6-27-2011

Seven-Sky v. Holder - Brief of United States

Eric Holder
Attorney General of the United States

[ORAL ARGUMENT SCHEDULED FOR SEPTEMBER 23, 2011]

No. 11-5047

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

SUSAN SEVEN-SKY, et al.,

Plaintiffs-Appellants,

v.

ERIC H. HOLDER, JR., et al.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIEF FOR APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Counsel for Appellees certifies the following:

A. Parties and Amici

Except for the following, all parties, intervenors, and amici appearing before the district court and in this court are listed in the Opening Brief of Plaintiffs-Appellants:

No amici or intervenors appeared in the district court proceedings. Mountain States Legal Foundation; Judicial Watch, Inc.; Gary Lawson; Association of American Physicians and Surgeons, Inc.; Caesar Rodney Institute; Cato Institute; CatholicVote.org; State of Texas; Robert Natelson; Alliance for Natural Health USA; Pacific Legal Foundation; State of Florida; Guy Seidman; Competitive Enterprise Institute; State of Alabama; Independence Institute; Goldwater Institute; State of Indiana; Revere America; State of Kansas; Idaho Freedom Foundation; State of Maine, Randy E. Barnett, Professor; State of Michigan; State of Nebraska; State of North Dakota; State of Ohio; State of Pennsylvania; State of South Dakota; State of Washington; and State of Wisconsin appear before this Court as amici in support of appellant. Steven J. Willis appears before this Court as amicus in support of reversal. Service Employees International Union, Change to Win, and AARP have indicated their intention to participate in this Court as amici in support of appellee. Chamber of Commerce of the United States of America appears before this Court as amicus in

support of neither party.

B. Ruling Under Review

Plaintiffs-Appellants appeal from Judge Gladys Kessler's February 22, 2011 memorandum opinion and order granting the United States' motion to dismiss. JA 101-166. The memorandum opinion appears on Westlaw with the following citation: *Mead v. Holder*, __ F. Supp. 2d __, No. 10-950, 2011 WL 611139 (D.D.C. Feb. 22, 2011).

C. Related Cases

This case has not previously been before this Court or any other court than the district court from which this case has been appealed. Counsel for Appellees are not aware of any related cases pending in this Court within the meaning of Circuit Rule 28. Counsel for Appellees provide the following list of related cases pending in other U.S. courts of appeals and in courts in the District of Columbia:

Thomas More Law Center v. Obama, No. 10-2388 (6th Cir.)

Liberty University, Inc. v. Geithner, No. 10-2347 (4th Cir.)

Virginia ex rel. Cuccinelli v. Sebelius, Nos. 11-1057 & 11-1058 (4th Cir.)

Florida ex rel. Bondi v. U.S. Department of Health & Human Services, Nos. 11-11021 &
11-11067 (11th Cir.)

Baldwin v. Sebelius, No. 10-56374 (9th Cir.)

New Jersey Physicians, Inc. v. President of the United States, No. 10-4600 (3d Cir.)

U.S. Citizens Association v. Sebelius, No. 11-3327 (6th Cir.)

Kinder v. Geithner, No. 11-1973 (8th Cir.)

Purpura v. Sebelius, No. 11-2303 (3d Cir.)

Sissel v. U.S. Department of Health & Human Services, No. 1:10-cv-1263 (D.D.C.)

Association of American Physicians & Surgeons, Inc. v. Sebelius, No. 1:10-cv-499 (D.D.C.)

/s/ Samantha L. Chaifetz
Samantha L. Chaifetz
Attorney for Appellees

Date: June 27, 2011

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GLOSSARY

Affordable Care Act	Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
EMTALA	Emergency Medical Treatment and Labor Act
HHS	U.S. Department of Health and Human Services
IFHP	International Federation of Health Plans
RFRA	Religious Freedom Restoration Act
TMLC	Thomas More Law Center

STATEMENT OF JURISDICTION

The district court's jurisdiction arose under 28 U.S.C. §§ 1331 and 1346. The court entered final judgment on February 22, 2011. Plaintiffs filed a notice of appeal on February 25, 2011. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly held that the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act") is a valid exercise of Congress's commerce power.

2. Whether Congress's taxing power provides independent authority for the minimum coverage provision.

3. Whether the district court correctly rejected the claim that the minimum coverage provision will violate the rights of plaintiffs Seven-Sky and Lee under the Religious Freedom Restoration Act ("RFRA").

STATEMENT OF THE CASE

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

The Act's minimum coverage provision regulates the timing and method of payment for health care services. To uphold this provision, this Court need not make new law or alter the established allocation of authority between state and federal

government. The Court need only apply longstanding principles recognizing congressional authority to regulate economic conduct in or substantially affecting interstate commerce.

Unlike other markets with general participation, such as markets for food and housing, expenses in the health care services market are often too sudden, unpredictable and ruinously high to be reliably financed out-of-pocket. For that reason, insurance — a financial instrument — has long been the primary means of payment for health care services.

Tens of millions of Americans, however, do not have health insurance. Some lack the resources to purchase insurance. Some are denied insurance or charged exceedingly high premiums because of their preexisting medical conditions. And some "make an economic and financial decision" to "attempt to self-insure." 42 U.S.C.A. § 18091(a)(2)(A).

Despite being uninsured, these individuals, like all of us, may still need and obtain health care. Unfortunately, they often lack the means to pay for these services, resulting in tens of billions of dollars — $43 billion in 2008 — in uncompensated health care costs that are shifted to health care providers regularly engaged in interstate commerce. Providers pass on much of this cost to insurance companies, which also operate interstate. Those costs further raise premiums, which in turn

makes insurance unaffordable to even more people.

The Affordable Care Act reflects a cohesive effort to address these national problems. It seeks to increase the availability of health care coverage by expanding Medicaid, establishing insurance exchanges, and authorizing premium tax credits. It also regulates the insurance industry — barring insurers from denying or charging more for coverage because of a person's medical history or condition. And, in furtherance of these consumer protections — so as not to "undercut [this] Federal regulation of the health insurance market," 42 U.S.C.A. § 18091(a)(2)(H) — starting in 2014, the Act requires most individuals to maintain a minimum level of coverage or pay a tax penalty. 26 U.S.C.A. § 5000A.

In enacting this minimum coverage provision, Congress marshaled relevant facts in detailed statutory 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.A. § 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. *Id*. § 18091(a)(2)(A), (F). In addition, Congress found that the minimum coverage provision is "essential" to the

Act's reforms that prevent insurers from denying coverage because of an individual's medical condition or history. *Id*. § 18091(a)(2)(I). Congress found that, without the requirement, people would take advantage of these new consumer protections by postponing the purchase of insurance until they are injured or sick, a result that is untenable in an insurance market. *Ibid*.

2. Plaintiffs are four individuals who have brought a facial challenge to the minimum coverage provision. Pl. Br. 1. They allege that the provision exceeds Congress's Article I powers. Two plaintiffs (Seven-Sky and Lee) also contend that the provision will violate their free exercise rights under RFRA.

The individual plaintiffs claim to be "generally in good health" and state that they have not had health insurance "for a number of years." JA 49 ¶¶ 27, 30. For example, the declaration of Susan Seven-Sky, who is 53, states that she is "generally in good health"; that she "pay[s] for any health care expenses as they arise"; that she "could afford health insurance" but has "elected not to purchase such insurance"; and that she has "not had health insurance coverage for at least six years." JA 83-84 ¶¶ 2-4; *see also, e.g.*, JA 90 ¶¶ 2-4.

The district court upheld the minimum coverage provision as a valid exercise of Congress's commerce power. The court rejected the premise of plaintiffs' argument, which is that the minimum coverage provision regulates "inactivity."

JA 148. The court explained that virtually everyone participates in the health care services market and that the minimum coverage provision regulates the way people pay for health care services, which is economic activity that substantially affects interstate commerce. JA 140-143, 147-151. Noting Congress's findings, the court explained that people without insurance actively participate in the health care services market and shift much of the cost of their care to providers, who are often required to provide services without regard to a person's ability to pay. JA 141, 148. Providers, in turn, shift these uncompensated costs to insurance companies, which raises premiums for insured consumers in the health care services market. JA 141-142.

The court explained that the minimum coverage provision is also instrumental to the Act's insurance industry reforms that, beginning in 2014, will bar insurers from denying coverage because of pre-existing medical conditions ("guaranteed issue") or charging higher premiums based on medical history ("community rating"). JA 144-145. In addition, the court concurred in Congress's determination that the minimum coverage provision is essential to this larger regulation of interstate commerce because, without such a provision, people would wait until they are sick or injured to obtain insurance — an untenable result in an insurance market. JA 145.

The court rejected plaintiffs' RFRA claim, JA 161-166, and entered judgment

for the government.[1]

STATEMENT OF FACTS

I. Background

In responding to the crisis in the health care market, Congress confronted a market different from any other. Although participation in the health care market is virtually universal, an individual's need for medical care is unpredictable, as is the cost of medical care, which can easily exceed the economic means of all but the most wealthy. Insurance is thus the customary means by which people pay for health care services. Millions of people do not have insurance, however, and – unlike providers in other markets – health care providers are often legally required to provide medical services in times of need without regard to a consumer's ability to pay. As a result, people without insurance collectively shift the ongoing financial risk that they will incur costs beyond their ability to pay, and tens of billions of dollars of actual medical costs each year, to other participants in the health care market, thereby raising the premiums of insured consumers.

[1] As discussed in the Argument, the court erred in concluding that the minimum coverage provision is not independently authorized by Congress's taxing power, a power that provides an alternative ground for affirmance. The government does not challenge the court's conclusion that at least one plaintiff has standing and that the suit is ripe.

A. Participation in the health care services market is virtually universal, and the need for and cost of medical services are highly unpredictable.

Nearly everyone participates in the health care services market, regardless of whether they have insurance. In 2008 alone, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. U.S. Dep't of Health & Human Servs. ("HHS"), ASPE Research Brief, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills ("ASPE Research Br."), at 5 (May 2011). In 2009, almost 60% of Americans under age 65 who were "uninsured more than 12 months" had at least one visit with a doctor or to an emergency room; approximately 80% of those who were "uninsured for any period up to 12 months" did so. Centers for Disease Control and Prevention ("CDC"), Health, United States, 2010, table 79 (2011). One out of five uninsured individuals visits the emergency room each year. *Id.* table 89; CDC, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009, table 16 (2010).

The risk of illness or injury is ever-present, and, over time, virtually everyone participates in the health care market, yet the timing of an individual's need for expensive medical care is unpredictable. "Most medical expenses for people under 65" result "from the 'bolt-from-the-blue' event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim

we cannot (and they cannot) predict well in advance." Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance, Hearing Before the Joint Economic Comm. 32 (2004) (Prof. Pauly). "[E]ven the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur; the vast bulk of spending needs cannot be forecast in advance." Amicus Br. of Economic Scholars, *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir.) ("Economic Scholars Br."), at 10-11 (citing Winkelman & Mehmud, Society of Actuaries, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment, Apr. 2007).

Costs can mount rapidly for even the most common medical procedures. For example, approximately one in three babies is born by Cesarean delivery, the cost of which averages more than $13,000. *See* National Vital Statistics Reports, Births: Preliminary Data for 2009 (Dec. 2010); International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country ("IFHP Rep."), at 12. The average bill for a single hospital stay for an uninsured person is $22,200. ASPE Research Br. 8. The average cost of bypass surgery is nearly $60,000; of an appendectomy, $13,000; of an angioplasty, $29,000. IFHP Rep., at 14, 16, 17. An MRI scan alone costs $1,000 on average. *Id*. at 8. *See also, e.g.*, Meropol & Schulman, *Cost of Cancer Care: Issues and Implications*, 25 J. Clin.

Oncol. 180, 182 (2007) (one year of drug treatment for metastatic colorectal cancer can cost $150,000-$200,000).

The potential for financially ruinous burdens is plain, and 62% of all personal bankruptcies are caused in part by medical expenses. 42 U.S.C.A. § 18091(a)(2)(G). The risk we all confront can be expressed statistically for large populations, but what actually will happen to any given individual in a particular time period — the "frequency, timing and magnitude" of an individual's demand for health care services — is largely unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007); *see* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941, 948-49 (1963).

B. Private or government insurance is the customary means by which people pay for health care services, and the federal government's involvement in health care financing is pervasive.

Insurance, either private or governmental, is the customary means by which people manage this risk and pay for health care in the United States. In 2009, payments by private insurers constituted 32% of national health care spending. CMS, 2009 National Health Expenditure Data, table 3 (2011). Payments by government programs comprised over 43% of health care spending that year. *Id*., tables 5 & 11. Consumers' out-of-pocket expenses — including deductibles, copayments, and payments for uncovered services — accounted for only 12% of national health care

spending in 2009. *Id*., table 3.

The federal government's involvement in health care financing is pervasive. Virtually all Americans aged 65 or older are insured through the federal Medicare program. The Uninsured: A Primer, Kaiser Family Foundation, at 1 (Dec. 2010). Medicaid and the Children's Health Insurance Program cover 20% of the non-elderly population by covering four principal categories of low-income individuals: children, their parents, pregnant women, and disabled persons. *Id*. at 3. In 2010, federal spending on Medicare and Medicaid was over $790 billion, with billions more spent on other health care programs. CBO, The Long-Term Budget Outlook, at 37-39, (2011). These figures do not include the federal government's longstanding use of tax incentives to finance health care costs. CBO, Key Issues In Analyzing Major Health Proposals ("CBO, Key Issues"), at 30 (2008).

C. As a class, people who attempt to pay for health care services through means other than insurance shift significant costs to other participants in the interstate health care market.

An estimated 50 million people (18.8% of the non-elderly population) lacked health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009 ("Census Rep."), at 23 table 8. As discussed above (p.7, *supra*), these people actively participate in the interstate health care market, consuming more than $100 billion of health care services annually.

Families USA, Hidden Health Tax: Americans Pay a Premium, at 2 (2009) ($116 billion in 2008).

In the health care market, unlike in other markets, people receive expensive services in times of need without regard to their ability to pay. For decades, state and federal laws have required emergency rooms to stabilize any patient who arrives with an emergency condition, and common-law and ethical duties restrict a physician's ability to terminate a patient-physician relationship. *See* pp.39-42, *infra*. As a result, people without insurance "receive treatments from traditional providers for which they either do not pay or pay very little." CBO, Key Issues, at 13.

Congress found that, in 2008, the cost of uncompensated health care for the uninsured — *i.e.*, care received by uninsured patients but not paid for by them or a third party — was $43 billion. 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax, at 2, 6. Congress found that health care providers pass on a significant portion of these costs "to private insurers, which pass on the cost to families," increasing the average premium for insured families by "over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax, at 2, 6.

D. Before the Affordable Care Act, the percentage of people with private health insurance steadily decreased.

In 2009, the percentage of the non-elderly with private health insurance coverage (64.2%) was significantly lower than in 2000 (73.4%), meaning that millions more lacked insurance. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). The percentage covered by employment-based plans dropped from 68.3% in 2000 to 59% in 2009. *Ibid*.

People who attempt to purchase health insurance in the individual insurance market face significant obstacles. Insurers scrutinize applicants' medical condition and history to determine eligibility and premiums, a process known as "medical underwriting." CBO, Key Issues, at 8, 80. A recent national survey estimated that 9 million non-elderly adults — 35% of those who tried to purchase health insurance in the individual insurance market in the previous three years — were denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition. Help on the Horizon, Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010 ("Help on the Horizon"), at xi (2011).

Medical underwriting is expensive, and insurers pass on that expense through increased premiums in the individual market. Administrative costs for private health insurance, including underwriting costs, totaled $90 billion in 2006 — 26% to 30%

of the cost of the premiums charged in the individual and small group markets. 42 U.S.C.A. § 18091(a)(2)(J).

Given the cost of policies and restrictions on coverage, only 20% of Americans who lack employer insurance, government insurance, or other coverage options purchase a policy in the individual market. CBO, Key Issues, at 9. The remaining 80% are uninsured. *Ibid.*

II. The Affordable Care Act

The Affordable Care Act addresses problems in the national health care system that states individually have proven unable to solve effectively. Through comprehensive reforms, the Act seeks to make health care coverage widely available and affordable, protect consumers from adverse underwriting practices, and reduce the uncompensated care that shifts financial risks and costs to other participants in the interstate health care market and thereby increases premiums for insured consumers.

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.A. § 45R, and prescribed tax penalties under certain circumstances for large employers that do not offer full-time employees adequate coverage, *id*. § 4980H.

Second, the Act provides for the creation of health insurance exchanges to allow individuals, families, and small businesses to aggregate their buying power to obtain prices competitive with those of large-employer group plans. 42 U.S.C.A. § 18031.

Third, the Act offers tax credits to assist households with incomes from 133% to 400% of the federal poverty line in purchasing insurance through the exchanges. 26 U.S.C.A. § 36B(a), (b).[2] Congress also authorized federal payments to help cover out-of-pocket expenses (e.g., co-payments or deductibles) for eligible individuals who obtain coverage through an exchange. 42 U.S.C.A. § 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. Among other things, the Act bars insurers from refusing coverage because of pre-existing medical conditions and from charging higher premiums based on a person's medical history. *See, e.g.*, *id.* §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a).

Fifth, the Act's minimum coverage provision requires that non-exempted

[2] Except in Alaska and Hawaii, the federal poverty line in 2011 is $10,890 for one person and $22,350 for a family of four. HHS Poverty Guidelines, 76 Fed. Reg. 3637-02 (Jan. 20, 2011).

individuals maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C.A. § 5000A. The requirement may be satisfied through enrollment in an employer-sponsored plan; an individual market plan, including one offered through a health insurance exchange; a grandfathered plan; such government-sponsored programs as Medicare, Medicaid, or TRICARE; or similar coverage as recognized by the Secretary of 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 the requirement would impose a hardship. *Id.* § 5000A(e).

The CBO has projected that, by 2019, the Act will reduce the number of non-elderly people without insurance by about 33 million. Letter from CBO Director Douglas Elmendorf to House Speaker John Boehner, table 3 (Feb. 18, 2011).

SUMMARY OF ARGUMENT

The Affordable Care Act as a whole, and the minimum coverage provision in particular, regulate the way consumers pay for services in the interstate health care market. The Act reflects the considered effort of the elected Branches of government to stem a crisis in the health care market.

I. A. The minimum coverage provision is a quintessential exercise of the commerce power, which allows Congress to regulate not only interstate commerce but also economic conduct that substantially affects interstate commerce. As Congress found, the minimum coverage provision regulates economic activity — how participants in the health care market pay for their services — that substantially affects interstate commerce. The regulation furthers two principal economic goals. First, it prevents people from shifting the financial risks and actual costs of their care to other participants in the interstate health care market. Second, it is key to the viability of the Act's regulatory provisions barring insurers from relying on medical conditions or history to deny coverage or set premiums.

Fundamental features of the health care market are undisputed. Health care providers, suppliers, and insurers operate interstate. Virtually all Americans participate in the health care market, and all face the risk of unpredictable medical needs that may require services easily exceeding one's ability to pay. People are legally entitled to receive costly medical treatment in times of need even if they cannot pay. Congress found that people who endeavor to pay for health care without insurance often fail, and, as a class, do not pay for tens of billions of dollars of costs each year.

The federal government, along with state governments, shoulders some of these

costs. Health care providers pass much of the remainder on to private insurers, yielding higher premiums for the insured. Rising premiums mean more people cannot afford insurance, which contributes to the decline in the privately insured population. Completing the cycle, the growing number of uninsured persons further inflates premiums for others.

The Affordable Care Act breaks this cycle by requiring participants in the health care market to maintain a minimum level of insurance to meet their health care costs. The Act also restricts the underwriting practices of the insurance industry that have deprived many Americans of affordable insurance because of pre-existing medical conditions. The Act thus makes people legally insurable regardless of illness or injury and protects against higher premiums based on medical condition or history. The experience of state insurance regulators demonstrated that this system of guaranteed issue and community rating would be unworkable without a minimum coverage provision that prevents health care consumers from exploiting the new guarantees by delaying their purchase of insurance until their medical costs outstrip their premiums.

The minimum coverage provision falls within Congress's commerce power as Congress had far more than a rational basis for choosing it as a means of regulating the way individuals finance health care services, of preventing consumers from

shifting costs to other market participants, and of effectuating the Act's regulatory requirements of guaranteed issue and community rating. *Gonzales v. Raich*, 545 U.S. 1, 16-17, 22 (2005).

B. The district court correctly rejected the premise of plaintiffs' argument, which is that the minimum coverage provision regulates "inactivity." People without insurance are not "inactive"; they actively participate in the market for health care services. Health insurance is a means to pay for such services; health insurance is not obtained for its own sake. The minimum coverage provision regulates the way people pay for health care services — activity that is "commercial and economic in nature" and that has a substantial effect on interstate commerce. 42 U.S.C.A. § 18091(a)(2)(A), (F).

Plaintiffs concede that Congress can regulate the way people pay for health care services "'at the time that they initially seek medical care.'" Pl. Br. 32 (quoting *Florida v. HHS*, __ F. Supp. 2d __, 2011 WL 285683, *26 (N.D. Fla. 2011)). Plaintiffs take issue only with the timing of the minimum coverage requirement, asserting that it cannot be imposed until medical care is actually needed. *Ibid*.

This contention is premised on a deep misunderstanding of the nature of insurance and its role in the health care services market. Health insurance, by its nature, must be obtained before medical care is actually needed. Common sense,

experience, and economic analysis show that a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, Hearing Before the S. Comm. on Finance, 110th Cong. 52 (2008) (Prof. Hall). Moreover, it was clearly appropriate under the Necessary and Proper Clause for Congress to take into account the societal judgment — long reflected in state law, as well as the federal Emergency Medical Treatment and Labor Act ("EMTALA") — that it would be unconscionable to adopt an approach that would require providers to deny care because a person lacks insurance.

Even assuming, however, that plaintiffs could identify a preferable regulatory alternative, that would not provide a basis to invalidate the statute that Congress enacted. The Supreme Court has long stressed the deference owed to Congress's choice of means to accomplish its legitimate regulatory objectives. That deference reflects the constitutional authority and institutional capacity of the political Branches to make such operational choices. "The relevant question is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (citation omitted). That standard echoes the principles set forth in *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819), and reaffirmed countless times since: "Let the end be legitimate, let it be within the scope of the constitution, and all means which

are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional."

The end that Congress addressed in the minimum coverage provision is undoubtedly a proper regulatory objective under the Commerce Clause. People who forgo insurance and attempt to "self-insure" shift substantial risks and costs to others in the health care market. And the means that Congress selected — requiring people who can afford insurance to maintain a minimum level of coverage to meet their health care needs — is adapted to the health care market, in which insurance is already the customary means of payment. Moreover, the minimum coverage provision forms an essential part of the Act's regulation of insurers that guarantees that individuals like plaintiffs will be able to obtain affordable insurance even if they become injured or sick — insurance regulation that is indisputably legitimate under the Commerce Clause.

II. Congress's taxing power provides independent authority for the minimum coverage provision. The provision amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of health insurance will pay a tax penalty. The amount is calculated as a percentage of household income, above a flat dollar amount and subject to a cap. Like the federal income tax, it will be reported on the individual's tax return for the taxable year, and assessed and

collected in the same general manner as certain other federal tax penalties. The minimum coverage provision thus operates as a tax, and it is projected to raise billions of dollars in revenue each year.

Contrary to the district court's understanding, the validity of this provision under the taxing power does not turn on whether the assessment is labeled a "tax." The Affordable Care Act uses terms like "tax" and "assessable payment" interchangeably, and the Constitution itself uses various terms to describe the power of taxation. In "passing on the constitutionality of a tax law," a 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). Because the minimum coverage provision operates as a tax and is projected to raise revenue, it is a valid exercise of the taxing power.

III. Plaintiffs' RFRA claim is insubstantial for the reasons set out by the district court.

STANDARD OF REVIEW

The district court's rulings are subject to *de novo* review.

ARGUMENT

I. The Minimum Coverage Provision Is a Valid Exercise of Congress's Commerce Power.

The Constitution grants Congress 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. These grants of authority allow Congress to regulate not only interstate commerce but also other economic conduct that "substantially affect[s] interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing such substantial effects, Congress's focus is necessarily broad. Congress may consider the aggregate effect of a particular category of conduct, and need not predict case by case whether and to what extent particular individuals in the class will contribute to those aggregate effects. *Id.* at 22; *see also United States v. Sullivan*, 451 F.3d 884, 888 (D.C. Cir. 2006).

In reviewing the validity of Commerce Clause legislation, a court's task "is a modest one." *Raich*, 545 U.S. at 22. The court "need not determine" whether the regulated conduct, "taken in the aggregate, substantially affect[s] interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Ibid*. A court is similarly deferential in reviewing the means Congress chose to achieve legitimate ends. "[T]he Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or

'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch*, 17 U.S. at 413, 418). This deference reflects separation-of-powers principles and Congress's superior capacity to make empirical and operational judgments. It "has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity." *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 196 (1997).

Congress's findings and the legislative record leave no doubt that the minimum coverage provision — which regulates how people pay for services in the interstate health care market — is a valid exercise of the commerce power under the standards established by the Supreme Court. The provision "regulates activity that is commercial and economic in nature," 42 U.S.C.A. § 18091(a)(2)(A), and that substantially affects interstate commerce. First, Congress found that people who endeavor to pay for health care through means other than insurance shift billions of dollars of costs annually to other participants in the interstate health care market. *Id*. § 18091(a)(2)(F). Second, Congress found that the minimum coverage provision is key to the viability of the Act's insurance reforms that make individuals insurable at non-discriminatory rates regardless of illness or injury. *Id*. § 18091(a)(2)(I), (J).

A. The minimum coverage provision regulates economic activity that imposes a substantial burden on interstate commerce.

1. Congress enacted the minimum coverage provision as part of a broad scheme to regulate the payment for health care services. In findings set out in the statute, Congress explained that the minimum coverage provision "regulates activity that is commercial and economic in nature," including "how and when health care is paid for." 42 U.S.C.A. § 18091(a)(2)(A).

Congress identified the substantial burden on interstate commerce that it was seeking to alleviate. Congress found that people who "forego health insurance coverage and attempt to self-insure" fail to pay for the medical services that they consume. *Id*. § 18091(a)(2)(A), (F). Congress found that "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008." *Id*. § 18091(a)(2)(F). Congress also made findings about how these uncompensated costs affect the interstate health care market — costs are passed on from providers "to private insurers, which pass on the cost to families." *Ibid.* Congress determined that this cost-shifting inflates family health insurance premiums "by on average over $1,000 a year." *Ibid*.; *see also* Families USA, Hidden Health Tax, at 2, 6. In California, for example, uncompensated care for the uninsured accounts for an estimated 10% of premiums. S. Rep. No. 111-89, at 2 (2009).

In acting to reduce this cost-shifting, Congress dealt with the reality that all

people are at risk of injury and illness, and even those without insurance actively participate in the market for health care services. *See* p.7, *supra*. As a class, people without insurance pay only 37% of their health care costs out of pocket. Families USA, Hidden Health Tax, at 6. Third parties, including government programs that provide funding to offset the costs of care for the uninsured, pay for another 26% of the costs of care for the uninsured. *Ibid*. The remaining amount is "uncompensated care" that totaled approximately $43 billion in 2008, raising the annual insurance premiums paid by families by an average of $1000. *Ibid*.

Contrary to plaintiffs' suggestion, the problem of uncompensated care is not confined to a "small subset" of the uninsured population. Pl. Br. 6-7. Even in households at or above the median income, people without insurance pay, on average, for less than half the cost of the health care they consume. Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 229-31 (2005). And, in such households, uninsured people who consume more than $10,000 in medical services pay only 22% of the cost. *Id*. at 230.

As noted above, millions of uninsured people are hospitalized each year. Almost 60% of these hospitalizations of the uninsured result in bills over $10,000. ASPE Research Br. 5. About one-third result in bills in excess of $20,000, and more

than a quarter result in bills greater than $25,000. *Id*. at 5. In families with income above 400% of the federal poverty level — *i.e.*, nearly $90,000 for a family of four — people without insurance pay in full for only 37% of their hospitalizations. *Id*. at 1. Even uninsured families at the 90th percentile of savings pay in full for only half of their hospitalizations, and these bills account for just 14% of the total amount that hospitals bill the uninsured. *Id*. at 6.

2. Established Commerce Clause precedent leaves no doubt that Congress has the power to address this economic problem. In *Wickard v. Filburn*, 317 U.S. 111 (1942), and, more recently, in *Raich*, the Supreme Court found there was a rational basis for Congress to have concluded that leaving home-grown and home-consumed commodities (wheat and marijuana respectively) outside of a comprehensive federal regulatory scheme would affect the price and market conditions for those commodities. "In both cases," the Court explained, "the regulation is squarely within Congress' commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *Raich*, 545 U.S. at 19. Given that this level of effect on interstate commerce is sufficient to justify congressional exercise of the commerce authority, it is clear that the regulation of the means of payment for health care services at issue here — a multi-billion dollar problem resulting from the

failure of millions of uninsured patients to pay the full cost of the services they consume in an interstate market — satisfies the "substantial effects" standard and therefore is within Congress's commerce power.

For purposes of the commerce power, it is irrelevant that some uninsured individuals may not generate uncompensated costs in a particular month or year. The Supreme Court has never required Congress "to legislate with scientific exactitude," *Raich*, 545 U.S. at 17, and Congress is not required to predict, person-by-person, who among the uninsured will receive uncompensated health care services in a given month or year. Where "Congress decides that the 'total incidence' of a practice 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)) (quoted in *Sullivan*, 451 F.3d at 888).

Here, Congress determined that people who "forego health insurance coverage and attempt to self-insure" often fail, with corresponding "financial risks to households and medical providers." 42 U.S.C.A. § 18091(a)(2)(A). "Given the extremely high costs of health care for all but the most routine treatments and procedures, the cost of medical care is beyond the means of all but the most wealthy Americans." Economic Scholars Br. 4. Congress found that 62% of personal bankruptcies are caused in part by medical expenses. *Id*. § 18091(a)(2)(G). Given

that people without insurance actively participate in the health care services market, and that, as a class, they fail to pay for 63% of the services they receive, Congress had far more than a rational basis to conclude that attempts to "self-insure" pose "a threat to a national market." *Raich*, 545 U.S. at 17. Indeed, the predominance of insurance as the means of payment for health care reflects the fact that individual need for expensive medical care cannot accurately be predicted and personally funded ahead of time.

Although plaintiffs may prefer to "pay for health care expenses as they arise," JA 90 ¶ 4 (Rodriguez); JA 87 ¶ 4 (Ruffo); JA 83-84 ¶ 4 (Seven-Sky), Congress was not required to accept an individual's preference to finance health care costs in a particular way (or his prediction that he will be able to do so when the time comes). Even if plaintiffs here could somehow guarantee that they would be able to pay for whatever health care needs might arise for them, no matter the expense, and therefore not shift costs, that would provide no basis for exempting them from the reach of the statute. As a class, people who forgo insurance and attempt to "self-insure" pose a threat to the interstate health care services market, and "'the courts have no power to excise, as trivial, individual instances of the class.'" JA 153 (quoting *Perez*, 402 U.S. at 154-55) (quoted in *Raich*, 545 U.S. at 23).

In any event, plaintiffs' preference for paying future health expenses "as they

arise" does not change the fact that plaintiffs are presently shifting to other market participants the risk that plaintiffs will be unable to cover those expenses. The seriousness of that risk is underscored by plaintiffs' own allegations. Although plaintiffs claim to be in generally good health, they cannot guarantee their health or predict "what their future medical costs will be." JA 152. Nor do plaintiffs claim to have saved enough money to meet the need for expensive medical care. To the contrary, plaintiffs' own declarations suggest that a medical expense of any significance could exceed their ability to pay. Plaintiff Seven-Sky, for example, stated that she must reorganize her financial affairs now to save enough money to pay, over the course of a seven-year period beginning in 2014, a total of $3,895 in tax penalties. JA 85 ¶ 12, JA 86 ¶ 14;[3] *see* JA 89 ¶¶ 11-12 (Ruffo).

Plaintiffs' circumstances thus create a risk that they will incur medical expenses they cannot afford. The purchase of insurance is the classic mechanism for addressing that risk. Those, like plaintiffs, who forgo insurance expect instead to rely on other market participants to pick up the tab when they cannot pay. Moreover, they effectively rely on the insured to pay on an ongoing basis to maintain the emergency rooms, medical personnel, and other elements of the Nation's health care

[3] Public records indicate that Seven-Sky filed a voluntary bankruptcy petition in 2006. *In re Susan M. Seven-Sky*, No. 7:06-BK-22643 (Bankr. S.D.N.Y.).

infrastructure, which will be available to those who are now uninsured when their medical needs arise. The minimum coverage provision properly requires plaintiffs to contribute to the medical system they will almost certainly utilize and properly bars them from continuing to shift their own risk of costly illness and injury to others.

B. The minimum coverage provision is essential to the Act's guaranteed-issue and community-rating reforms, which prohibit insurers from relying on medical condition or history to deny coverage or set premiums.

1. The minimum coverage provision is also valid Commerce Clause legislation because it is integral to broader economic regulation — the requirement that insurers extend coverage and set premiums without regard to pre-existing medical conditions or history. *See Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981) (rejecting Commerce Clause challenge to "specific provisions" that were "integral" to a "complex regulatory program," which "as a whole" was designed to "prevent[] adverse effects on interstate commerce").

There is no dispute that these insurance regulations are valid exercises of Congress's commerce power. *See United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944) (insurance business is interstate commerce within the meaning of the Commerce Clause). Congress found, based on the experience of state regulators, that these guaranteed-issue and community-rating requirements would be unsustainable if participants in the health care market could postpone purchasing

insurance until an acute need arose. Congress thus concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in that regulatory scheme. *Raich*, 545 U.S. at 22. Thus, the minimum coverage provision forms "'an essential part of a larger regulation of economic activity.'" JA 145 (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995)).

The Nation has faced a serious shortage of affordable health insurance. More than 50 million non-elderly Americans went without insurance in 2009. Census Rep., at 23 table 8. Rising premiums have priced many out of the market. Between 1999 and 2010, for example, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Foundation Employer Health Benefits, 2010 Annual Survey, at 31, table 1.11 (2010).

Many in the individual market are excluded from coverage by "medical underwriting," a process by which insurers establish eligibility and premiums based on individual health status or history. Depending on the definition used, between 50 and 129 million non-elderly Americans (19% to 50% of the non-elderly population) have at least one pre-existing condition, and the four largest for-profit insurers excluded more than 600,000 individuals from coverage because of such conditions in the three years before the Affordable Care Act. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011); Chairman Henry A. Waxman and

Rep. Bart Stupak, Memorandum on Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market to H. Comm. on Energy & Commerce, at 1 (Oct. 12, 2010); *see also* Help on the Horizon, at xi (finding, during a three-year period, about 35% of non-elderly adults in the individual market were denied coverage, charged higher premiums, or offered limited coverage because of pre-existing conditions).

Insurers often deny coverage even for minor pre-existing conditions, including "conditions as common as asthma, ear infections, and high blood pressure." 47 Million and Counting, 110th Cong. 52 (Hall). "The four largest for-profit health insurance companies ... have each listed pregnancy as a medical condition that would result in an automatic denial of individual health insurance coverage." Chairman Waxman and Rep. Stupak, Memorandum on Maternity Coverage in the Individual Health Insurance Market to H. Comm. on Energy & Commerce, at 1 (Oct. 12, 2010).

The Act's guaranteed-issue and community-rating requirements will end these restrictive underwriting practices. Congress found that these requirements would not work without a minimum coverage provision to prevent health care consumers from taking advantage of the new protections by waiting to buy insurance until they are injured or sick. 42 U.S.C.A. § 18091(a)(2)(I). Congress thus found the provision "essential to creating effective health insurance markets in which improved health

insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id*. § 18091(a)(2)(I).

The legislative record demonstrated that the absence of a minimum coverage requirement linked to guaranteed-issue and community-rating requirements had undermined health care reform efforts in several states. For example, citing New Jersey's experience, Princeton University Professor Uwe 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." Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong., Prepared Testimony, at 11 (Mar. 17, 2009). In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & Law 71, 91-92 (2000). And, when Maine enacted similar legislation, most insurers withdrew from the state. Health Reform in the 21st Century: Insurance Market Reforms, Hearing Before the H. Comm. on Ways & Means, 111th Cong. 117 (2009) (Phil Caper, M.D., and Joe Lendvai). In contrast, Congress found that Massachusetts avoided these perils by enacting a minimum coverage requirement as part of broader insurance reforms. That requirement "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.A. § 18091(a)(2)(D).

2. Plaintiffs do not dispute that the minimum coverage requirement 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). They assert, however, that Congress has no power to address "'the adverse consequences of the Act itself.'" Pl. Br. 50 (quoting *Florida*, 2011 WL 285683, *31). This argument is doubly flawed.

First, the Supreme Court has made clear that Congress has particular latitude to enact provisions in aid of its broader regulatory programs. In *Raich*, for example, the Court upheld a ban on possession of home-grown marijuana as necessary to the efficacy of a broader scheme to suppress the interstate marijuana market. *Raich*, 545 U.S. at 22 & 25 n.34. As Justice Scalia stressed in his concurrence, where "Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" 545 U.S. at 36 (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

Applying this principle, in *United States v. Comstock*, the Supreme Court upheld a federal statute authorizing the civil commitment of certain mentally-

disordered prisoners otherwise due for release from federal custody. In concluding that the statute was "necessary and proper" to the government's role as custodian of federal prisoners, the Court observed that the statute was responsive to the problem created by "the Federal Government itself" when it incarcerates individuals "in remote federal prisons" and thereby "sever[s] their claim to legal residence in any State," making it less likely that they will "be detained by the States if released from federal custody." *Comstock*, 130 S. Ct. at 1961 (internal quotation marks omitted). *See also Jinks v. Richland County*, 538 U.S. 456, 461-64 (2003); *Navegar, Inc. v. United States*, 192 F.3d 1050, 1058 (D.C. Cir. 1999).

Second, plaintiffs fail to appreciate the true scope of the problems the Affordable Care Act addresses, and thus misperceive the role of the minimum coverage provision. For many people, the question is not *whether* to obtain insurance but *when* to obtain it. Substantial numbers move in or out of insurance coverage each year. CBO, How Many People Lack Health Insurance and for How Long? at 4, 9 (2003). Moreover, as a general matter, "young adults move into coverage as they grow older." Glied & Stabile, *Generation Vexed: Age-Cohort Differences in Employer-Sponsored Health Insurance Coverage*, 20 Health Affairs 184, 189 (2001); *see also* Census Rep., at 23 table 8 (showing that, in 2009, about 30% of individuals ages 18 to 34 lacked coverage, compared with about 16% of those ages 45 to 64).

It may seem rational to some healthy, young individuals to postpone joining the insurance pool — as long as insurance remains available at a later date. Many find, however, that changes in their medical condition render insurance unavailable. (Even a temporary condition as common as pregnancy can result in an automatic denial of individual health insurance coverage, p.32, *supra.*) And, when the uninsured develop significant medical needs, they resort to the "backstop of uncompensated care funded by third parties." *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010) ("*TMLC*").

The Affordable Care Act breaks this cycle by making all individuals insurable at non-discriminatory rates. "The uninsured ... benefit from the 'guaranteed issue' provision in the Act, which enables them to become insured even when they are already sick." *Ibid*. At the same time, the minimum coverage provision ensures "that all Americans who can afford it contribute to the costs of their own health care by maintaining reasonable insurance coverage." Economic Scholars Br. 5. Accordingly, the Act's provisions work in tandem to reduce cost-shifting by the uninsured and to reform dysfunctional markets in which people who need medical care cannot currently get insurance.

C. The minimum coverage provision is a necessary and proper means of regulating interstate commerce.

1. The minimum coverage provision is plainly adapted to the conditions of the health care market.

Plaintiffs do not dispute that people who forgo insurance and attempt to "self-insure" impose a substantial burden on the interstate health care market. Nor do plaintiffs question the centrality of the Act's guaranteed-issue and community-rating requirements. Instead, plaintiffs take issue with the means that Congress chose to ensure that participants in the health care market pay for the services they obtain. Plaintiffs concede that Congress could require that people have insurance "'at the time that they initially seek medical care.'" Pl. Br. 32 (quoting *Florida*, 2011 WL 285683, *26).[4] Plaintiffs object only to the *timing* of the insurance requirement, which, they contend, cannot be imposed before medical care is actually needed. Pl. Br. 32.

Governing precedent does not permit a court to override Congress's judgment about the appropriate means to achieve objectives that are within the scope of the commerce power. The federal government is "'one of enumerated powers,'" but, "at

[4] *See also* Opening/Response Br. of the State of Florida, et al., *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir.), at 31-32 (plaintiffs' concession that Congress could "impos[e] restrictions or penalties on individuals who attempt to consume health care services without insurance").

the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 405, 408). 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 *Wrightwood Dairy Co*., 315 U.S. at 118-19). Accordingly, "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) (quoting *United States v. Darby*, 312 U.S. 100, 121 (1941)).

In particular, the Supreme Court long ago rejected the contention that the commerce power cannot be exercised until after the harm to commerce – such as the receipt of uncompensated care – takes place. "It cannot be maintained that the exertion of federal power must await the disruption of ... commerce." *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 222 (1938). To the contrary, Congress may adopt "reasonable preventive measures" to avoid disruptions to interstate commerce before they occur. *Ibid.*

The minimum coverage provision is just such a "reasonable preventive measure." It is reasonably adapted to the practical and moral imperatives of the health care market, which require that insurance be obtained before the need for medical care is imminent. The minimum coverage provision ensures that non-exempted individuals who can afford insurance will pay for the health care services they consume, rather than shift their risks and costs to others. It is hardly novel for the government to require the purchase of insurance to prevent the externalization of costs. In the case of motor vehicle insurance, the requirement may accompany registration or use of a vehicle. *See, e.g.*, 49 U.S.C. § 13906(a). Notably, the risks addressed by health insurance are always present. Indeed, that is why health insurance is already the predominant means of payment for health care services in the United States.

Although plaintiffs urge that health insurance cannot be required until the time that people seek medical care, a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, 110th Cong. 52 (Hall). Moreover, our society has long recognized that it would be unconscionable to deny medical care to someone in an emergency because he failed to carry insurance. Well before the enactment of the federal Emergency Medical Treatment and Labor Act in 1986, state court rulings had imposed "a

common law duty on doctors and hospitals to provide necessary emergency care." H.R. Rep. No. 99-241(III) (1985), at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727. The modern rule "is that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency." *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) (citing *Valdez v. Lyman-Roberts Hosp., Inc.*, 638 S.W.2d 111, 114 (Tex. App. 1982); 35 A.L.R. 3d 841, § 4, at 846-47). In addition, longstanding common law restricts a physician's ability to terminate an existing physician-patient relationship. *See*, *e.g.*, 57 A.L.R. 2d 432, § 22[a] (1958); *Ricks v. Budge*, 64 P.2d 208, 210-13 (Utah 1937) (holding a physician subject to liability for refusing to continue treatment until the patient's outstanding account balance was paid).[5]

By 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists," which added to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care." H.R. Rep. No. 99-241(III) (1985), at 5. Finding these measures inadequate to prevent "hospital emergency

[5] *See also Woodfolk v. Group Health Ass'n, Inc.*, 644 A.2d 1367, 1368 (D.C. 1994) ("Generally, the patient's inability or failure to pay does not justify unilateral abandonment by the physician."); *Ascher v. Gutierrez*, 533 F.2d 1235, 1236-38 (D.C. Cir. 1976) ("[O]nce a physician enters into a professional relationship with a patient, he is not at liberty to terminate that relationship at will.").

rooms [from] refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance," H.R. Rep. No. 99-241(I), at 27, Congress augmented state law through EMTALA in 1986. The federal statute requires all hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, without regard to ability to pay. 42 U.S.C. § 1395dd; *see also Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999).

In devising its legislation, it was clearly "proper" for Congress to take into account the societal judgment — reflected in state and federal law — that denying emergency care because the patient lacks insurance would be unconscionable. *Cf. Comstock*, 130 S. Ct. at 1961 (noting the "common law" duty not to release dangerous persons in one's custody, in finding it "necessary and proper" for Congress to confine a federal prisoner whose mental illness threatens others). Indeed, that judgment is reflected in the laws of the very states that are plaintiffs' *amici* here.[6]

Plaintiffs suggest that Congress should have addressed its objectives by making an insurance requirement applicable when individuals seek health care services. Under such a scheme, the penalty for failing to maintain coverage — denial of

[6] *See*, *e.g.*, Fla. Stat. Ann. § 395.1041(3)(k)(1); Tex. Health & Safety Code Ann. § 311.022(a), (b); South Carolina Code Ann. § 44-7-260(E); La. Rev. Stat. Ann. § 40:2113.4(A); Idaho Code Ann. § 39-1391b; Wash. Rev. Code § 70.170.060(2); Utah Code Ann. § 26-8a-501(1).

treatment — would be far more draconian than the tax penalty that Congress enacted. Congress did not exceed its commerce power by requiring minimum coverage or payment of a tax, instead of conditioning access to medical care on the purchase of insurance and thereby denying treatment to the sick and injured if they lack coverage.

2. Congress can regulate participants in the health care market even if they are not currently "active" in the insurance market.

The district court correctly rejected the premise of plaintiffs' argument, which is that the minimum coverage provision regulates "inactivity." People without insurance are not "inactive"; they actively participate in the market for health care services and shift substantial costs to other market participants. The minimum coverage provision regulates the way participants in the health care market pay for the services they obtain — activity that is itself "commercial and economic in nature" and a subject of interstate commerce. 42 U.S.C.A. § 18091(a)(2)(A). Congress may regulate the conduct of participants in the health care market even if those individuals are, at a particular point in time, "inactive" in the insurance market.

Plaintiffs treat the minimum coverage requirement as if it were an end in itself that functioned only in the insurance market. Congress, however, viewed the requirement as a means of regulating payment for services in the health care market. That congressional judgment was not merely reasonable; it was correct. Health

insurance is not bought for its own sake; it is bought to pay for health care expenses. Porat, et al., *Market Insurance Versus Self Insurance*, 58 J. Risk & Ins. 657 (1991); Martin Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. Pol. Econ. 251, 253 (1973) ("Health insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchases of health services.").

Those who resort to other options to pay medical expenses may attempt to "use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, at 55; *see also* Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007). "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 University Inc. v. Geithner*, 753 F. Supp. 2d 611, 633 (W.D. Va. 2010). Some individuals may prefer to attempt to pay for health care services out-of-pocket rather than through insurance. But such economic conduct is plainly subject to regulation under the Commerce Clause. These individuals actively participate in the market for health care services and impose "a substantial impact on the national market for health care by collectively shifting billions of dollars on to other market participants and driving up the prices of insurance policies." *Ibid*.; *accord TMLC*, 720 F. Supp.

2d at 894.

In declaring that "the *inactive* private parties here affect the market only in the way that a teetotaler affects the liquor market," Pl. Br. 25 (citation omitted), plaintiffs ignore the fact that health insurance is not a commodity like liquor, but rather a means of paying for services in the interstate health care market. Medical services and health insurance are thus integrally related components of the overall health care market, as the prevalence of various forms of health insurance coverage attests. At the very least, Congress rationally could so conclude and address the problems of the market as it has done in the Affordable Care Act.

Although plaintiffs would divorce the insurance market from the health care market that it finances, the Supreme Court has long rejected such "formalistic" distinctions between categories of economic conduct in favor of "broad principles of economic practicality." *Lopez*, 514 U.S. at 569, 571 (Kennedy, J., concurring). "[Q]uestions of the power of Congress are not to be decided by reference to any formula" 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) ("[C]ommerce among the States is not a technical legal conception, but a practical one, drawn from the course of business."); *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962) (Congress in the Clayton Act

"prescribed a pragmatic, factual approach to the definition of the relevant market"); *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 414-15 (1914) (observing that insurance is "essentially different from ordinary commercial transactions").

In any event, even plaintiffs' narrow conception of market activity would not support their "facial challenge" to the minimum coverage provision because it would not "show that the Act would be constitutional under no set of circumstances." *Nebraska v. EPA*, 331 F.3d 995, 998 (D.C. Cir. 2003) (quotation marks and citations omitted); *see also Sabri v. United States*, 541 U.S. 600, 608-09 (2004); *United States v. Salerno*, 481 U.S. 739, 745 (1987). As discussed (p.35, *supra*), many people move in and out of the health insurance market and are thus "active" in that market even under plaintiffs' theory. Indeed, plaintiffs here have previously been insured, JA 49 ¶ 30, and a plaintiff in another suit obtained health insurance while her suit was pending, *see* Plaintiffs' Letter of May 25, 2011, *TMLC*, No. 10-2388 (6th Cir.).

D. Plaintiffs' legal arguments contradict governing Commerce Clause precedent.

1. Plaintiffs fail to identify any support for their contention that a federal insurance requirement cannot be imposed until people seek medical care. Plaintiffs declare, without support, that "[t]he power to regulate an interstate market extends to those who *voluntarily enter it during the duration of their participation* in that market[.]" Pl. Br. 7 (plaintiffs' emphasis). The Supreme Court, however, has

repeatedly rejected the argument that the exercise of the commerce power must await specific market transactions.

In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana grown at home for personal use. The Court found it irrelevant that the individuals were not engaged in commerce and did not buy, sell, or distribute any portion of the marijuana they possessed. The regulation was proper under the Commerce Clause 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. As to timing, Justice Scalia's concurrence noted that marijuana grown for home use "is never more than an instant from the interstate market." *Id.* at 40.

Raich reflected principles established more than half a century earlier in *Wickard v. Filburn*, which upheld the federal regulation of wheat that was neither "sold [n]or intended to be sold." 317 U.S. 119. The Court held that Congress's exercise of the commerce power was an appropriate means to control the volume and price of wheat in the interstate market, 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.

Plaintiffs seek support for their position from *Lopez* and *Morrison*. In those cases, however, the Supreme Court confronted a different issue under the Commerce Clause and rejected "the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce." *United States v. Morrison*, 529 U.S. 598, 617 (2000). In *Lopez*, the Court struck down a ban on possession of handguns in school zones. In *Morrison*, the Court invalidated a tort cause of action for gender-motivated violence. Neither measure played any role in broader regulation of economic activity, and the "noneconomic, criminal nature of the conduct at issue was central" to the decisions. *Id*. at 610; *accord Sabri*, 541 U.S. at 607; *Raich*, 545 U.S. at 35-36 (Scalia, J., concurring in the judgment).

The minimum coverage provision, in contrast, concerns intrinsically economic activity by requiring that non-exempted individuals maintain health insurance as a means to pay for services in the health care market. It is part of a broad economic regulation of financing in the massive interstate health care market, and it is essential

to the Act's regulation of underwriting practices in the insurance industry.[7] It is difficult to conceive of statutory provisions more clearly economic than the ones here, which regulate the means of payment for health care services and impose requirements on insurers and individuals made insurable by the Act.

Nor does the minimum coverage provision implicate the concern that animated *Lopez* and *Morrison*, which was 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 (quoting *Lopez*, 514 U.S. at 554). While the statutes at issue in *Lopez* and *Morrison* regulated local violence, long

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[7]The minimum coverage provision is so closely and inextricably linked to the new guaranteed issue and community rating reforms that the Government has acknowledged that those reforms are not severable from that provision. *See* 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). But plaintiffs' assertion (Pl. Br. 50 n.9) that the minimum coverage requirement cannot be severed from any other provision of the Affordable Care Act for the reasons set forth in the *Florida* district court decision, 2011 WL 285683, *33-39, 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 v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quotations omitted); *see also* Reply/Response Br. of HHS, et al., *Florida v. HHS*, at 56-58. However, 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). In all events, plaintiffs' contention is irrelevant, as the minimum coverage provision falls well within Congress's constitutional authority.

a subject of state criminal laws, the Affordable Care Act regulates economic activity in interstate markets. Even plaintiffs do not suggest that states, acting individually, could effectively solve all the problems that beset the Nation's health care system. *See Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 281-82 (1981) (Congress acted within its "traditional role ... under the Commerce Clause" where state-level regulation had proven inadequate); *Darby*, 312 U.S. at 122-23.

The modern health care system is interdependent and operates across state boundaries. Providers and insurers are joined in national networks, and consumers cross state lines to obtain health care services. "Hospitals are regularly engaged in interstate commerce, performing services for out-of-state patients and generating revenues from out-of-state sources." *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 213 (4th Cir. 2002) (citing *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 329-30 (1991)). Consumers also travel to obtain services not readily available in their own state. For example, residents of southwestern Pennsylvania make more than 1500 emergency room visits each year to a teaching hospital in West Virginia. *See* Amicus Br. of the Governor of Washington, *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir.), at 20-21 (noting also that a medical center in Seattle is the only Level 1 trauma center for the four-state region of Washington, Alaska, Montana, and Idaho); *see also Terry v. Reno*, 101 F.3d 1412, 1415 (D.C. Cir. 1996) (abortion clinics

"obtain medical equipment and supplies through interstate commerce" and "treat patients who travel interstate to obtain services").

Likewise, most health insurance is sold by national or regional companies that operate interstate, 42 U.S.C.A. § 18091(a)(2)(B), and that are characterized by "[i]nterrelationship, interdependence, and integration of activities in all the states in which they operate." *South-Eastern Underwriters Ass'n*, 322 U.S. at 541. "[I]nsurance ... pays for medical supplies, drugs, and equipment that are shipped in interstate commerce," and "claims payments also flow through interstate commerce." 42 U.S.C.A. § 18091(a)(2)(B).

2. Rather than address the pertinent features of the statute before this Court, plaintiffs attack a variety of far-fetched hypothetical statutes that bear no resemblance to the minimum coverage provision. Plaintiffs purport to see no difference between a requirement to maintain insurance to pay for health care costs and a requirement to "buy a General Motors automobile" or to "buy and consume broccoli at regular intervals." Pl. Br. 38 (quoting *Florida*, 2011 WL 285683, *24). They declare, for example, that the government's theory would support a mandate to buy a GM vehicle "so long as it was accompanied by a mandate that General Motors dealers provide vehicles to all who demonstrate a need for them (regardless of their ability to pay)." Pl. Br. 40.

As an initial matter, no state or federal law requires GM dealers to give away vehicles to those who cannot pay. The far-fetched nature of plaintiffs' hypothetical only underscores the fact that "health care is different." Stuart M. Butler, *The Heritage Lectures 218: Assuring Affordable Health Care for All Americans*, at 6 (Heritage Foundation 1989). "If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car." *Ibid*. By contrast, "[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." *Ibid*. "If we find that he has spent money on other things rather than insurance, we may be angry but we will not deny him services — even if that means more prudent citizens end up paying the tab." *Ibid*.

Moreover, plaintiffs' imaginary mandate confuses a directive to make a particular purchase with the minimum coverage provision, which regulates the way payments for health care services are made. There is no doubt that Congress can regulate the way people pay for products and services in interstate markets. *See*, *e.g.*, 15 U.S.C. § 1639(e) (provision of the Dodd-Frank Wall Street Reform and Consumer Protection Act that regulates the terms of mortgage financing).

Plaintiffs' hypothetical directive to eat broccoli has nothing to do with the Commerce Clause, but rather conjures up a due process argument that would apply

equally if a state adopted such a regulation. Even on its own terms, plaintiffs' argument is inapposite. Regulating the means of financing a purchase is fundamentally different from forced consumption of a food. Plaintiffs do not – and cannot – assert that the minimum coverage provision violates any "substantive due process" right. Such a claim "would have found Constitutional support in the Supreme Court's decisions in the years prior to the New Deal legislation of the mid-1930's, when the Due Process Clause was interpreted to reach economic rights and liberties," but the *Lochner*-era doctrine "has long since been discarded." *Florida v. HHS*, 716 F. Supp. 2d 1120, 1161 (N.D. Fla. 2010).

To be sure, the limitations on congressional power play a role in safeguarding individual rights. But stripped of rhetorical excess, the practical right plaintiffs seek to vindicate is the ability to consume health care services without insurance and to pass costs on to other market participants. There is, of course, no such right in the Constitution. Rather, the Commerce Clause provides Congress with ample authority to prevent such practices and to curb their substantial adverse effects on interstate commerce.

II. The Minimum Coverage Provision Is Also Independently Authorized by Congress's Taxing Power.

A. The minimum coverage provision operates as a tax.

The minimum coverage provision is also independently authorized by Congress's power to "lay and collect Taxes." U.S. Const. art. I, § 8, cl. 1. The taxing power is "comprehensive," *Steward Mach. Co. v. Davis*, 301 U.S. 548, 581-82 (1937)), and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-83 (D.C. Cir. 2007). In "passing on the constitutionality of a tax law," a 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*, 312 U.S. at 363; *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 a "penalty").

The "practical operation" of the minimum coverage provision is as a tax. *Nelson*, 312 U.S. at 363. The provision amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of coverage shall pay a monthly penalty for so long as he fails to maintain that minimum. 26 U.S.C.A. § 5000A. The amount of the penalty is calculated as a percentage of household income for federal income tax purposes, subject to a floor and a cap. *Id.* § 5000A©. The payment is reported on the individual's federal income tax return for the taxable year, and is "assessed and collected in the same manner as" other

specified federal tax penalties. *Id.* § 5000A(b)(2), (g). Individuals who are not required to file income tax returns for a given year are not required to pay the penalty. *Id.* § 5000A(e)(2). The taxpayer's responsibility for family members depends on their status as dependents under the Internal Revenue Code. *Id.* § 5000A(a), (b)(3). Taxpayers filing a joint tax return are jointly liable for the penalty. *Id.* § 5000A(b)(3)(B). And the Treasury Secretary is empowered to enforce the penalty provision. *Id.* § 5000A(g).

It is undisputed that the minimum coverage provision will be "productive of some revenue." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937). The Congressional Budget Office found that it will raise at least $4 billion a year in revenues for the general treasury, *see* Letter from CBO Director Douglas Elmendorf to House Speaker Nancy Pelosi, table 4 (Mar. 20, 2010), and Congress adopted that finding to conclude that the provision, together with the rest of the Act, will reduce the federal deficit, *see* Pub. L. No. 111-148, § 1563(a)(1), 124 Stat. 119, 270 (2010). More recent CBO projections indicate that the provision will yield $5 billion annually by 2021. Letter from Elmendorf to Boehner, table 3. The provision bears "some reasonable relation" to the "raising of revenue," *United States v. Doremus*, 249 U.S. 86, 93-94 (1919), and it is therefore within Congress's taxing power. *See also Nigro v. United States*, 276 U.S. 332, 353 (1928) (any "doubt as to the character" of a tax

was removed because provision raised "substantial" sum of $1 million per year).

B. The provision's validity under the taxing power does not depend on how the assessment is labeled.

Contrary to the district court's understanding (JA 159), Congress was not required to invoke its taxing power in the Act itself. "[T]he constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise." *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948). Applying the presumption of constitutionality, a court's task is "to determine whether Congress had the authority to adopt the legislation, not whether it correctly guessed the source of that power." *Usery v. Charleston Co. Sch. Dist.*, 558 F. 2d 1169, 1171 (4th Cir. 1977).

In any case, Congress did rely on its taxing power: the taxing power was expressly invoked to defeat constitutional points of order against the minimum coverage provision in the Senate. 155 Cong. Rec. S13,830, S13,832 (Dec. 23, 2009); *see also* H.R. Rep. No. 111-443(I), at 265 (2010). Moreover, the legislative history of the provision shows that terms like "excise tax" and "penalty" were used interchangeably. *Compare* S. 1796 (Oct. 19, 2009) (Senate Finance Committee bill) (using term "excise tax"), *with* S. Rep. No. 111-89, at 52 (Oct. 19, 2009) (Committee Report) (describing it as a "penalty ... accounted for as an additional amount of Federal tax owed"). Similarly, in the Act's employer responsibility provision,

Congress alternated among the terms "tax," "assessable payment," and "assessable penalty." 26 U.S.C.A. § 4980H(b)(1), (2), (c)(2)(D), (d)(1).

Far from disclaiming its taxing power, Congress placed the minimum coverage provision in the Internal Revenue Code; required that payment be included on the taxpayer's income tax return; and calculated the amount owed as a percentage of income, subject to a floor (like the Alternative Minimum Tax) and a cap (like the Social Security tax). Moreover, during the legislative debates, congressional leaders defended the provision as an exercise of the taxing power. *E.g.*, 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); *id.* at H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (Dec. 22, 2009) (Sen. Leahy); *id.* at S13,558, S13,581-82 (Dec. 20, 2009) (Sen. Baucus).

In short, the minimum coverage provision is a tax in both administration and effect. It is enforced by the Internal Revenue Service and — in conjunction with the rest of the Act — has been determined by the CBO and Congress to reduce the budget deficit. Any doubt as to the meaning of the words in the Affordable Care Act should be construed in favor of the statute's constitutionality. *Nw. Austin Mun. Utility Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009); *Ashwander v. TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring).

C. Congress may impose taxes that also regulate the activity taxed.

The district court concluded that the goal of the minimum coverage provision is not to raise revenue, but to achieve near-universal health care coverage. JA 160. It is settled, however, that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States v. Sanchez*, 340 U.S. 42, 44 (1950). "Every tax is in some measure regulatory" in that "it interposes an economic impediment to the activity taxed as compared with others not taxed." *Sonzinsky*, 300 U.S. at 513. 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." *Id*. at 514; *id.* at 512 (rejecting the argument that a tax on firearms dealers was "not a true tax, but a penalty imposed for the purpose of suppressing traffic in a certain noxious type of firearms"). Accordingly, "'the courts 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 (quoting *A. Magnano Co. v. Hamilton*, 292 U.S. 40, 47 (1934)) (rejecting challenge to tax on marijuana transfers that rested "on the regulatory character and prohibitive burden of the section as well as the penal nature of the imposition"). The Supreme Court has long "abandoned the

view that bright-line distinctions exist between regulatory and revenue-raising taxes." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 743 n.17 (1974).[8]

Although the taxing power may not be used to impose "punishment for an unlawful act," *United States v. LaFranca*, 282 U.S. 568, 572 (1931), the minimum coverage provision has none of the hallmarks of a "punitive" sanction. *Dep't of Revenue v. Kurth Ranch*, 511 U.S. 767, 778-79 (1994). It does not turn on the taxpayer's scienter. *Cf. The Child Labor Tax Case*, 259 U.S. 20, 36-37 (1922). And, unlike in cases where a "highly exorbitant" tax rate showed an intent to "punish rather than to tax," *United States v. Constantine*, 296 U.S. 287, 294, 295 (1935), the penalty under the minimum coverage provision can be no greater than the cost of qualifying insurance, 26 U.S.C. § 5000A(c)(1)(B). *Cf. Sanchez*, 340 U.S. at 45 ("rational foundation" for tax rate showed it was not a punitive sanction in disguise). Moreover, the penalty is imposed on a month-by-month basis, 26 U.S.C. § 5000A(b)(1), and payment of the penalty relieves the taxpayer of the obligation to purchase insurance, in contrast with instances in which an individual who violates a statute must pay a penalty and is still required to satisfy the underlying obligation. *See United States v. Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 224-

[8] Congress broke no new ground in using the tax code to shape decisionmaking related to health care. For more than fifty years, federal tax law has pervasively regulated this area. *See, e.g.*, 26 U.S.C. §§ 35, 106, 223, 4980D, 9801-34.

25 (1996). Thus, the minimum coverage provision is not a "punitive measure." JA 159.

III. THE DISTRICT COURT CORRECTLY REJECTED PLAINTIFFS' RFRA CLAIM.

Congress exempted from the minimum coverage requirement individuals who qualify for specified "religious exemptions." 26 U.S.C.A. § 5000A(d)(2). The Affordable Care Act's "religious conscience exemption" incorporates a longstanding provision of the Internal Revenue Code that applies to members of religious sects that "make provision for their dependent members," who are "conscientiously opposed to acceptance of the benefits of any private or public insurance" (including Medicare and Social Security benefits). 26 U.S.C.A. § 1402(g)(1) (incorporated by § 5000A(d)(2)(A)). In addition, the Affordable Care Act's "health care sharing ministry" provision exempts members of § 501(c)(3) organizations whose members share a common set of religious or ethical beliefs, share medical expenses among themselves in accordance with those beliefs, and retain membership even after they develop a medical condition. 26 U.S.C.A. § 5000A(d)(2)(B).

Plaintiffs Seven-Sky and Lee do not claim to qualify for either of these statutory exemptions. They urge, instead, that they are entitled to an exemption under RFRA, which prohibits the federal government from imposing a substantial burden on a person's exercise of religion unless the burden is the least restrictive means of

furthering a compelling governmental interest. *Kaemmerling v. Lappin*, 553 F.3d 669, 677 (D.C. Cir. 2008). A substantial burden upon religious exercise exists when "government action puts substantial pressure on an adherent to modify his behavior and to violate his beliefs." *Id*. at 678 (quotation marks and citation omitted). The "claimed beliefs must be sincere and the practice[] at issue must be of a religious nature." *Ibid*. (quotation marks and citation omitted). "An inconsequential or *de minimis* burden on religious practice does not rise to this level, nor does a burden on activity unimportant to the adherent's religious scheme." *Ibid*.

The district court correctly held that Seven-Sky and Lee failed to allege facts showing that the minimum coverage provision will impose a substantial burden on their religious exercise. JA 163. Although these plaintiffs claim to oppose insurance on religious grounds, neither claimed to have objected to contributing to other public insurance programs or to have waived their rights to such benefits. To the contrary, Seven-Sky and Lee "routinely contribute to other forms of insurance, such as Medicare, Social Security, and unemployment taxes, which present the same [asserted] conflict with their belief that God will provide for their medical and financial needs." JA 164; *cf*. 26 U.S.C. § 1402(g)(1)(B) (to qualify for a federal tax exemption under § 1402(g)(1), an individual must submit an application that waives the right to Social Security and Medicare benefits).

Although Seven-Sky and Lee alleged that they will not enroll in Medicare, they did not allege that they would forgo Social Security insurance benefits, or explain how contributing to or receiving such benefits is consistent with their allegedly burdened religious practices. *E.g.*, JA 50 ¶¶ 35, 37; JA 20-21 ¶¶ 29, 32; JA 22-23 ¶¶ 43, 45. And, as the district court explained, enrollment in Medicare Part A is automatic for anyone who is entitled to Social Security benefits. JA 116-117 (citing 42 U.S.C. § 426(a)).

Moreover, courts have repeatedly declined to exempt from required Social Security contributions persons who assert religious objections but fall outside of the exceptions provided by Congress. *See, e.g.*, *United States v. Lee*, 455 U.S. 252 (1982); *Droz v. Comm'r, IRS*, 48 F.3d 1120, 1123-24 (9th Cir. 1995). As the Supreme Court explained in *Lee*, "mandatory participation is indispensable to the fiscal vitality" of a "comprehensive insurance system." 455 U.S. at 258. Congress crafted § 1402(g)(1) to exempt religious sects that "provide[] for their own needy," *Varga v. United States*, 467 F. Supp. 1113, 1117 (D. Md. 1979), *aff'd*, 618 F.2d 106 (4th Cir. 1980), and courts have recognized that permitting individuals who do not belong to such groups (and thus are not "provided for" in this way) "to opt out" would "threaten the integrity" of the scheme, *Droz*, 48 F.3d at 1123. Likewise, here, Congress established a comprehensive scheme, and exempted individuals who belong

to groups with established records of providing for the medical needs of their members and whose members have a demonstrated history of maintaining membership even after becoming ill. Congress was not required to exempt Seven-Sky or Lee, who belong to no such groups. Their RFRA claim offers no basis on which to override Congress's calibrated approach.

CONCLUSION

For the foregoing reasons, the district court's judgment should be affirmed.

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B). It has been prepared in Times New Roman, 14-point font. The Corel WordPerfect X5 word count is 13,994, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii) and Circuit Rule 32(a)(1).

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Date: June 27, 2011

CERTIFICATE OF SERVICE

I hereby certify that on June 27, 2011 the foregoing brief was filed via the CM/ECF system with the Court and served via the CM/ECF system to the following counsel of record:

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ADDENDUM

26 U.S.C.A. § 5000A
(Affordable Care Act minimum coverage provision)

§ 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.--An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.--

(1) In general.--If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.--Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.--If an individual with respect to whom a penalty is imposed by this section for any month–

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.--

(1) In general.--The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of--

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.--For purposes of paragraph (1)(A), the monthly penalty

amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.--An amount equal to the lesser of--

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.--An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.--For purposes of paragraph (1)--

(A) In general.--Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.--The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.--If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.--In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to--

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.--For purposes of this section--

(A) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.--The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of--

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who--

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.--The term "modified adjusted gross income" means adjusted gross income increased by--

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) Applicable individual.--For purposes of this section--

(1) In general.--The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions.--

(A) Religious conscience exemption.--Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is--

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry.--

(i) In general.--Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.--The term "health care sharing ministry" means an organization--

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.--Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.--Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.--No penalty shall be imposed under subsection (a) with respect to--

(1) Individuals who cannot afford coverage.--

(A) In general.--Any applicable individual for any month if the applicable

individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.--For purposes of this paragraph, the term "required contribution" means--

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.--For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) Indexing.--In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.--Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes.--Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.--

(A) In general.--Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.--For purposes of applying this paragraph--

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.--Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.--For purposes of this section--

(1) In general.--The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.--Coverage under--

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan.--Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.--Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.--Coverage under a grandfathered health plan.

(E) Other coverage.--Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.--The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is--

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.--The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits--

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.--Any applicable individual shall be treated as having minimum essential coverage for any month--

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.--Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.--

(1) In general.--The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.--Notwithstanding any other provision of law--

(A) Waiver of criminal penalties.--In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.--The Secretary shall not--

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

42 U.S.C.A. § 18091
(Affordable Care Act congressional findings)

§ 18091. Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement 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.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

42 U.S.C. § 2000bb-1
(Religious Freedom Restoration Act)

§ 2000bb-1. Free exercise of religion protected

(a) In general

Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability, except as provided in subsection (b) of this section.

(b) Exception

Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person--

(1) is in furtherance of a compelling governmental interest; and

(2) is the least restrictive means of furthering that compelling governmental interest.

(c) Judicial relief

A person whose religious exercise has been burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding and obtain appropriate relief against a government. Standing to assert a claim or defense under this section shall be governed by the general rules of standing under article III of the Constitution.