NO. 11-3327

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

U.S. CITIZENS ASSOCIATION, ET AL.,

PLAINTIFFS-APPELLANTS,

v.

KATHLEEN SEBELIUS, ET AL.,

DEFENDANTS-APPELLEES.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OHIO

BRIEF IN REPLY

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SUMMARY OF ARGUMENT IN REPLY

This Court has appellate jurisdiction under 28 U.S.C. § 1291 and Rule 54(b) of the Federal Rules of Civil Procedure. The district court properly exercised its broad discretion to certify counts 2 through 4 for appeal, while withholding jurisdiction of count 1 which is governed by this Court's decision in *Thomas More Law Center, et al. v. Obama*, *Thomas More Law Center v. Obama*, --- F.3d ---, 2011 WL 2556039 (June 29, 2011). The court appropriately concluded that prompt appeal best suited the litigation. Even were appeal of Counts 2 through 4 improper under Rule 54(b), the district court entered final judgment on Plaintiffs' Count 1 two days after this Court's *Thomas More* decision, doing so on July 1, 2011. The case is thus closed at the district court level. If this court rejects appellate jurisdiction, the same appeal would come immediately before this court as a matter of right.

The PPACA is unconstitutional because it compels those subject to its individual mandate, including the individual named Plaintiffs, to associate with private insurance companies and purchase private insurance, 26 U.S.C. § 5000A(a), in violation of their constitutional liberty rights, including the right to refuse medical care, the freedom of intimate and expressive association, and the right of privacy in medical information.

The minimum coverage provision imposes a penalty on those citizens who refuse medical care covered by PPACA-qualified insurance policies by forcing those citizens to pay for that care nonetheless. *See* 26 U.S.C. § 5000A(a)-(f). That burden on the right, no less than an absolute ban of the right, is unconstitutional. *See* U.S. Const. Amend. I, V. The penalty burdens exercise of the fundamental liberty right to refuse medical care, imposing upon the exercise of that rightan economic cost.

Under the PPACA, citizens also face penalties under 26 U.S.C. § 5000A for choosing practitioners who offer treatments not covered by PPACA-qualified insurance policies. Plaintiffs are also forced to divulge their medical confidences to private health insurers who offer PPACA-qualified plans. The PPACA thus employs coercion, penalizing with financial burden those who would prefer to obtain treatments not covered by PPACA-qualified insurance policies and forcing intimate associations with private insurers against the will of those who wish not to be insured and to pay out of pocket for their medical care. That coercion violates the freedoms of expressive and intimate association, including the freedom not to associate.

Finally, the PPACA requires disclosure of confidential medical information to private insurers (information essential to the operation of health insurance companies). The Act does nothing to prevent disclosure of that information. The

Defendants offer no basis to conclude that disclosure of medical information is not required under the PPACA's reforms, and, in fact, insurance company compliance with the reforms (particularly in ascertaining who is an insured at high risk for possible transference to an exchange) requires investigation of the insureds medical history. *See* DiStefano Affidavit at ¶¶ 7-9, 10 (R.E. 50-7); Report of Dr. Joanna M. Shepherd-Bailey at 16-18 (R.E. 50-2). The Appellees (hereinafter "the Secretary" or "Sebelius") admit that the PPACA could operate in the same fashion without disclosure of medical information, suggesting an absence of any state interest in compelling disclosure, *see* Appellees' Br. at 22-23, yet the PPACA allows and, as a practical matter, requires insurers to ascertain that information to identify high risk patients eligible for under the reinsurance programs. *See* Report of Dr. Joanna M. Shepherd-Bailey at 16-18 (R.E. 50-2); 42 U.S.C. § 18061. Therefore, the Plaintiffs' interest in maintaining privacy outweighs the government's admitted non-interest, and the PPACA violates Plaintiffs' right to privacy.

ARGUMENT IN REPLY

I. APPELLATE JURISDICTION IS PROPER

Secretary Sebelius, et al. ask this Court to reject appellate jurisdiction under the District Court's Rule 54(b) certification. *See* Fed. R. Civ. P. 54(b). *See* R.E. 82. On February 28, 2011, the District Court dismissed Plaintiffs' individual

liberty claims 2, 3, and 4, but retained jurisdiction on claim 1 which concerned whether Congress had authority to enact the Patient Protection and Affordable Care Act ("PPACA") under the Commerce Clause. The Court appropriately exercised its discretion and determined that certification of counts 2, 3, and 4 for appeal was justified to preserve the plaintiffs' right to a prompt appeal. *See Corrosioneering v. Thyssen Envtl. Sys.*, 807 F.2d 1279, 1282-83 (6th Cir. 1986).

When Appellants filed their notice of appeal, the parties had pending before the District Court cross-motions for summary judgment concerning whether Congress had authority under Article I to enact the PPACA's individual mandate. That same issue was before this Court in *Thomas More Law Center, et al. v. Barack Hussein Obama, et al.*, No. 10-2388 (June 29, 2011). The District Court "question[ed] the relevance of any ruling it may make regarding the Commerce Clause issue given the more advanced stage of challenges to the Act in other jurisdictions and the ultimate impact of the appellate rulings in those cases on the instant case." R.E. 82, at 3.

Absent actual prejudice to a litigant, the Court has discretion to control and manage its docket. *See FENF, LLC v. Healio Health Inc.*, Slip Copy, 2011 WL 3489109, at *1 (N.D. Ohio 2010) (quoting *In re Air Crash Disaster*, 86 F.3d 498, 516 (6th Cir. 1996)). This Court reviews the District Court's exercise of that

discretion under an "abuse of discretion" standard. *See Corrosioning*, 807 F.2d at 1282-83; *Pittman v. Franklin*, 282 Fed. Apps. 418, 430 (6th Cir. 2008).

The District Court properly exercised its discretion and the Secretary has not met her burden to show otherwise. Rule 54(b) of the Federal Rules of Civil Procedure was intended to "strike a balance between the undesirability of piecemeal appeals and the need for making review available at a time that best serves the needs of the parties." *Corrosioneering*, 807 F.2d at 1282. Thus, the "district court acts as a 'dispatcher' and is permitted to determine, in the first instance, the appropriate time when each final decision is ready for appeal." *Id.* (collecting cases). The underlying policy is to prevent piecemeal appeals, not erect rigid rules that preclude immediate appeal despite the equities. *See Curtiss-Wright Corp. v. General Elec. Co.*, 446 U.S. 1, 7-8 (1980) (explaining that final judgments may be immediately appealable if they are "in some sense separable from the remaining unresolved claims"). The district court must proceed "in the interest of sound judicial administration." *Sears, Roebuck & Co. v. Mackey*, 351 U.S. 427, 437-38 (1956).

The district court dismissed plaintiffs' counts 2, 3, and 4 on November 22, 2010. *See* R.E. 58. In his final order, Judge David Dowd explained that "the dismissed claims are entirely separate from the single remaining claim." R.E. 82, at 2. He continued, "[t]he nature of the constitutional challenges in Claims 2, 3,

and 4 are independent from the constitutional challenge of Count 1, so the appellate court will not likely face the same issue a second time in the future." *Id.* at 2-3 (explaining that "the litigants are best served by allowing an immediate appeal of the Court's dismissal of Counts 2, 3, and 4 given the uncertainty of the time period in which the constitutionality of the Act relative to the Commerce Clause will be determined in the federal courts").

Counts 2, 3, and 4 were distinct from Count 1. In Counts 2, 3, and 4, the plaintiffs alleged violations of their individual liberty rights protected under the United States Constitution. While those counts share common issues of law, Congress's authority under Article I was a legally distinct challenge, pled in the alternative to Counts 2 through 4. Count 1 concerns whether Congress had the constitutional authority to act *ab initio* under the Commerce Clause. The remaining counts address whether the individual mandate, assuming its constitutionality under Article I, imposes an unconstitutional burden on the individual Plaintiffs' liberty, association, and privacy rights. Count 1 asks whether Congress had power to act; Counts 2 through 4 ask whether the power to act is applied unconstitutionally to the individual Plaintiffs. The individual liberty claims were not argued before the Court in the *Thomas More* decision. *See Thomas More Law Center v. Obama*, --- F.3d ---, 2011 WL 2556039 (June 29,

2011). Thus, while the *Thomas More* decision governed Count 1, plaintiffs remaining claims were unaffected by *Thomas More*.

By certifying Counts 2 through 4, Judge Dowd appropriately balanced the judicial economies in this case. He abstained from a decision on Count 1 until receiving guidance from this Court in *Thomas More*, yet he permitted an immediate appeal of Counts 2 through 4 to prevent undue delay of appellate claims that would reach this Court regardless of the outcome in *Thomas More*. The Court's certification, therefore, struck "a balance between the undesirability of more than one appeal in a single action and the need for making review available in multiple-party or multiple claim situations at a time that best serves the need of the litigation." R.E. 82, at 2 (quoting *Good v. Ohio Edison*, 104 F.2d 93, 95 (6th Cir. 1997)).

Even if the District Court's certification was improper, the Secretary's concerns are mooted by the District Court's final order and judgment on Count 1 entered July 1, 2011. *See* R.E. 90, 91. On June 29, 2011, this Court published its opinion in *Thomas More*, holding that "the minimum coverage provision is a valid exercise of the legislative power by Congress under the Commerce Clause." *Thomas More*, 2011 WL 2556039, a *1. Two days later, on July 1, 2011, the District Court entered final judgment. *See* Order, R.E. 90 (finding that the "Court is bound by the Sixth Circuit's majority ruling in *Thomas More*" and, so, "the

Court grants defendants' motion for summary judgment on Count 1 of the plaintiffs' second amended complaint"). Nothing remains pending at the district court level. The issues before this Court on Counts 2 through 4 are fully briefed. A decision by this Court denying appellate jurisdiction would waste time and expense, as this appeal would return as of right under Rule 4 of the Federal Rules of Appellate Procedure.

The district court's Rule 54(b) certification was appropriate. Even if certification was improper, this Court should exercise appellate jurisdiction in the interests of justice and judicial economy.

II. THE MINIMUM COVERAGE PROVISION VIOLATES THE PLAINTIFFS' CONSTITUTIONAL RIGHTS TO LIBERTY, ASSOCIATION, AND PRIVACY

Congress for the first time in American history has compelled citizens to purchase a private good or service, to wit, private health insurance. *See* Jennifer Staman & Cynthia Brougher, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, Cong. Res. Serv., at 3 (July 24, 2009).[1] The third-party health insurance model is well-defined by customs and practices, many of which are unaffected by the PPACA. The compulsory relationship with health insurance companies forces citizens to suffer natural and foreseeable consequences of that

[1] R.E. 69-6.

relationship. Those consequences are not conjectural or speculative. It was incumbent upon Congress to alter health insurance customs and practices, if it wished to liberate those it compels to be insured from those very customs and practices. To the extent that it left those customs and practices unchanged, it bears the burden of proving them lawful. Health insurance is traditional medical care paid forward. A compulsory relationship with insurance companies affects all who would contract for health insurance, whether or not the individual accepts or desires coverage. Whether a citizen would choose health insurance is of no moment. The PPACA violates all citizens' liberty rights because it deprives them of that freedom of choice.

A. The Right to Refuse Medical Treatment, or Payment for Treatment Refused, Is a Fundamental Right

The Secretary accepts that the right "to refuse unwanted medical service" is a protected right. *See* Appellees' Brief, at 16 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990)). "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from [] prior decisions." *Cruzan*, 497 U.S. at 278. The Secretary does not dispute that the right of refusal is fundamental. Rather, the Secretary claims that the PPACA's minimum coverage provision "in no way implicates this fundamental right to refuse unwanted medical care" because "the provision will not require that people obtain medical services of any kind." Appellees' Br. at 16.

According to the Secretary, "individuals will still be able to determine whether to obtain medical care, what care to obtain, when, and from whom." *Id.* In short, the Secretary argues that the PPACA interferes only "with economic freedom by requiring [citizens] to pay for insurance or tax penalties." *Id.* at 17.

The argument is myopic and misplaced. The freedom in issue is not an economic liberty but a political liberty (the freedom to refrain from receipt of unwanted care and to refrain from paying for unwanted care). The federal government need not ban exercise of a right before having to justify a burden on the exercise of it. Rather, the federal government must satisfy heightened judicial scrutiny for imposition of a burden (here, an economic cost). *See U.S. v. Brandon*, 158 F.3d 947, 956 (6th Cir. 1998); *Toledo Area AFL-CIO Council v. Pizza*, 154 F.3d 307, 321 (6th Cir. 1998). It is undeniable that those who would prefer not to receive any medical care or any medical care covered by the PPACA (such as the individual Plaintiffs) are nevertheless forced to pay for the care they do not want. Health insurance, according to the customs and practices left unaffected by the PPACA, is for care paid forward.

The PPACA burdens the right of citizens to refuse unwanted medial care, a fundamental right, because it burdens the choice to refuse care and financially penalizes the refusal. It burdens the right just as a tax on marriage or child rearing would influence constitutionally protected decisions and behavior. Many federal

regulations impose economic burdens, but not all such regulations burden the exercise of fundamental rights. That is the distinction which eludes the government. For example, a requirement that families reside in-state for five years before collecting welfare benefits is principally an economic measure; it imposes conditions on the receipt of funding, *See Barnes v. Board of Trustees, Mich. Veterans Trust Fund*, 369 F.Supp. 1327, 1334 (W.D. Mich. 1973), yet the law also inescapably burdens the fundamental right to travel and is thus unconstitutional. *Id.*

When the exercise of constitutional liberties are burdened by law, it is no excuse that the law also has an economic effect. *See Toledo Area AFL-CIO Council v. Pizza*, 154 F.3d 307, 321 (6th Cir. 1998) ("[a]llowing the government to penalize conduct it cannot directly ban raises concerns that the government will be able to curtail by indirect means what the Constitution prohibits it from regulating directly"). Otherwise, Congress could legislate without limitation by citing economic incentives or consequences in every act. Congress is not empowered to violate Constitutional rights whenever it premises legislation on an economic need. Moreover, it is undeniable that the primary aim of the PPACA's individual mandate was not to raise revenue but to compel Americans to obtain health insurance so that they would have access to care Congress deemed appropriate. In short, the measure was inextricably aimed at depriving individuals of their freedom

to decline payment for unwanted care and not to raise revenue. *See Thomas More*, --- F.3d ---, 2011 WL 2556039, *18 ("the central function of the mandate was *not* to raise revenue. It was to change individual behavior by requiring all qualified Americans to obtain medical insurance") (emphasis original).

The inquiry is whether the act burdens the free exercise of a fundamental right. *See, e.g., Toledo Area AFL-CIO Council*, 154 F.3d at 321. Whether that obstacle be a direct prohibition, economic penalty, or incentive, if the law burdens a fundamental right then it must pass strict scrutiny. *See U.S. v. Brandon*, 158 F.3d 947, 956 (6th Cir. 1998) ("[g]overnment action that burdens a fundamental right will survive a substantive due process challenge only if it can survive strict scrutiny, i.e., if it is narrowly tailored to a compelling governmental interest"). "Simply put, the government may not place obstacles in the path of a person's exercise of a constitutionally protected right by impinging on the right absent a compelling justification." *Toleda Area AFL-CIO Council*, 154 F.3d at 321 (quoting *Harris v. McRae*, 448 U.S. 297, 317 n.19 (1980)).

The PPACA's minimum coverage provision erects obstacles to the exercise of citizens' right to refuse medical care in two ways. First, it penalizes citizens who refuse medical care by requiring payment for refused care (indeed, plaintiff Jim Grapek would refuse). Second, the PPACA compels payment for government-qualified medical care even when a citizen wishes not to receive such care. Under

the PPACA, citizens cannot refuse the burden of medical care. They may refuse the physical procedure, but they cannot refuse the cost. The right to refuse medical care must necessarily include the right to refuse payment for the care refused. The federal government may not financially burden the exercise of a fundamental right. *See Toledo Area AFL-CIO Council*, 154 F.3d at 321; *Brandon*, 158 F.3d at 956

Moreover, by diminishing the finances of those who pay out-of-pocket for preferred, non-PPACA-covered, health care, the PPACA in a very real sense limits the freedom to dissent from receipt of unwanted care and the freedom to obtain receipt of wanted care. That coercion violates the fundamental liberty right to refuse medical care. PPACA-covered services are enumerated in Section 1302. All PPACA-compliant insurance packages must include coverage for, *inter alia*: mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services; and chronic disease management. *See* 42 U.S.C. § 18022(b)(1). Here, the premiums that flow to insurance companies for PPACA-compliant plans are to pay for the enumerated services. Health insurance is medical care paid forward. That concept is essential to the continuing operation of health insurance companies. Premiums were customarily adjusted to fit the risk of treatment. Before PPACA, individuals obtained health insurance to cover payment for

services the insured desired or intended to use (e.g., preventative wellness checks). Now, all citizens will pay for those services whether or not they ever use them.

The right or choice not to pay for medical treatment is inherent to the decision to refuse treatment. Indeed, if a state enacted a tax on marriages between residents and non-residents, the tax would burden the right to marry, even if those affected decided to pay the tax and marry. Here, the plaintiffs' right to refuse payment stems from the exercise of their fundamental right to refuse medical treatment. The penalty assessed on individuals for choosing one form of health care over government-qualified care burdens the right.

Finally, because the PPACA eliminates freedom of choice for all, and the facts necessary for a full adjudication are established, the plaintiffs' facial challenge under the due process clause is proper. *See Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449-50 (2008). The primary concern with facial challenges is that the court should "be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases." *Id.*; *Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517 U.S. 1174, 1175 (1996) (Mem) (explaining that the "no circumstance" language concerning facial challenges in *United States v. Salerno*, 481 U.S. 739 (1987) "does not accurately characterize the standard for deciding facial challenges"). For example, in *Washington State Grange*, pre-enforcement review on a facial challenge was

inappropriate where Washington had not implemented the election law because the challenge depended on the "possibility that voters will be confused as to the meaning" of a ballot designation. *Id.* at 454. Here, the plaintiffs demonstrate an actual, not hypothetical, consequence caused by the PPACA's individual mandate that impacts all United States citizens. Appellant Jim Grapek's sworn affidavit stated that he prefers complementary and alternative medicine not covered by traditional health insurance, and he would refuse certain traditional care. *See* Appellants' Brief, at 14-16 (citing Grapek Affidavit § 12). The alternative therapies chosen by Mr. Grapek are not offered through PPACA-compliant plans and traditionally have not been covered by health insurance plans in the past. *See* Appellants' Br. at 14-16.

The PPACA's minimum coverage provision requires the compulsory purchase of specific medical care, funded through an insurance contract. Many citizens may desire that coverage. But each citizen loses his or her right to exercise freedom of choice in the receipt of care without financial burden. The PPACA's blanket application renders a due process challenge appropriate at this stage.

B. The Minimum Coverage Provision Substantially Burdens the Plaintiffs' Fundamental Right to Associate with a Physician of Their Choosing

The Secretary argues that the right of intimate association does not encompass a citizen's relationship with his or her doctor. According to the Secretary, even if that relationship were protected, it would not be burdened by the PPACA. *See* Appellees' Br. at 18-20. The Secretary is in error. An individual's relationship with a physician of his or her choosing includes all characteristics recognized by the Supreme Court for intimate association. *See Roberts v. U.S. Jaycees*, 468 U.S. 609, 619, 620 (1984). Moreover, the PPACA burdens that relationship by penalizing citizens who associate with alternative practitioners not covered by PPACA-compliant insurance contracts. In addition, the PPACA limits citizens' abilities to obtain medical care uninfluenced by the "third party" payer. Those burdens on the right to intimate association flow from the known and expected effects of PPACA.

The relationship between doctor and patient is supported through the constitutional rights to one's bodily integrity and to refuse treatment. *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992); *Roe v. Wade*, 410 U.S. 113, 153-54 (1973); *Griswold v. Conn.*, 381 U.S. 479, 485 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Washington v. Harper*, 494 US. 210, 222-23 (1990); *Mills v. Rogers*, 457 U.S. 291, 299 (1982); *Cruzan*, 497 U.S. at 278. In *Cruzan*,

the Court connected the right of bodily integrity to the concept of informed consent:

> [N]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person…. This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment.

Cruzan, 497 U.S. at 269*; Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

In *Roberts*, the Court defined "intimate associations" as those "distinguished by such attributes as relative smallness, a high degree of selectivity in decision to begin and maintain the affiliation, and seclusion from others in critical aspects of the relationship." *Roberts*, 468 U.S. at 620; *see also Rust v. Sullivan*, 500 U.S. 173, 174-75 (1991). A patient's relationship with a physician of his or her choosing meets every one of those distinguishing characteristics. The relationship is one-on-one association. The patient carefully chooses a doctor based on skill, compassion, medical or ideological beliefs, and, most importantly, trust. The relationship is deeply private, secluded from others. Outside of marriage, there is likely no more intimate association than that between a doctor and a patient. The patient shares intimate facts about his or her physical, mental, and social condition relevant to a clinical diagnosis; facts concerning body and mind so private that they

may not have been shared with spouses or family. To the patient, the relationship is built upon trust. The doctor receives the patient often in a vulnerable state.

For those reasons, courts have held the relationship between doctor and patient protected. *See Rust*, 500 U.S. at 174-75 ("[i]t could be argued by analogy that traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment form Government regulation…"). The Federal District Court for the Southern District of Texas held that decisions related to medical treatment are "to an extraordinary degree, intrinsically personal." *Andrews v. Ballard*, 498 F.Supp. 1038, 1047 (S.D. Tex. 1980). The Court continued,

> [I]t is the individual making the decision, and no one else, who, if he or she survives, must live with the results of that decision. One's health is a unique personal possession. The decision of how to treat that possession is of no less personal nature.

Id. The patient's trust in a practitioner to assist with those crucial decisions and treatment are among the most intimate, if not the most intimate, of those we encounter in life.

The Secretary argues that "relationships with doctors" are not "the type protected by the freedom of intimate association." *See* Appellees' Br. at 19 (citing *Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043, 1050 (9th Cir. 2000) (hereinafter "*Psychoanalysis*"). The Secretary's reliance on *Psychoanalysis* is misplaced, however, because that Court only had

occasion to explore where the doctor, not the patient, had a protected right in the relationship. *See Psychoanalysis*, 228 F.3d at 1050. Unlike patients, doctors cannot claim a right to associate with paying customers. *See id.*; *Hyman v. City of Louisville*, 132 F.Supp. 2d 528, 543 (W.D.Ky. 2001), *rev'd*, 53 Fed. Appx. 740 (6th Cir. 2002) (reversed for lack of standing). By contrast, in this case, the *patients'* right to choose is infringed. Patients have no financial interest in the relationship. Their interests are focused on receiving care from a trustworthy source. The right to associate with trustworthy medical practitioners is a lifelong pursuit that only increases in importance with age.

Moreover, in *Psychoanalysis*, the Court's driving rationale was that substantive due process rights do not extend to the choice or type of a particular health care provider only when the "government has reasonably prohibited that type of treatment or provider." *Psychoanalysis*, 228 F.3d at 1050 (citing *Mitchell v. Clayton*, 995 F.2d 772, 775 (7th Cir. 1993). In this case, the PPACA burdens citizens' ability to access medical treatment and care that has not been deemed unsafe or unlawful. Congress has simply erected obstacles to access that care, and those obstacles infringe on the protected relationship between a patient and his doctor.

The protected relationship is burdened when financially penalized. The Secretary argues that money is fungible, but that argument is belied by the fact that

here the government's system works a coercive effect. On the one hand, it is illegal not to associate with a private insurer who provides a PPACA-qualified plan and on the other, by electing to pay for care directly, the payer must finance two systems, the PPACA insurer and the physician not accepting insurance reimbursement. That combination of penalty and compelled association with payment burdens Plaintiffs' freedom to associate with practitioners of the Plaintiffs' choosing and compels their association with health care providers the Plaintiffs wish to avoid. The forced association on pain of federal penalty and outlaw status is an intended coercive mechanism in the statute that deprives Plaintiffs of their freedom of intimate association.

For Plaintiff Jim Grapek, his annual health care budget is effectively doubled under the PPACA because (in addition to the unwelcomed burden of having to divulge his medical confidences to PPACA covered care providers), he must pay for the PPACA covered care he does not want while also financing the non-PPACA covered care he presently receives and desires. *See* Appellants' Br. at 14-15; Grapek Affidavit ¶ 10 (R.E. 50-5). Plaintiff Maurice Thompson contracts directly with physicians who do not accept insurance reimbursement because he does not want the third party insurance system second guessing the independent professional judgment of his preferred physician (so he can be assured of receiving the best quality care, regardless of its reimbursement status). *See* Appellants' Br.

at 13-14; Thompson Affidavit ¶ 10 (R.E. 50-6). Plaintiff Thompson is thus also compelled to reduce his health care budget by the cost of PPACA insurance he does not want (and opposes on grounds of principle) as a penalty for the exercise of his right to continue contracting with his preferred physician who does not accept insurance reimbursement.

Second, the PPACA compels an association with a health care system the Plaintiffs seek to avoid. Health insurance is one of the largest expenses an average American household will incur. *See* Appellants' Br. at 17-18. Purchasing health insurance creates an immediate association with a medical orthodoxy, including all in-network practitioners. The right of intimate association also entails the right to be free from compulsory relationships of this kind. *See Roberts*, 468 U.S. at 623; *see also Thomas S. by Brooks v. Flaherty*, 699 F.Supp. 1178, 1203 (W.D.N.C. 1988) (freedom of expressive association case that explained "the right [to freedom of association] includes freedom from state coerced association. Even an indirect infringement on associational rights is impermissible and subject to the closest scrutiny"). The PPACA creates a forced, ideologically objectionable private association for the Plaintiffs that requires dedication of the same funds which would ordinarily be reserved for health care of the Plaintiffs' choosing.

The Federal Government need not expressly eliminate the choice of CAM health care for the right to medical choice to be implicated. The question is

whether the challenged statute effectively denies the right of privacy by "imposing a burden on," or "significantly interfer[ing] with," the citizen's choice of association. *See Carey v. Population Services, Intern.*, 431 U.S. 678, 686 (1977); *Zablocki v. Redhail*, 434 U.S. 374, 388 (1978). The argument that American citizens can purchase alternative health care services of their choosing in addition to the government qualified care does not lessen the burden on citizens' right of choice to purchase that health care in lieu of government qualified care. *See Andrews*, 498 F.Supp. at 1041, 1051.

When government action burdens a fundamental right or protected relationship, it must pass heightened judicial scrutiny. *See U.S. v. Brandon*, 158 F.3d 947, 956 (6th Cir. 1998) ("[g]overnment action that burdens a fundamental right will survive a substantive due process challenge only if it can survive strict scrutiny, i.e., if it is narrowly tailored to a compelling governmental interest."); *Am. Booksellers Found. for Free Expression v. Strickland*, 601 F.3d 622, 628 (6th Cir. 2010) (holding that "narrow tailoring" requires that the government act be the least restrictive means of promoting the compelling interest). The PPACA is the broadest possible means and, so, it is unconstitutional. Congress, for example, could have allowed citizens to seek exemptions from the PPACA based on independent medical coverage that was sufficient to meet certain standards. If uncompensated care was the concern, Congress could have raised taxes to pay for

increased subsidies to hospitals that provide services as required under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. The PPACA provides no option to escape the mandate for those citizens who do not want to associate with PPACA qualified providers or receive the care a PPACA qualified plan offers. The decision is foreclosed by the PPACA.

C. The PPACA Burdens the Plaintiffs' Fundamental Right of Expressive Association

The scope of protection afforded expression is broad. *See Boy Scouts of America v. Dale*, 530 U.S. 640, 648 (2000). The Secretary argues that citizens' freedom of expression is not implicated by the PPACA because the Act does not prohibit expression, but the Act does compel private associations that advance an insured care model that the Plaintiffs oppose. The promotion of insured private care is expressive activity, inasmuch as support for or opposition to abortion is ideological expression. In this case, the Plaintiffs' vocal support for direct payment for health care services and vocal opposition to insured care is undermined by the private association with and support for health insurance compelled by PPACA. The PPACA requires the plaintiffs to associate with the same private health insurance companies that Plaintiffs oppose on ideological grounds. The refusal is conduct. Under the Court's articulation of conduct in *Texas v. Johnson*, 491 U.S. 397 (1989), it should be "overly apparent" that a person choosing alternative medicine, or uninsured care, over conventional care

believes that the care chosen is more effective. By paying health insurance, the plaintiffs would endorse the system they believe provides inferior quality of care and denies physicians independent professional judgment needed to ensure the best quality care. Participation is antithetical to the Plaintiffs' ideological view against this type of care.

The Secretary argues that the Court's decision in *Rumsfeld v. Forum for Academic & Institutional Rights, Inc.* ("*FAIR*"), 547 U.S. 47 (2006) is dispositive. *See* Appellees' Br. at 21. In *FAIR*, however the court explained a critical distinction:

> Recruiters are, by definition, outsiders who come onto campus for the limited purpose of trying to hire students—not to become members of the school's expressive association. This distinction is critical. Unlike the public accommodations law in *Dale*, the Solomon Amendment does not force a law school "to accept members it does not desire."

Id. at 69. By contrast, the PPACA compels citizens to become dues-paying members in the system of third party health care, to ensure the survival and advancement of that system. More than forcing citizens to maintain a "mere presence" in the system, the PPACA compels membership and participation. *See id.* at 69, 70. The *FAIR* analogy is well-suited to the instant case. In *FAIR*, the Solomon Amendment could constitutionally allow military recruiters onto law school property for hiring purposes, but the law did not compel all students to attend interviews with military recruiters or to schedule such required interviews at

times when non-military recruiters were available to conduct interviews. *See id.* at 69-70. Indeed, the PPACA forces Plaintiffs' participation and replaces their opportunity to retain an exclusive association with the providers who do not accept insurance reimbursement who are their preferred providers.

D. The Minimum Coverage Provision Violates the Plaintiffs' Right to Privacy

The Secretary argues illogically that the PPACA does not require disclosure of medical information to insurance companies and health networks. As the affidavits from insurance broker DiStefano and economist Shepherd-Bailey confirm, insurance companies depend on detailed health information concerning individual enrollees to ensure that the companies remain going concerns. They must have that information to calculate risk management and margins and cannot function without that calculation. *See* Appellants' Br. at 53-43; DiStefano Affidavit at ¶¶ 7-9, 10 (R.E. 50-7); Report of Dr. Joanna M. Shepherd-Bailey at 16-18 (R.E. 50-2). An insurance company cannot determine whether to incur additional risk without an understanding of its current risk pool. Plaintiffs offered substantial evidence before the District Court, including the expert report of an econometrician and a health insurance agent, demonstrating that companies will continue to require disclosure of medical information. *See* Appellants' Br. at 53-43; DiStefano Affidavit at ¶¶ 7-9, 10 (R.E. 50-7); Report of Dr. Joanna M.

Shepherd-Bailey at 16-18 (R.E. 50-2). Any suggestion that insurance companies will alter their informational needs absent a statutory command to do so is wishful thinking by the Secretary, counterintuitive speculation unsupported by fact.

This appeal appears before the Court following a motion to dismiss. The plaintiffs' evidence should have been examined in a favorable light. *See Evans-Marshall v. Board of Educ. of Tipp City Exempted Village School Dist.*, 428 F.3d 223, 228 (6th Cir. 2005) (explaining that Court construes allegations in the light most favorable to the plaintiff and draws all reasonable inferences in favor of the pleader); *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984); *Grawey v. Drury*, 567 F.3d 302, 310 (6th Cir. 2009) (stating that, on appeal, "[t]he Court's *de novo* review must be based on the facts viewed in the light most favorable to the plaintiff"). There is nothing speculative about the impending disclosures under the law. The PPACA does nothing to prevent insurance companies from seeking the detailed medical information they must have to remain in business. Had Congress wished to deny insurers the ability to obtain that information, it would have been incumbent upon Congress to codify that change to the status quo. Congress did not, and the Secretary of HHS through regulation has not.

Moreover, what Appellees argue are discrete, "legitimate" requests for medical information are, in fact, all-encompassing medical status inquiries. *See* Appellees' Br. at 22-23. The Court analyzes forced disclosures of private

information under the two-step inquiry articulated in *Bloch:* (1) the interest at stake must implicate a fundamental right or one implicit in the concept of ordered liberty; and (2) the government's interest in disseminating the information must be balanced against the individual's interest in keeping the information private." *Bloch v. Ribar*, 156 F.3d 673, 684 (6th Cir. 1998). Limited, so-called "legitimate" requests may satisfy the *Bloch* analysis because the government's interest in disclosure outweighs the individual's interest in keeping that information private. Thus, in *Zuniga*, the government's need to investigate alleged schemes to defraud billings submitted to Michigan Blue Cross-Blue Shield outweighed the patients's interests in keeping private their relationships with psychoanalysts. *In re Zuniga*, 714 F.2d 632, 634, 639-42 (6th Cir. 1983).[2]

Zuniga demonstrates the risks inherent from insurance disclosures. The Court held that the patients' interest in privacy had been waived through the insurance contract:

[2] Appellees cite *NASA v. Nelson*, 131 S.Ct. 746, 761-63 (2011) as a recent case that "rejected an informational privacy claim based in part on the protections against disclosure to the public." Appellees' Br. at 22. The *NASA* decision, however, is congruous with the *Bloch* test. The *NASA* court struck a balance between the government's interest in disclosure and the employees' interest in privacy. *NASA*, 131 S.Ct. at 759-60. The Court held that the Government had an important interest in maintaining a reliable, law-abiding, efficient and effective workforce. *Id.* Knowing whether employees used illegal drugs was a useful means to assess those employees. *Id.* The interest in non-disclosure did not outweigh that government interest.

> Even assuming arguendo that the identity of a patient and the times and dates of his treatment were within the scope of the psychotherapist-patient privilege, the patients in this case could not benefit from that privilege. The patients in the case at bar have already disclosed their identities to a third party, i.e., Blue Cross/Blue Shield. In doing so they have waived the privilege to the extent of their disclosure.

Id. at 640. Under *Zuniga*, therefore, the PPACA may eviscerate certain privileges and protections in medical information when such information is forcibly disclosed to third party insurance entities. The *Zuniga* court further explained the degree of exposure for personal information disclosed to insurance companies and the risks thereof:

> In assenting to disclosure of these [insurance] documents, a reasonable patient would no doubt be aware that routine processing of reimbursement claims *would require these records to be brought into the hands of numerous anonymous employees within a large corporation*. While we might well have decided differently if the information sought under the subpoena involved detailed psychological profiles of patients or substantive accounts of therapy sessions, it cannot be said that the subsequent disclosure of such fragmentary data as is involved here as part of the insurance company's legal duties in assisting a federal criminal investigation would be beyond the contemplation of the patients' waiver.

Id. at 640-41 (quoting *In re Pebsworth*, 705 F.2d 261, 262-63 (7th Cir. 1983) (emphasis added).

The disclosure of medical information compelled under the PPACA fails the *Bloch* test because the government’s interest in disseminating information does not outweigh the individuals’ interest in keeping the information private. *Bloch*, 156

F.3d at 684. The information required by insurance companies is sweeping, embracing the entire health status of a patient and is not for a limited, discrete purpose in service to a substantial or compelling governmental interest. Congress has no interest in general health status disclosures to private insurance companies.

Although insurance companies demand medical information from enrollees, the Secretary argues that the PPACA does not directly compel the disclosure. *See* Appellees' Br. at 22-23. To make that argument, the Secretary must also argue that Congress did not expressly intend for the PPACA to function through the disclosure of sensitive medical information. *Id.* at 22 (suggesting that because "the Affordable Care Act will bar insurance companies from denying coverage or setting premiums on the basis of an individual's medical condition or history," then those insurance companies will refrain from seeking that information). It defies credulity to argue that Congress, aware of the common insurance practice of requiring health status information would leave that practice in place yet expect it to be eliminated in practice. Neither Congress nor the Secretary of HHS has proposed elimination of the common practice and procedure of insurance companies to compel all enrollees to divulge their health status information. Indeed, to determine which enrollees are pose high insurance risks and are candidates for the reinsurance programs, 42 U.S.C. § 18061, insurance companies must routinely evaluate health status of all enrollees. Congress made no findings

suggesting that disclosures were necessary to the operation of the PPACA such that an alternative constitutional approach could not be codified.

Congress could have placed in the PPACA limits on information required to be disclosed to companies in an insurance application or over the course of the relationship. It did not do so. Under the Secretary's argument, if the Act could operate in the same fashion without disclosure of medical information, then Congress has no basis to compel disclosure in the first instance. If the government has no reasoned basis for requiring disclosure of medical information, or at least preventing disclosure in the normal course of a now compulsory relationship, then the government cannot meet the *Bloch* test. Any individual interest in maintaining privacy will overcome the government's non-interest.

The plaintiffs-appellants have demonstrated a protected interest in maintaining the privacy of their medical information from disclosure to, *inter alia*, "the hands of numerous anonymous employees within a large corporation." *In re Zuniga*, 714 F.2d at 640-41. That protected interest outweighs the government's interest in disclosure and, therefore, the PPACA unconstitutionally abridges the plaintiffs' right to privacy.

CONCLUSION

For foregoing reasons, Appellants' respectfully request that this Court reverse the District Court, declare the PPACA's Individual Mandate unconstitutional, and enjoin its enforcement.

Respectfully submitted,

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DATED: July 18, 2011

CERTIFICATE OF COMPLIANCE UNDER FRAP 32(a)(7)

I certify that pursuant to Fed. R. App. P. 32(a)(7), the foregoing brief is proportionally spaced, has a typeface of 14 points Times New Roman, and contains 6,990 words, excluding those sections identified in Fed. R. App. P. 32(a)(7)(B)(iii).

U.S. CITIZENS ASSOCIATION

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CERTIFICATE OF SERVICE

I hereby certify that on July 18, 2011, I electronically filed the foregoing Appellants' Brief with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the Court's CM/ECF system. Participants in the case who are registered CM/ECF users will be served automatically by the CM/ECF system. I further certify that all of the participants in this case are registered CM/ECF users.

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