate market, given the way that the particular market operates. *Raich*, 545 U.S. at 19. In that way, Congress has authority to prevent an individual from contributing to the consequences that it has, in its legislative judgment, predicted might occur absent regulation. *See Turner Broad. Sys., Inc.*, 520 U.S. at 195 ("[C]ourts must accord substantial deference to the predictive judgments of Congress.").

Thus, in *Wickard* and *Raich*, the Court did not examine whether any particular plaintiff's consumption of home-grown wheat or home-grown marijuana, respectively, had any impact at all on the interstate markets for those commodities; the important point, in *Wickard*, was that "rising market prices *could* draw [home-grown] wheat into the interstate market, resulting in lower market prices." *Raich*, 545 U.S. at 19 (emphasis

added) (citing *Wickard*, 317 U.S. at 128). The parallel concern in *Raich* was "the *likelihood* that the high demand in the interstate market will draw [home-grown] marijuana into that market." *Id.* (emphasis added). In both cases, the Court recognized that these market probabilities could rationally lead Congress to conclude that the conduct at issue, "when viewed in the aggregate," would, if left unregulated, have a substantial impact on the interstate markets. *Id*. at 19.

Congress therefore need not predict, person-by-person, who among the uninsured will receive medical services and fail to pay in a given year. As a class, people who forego insurance and attempt to "self-insure" pose a threat to the interstate health care services market. *See Thomas More*, 2011 WL 2556039, at *31 (Sutton, J.) (explaining that "Congress generally has broad authority under the commerce power to choose the class of people it wishes to regulate, *see Raich*, 545 U.S. at 26-27, permitting it to group all of the self-insured together, whether they have many assets available for medical care, very few, or something in between, particularly since the financial wherewithal of the self-insured is unlikely to stay put"); *see also* SMF ¶¶ 19-24, 36. The Supreme Court has repeatedly held that where "Congress decides that the 'total incidence' of a practice,"—here, the practice of attempting to pay for health care without insurance—"poses a threat to a national market, it may regulate the entire class." *Raich*, 545 U.S. at 17 (quoting *Perez v. United States*, 402 U.S. 146, 154-55 (1971)).

2. The minimum coverage provision is essential to the Act's guaranteed issue and community rating insurance reforms

The minimum coverage provision is also valid Commerce Clause legislation because it "is an essential part of a broader economic regulatory scheme," which requires that insurers extend coverage and set premiums without regard to pre-existing medical conditions or medical history. *Thomas More*, 2011 WL 2556039, at *12 (Martin, J.). Congress's "guaranteed issue" and "community rating" regulations of the health insurance industry are, without question, valid exercises of its commerce power. *See id.* at *13 (Martin, J.). And learning from the experience of state regulators, Congress recognized that these insurance industry regulations could not succeed if participants in the health care market could wait to buy insurance until an acute medical need arises. *See* SMF ¶¶ 37-43. Congress accordingly concluded that its failure to include a minimum coverage requirement "would leave a gaping hole" in the regulatory scheme. *Raich*, 545 U.S. at 22; *see Thomas More*, 2011 WL 2556039, at *14 (Martin, J.) (explaining that it "was reasonable for Congress to conclude that failing to regulate those who self-insure would 'leave a gaping hole' in the Act"). Thus, even if the means of payment for health care services were not regarded as "commercial," Congress may properly regulate based on its conclusion that the "failure to regulate that class of activity would undercut the regulation of the interstate market[.]" *Raich*, 545 U.S. at 18; *see also id.* at 37-38 (Scalia, J., concurring in the judgment); *Thomas More*, 2011 WL 2556039, at *12 ("[E]ven if self-insuring the cost of health care were not economic activity with a substantial effect on interstate commerce, Congress could still properly regulate the

practice because the failure to do so would undercut its regulation of the larger interstate markets in health care delivery and health insurance.") (Martin, J.).

Although crucial to a consumer's ability to pay for health care, affordable health insurance is in increasingly short supply. SMF ¶¶ 23-26. Between 1999 and 2010, average premiums for employer-sponsored family coverage increased 138 percent. SMF ¶ 25 (citing KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 31, tbl 1.11 (2010)). These "[p]remium increases are driving people out of the insurance market." *47 Million & Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Fin.*, 110th Cong. 49 (2008) (Statement of Prof. Hall); SMF ¶ 24. As a result, between 2000 and 2009, the portion of the non-Medicare-eligible population covered by private insurance slipped from about 3/4 to about 2/3. SMF ¶ 25 (citing John Holahan, *The 2007-09 Recession and Health Insurance Coverage*, 30 HEALTH AFFAIRS 145, 148 (2011)). More than 50 million Americans went without insurance in 2009. *See* SMF ¶ 12 (citing U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 23, Table 8) (2010).

These trends are largely due to an insurance industry screening process known as "medical underwriting," a practice that makes health insurance difficult or impossible to obtain for the 50 to 129 million non-elderly Americans who have at least one pre-existing medical condition. SMF ¶¶ 16-18. Medical underwriting also increases premiums even for those who do obtain commercial insurance because of the high costs of the underwriting process itself. The Act addresses these problems by barring insurance

companies from denying coverage or setting premiums based on an individual's medical condition or history. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3(a), 300gg-4(a). But these guaranteed issue and community rating requirements would not work in a regulatory scheme that permits health care consumers to time their insurance purchases. *See* SMF ¶¶ 37-43. Indeed, a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." *Id.* ¶ 43 (quoting *47 Million & Counting*, 110th Cong. 52 (Prof. Hall)).

Congress found that, absent the minimum coverage provision, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(a)(2)(I). Accordingly, Congress concluded, the minimum coverage requirement "is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." *Id.* § 18091(a)(2)(J). The legislative record showed that the absence of a minimum coverage requirement had undermined guaranteed issue and community rating reform efforts in states such as New Jersey and New York. SMF ¶¶ 40-41. In these circumstances, many consumers "will go without insurance when they are healthy, but then have the privilege of throwing themselves on the mercy of community-rated premiums when they fall ill." *Id.* ¶ 39 (quoting *Making Health Care Work for American Families: Improving Access to Care: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Health*, 111th Cong. 11 (2009) (Prof. Reinhardt)). This in turn causes premiums to go up, which results in still fewer people getting health insurance. *Id.* ¶¶ 39-40. Describing the results of the

New Jersey reforms, Professor Reinhardt explained that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." *Id.* ¶ 40; *see also* Alan C. Monheit, et al., *Community Rating & Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFFAIRS 167, 168 (2004).

In the wake of similar legislation enacted in New York, there was "a dramatic exodus of indemnity insurers from New York's individual market." *Id.* ¶ 41 (quoting Mark Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POL., POL'Y & L. 71, 91-92 (2000)). And, when Maine enacted similar legislation, most health insurers withdrew from the state. *See id.* ¶ 41 (citing *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 117 (2009) (letter of Phil Caper, M.D., & Joe Lendvai)).

In contrast, Congress found that Massachusetts avoided some of these perils by enacting a minimum coverage provision as part of its broader insurance reforms. SMF ¶ 42. That provision "has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased." 42 U.S.C. § 18091(a)(2)(D); *see* SMF ¶ 42. But Massachusetts itself attests that the "interstate flow of patients (including uninsured patients) [illustrates] that individual states cannot effectively account for, let alone mitigate, the impact of healthcare trends felt on the national and interstate levels." Br. of the Commonwealth of Massachusetts as Amicus Curiae in Support of Appellants at 13, *State of Florida v. U.S.*

Dep't of Health & Human Servs., No. 11-11021 (11th Cir. filed Apr. 11, 2011); *see* SMF ¶ 42. The record thus fully supports the congressional finding that, given the national insurance reforms that it sought to make, a nationwide minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(a)(2)(I); *see Thomas More*, 2011 WL 2556039, at *14 ("Congress had a rational basis for concluding that the minimum coverage requirement is essential to its broader reforms to the national markets in health care delivery and health insurance."); *see also Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 634 (W.D. Va. 2010), *appeal pending*, No. 10-2347 (4th Cir.) (same); SMF ¶¶ 28-43.

B. The Minimum Coverage Provision Is a Necessary and Proper Means of Regulating Interstate Commerce

1. Courts accord broad deference to the means adopted by Congress to advance legitimate regulatory goals

Plaintiffs do not dispute Congress's conclusion that, in general, people who obtain health care services without insurance shift substantial costs to other market participants. Nor have they disputed the notion that the minimum coverage provision is essential to the Affordable Care Act's broader regulatory scheme. Nor has any court concluded that Congress's findings were irrational. Instead, plaintiffs and others who have opposed the minimum coverage provision complain of the means that Congress chose to regulate payment in the interstate market for health care services. No proper basis exists,

however, to override Congress's judgment about the appropriate means to achieve its legitimate regulatory objectives.

"The Federal 'Government is acknowledged by all to be one of enumerated powers,'" but, "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch v. Maryland*, 17 U.S. 316, 405, 408 (1819)). Accordingly, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

Thus, "the relevant inquiry" under the Necessary and Proper Clause "is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment)). "[I]n determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court asks "whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956 (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Raich*, 545 U.S. at 22; *United States v. Lopez*, 514 U.S. 549, 557 (1995); and *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 (1981)).

2. The minimum coverage requirement is plainly adapted to the unique conditions of the market for health care services

Contrary to plaintiffs' assertions, *see* Pls.' Mem. at 28, the means chosen by Congress to effectuate the Affordable Care Act's regulatory goals are closely tailored to the unique features of the market for health care services. SMF ¶¶ 3-18, 28-43. Participation in this market is essentially universal. *Id.* ¶ 3. The need for medical treatment may arise unexpectedly, and is not a matter of choice. *Id.* ¶ 4, 7. The cost of care, absent insurance, may overwhelm the typical family budget. *Id.* ¶ 4-7. And—unlike in other markets, including the markets for transportation or courier services, *see* Pls.' Mem. at 22—individuals can expect to receive expensive medical services in times of need without regard to their ability to pay. *See Thomas More*, 2011 WL 2556039, at *32 ("Regulating how citizens pay for what they already receive (health care), never quite know when they will need, and in the case of severe illnesses or emergencies generally will not be able to afford, has few (if any) parallels in modern life." (Sutton, J.)); *see also* SMF ¶¶ 10-15.

A government requirement to purchase insurance in order to avoid the externalization of costs is hardly novel. Indeed, insurance requirements are commonplace in the United States Code. *See, e.g.*, 49 U.S.C. § 13906(a)(1) (interstate motor carriers). In the case of vehicle insurance, the requirement typically coincides with the obligation to register one's automobile. But, while it is sensible for the government to make automobile insurance a condition for use of the highways, it would be entirely unacceptable to impose a similar requirement on the use of an emergency room. For,

although "'society feels no obligation to repair'" the Porsche of the uninsured motorist, "'[i]f a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance," even if that means "more prudent citizens end up paying the tab.'" SMF ¶ 14 (quoting Stuart Butler, *The Heritage Lectures 218: Assuring Affordable Health Care for All Americans*, at 6 (Heritage Found. 1989)).

Even before the enactment of the Emergency Medical Treatment and Labor Act ("EMTALA") in 1986, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. *Id.* ¶ 13-14. The common law has evolved to preclude hospitals from turning away patients with emergency needs because they will be unable to pay for services. *See id.* The modern rule is that "liability on the part of [the] hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency." *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists[.]" H.R. REP. NO. 99-241, pt. III, at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727; *see also Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975) (noting that the State of Arizona requires Samaritan and other private health care providers to provide necessary emergency medical services to all patients regardless of their ability to pay).

These measures were not adequate, however, to prevent hospitals from diverting patients or discharging them prematurely. Congress thus enacted EMTALA to end the practice of "patient dumping" by "ensur[ing] that individuals, regardless of their ability to pay, receive adequate emergency medical care," *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1165 (9th Cir. 2002); *cf.* H.R. REP. NO. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 605. The federal statute augmented the duties imposed under state law by requiring all hospitals that participate in Medicare and offer emergency services to stabilize anyone entering the emergency room with an emergency condition, without regard to ability to pay. 42 U.S.C. § 1395dd. Of course, after these individuals are stabilized, they are billed, and people may then go into debt or be driven into bankruptcy as a result of this or other expensive treatment, and any unpaid expenses are shifted elsewhere in the market. SMF ¶¶ 15-24.

Congress properly adapted the minimum coverage provision to these practical realities of the national health care market. Most significantly, as noted, with health insurance, timing is critical. The societal judgment reflected in both EMTALA and the common law is that it would be unconscionable to deny emergency medical care to someone without insurance. Congress therefore could not ethically have tied an insurance requirement to the availability of emergency medical care at the time it is received.[2] Moreover, from a purely economic standpoint, a health insurance market could never survive "'if people could simply buy their insurance on the way to the

[2] Nor could such a requirement work as a practical matter, given the risk that even individuals who had insurance might be turned away at the emergency room door if they were required to present proof of insurance and did not happen to have it on their person.

hospital.'" *Id.* ¶ 43 (quoting *47 Million and Counting*, 110th Cong. 14 (statement of Prof. Hall)). Insurance is a means of financing economic risk, and to be practical and ethical, a requirement to obtain medical insurance must therefore apply before the medical services are actually needed.

3. Congress can regulate participants in the national health care market, even if they do not currently maintain insurance coverage

Plaintiffs' claim is that Congress may not force an ostensibly passive individual to purchase insurance. Pls.' Mem. at 25. Their claim disregards the nature of the regulatory scheme that Congress enacted. Plaintiffs cannot dispute that "the individuals subject to [the minimum coverage provision] are either present or future participants in the national health care market." *Mead*, 766 F. Supp. 2d at 36. Indeed, as the Sixth Circuit concluded, whether individuals decide to purchase private health insurance or self-insure, "[n]o one is inactive when deciding how to pay for health care." *Thomas More*, 2011 WL 2556039, at *29 (Sutton, J.). Accordingly, Congress may regulate the economic conduct of participants in the health care market, even if at a given moment those participants are not signed up to finance their health care expenses through insurance.

Plaintiffs' theory restates arguments that have been repeatedly rejected by the Supreme Court. In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana that was grown at home for personal use. The Supreme Court found it irrelevant that the plaintiffs were not engaged in commercial activity and that they did not buy, sell, or distribute any portion of the marijuana that they possessed. The regulation was proper, the Court held, because "Congress had a rational

basis for concluding that leaving home-consumed marijuana outside federal control would . . . affect price and market conditions." *Raich*, 545 U.S. at 19. And that rational basis did not rest on the plaintiffs' own conduct but on the market's structural forces that created a "likelihood" that the plaintiffs would be drawn into an interstate market regardless of their stated intent. *Id.* at 18. Under that structure, the plaintiffs' marijuana was "never more than an instant from the interstate market." *Id.* at 40 (Scalia, J., concurring in judgment). In the aggregate, the failure to regulate home consumption such as the plaintiffs' would have a "substantial effect on supply and demand in the national market for that commodity." *Id.* at 19.

Raich reflected principles established more than half a century earlier in *Wickard*, which upheld the federal regulation of wheat that was grown and consumed on a family farm as part of a program to control the volume and price of wheat moving in interstate commerce. The Supreme Court sustained that exercise of the commerce power even though the wheat at issue was not "sold or intended to be sold," *Wickard*, 317 U.S. at 119, even though the home consumption of wheat by any individual "may be trivial by itself," *id*. at 127, and even though the regulation "forc[ed] some farmers into the market to buy what they could provide for themselves," *id.* at 129.

"While the unique nature of the market for health care and the breadth of the Act present a novel set of facts for consideration, the well-settled principles expounded in *Raich* and *Wickard* control the disposition of this claim." *Liberty Univ. Inc.*, 753 F. Supp. 2d at 633. The plaintiffs in *Raich* and *Wickard* could not exempt themselves from

regulation by declaring themselves to be "inactive" in a market, where the category of behavior that they were engaged in had concrete effects on the larger interstate market.[3] Similarly, the claim that an uninsured individual is "inactive" ignores that health insurance is not a stand-alone consumer product, but instead is the principal means of financing participation in the health care market. "Regardless of whether one relies on an insurance policy, one's savings, or the backstop of free or reduced-cost emergency room services, one has made a choice regarding the method of payment for the health care services one expects to receive." *Liberty Univ. Inc.*, 753 F. Supp. 2d at 633.

Even if the uninsured population does not currently participate in the health *insurance* market (though any given individual likely had or will have insurance in the near past or future),[4] it indisputably participates in the larger market for health care services. SMF ¶¶ 3-4, 19-21. Thus, plaintiffs' assertion "that the Commerce Clause power does not extend to regulations which require individuals to enter a market they would otherwise choose to remain outside of is irrelevant to this case." *Mead*, 766 F. Supp. 2d at 37. Nothing required Congress to focus exclusively on the submarket that plaintiffs define, and nothing barred Congress from focusing on economic conduct in the health care market. Some individuals may prefer to pay for their participation in that larger market out of pocket rather than through insurance. But that type of economic

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[3] Here, Coons is arguably more "active" in the interstate market than Raich or Filburn. Coons does not deny that he is a consumer of services in the health care market; by contrast, the plaintiffs in *Raich* and *Wickard* claimed they would not enter the marijuana or wheat markets.

[4] *See* SMF ¶ 10 (observing that "[o]f those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year").

preference—which, Congress recognized to have had adverse market consequences on a classwide basis—is plainly subject to regulation under the Commerce Clause. Congress had a rational basis to conclude that the uninsured shift billions of dollars annually on to other market participants when they use health care services for which they do not fully pay. Under this "common sense understanding of the [market] forces" at issue, Congress has the authority to regulate. *See United States v. Rodia*, 194 F.3d 465, 478 (3d Cir. 1999) (upholding federal ban on intrastate possession of child pornography based on court's recognition of the nexus between the regulated intrastate behavior and the interstate market).

Moreover, the uninsured population benefits directly from the Act's regulatory reforms. As noted, the Act prohibits insurers from denying coverage to, or charging more, for persons with pre-existing conditions. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3(a), 300gg-4(a). The Act makes everyone insurable, and thus provides tangible protection against the risk of being left destitute by catastrophic medical expenses. *See* 42 U.S.C. § 18091(a)(2)(G) (62% of all personal bankruptcies are caused in part by medical expenses). Even apart from the other rational bases for Congress's choice of means, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010).

Plaintiffs' theory—that conduct can be exempted from federal regulation simply by attaching the label of "inactivity" or "consumption" to that conduct—disregards the "broad principles of economic practicality" that underlie the commerce power. *Lopez*,

514 U.S. at 571 (Kennedy, J., concurring). The Court has long held that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature" without regard to "the actual effects of the activity in question upon interstate commerce." *Wickard*, 317 U.S. at 120; *see also Swift Co. v. United States*, 196 U.S. 375, 398 (1905) ("commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 336-337 (1962) (Congress chose in the Clayton Act to "prescribe[] a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one"). Indeed, the Supreme Court has expressly rejected the relevance of any distinction between "production" and "consumption" for purposes of Commerce Clause analysis. *Wickard*, 317 U.S. at 124.

Moreover, plaintiffs' "inactivity" fallacy not only ignores Congress's considered judgment but also is illogical. After all, if the uninsured were truly "passive" with respect to the relevant market, they could not shift costs to others through their participation in that market. *Cf.* SMF ¶¶ 19-24. It is the *conduct* of the uninsured, due to their participation in the health care market, that Congress identified as having a substantial economic effect on interstate commerce, due to the significant amount of uncompensated care that the uninsured receive, which shifts costs to others and drives up prices of both health care services and health insurance premiums. 42 U.S.C. § 18091(a)(2)(F). Indeed, "the notion that self-insuring amounts to inaction and buying insurance amounts to action is not self-evident[,]" particularly where, "[i]f done

responsibly, the former requires more action (affirmatively saving money on a regular basis and managing the assets over time) than the latter (writing a check once or twice a year or never writing one at all if the employer withholds the premiums)." *Thomas More*, 2011 WL 2556039, at *28 (Sutton, J.). Thus, "self-insurance and private insurance are two forms of action for addressing the same risk. Each requires affirmative choices; one is no less active than the other; and both affect commerce." *Id*. at *29. Congress plainly has the authority to regulate conduct that has substantial economic effects in the interstate market with which it is concerned.[5]

4. Congress's rational basis for enacting the Affordable Care Act does not depend upon attenuated links to interstate commerce

Plaintiffs' reliance on the holdings of *Lopez* and *Morrison*, the only modern cases to invalidate federal statutes as beyond the commerce power, is misplaced. Both statutes were stand-alone measures that involved no economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of a handgun in a school zone because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might undermine economic productivity. Similarly, in *Morrison*, the Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to

[5] Similarly unavailing is plaintiffs' argument that the term "regulate" "means to govern activity that is already ongoing or is initiated in [an] independent way. It does not mean to compel or require activity." Pls.' Mem. at 18. This argument ignores the undeniable fact that Congress has both the power to "prescribe and proscribe" rules of conduct, and that, in the legislative context, Congress may enact "rules of conduct, some which require action." *Thomas More*, 2011 WL 2556039, at *28 (Sutton, J.) (observing that federal sex-offender registration laws and federal laws governing child support payments compel some action on the part of certain individuals).

connect gender-motivated violence with interstate commerce. Neither of these measures played any role in a broader regulation of economic activity. *Lopez*, 514 U.S. at 561. Indeed, the "noneconomic, criminal nature of the conduct at issue was central" to the Court's decisions. *Morrison*, 529 U.S. at 610; *see also Sabri*, 541 U.S. at 607.

The minimum coverage provision, in contrast, "steers clear of the central defect in the laws at issue in *Lopez* and *Morrison*. Health care and the means of paying for it are 'quintessentially economic' in a way that possessing guns near schools . . . and domestic violence . . . are not." *Thomas More*, 2011 WL 2556039, at *25 (Sutton, J.) (citation omitted). The provision is also part of a broad economic regulation of health care financing in the massive interstate health care market, and it is essential to the Act's guaranteed issue and community rating reforms. Moreover, the minimum coverage provision regulates economic conduct—the means of payment for health care services in a market that accounts for over one-sixth of the nation's GDP. *See* SMF ¶ 1. Indeed, it is difficult to conceive of legislation that is more clearly economic.

Likewise, "[n]o one must 'pile inference upon inference' . . . to recognize that the national regulation of a $2.5 trillion industry, much of which is financed through 'health insurance . . . sold by national or regional health insurance companies' . . . is economic in nature." *Id.* (Sutton, J.). As noted, the Supreme Court has clearly held that Congress may consider the effects of an entire class of conduct "in the aggregate." *Raich*, 545 U.S. at 22. And, in the aggregate, the direct result of the decision to attempt to pay for health care expenses out of pocket is that "Congress's efforts to stabilize prices for [health

insurance] are thwarted." *Mead*, 766 F. Supp. 2d at 34. Thus, "there is no need for metaphysical gymnastics of the sort proscribed by *Lopez*" to understand the direct connection between choosing to forego insurance, on the one hand, and cost-shifting—which is the very thing that, according to Congress, has a substantial effect on interstate commerce—on the other. *Thomas More*, 720 F. Supp. 2d at 894.

Ultimately, the concerns underlying the Supreme Court's decisions in *Lopez* and *Morrison* are inapplicable here. Those cases sought to avoid a view of economic causation so broad that it would "'obliterate the distinction between what is national and what is local in the activities of commerce.'" *Morrison*, 529 U.S. at 616 n.6 (quotations omitted). By contrast, the problems that are addressed by the Affordable Care Act are by no means local. "'The modern health care system is highly interdependent and operates across state boundaries.'" SMF ¶ 28 (quoting Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 NEW ENG. J. MED. e29, at 3 (2010)); *see Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 213 (4th Cir. 2002) ("Hospitals are regularly engaged in interstate commerce, performing services for out-of-state patients and generating revenues from out-of-state sources.") (citing *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 329-30 (1991)); Amicus Br. of the Commonwealth of Massachusetts in Support of Appellant at 12-13, *State of Florida et al. v. U.S. Dep't of Health & Human Servs.*, No. 11-11021 (11th Cir. filed Apr. 11, 2011). As just one example, Pennsylvanians make over 1500 emergency room visits each year to a hospital across state lines in West Virginia, resulting in over $820,000 owed, and not yet paid, for visits

that occurred in fiscal year 2007 alone. *See* SMF ¶ 28 (citing Amicus Br. of the Governors of Washington, Colorado, Michigan, and Pennsylvania, *State of Florida v. HHS*, No. 3:10-cv-91 (N.D. Fla. filed Nov. 19, 2010), at 9). Congress reasonably found that the Act's national standards were required to ensure that employers and individuals would not be subject to a state-by-state "patchwork of requirements and protections." H.R. REP. NO. 111-443, pt. I, at 211-12 (2010). The minimum coverage provision, a quintessentially economic regulation, addresses national problems that arise in the context of a vast interstate market. It is a means reasonably adapted to that legitimate end.

This fact rebuts plaintiffs' claim that upholding the minimum coverage provision—regulating "inactivity," in their parlance—obliterates any limitations on the Commerce Clause. *Lopez* and *Morrison* imposed limits that have nothing to do with "activity" or "inactivity." The minimum coverage provision falls well within those boundaries, and upholding the provision leaves them unaltered.

II. CONGRESS ENACTED THE MINIMUM COVERAGE PROVISION PURSUANT TO ITS INDEPENDENT POWER UNDER THE GENERAL WELFARE CLAUSE

Plaintiffs' challenge fails for an additional reason. Independent of its power under the Commerce Clause, Congress has the "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." U.S. CONST. art. I, § 8, cl. 1. Congress's power to collect revenue and make expenditures under the General Welfare Clause is "comprehensive."

Charles C. Steward Machine Co. v. Davis, 301 U.S. 548, 581 (1937); *see also Veazie Bank v. Fenno*, 75 U.S. 533, 541 (1869) ("[I]t was the intention of the Convention that the whole power should be conferred…."). Indeed, Congress may use its general welfare authority for purposes beyond its powers under other provisions of Article I. *See United States v. Sanchez*, 340 U.S. 42, 44 (1950) ("Nor does a tax statute necessarily fall because it touches on activities which Congress might not otherwise regulate."); *Knowlton v. Moore*, 178 U.S. 41, 59-60 (1900) (Congress may tax inheritances, even if it may not regulate them under the Commerce Clause); *United States v. Doremus*, 249 U.S. 86, 94 (1919). As long as a statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax."[6] *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see also United States v. Gianni*, 455 F.2d 147, 148 (9th Cir. 1972). In determining whether a congressional enactment is authorized under the taxing power, the only question is therefore whether the regulation bears "some reasonable relation" to the "raising of revenue." *Doremus*, 249 U.S. at 93-94; *see also J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 412 (1928) ("motive" and "effect" "to secure revenue" bring measure within taxing power, even if Congress announces other motives to regulate

[6] *Sozinsky* forecloses plaintiffs' argument that the minimum coverage provision is an invalid exercise of Congress's taxing power because its purpose is regulatory. *See* Pls.' Mem. at 32. As the Supreme Court recognized, "[e]very tax is in some measure regulatory" in that "it interposes an economic impediment to the activity taxed as compared with others not taxed." *Sozinsky*, 300 U.S. at 513. "[C]ourts have sustained taxes although imposed with the collateral intent of effecting ulterior ends which, considered apart, were beyond the constitutional power of the lawmakers to realize by legislation directly addressed to their accomplishment." *Sanchez*, 340 U.S. at 44-45 (internal quotation and citation omitted).

commerce).

In contrast to the Sixth Circuit's conclusion, *see Thomas More*, 2011 WL 2556039, at *17-21 (Sutton, J.), the minimum coverage provision falls within Congress's comprehensive taxing power. The Affordable Care Act requires "taxpayers" not exempt to obtain "minimum essential coverage" or pay a penalty. 26 U.S.C. § 5000A(a), (b)(1). "Taxpayers" who are not required to file income tax returns for a given year are not subject to this provision. 26 U.S.C. § 5000A(e)(2). If the penalty applies, the taxpayer must report it on his income tax return for the taxable year, as an addition to his income tax liability. 26 U.S.C. § 5000A(b)(2). The resulting penalty is a percentage of the taxpayer's household income, subject to a floor and a cap of the national average premium for the lowest-tier plans offered in the new Exchanges for the taxpayer's family size. 26 U.S.C. § 5000A(c)(1), (2). The taxpayer's responsibility for his family members turns on their status as dependents under the Internal Revenue Code. 26 U.S.C. § 5000A(a), (b)(3). The Secretary of the Treasury is empowered to enforce the provision, and he collects the penalty in the same manner as other assessable penalties under the Internal Revenue Code. 26 U.S.C. § 5000A(g).[7]

Because the provision, where it applies, will increase a taxpayer's total liability, there can be no dispute that the provision will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. Indeed, the Congressional Budget Office ("CBO") estimated that $4 billion in revenues will be derived each year from the provision when it is fully in

[7] The Secretary of the Treasury may not collect the penalty through notice of federal tax liens or levies, and may not bring a criminal prosecution for a failure to pay it. 26 U.S.C. § 5000A(g)(2).

effect. *See* SMF ¶ 44 (citing Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 2 tbl. 4 (Mar. 20, 2010)). Plaintiffs attempt to undermine these facts by arguing that the provision is beyond Congress's taxing power because "[i]f every individual subject to the [provision] complied, the penalty would produce *no* revenue." Pls.' Mem. at 32. But, as the Supreme Court has instructed, "a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed."[8] *Sanchez*, 340 U.S. at 44.

Beyond the determinative fact that the minimum coverage provision will be "productive of some revenue," the provision operates as a tax in every meaningful sense, that is, as a "pecuniary burden laid upon individuals or property for the purpose of supporting the government." *United States v. New York*, 315 U.S. 510, 515-16 (1942). Congress placed the provision in the Internal Revenue Code; directed that the amount a taxpayer owes under the provision be reported on the taxpayer's annual tax return and added to the taxpayer's annual tax liability; and granted enforcement authority to the Secretary of the Treasury. Revenues from the provision go to the general treasury. In all practical respects, the provision is a tax. *Cf. In re Chateaugay Corp.*, 53 F.3d 478, 498

[8] In the same vein, plaintiffs' argument that the minimum coverage provision is punitive is without merit. As discussed in prior briefing, *see* Defs.' Reply 22-23, § 5000A has none of the hallmarks of a punishment. It does not have a scienter requirement, *cf. The Child Labor Tax Case*, 259 U.S. 20, 36-37 (1922), and is "not conditioned upon the commission of a crime," *Sanchez*, 340 U.S. at 45, nor is the penalty so "exorbitant" that it demonstrates an intent to "punish rather than to tax," *United States v. Constantine*, 296 U.S. 287, 294, 295 (1935).

(2d Cir. 1995) ("Coal Act was at least partially an exercise of the taxing power," given placement in Internal Revenue Code and grant of enforcement authority to Treasury).

The only basis that has been offered for refusing to recognize the minimum coverage provision as a valid taxing measure is that Congress did not label the § 5000A penalty a "tax." But the substance of the provision, not its label, is dispositive. *Penn Mut. Indem. Co. v. Comm'r of Internal Revenue*, 277 F.2d 16, 20 (3d Cir. 1960) ("the tax itself" need not "bear an accurate label" in order to be upheld as a valid taxing measure). The Supreme Court has emphasized that, "[i]n passing on the constitutionality of a tax law [the Court is] concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (internal quotation omitted); *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalty").

Indeed, Congress was under no obligation to identify the § 5000A penalty as a tax or otherwise expressly invoke the General Welfare Clause in order to enact legislation pursuant to its taxing power.[9] "'The constitutionality of action taken by Congress does

[9] Plaintiffs' argument that the minimum coverage provision is an unconstitutional direct tax is without merit. As the government explained in prior briefing, the minimum coverage provision conditions its tax on a number of factors, including the receipt of a threshold amount of income, and the absence of qualifying coverage. It is not a direct tax, which is a tax imposed on property "solely by reason of its ownership." *Knowlton*, 178 U.S. at 81; *see Quatry v. United States*, 170 F.3d 961, 970 (9th Cir. 1999). Nor does any precedent require defendants to identify specifically the category of tax—direct, excise, impost, or duty—in which the minimum coverage penalty provision falls. The Supreme Court rejected the same argument in *Charles C. Steward Mach. Co.*, upholding the employment taxes in the Social Security Act against a claim that they did not qualify

not depend on recitals of the power which it undertakes to exercise.'" *United States v. Nelson*, 277 F.3d 164, 178 n.14 (2d Cir. 2002) (quoting *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948)); *see Oregon Short Line R.R. v. Dep't of Revenue Or.*, 139 F.3d 1259, 1266 (9th Cir. 1998) (noting that the constitutionality of congressional action does not depend on recitals of the power which it undertakes to exercise).

In any event, even if Congress did not expressly invoke its taxing power, as defendants discussed in prior briefing, the word "tax" or a derivative of it appears more than forty times in the minimum coverage provision. Placing the provision in the Tax Code, requiring that compliance be reported on the tax return, providing that any penalties be paid every April 15 with income taxes, and referring repeatedly to the obligations of the taxpayer are all clear indicators that Congress intended the provision to operate as a tax. Moreover, the taxing power was expressly invoked in the Senate to defeat constitutional points of order against the provision. 155 Cong. Rec. S13,830, S13,832 (Dec. 23, 2009). During the floor debates, congressional leaders explicitly defended the provision as an exercise of the taxing power. *See, e.g.*, 156 Cong. Rec. H1882 (Mar. 21, 2010) (statement of Rep. Miller); 156 Cong. Rec. H1824, H1826 (Mar. 21, 2010) (statement of Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (Dec. 22, 2009) (statement of Sen. Leahy); 155 Cong. Rec. S13,581-82 (Dec. 20, 2009) (statement

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as "excise." "The subject-matter of taxation open to the power of the Congress is as comprehensive as that open to the power of the states." *Id.* at 581. The General Welfare Clause power "may be applied to every object of taxation, to which it extends, in such measure as Congress may determine. . . . [I]t was the intention of the Convention that the whole power should be conferred. The definition of particular words, therefore, became unimportant." *Veazie Bank*, 75 U.S. at 541.

of Sen. Baucus). There is no doubt on that score, and no ambiguity arising simply from the fact that the word "penalty" can be used outside the tax context. If there were such ambiguity, however, the presumption of constitutionality would dictate that it be resolved in favor of upholding the provision as an exercise of the taxing power. *See Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg.*, 485 U.S. 568, 575 n.1 (1988)).

III. THE AFFORDABLE CARE ACT DOES NOT UNCONSTITUTIONALLY DELEGATE LEGISLATIVE POWER TO THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The only IPAB-related issue remaining here is plaintiffs' non-delegation doctrine challenge. After the Supreme Court's decision in *Nevada v. Carrigan*, plaintiffs withdrew Count VI, which had asserted that the ACA unconstitutionally prohibits the repeal of the IPAB. *See* Pls.' Mem. at 1, ECF No. 51 (voluntarily dismissing Count VI).[10]

As for the non-delegation claim, defendants have explained that the pages of detailed requirements contained in the ACA easily establish the required "intelligible principle." In particular, the ACA specifies a list of "considerations" that the Board *must* take into account (42 U.S.C. § 1395kkk(c)(2)(B)); it contains a general statement of purpose (*id.* § 1395kkk(b)); and it prohibits the Board from making certain types of recommendations (*id.* § 1395kkk(c)(2)(A)). The Supreme Court and the Ninth Circuit

[10] For this reason, the ten pages of speculation that the amicus brief devotes to this issue (*see* Amicus Br. 12-22, ECF No. 53) are irrelevant. "While an amicus may offer assistance in resolving issues properly before a court, it may not raise additional issues or arguments not raised by the parties." *Cellnet Commc'ns Inc. v. FCC*, 149 F.3d 429, 443 (6th Cir. 1998); *see also Swan v. Peterson*, 6 F.3d 1373, 1383 (9th Cir. 1993) ("Generally, we do not consider on appeal an issue raised only by an amicus.").

have upheld statutes containing far broader delegations. *See New York Cent. Sec. Corp. v. United States*, 287 U.S. 12, 24-25 (1932) (the "public interest"))*; Freedom to Travel Campaign v. Newcomb*, 82 F.3d 1431, 1436-38 (9th Cir. 1996) ("in the national interest"). Plaintiffs' insistence that the IPAB lacks an "intelligible principle" is therefore unsupportable.

Moreover, plaintiffs and the amicus are wrong to say that the congressional review procedures are the only way that Congress may exert control over the Board's recommendations. *See, e.g.*, Amicus Br. 6. In fact, the ACA establishes "fast-track" parliamentary procedures to ensure Congress, should it choose to do so, has sufficient time to consider its own legislative alternative to IPAB's recommendations. As the government has observed, nothing prevents Congress from repealing or suspending the rules governing congressional changes to IPAB recommendations while voting on superseding legislation. Congress is constitutionally entitled to set its own rules. *See* U.S. CONST. art. I, § 5.[11]

IV. THE MINIMUM COVERAGE PROVISION AND THE PROVISIONS CREATING THE IPAB ARE SEVERABLE FROM THE ACA'S REMAINING PROVISIONS

Plaintiffs' insistence that the minimum coverage provision and the provisions of the ACA creating IPAB are not severable from the rest of the ACA is irrelevant, as these provisions fall well within Congress's constitutional authority. If this Court reaches

[11] The government incorporates by reference the non-delegation doctrine discussions contained in prior briefing. *See* Local Rule 7.1(d).

severability, however, it should conclude that these provisions are severable from the vast majority of the ACA's provisions.

The Supreme Court has repeatedly held that, "when confronting a constitutional flaw in a statute," courts must "try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (internal quotation marks omitted). "[T]he 'normal rule,'" therefore, "is that 'partial, rather than facial, invalidation is the required course' such that a 'statute may ... be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006) (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). If provisions are "fully operative as a law," they must be sustained "[u]nless it is evident that the Legislature would not have enacted those provisions ... independently of that which is [invalid]." *Free Enterprise Fund*, 130 S. Ct. at 3161 (internal citation and quotation marks omitted).

The government's position is that the minimum coverage provision is so closely and inextricably linked to the new guaranteed issue and community rating reforms that those reforms are not severable from that provision. *See, e.g.*, Reply/Response Br. of HHS, et al., *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir.), at 24-26 (noting that §§ 2701, 2702, 2704 (with respect to adults), and 2705(a) of the Public Health Service Act, as added by § 1201 of the Affordable Care Act are not severable from the minimum coverage provision).

But plaintiffs' assertion, *see* Pls.' Mem. at 56-58, that neither the minimum coverage requirement nor the IPAB can be severed from any other provision of the Affordable Care Act for the reasons set forth in the Florida district court decision, *Florida ex rel. Bondi v. HHS*, 2011 WL 285683,*33-39 (N.D. Fla. Jan. 31, 2011), which has been appealed and is awaiting decision by the Eleventh Circuit, is simply wrong. The other provisions of the Act are "fully operative as a law," and plaintiffs have not shown that "the Legislature would not have enacted those provisions . . . independently of" the minimum coverage provision. *Free Enterprise Fund*, 130 S. Ct. at 3161 (quotations omitted); *see also* Reply/Response Br. of HHS, et al., *Florida v. HHS*, at 56-58.

The *Florida* court reasoned that "[g]oing through the 2,700–page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds) of others, would not only take considerable time and extensive briefing, but it would, in the end, be tantamount to rewriting a statute in an attempt to salvage it." *Florida*, 2011 WL 285683, at *38. But this conclusion fails to follow the rule that "partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades*, 472 U.S. 491, 504 (1985). Indeed, as the *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 789-90 (E.D. Va. 2010) court recognized, the Act contains provisions that are plainly severable from the minimum coverage provision and the IPAB. For example, parts of the ACA make changes to Medicare payment rates for 2011, ACA Title III, and "provide for more rigorous enforcement" of drug pricing requirements. *Astra USA, Inc. v. Santa Clara Cnty.*, 131 S. Ct. 1342, 1346 (2011). Other provisions re-authorized programs already on

the books, *e.g.*, ACA §§ 4204(c), 5603, amended the False Claims Act, ACA § 10104(j)(2), and imposed requirements to eliminate Medicaid waste and fraud, *e.g.*, ACA §§ 6402(h)(2), 6411. Without question, these provisions can survive without the minimum coverage provision or the IPAB provisions.[12]

Plaintiffs are equally wrong to rely on the lack of a severability clause in the ACA. "In the absence of a severability clause . . . Congress' silence is just that-silence-and does not raise a presumption against severability." *Alaska Airlines v. Brock*, 480 U.S. 678, 686 (1987). Indeed, even if a severability clause had been removed, the "unexplained disappearance" of text during the progress of a bill is rarely a "reliable indicator[] of congressional intent." *Mead Corp. v. Tilley*, 490 U.S. 714, 723 (1989). That principle has particular force here because Congress legislated against the background presumption of severability. Indeed, both the Senate Legislative Drafting Manual and the House Legislative Counsel's Manual on Drafting Style "advise drafters that a 'severability clause is unnecessary' unless Congress intends to make certain portions of a statute unseverable." Interpreting by the Book: Legislative Drafting Manuals and Statutory Interpretation, 120 Yale L.J. 185, 190 (2010). Plaintiffs' description of the legislative history is, moreover, misleading. Although a bill initially passed by the House contained a severability provision, none appeared in the bills considered by the Senate or enacted as the Affordable Care Act.

[12] Moreover, the Court should not reach the question of the severability of those other provisions. *See Printz v. United States*, 521 U.S. 898, 935 (1997).

CONCLUSION

Plaintiffs' motion for summary judgment should be denied, and defendants' cross-motion for summary judgment should be granted.

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CERTIFICATE OF SERVICE

I hereby certify that on August 10, 2011, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF system for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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