1-1-2011

Bryant v. Holder - U.S. Reply Brief

Eric Holder
United States Office of the Attorney General

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

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

REPLY IN SUPPORT OF MOTION TO DISMISS

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INTRODUCTION

Congress passed the minimum coverage provision, which plaintiffs challenge in this case, as part of a comprehensive health care reform scheme. Patient Protection and Affordable Care Act ("ACA" or the "Act"), Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (2010) (codified at 26 U.S.C. § 5000A). To remedy significant problems in the availability and affordability of health care and health insurance, the ACA expands government insurance programs and bars private insurers from denying or charging more for insurance coverage based on the health of the applicant. Congress enacted the minimum coverage provision as an essential precondition to the ACA's reforms of the insurance industry. Without this requirement that individuals maintain a minimum level of insurance coverage to pay for the health care services that they will later receive, the ACA's guarantee of access to insurance would enable individuals to hold off purchasing insurance until they became ill, leading ultimately to the collapse of the insurance system. In addition, Congress expressly found that the "economic and financial decision[s]" of some individuals "to forego health insurance coverage and attempt to self-insure," 42 U.S.C. § 18091(a)(2)(A), had shifted billions in costs to other participants in the health care market when those individuals were unable to pay at the point when health care expenses arose. *Id.* § 18091(a)(2)(F). The minimum coverage provision was intended to alleviate this significant burden on the interstate health care market.

The minimum coverage provision will not go into effect until 2014, and the penalty that serves as its enforcement mechanism, set forth in § 5000A(b), will not be assessed until 2015, when taxpayers record it on their tax return and pay it with their 2014 taxes. Plaintiffs insist that they are certain to incur the § 5000A penalty four years from now, but intent does not establish an impending injury in this case. The issue is not whether the minimum coverage provision is certain to go into

effect, but whether the provision is certain to apply to plaintiffs and whether they are certain not to satisfy it in three years. Plaintiffs allege no facts to support any such conclusion. Indeed, the Amended Complaint ("Complaint") expressly alleges that plaintiff Bryant sues on behalf of a "class or subclass" of state government employees covered by the state health plan. Under 26 U.S.C. § 5000A(f)(1)(B), (2)(A), individuals covered under such a plan will likely meet the minimum coverage requirement. Moreover, plaintiffs advance no claim in the Complaint regarding any current financial effect stemming from the potential future penalty that they assert they will face. Plaintiffs therefore lack standing to challenge the minimum coverage provision, and their claims are unripe.

Even if this Court concludes that it has subject matter jurisdiction, it should recognize the fundamental fallacy at the heart of plaintiffs' claims and dismiss those claims on the merits. The implication of plaintiffs' argument that the minimum coverage provision falls beyond Congress's Article I powers is that only States could impose such a requirement. The well-worn Commerce Clause jurisprudence seeks to distinguish between what is national (truly related to "interstate commerce") and what is local. Under that analysis, the minimum coverage provision clearly falls on the "national" side of the line. It is an integral part of a comprehensive regulation of the vast interstate health care market. It regulates the means of payment in that interstate market, where the dominant means is through health insurance. And it is essential to regulatory reforms in the interstate health insurance market. Congress's conclusion that, in the aggregate, uncompensated care has a substantial effect on the health care market is undeniably rational, given the significant costs that such care imposes on third parties, including governments, private insurers, and families throughout the nation that face spiraling premiums and health care bills as a result.

While plaintiffs invoke the rhetoric of state sovereignty in their Complaint and opposition

brief, they fail to explain how states could be deemed the only parties that could validly, or even practically, address the problems in these national markets. And the essence of their argument is not focused on state sovereignty at all. Instead, the "inactivity" exception that they seek to insert, for the first time, into Commerce Clause analysis reflects the focus of their real concern as individual liberty, not state sovereignty.

The premise of plaintiffs' argument – that the minimum coverage provision "regulates inactivity," and is therefore beyond Congress's Article I powers – is simply wrong. The Commerce Clause empowers Congress to regulate participants in a relevant market, and Congress is entitled to define the market in which it wishes to regulate. Those regulated by the minimum coverage provision are participants in the health care market who are faced with the question of how to pay for the health care that they will almost inevitably receive. Because, as a practical matter, health insurance must be purchased before health care expenses are incurred, Congress rationally imposed the requirement to maintain health insurance at the point when individuals face the decision of how to finance their future health care costs. However, those who would otherwise decide to risk incurring catastrophic costs that they cannot afford, and shifting those costs to third parties, cannot be deemed "inactive" in the health care market. Moreover, the provision regulates those who have insurance as well, specifying the appropriate level of coverage. Those individuals cannot be deemed inactive even under plaintiffs' theory. Even if plaintiffs' "inactivity" argument otherwise had merit, they could not prevail in a facial challenge solely on that basis because the provision is necessarily valid when applied to those whom plaintiffs would agree are "active," and who are a significant majority of the participants in the health care market. Plaintiffs' attempt to misconstrue the Supreme Court's latest application of the Necessary and Proper Clause must also be rejected, as must their

assertion that the § 5000A penalty cannot be sustained as a valid tax.

The proper focus of plaintiffs' individual-liberty claim is not Article I at all, but the Due Process Clause of the Fifth Amendment, and plaintiffs do raise such a claim. However, the economic rights that plaintiffs attempt to assert cannot be deemed "fundamental" in the post-*Lochner* era. Moreover, their claim that the minimum coverage provision compels them to disclose private medical information is far fetched, particularly since they assert that they have no intention of acquiring health insurance, and the nature of information that health insurance companies may require to enroll in qualifying plans three years from now is unknown. Because the minimum coverage provision easily satisfies the applicable rational basis review, plaintiffs state no viable claim on this ground.

The claim that Lieutenant Governor Bryant separately raises and defends must also be dismissed. The Lieutenant Governor does not explain how he, as an individual, is affected by the ACA's regulation of employers. Moreover, his assertion that the application of these requirements to states is equivalent to "commandeering" states to implement federal policy has no merit. It is well established that the states are subject to generally applicable federal regulations, and the application of federal requirements to employee benefit programs is a commonplace that has absolutely no impact on state sovereignty.

ARGUMENT

I. THIS COURT LACKS SUBJECT MATTER JURISDICTION

Plaintiffs cite the wrong standard for reviewing the jurisdictional issues that defendants raise in their Motion to Dismiss. Dismissal based on lack of subject matter jurisdiction is governed by Rule 12(b)(1) rather than Rule 12(b)(6) and is appropriate where "it appears certain that the plaintiff

cannot prove a plausible set of facts that establish subject-matter jurisdiction." *Davis v. United States*, 597 F.3d 646, 649 (5th Cir. 2009) (internal quotation omitted). Plaintiffs bear the burden to establish the Court's jurisdiction. *Id.* (citing *Ramming v. United States*, 281 F.3d 158, 161 (5th Cir. 2001)). Moreover, the "plausibility standard" that the Supreme Court has explained in *Bell Atlantic Corp. v. Twombly,* 550 U.S. 544 (2007), and *Ashcroft v. Iqbal,* 129 S. Ct. 1937 (2009), applies to standing and ripeness, and requires that a complaint contain sufficient factual allegations to establish an Article III case or controversy, if true. *White v. United States*, 601 F.3d 545, 552 (6th Cir. 2010).

A. Plaintiffs Have Failed to Establish Their Standing To Bring This Suit

Plaintiffs do not meet their burden to establish standing. In their Complaint, plaintiffs assert that they currently have no health insurance and "have no intention" of complying with the minimum coverage provision when it goes into effect in 2014. Comp. ¶¶ 26-27. Plaintiffs therefore rest their standing to challenge the provision solely on the notion that they face a "credible threat" of owing a penalty when they file their tax returns in 2015. *See id.* ¶ 27. As explained in defendants' opening brief, this proclaimed intent is insufficient to establish an "actual or imminent" injury in fact, as Article III requires. Memorandum in Support of Motion to Dismiss ("Def. Op. Br.," dkt. #14) at 8 (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). Plaintiffs fail to assert a single fact to suggest, much less demonstrate, that they are "*immediately in danger of sustaining*" any direct injury as a result of the minimum coverage provision's possible enforcement against them more than four years in the future. *Roark & Hardee LP v. City of Austin*, 522 F.3d 533, 542 (5th Cir. 2008).

In their opposition brief, plaintiffs again rely, for standing purposes, solely on the notion that they are certain to incur a penalty after the minimum coverage provision goes into effect in 2014.

However, they fail to provide any genuine support for this supposed certainty. For example, plaintiffs rely heavily on a congressional budgetary projection, estimating that around four million people will pay the § 5000A penalty in the year 2017, after failing to maintain the required level of health insurance coverage during the previous year. Plaintiffs' Response to Defendants' Motion to Dismiss ("Pl. Opp.," dkt. #20) at 9-10 (citing Congressional Budget Office ("CBO"), *Payments of Penalties for Being Uninsured Under the [ACA]* (Apr. 2010)). Given that the population of the United States is approximately 307 million, this projection fails to establish that plaintiffs themselves are likely to incur the penalty. *Raines v. Byrd*, 521 U.S. 811, 829 (1997) (injury must be to plaintiffs "themselves as individuals"); *Gollust v. Mendell*, 501 U.S. 115, 126 (1991) (a plaintiff "must allege a distinct and palpable injury to himself" and must "maintain a 'personal stake' in the outcome of the litigation throughout its course" (internal quotation omitted)). The predicate for incurring the penalty is being subject to and violating the minimum coverage provision, and plaintiffs plead no facts suggesting that they will fall within the scope of the provision and outside its exemptions, and that they will not otherwise satisfy its requirements, for example, by qualifying for Medicare.

Whatever plaintiffs' current intentions might be, they cannot assert a plausible – much less certain – likelihood of future injury due to the § 5000A penalty when their claim is entirely dependent on an untenable assumption – that their current health, employment, and financial status will not change between the time they filed suit and 2014. This case differs from *Village of Bensenville v. FAA*, 376 F.3d 1114 (D.C. Cir. 2004), where a court determined that three municipalities in the Chicago vicinity had standing to challenge a Chicago airport fee that was not scheduled to go into effect for 13 years. *Id.* at 1119. There, the court concluded that the

municipalities' injuries were "'certainly impending'" because the municipalities paid for their employees' business travel, and would therefore undoubtedly incur these fees after the fees went into effect. *See id.* (quoting *Whitmore v. Arkansas,* 495 U.S. 149, 158 (1990)). Here, on the other hand, whether plaintiffs will incur § 5000A penalties in the future is governed by circumstances that, by their very nature, cannot be predicted.

An asserted injury is "too remote temporally" when the time period that will pass before any injury could be sustained is sufficiently long that a plaintiff's relevant circumstances might reasonably change within that period. *See McConnell v. FEC*, 540 U.S. 93, 226 (2003). Thus, in *McConnell*, the Supreme Court recognized that five years was too far into the future to predict whether a particular Senator would run for reelection. *Id.* Similarly here, a period of years is too long a time to predict whether a particular individual will find a different job that provides qualifying insurance, or sustain significant health care expenses causing the individual to desire health insurance, or experience economic hardship causing the individual to be exempt from any penalty under § 5000A. Any number of unexpected events could occur in a person's life during a single year, and each year beyond that only compounds the uncertainty. While plaintiffs might now have every intention of "resist[ing] the statute," Pl. Opp. at 6, neither they nor the Court can rely on plaintiffs' current intentions – supported by no facts other than the bald assertion that they currently lack insurance, Comp. ¶ 26; *but see id.* ¶ 97 (indicating plaintiff Lieutenant Governor Bryant does in fact have insurance) – as establishing a genuine probability of future injury. Even at the pleading stage, "'naked assertion[s] devoid of further factual enhancement'" are insufficient to establish standing. *White*, 601 F.3d at 552 (quoting *Iqbal,* 129 S. Ct. at1949). Moreover, "allegations of injury that is merely conjectural or hypothetical" also do not suffice. *Little v. KPMG LLP*, 575 F.3d 533,

540 (5th Cir. 2009). Just as a dependence on decisions of third parties moved the plaintiffs' claims of injury in *Little* from the realm of plausibility into the sphere of pure conjecture, *see id.*, so too does the dependence here of plaintiffs' claims on unknowable future events.[1]

Courts in other districts have dismissed challenges by individuals to the minimum coverage provision for lack of standing because the plaintiffs' asserted future injury – similar to the injury alleged here – was too speculative. *See N.J. Physicians v. Obama*, No. 10-1489, 2010 WL 5060597, at *4 (D.N.J. Dec. 8, 2010); *Baldwin v. Sebelius,* No. 10-1033, 2010 WL 3418436, at *9 (S.D. Cal. Aug. 27, 2010). Unlike some plaintiffs in other cases involving the ACA, plaintiffs here do not allege that they are "being compelled to reorganize their affairs" now, or that they have decided "to forego certain spending today, so that they will have the funds to pay for health insurance" when the minimum coverage provision goes into effect in 2014. *Thomas More Law Center* ("*TMLC*") *v. Obama*, 720 F. Supp. 2d 882, 889 (E.D. Mich. 2010); *see also Liberty Univ. v. Geithner*, No. 10-15, 2010 WL 4860299, at *5-7 (W.D. Va. Nov. 30, 2010). The absence of any concrete information about any present injury here squarely distinguishes this case from others in which courts have found

[1]The other cases cited by the court in *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1144-47 (N.D. Fla. 2010), are inapplicable here for similar reasons. For example, in *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 535-36 (1925), the Supreme Court held that a private school had standing to challenge a compulsory-public-education law that would take effect in two years where the school had already lost income from students withdrawing in anticipation of the law's enforcement; the Court apparently deemed the possibility that the school might close down for other reasons before the law went into effect to be too remote to deprive the school of standing, while explaining that if the challenged law forced the school out of business, the injury would be irreparable. In contrast, the possibility that individuals will suffer changes to their health, employment, or financial status within a four-year period, while impossible to predict, could hardly be considered "remote." The *Florida* court's discounting of the potential impact of the "'vagaries' of life"on the plaintiffs in that case fails to acknowledge what the Supreme Court recognized in *McConnell* – that even unpredictable "vagaries" become more likely over a longer period of time and, in circumstances such as this one, prevent an asserted future injury from being considered "certainly impending."

standing to challenge the minimum coverage provision.[2]

B. Plaintiffs' Claims Are Unripe

For similar reasons, plaintiffs fail to establish that their claim is ripe. Because there is a genuine possibility that plaintiffs' circumstances may change before the minimum coverage provision takes effect in 2014, their asserted injury rests on "contingent future events that may not occur as anticipated, or indeed may not occur at all." *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985) (internal quotation omitted). Plaintiffs' Complaint contains no factual allegations that, if true, could establish with any certainty that they will face a § 5000A penalty in 2015, and their claim is therefore unripe. *Toilet Goods Ass'n v. Gardner,* 387 U.S. 158, 163-64 (1967).

In their opposition brief, plaintiffs' sole arguments in favor of ripeness rest on inapplicable or incorrect standards. First, plaintiffs argue that their claim is ripe because they face a "threat of prosecution." *See* Pl. Opp. at 6. However, as indicated in the case that plaintiffs cite, that standard applies only when a plaintiff seeks to challenge a law imposing *criminal* penalties. *See, e.g.*, *Trimble v. City of New Iberia*, 73 F. Supp. 2d 659, 664 (W.D. La. 1999) (holding that the plaintiff could raise a preenforcement challenge to criminal ordinance on First Amendment grounds). Because the minimum coverage provision imposes no criminal penalty, plaintiffs face no "threat of prosecution" under the provision.

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[2]In their Complaint, plaintiffs make reference to "plan[ning]", "invest[ing]," and "sav[ing]," but they do not indicate whether any of the plaintiffs are currently engaged in any of those activities, or whether, if they are, it is due to the minimum coverage provision. Comp. ¶ 27. In any event, planning, saving, or investing do not entail any immediate loss or harm such that they could qualify as concrete injuries in fact, and plaintiffs' opposition brief does not purport to rely on those allegations to establish standing.

Second, plaintiffs attempt to analogize this case to others where courts concluded that a preenforcement statutory challenge in the civil context was ripe because the statute's enforcement was "inevitab[le]" or "certain." Pl. Opp. at 11 (citing *Blanchette v. Ct. Gen. Ins. Corps.*, 419 U.S. 102, 143 (1974); *Fla. State Conference of NAACP v. Browning*, 522 F.3d 1153, 1164 (11th Cir. 2008)). However, the courts in those cases emphasized that it must be inevitable or certain that the statute would be enforced *against the plaintiffs themselves*, or their members. *See Blanchette*, 419 U.S. at 143 (statutory challenge was ripe where statute would inevitably operate "against certain individuals," including plaintiffs); *Browning*, 522 F.3d at 1164 ("Since enforcement of [the challenged provision] is automatic for all new voter registrants, there is no doubt that the statute will be enforced against some of plaintiffs' members."). Here, plaintiffs suggest that because they currently do not have the minimum essential coverage required by the ACA and have no intention of obtaining such coverage, they will inevitably incur the § 5000A penalty. Pl. Opp. at 9, 11. However, for the same reasons explained above, it is neither inevitable nor certain that the minimum coverage provision will be enforced against plaintiffs. Indeed, it is far from certain that any of these plaintiffs' circumstances, as they are relevant to decisions or options regarding health insurance coverage or qualification for an exemption, will not change during the years before the provision goes into effect.[3]

[3]Defendants do not, for purposes of this Motion to Dismiss, intend to pursue the argument in Part I, B of their opening brief, in which defendants contended that plaintiffs claims are barred by the Anti-Injunction Act.

II. PLAINTIFFS FAIL TO STATE A CLAIM UPON WHICH RELIEF MAY BE GRANTED[4]

A. Plaintiffs Cannot Prevail in a Facial Commerce Clause Challenge Based on the Notion that the Minimum Coverage Provision Regulates "Inactivity"

The minimum coverage provision is a valid exercise of Congress's commerce power. The provision regulates the means of payment for the health care that almost all Americans, including plaintiffs, unquestionably receive. As explained in defendants' opening brief, Congress had a rational basis to conclude that, in the aggregate, the receipt of health care services without having previously obtained health insurance has a "substantial economic effect," *Gonzales v. Raich*, 545 U.S. 1, 17 (2005), on the interstate health care market. Def. Op. Br. at 24-28. By requiring that individuals who are already in the health care market pay for the care they receive by maintaining a minimum level of health insurance, the minimum coverage provision is designed to prevent the shifting of tens of billions of dollars in costs to others, including the majority of people who already pay for their care through insurance. Congress also had a rational basis to conclude that the minimum coverage provision is an "integral part" of the comprehensive health insurance reforms that it adopted in the ACA, *see Groome Res. Ltd. v. Parish of Jefferson*, 234 F.3d 192, 210 (5th Cir. 2000), and that failure to regulate the manner of payment would "undercut the regulation of the interstate market" in health care, *see Raich*, 545 U.S. at 18. Def. Op. Br. at 21-24. In particular, the provision's requirement of universal coverage is essential to the viability of the ACA's guaranteed issue and community rating reforms, which prohibit insurance companies from denying coverage or adjusting rates based on an individual's medical history or current health status.

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[4]Plaintiffs' opposition brief does not attempt to defend the merits of their argument that the minimum coverage provision is an unconstitutional taking. That argument should therefore be deemed waived, and it is in any event without merit. *See* Def. Op. Br. at 31-33.

Plaintiffs do not contest Congress's findings regarding the substantial costs that uninsured individuals, as a class, pass on to others when they receive uncompensated care.[5] Nor do they dispute Congress's conclusion that the minimum coverage provision is essential to the ACA's insurance reforms. Rather than address the applicable Commerce Clause analysis, plaintiffs seek to distinguish the minimum coverage provision from other legitimate regulations of interstate commerce on grounds that are not only unprecedented but also dead wrong.

Plaintiffs rely on the fallacy that the minimum coverage provision is a regulation of "inactivity," Pl. Opp. at 29, and an effort to "compel commerce" where there otherwise would be no commercial transaction, *id.* at 32. Plaintiffs point to no Commerce Clause case that has drawn a distinction between regulation of "activity" and regulation of "inactivity." The lack of any authority for the new test that plaintiffs propose is not surprising, given that the focus of any Commerce Clause analysis is on determining whether the object of the federal government's regulation is sufficiently interstate in character. The Supreme Court's three-part list of permissible subjects of federal regulation – (1) "channels of interstate commerce," (2) "instrumentalities" or "persons or things in interstate commerce," and (3) "activities that substantially affect interstate commerce," *Raich*, 545 U.S. at 16-17 – is meant to distinguish between "what is truly local" (and thus properly reserved to state regulation) and "what is truly national." *United States v. Morrison*, 529 U.S. 598, 608 (2000) (citing *United States v. Lopez*, 514 U.S. 549, 568 (1995)). Plaintiffs surely do not intend to suggest that a state, unlike the federal government, would have absolute power to

[5]While Congress is entitled to consider substantial effects "in the aggregate," without regard to any particular individual's circumstance, *Raich*, 545 U.S. at 22, none of the plaintiffs here deny that any one of them could, if they remain uninsured, incur health care costs that are beyond their ability to pay.

force citizens to buy any consumer products that the state chooses to require, but that suggestion is necessarily implicit in their argument as formulated under the Commerce Clause. That result makes no sense. Plaintiffs' "inactivity" argument is, in truth, simply a reformulation of their substantive due process argument. The Due Process Clause, not the Commerce Clause, is the constitutional provision that protects against government infringements on individual liberty.

Beyond the fact that plaintiffs here are attempting to introduce an entirely novel "inactivity exception" to Congress's power under the Commerce Clause, plaintiffs' position is factually wrong. The subject of Congress's regulation through the minimum coverage provision does not qualify as "inactivity" in any sense. Nowhere in their Complaint or opposition brief do plaintiffs deny that they use health care, and that, by using these services and paying for them, if they can, they are participants in the health care market. Indeed, almost all Americans, "as living, breathing beings, who do not oppose medical services on religious grounds," are participants in this market and "cannot opt out" of it. *TMLC*, 720 F. Supp. 2d at 894; *see also Liberty Univ.*, 2010 WL 4860299, at *15 ("Nearly everyone will require health care services at some point in their lifetimes . . . .").[6] Participation in a relevant market is sufficiently "active" for Commerce Clause purposes.

The key point that plaintiffs appear to miss is that the health care market is the relevant

[6]Those who have a religious objection to medical care may legitimately claim to be nonparticipants in the health care services market. Such individuals are, of course, exempt from the minimum coverage provision. 26 U.S.C. § 5000A(d)(2). Otherwise, there may be extremely rare individuals who, despite having no objection, will never seek medical care during their lifetimes, but it is impossible to know who these individuals are until their lives are over. Plaintiffs do not dispute the universal nature of participation in the health care market, nor could they, and the Court may take judicial notice of it. *See, e.g.*, Centers for Disease Control and Prevention ("CDC"), National Center for Health Statistics, Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009, tbl. 35 (2010); CDC, National Center for Health Statistics, Health, United States, 2009, at 318, tbl. 80 (2010) (indicating that, in recent years, between 60 and 80 percent of the uninsured have visited a doctor or emergency room at least once within a twelve-month period).

market. Plaintiffs' claim is that they are not currently in the market for health insurance, and that by requiring individuals to maintain a certain level of insurance, the minimum coverage provision "mandates that individuals affirmatively engage in economic activity where they might otherwise choose not to." Pl. Opp. at 25. Plaintiffs focus solely on one market and ignore the enormous nationwide market that was the principal focus of Congress's regulation. Even if plaintiffs do not currently participate in the *insurance* market, they indisputably participate in the market for health care services. Nothing required Congress to focus exclusively on the market that plaintiffs define, and nothing barred Congress from focusing on economic conduct in the health care market. Requirements to obtain insurance are not imposed because of participation in the insurance market itself; they are imposed because of concerns that individuals or corporations may be unable to meet costs resulting from activities in other markets. Under plaintiffs' logic, Congress would be constitutionally precluded from applying any insurance requirement to anyone who is not already insured, on the theory that such people are not "active" in the insurance market — a proposition without support in precedent, practice, or common sense. Plaintiffs' attempt to dismiss the interrelationship between health insurance and the health care market as "a series of unsubstantiated and unquantifiable inferences," Pl. Opp. at 34, should be soundly rejected.

A Commerce Clause analysis requires a practical understanding of how the market at issue operates. *Lopez*, 514 U.S. at 572 (Kennedy, J., concurring) (discussing the Court's adoption of "a practical conception of the commerce power"); *see also Wickard v. Filburn*, 317 U.S. 111, 120 (1942) ("[Q]uestions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce.");

Swift & Co. v. United States, 196 U.S. 375, 398 (1905) ("commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 336-337 (1962) (Congress chose in the Clayton Act to "prescribe[] a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one"). In *Wickard* and *Raich* – both involving, as this case does, a comprehensive federal regulatory scheme addressed to broad interstate markets – the Court focused on the operation of the markets at issue – the market for wheat, in *Wickard*, and the market for controlled substances, in *Raich*. In each case, the Court ultimately deferred to Congress's determination that its regulation of the class that included the plaintiffs in those cases – whether by penalizing excess consumption of home-grown wheat or by prohibiting the home production and possession of marijuana – was essential to its regulatory scheme, and that the regulated activity, in the aggregate, substantially affected interstate commerce. *Raich*, 545 U.S. at 13-14, 22; *Wickard*, 317 U.S. at 128-29.

A similar analysis should lead this Court to a similar conclusion in this case. Plaintiffs' attempt to draw an impermeable line separating participation in the health market from the maintenance of insurance coverage ignores the fundamental feature and essential function of health insurance. As Congress understood, health insurance exists not as an independent consumer product but as the dominant means of payment for health care services.[7] Implicitly or otherwise, individuals

[7] *See, e.g.*, Martin S. 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."). The sole purpose of many types of insurance is to provide protection "against events that are highly unlikely to occur but involve large losses if they do occur." Milton Friedman, *How To Cure Health Care, The Public Interest*, Winter 2001, at 10. There is certainly a risk of unpredictable, catastrophically high expenses in the health care context. At the same time, "it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions." *Id.* at 10. This reality reflects the fact that the costs associated with even the most common health problems can quickly reach thousands of dollars.

engage in economic assessments of the relative advantages of obtaining insurance versus other means of attempting to pay for health care services, although those assessments often ignore or underestimate the risks. *See* 42 U.S.C. § 18091(a)(2)(G) (62% of all personal bankruptcies are caused in part by medical expenses); Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007). Significantly, it is the conduct of the *uninsured*, due to their participation in the health care market, that Congress identified as having a substantial economic effect, due to the significant amount of uncompensated care that the uninsured receive, which shifts costs to others and drives up prices of both health care services and health insurance premiums. 42 U.S.C. § 18091(a)(2)(F). Congress found that the amount of shifted costs due to the aggregate impact of providing uncompensated care to the uninsured in 2008 was $43 billion, and found that these costs were passed from providers "to private insurers, which pass on the cost to families," raising premiums "by an average of over $1,000 a year." *Id.*; *see also* 156 Cong. Rec. E506-01, 2010 WL 1133757 (Rep. Waxman) (Mar. 21, 2010). In California, for example, an estimated ten percent of the cost of health insurance premiums is attributable to uncompensated care consumed by people without insurance. S. Rep. No. 111-89 at 2 (2009). Thus, as other courts have rightly recognized, "decisions whether to purchase insurance or to attempt to pay for health care out of pocket" are "plainly economic" and, "in the aggregate, have clear and direct impacts on health care providers, taxpayers, and the insured population who ultimately pay for the care provided to those who go without insurance." *TMLC*, 720 F. Supp. 2d at 893. Indeed, "[a]s Congress found, the total incidence of these economic decisions has a substantial impact on the national market for health

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International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country.

care by collectively shifting billions of dollars on to other market participants and driving up the prices of insurance policies." *Liberty Univ.*, 2010 WL 4860299, at *15.

Plaintiffs therefore miss the mark when they argue that Congress cannot regulate decisions about how to pay for health care services because "a decision" is nothing but a "*mental process* which may, or may not, result in activity." Pl. Opp. at 33. The decision at issue here is not a decision about *whether to enter* the health care market; rather, as Congress explicitly found, it is the decision *how and when to pay* for health care services that the regulated individuals will inevitably receive. *See* 42 U.S.C. § 18091(a)(2)(A). Because individuals cannot "decide" not to become ill or have an accident, those who have no religious objection cannot simply "decide," as a matter of volition, not to participate in the health care market, and indeed, plaintiffs do not allege that they have made any such decision. As a practical matter, of course, those who pay for health care with insurance must obtain the insurance *before* health care costs are incurred, and before the extent of those costs are known with certainty.[8] Thus, Congress imposed the minimum coverage requirement at the point when individuals are able to make the decision to pay for their health care through insurance, which is before they actually receive care. Congress's conclusion that "decisions about how and when health care is paid for, and when health insurance is purchased," by individuals who are active participants in the health care market, are "economic and financial" activities that substantially affect

[8]For this reason, those who do not obtain health insurance before health care needs arise must face the prospect of attempting to pay their health care expenses out of pocket, whether or not they have consciously decided that such a payment method is their preference. Congress's use of the term "decisions" in 42 U.S.C. § 18091(a)(2)(A) simply reflects the fact that, in this context, an individual's means of payment is necessarily determined before expenses are incurred. There is no real option to choose "inactivity" because, ultimately, the individual will incur those expenses. "'Far from 'inactivity,' by choosing to forgo insurance, Plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance.'" *Liberty Univ.*, 2010 WL 4860299, at *15 (quoting *TMLC*, 720 F. Supp. 2d at 894).

interstate commerce, 42 U.S.C. § 18091(a)(2)(A), again reflects Congress's understanding of how health insurance functions as a means of payment in the health care market. Almost every American participates in the health care market and is therefore faced with managing the financial risks associated with unpredictable future health care costs. As a class, however, those participants in the market who do not have insurance end up passing their costs on to others. It does not matter that not every uninsured person will shift health care costs in any given year. Millions will do so, and the cumulative impact of such cost-shifting is to impose a multi-billion dollar annual burden on interstate commerce. The Supreme Court has repeatedly held that where "Congress decides that the 'total incidence' of a practice" — here, the practice of consuming health care without insurance — "poses a threat to a national market, it may regulate the entire class." *Raich*, 545 U.S. at 17 (citing *Perez v. United States*, 402 U.S. 146, 154-55 (1971)). The record supports Congress's conclusion that the uninsured's participation in the health care market, in the aggregate, has a substantial effect on interstate commerce.

The record also supports the conclusion that the minimum coverage provision is essential to the ACA's guaranteed issue and community rating reforms. Although insurance coverage is crucial to a consumer's ability to pay for health care, escalating costs have made health insurance increasingly unaffordable, "driv[ing] people out of the insurance market." *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 49 (2008) (statement of Mark Hall, Prof. of Law & Public Health, Wake Forest Univ.). The resulting smaller risk pool further contributes to an ongoing "premium spiral." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 118-19 (2009) (American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at

985 (2010). Thus, in the absence of the ACA's reforms, "[t]he market for health insurance . . . is not a well-functioning market." Council of Economic Advisors, *The Economic Case For Health Care Reform* 16 (June 2009); *see also Health Reform in the 21st Century*, at 49-50 (statement of Dr. Linda Blumberg, Urban Institute) (describing "shortcomings" in health insurance market). The problem is in large part due to the insurance industry's practice of "medical underwriting," whereby individuals seeking insurance are screened, and their eligibility and premium levels are established based on their health status or history. *See id.*; Dep't of Health and Human Services, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind*, at 1 (2009). The ACA addresses these harsh underwriting practices by barring insurance companies from denying or revoking coverage or setting premiums based on medical condition. 42 U.S.C. §§ 300gg to 300gg-3.

However, these guaranteed-issue and community-rating requirements would not work in a regulatory scheme that permits health care consumers to time their insurance purchases based on their current cost-benefit evaluations. Indeed, 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 (2008) (Prof. Hall). Congress found that, absent the minimum coverage requirement, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(a)(2)(I). Congress thus found the requirement "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." *Id*. § 18091(a)(2)(J). That determination, like Congress's determination regarding the costs of uncompensated care, is supported by the legislative record, and plaintiffs do not even attempt to contest its rationality.

The Court must defer to these legislative judgments, in light of both separation of powers

principles and Congress's superior capacity to make empirical judgments and operational choices. Courts owe "Congress' findings deference in part because the institution is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions." *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195 (1997) (internal quotation omitted). "This principle has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity[.]" *Id*. at 196. Moreover, courts "owe Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power," lest a court "infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Id.* Here, then, the Court "need not determine" whether decisions to forgo health insurance and instead attempt to pay for health care out of pocket, "taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Raich*, 545 U.S. at 22. Congress's findings and the legislative record leave no doubt that the minimum coverage provision regulates economic conduct that has enormous impact on interstate commerce.

The other arguments scattered within plaintiffs' overarching "inactivity" discussion are all without merit. Plaintiffs argue that the minimum coverage provision is "even further removed" from Congress's commerce power than the statutory provisions that the Supreme Court struck down in *Lopez* and *Morrison*. Pl. Opp. at 30. However, the statutes at issue in *Lopez* and *Morrison* were stand-alone measures that involved no form of economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of a handgun in a school zone because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might undermine economic productivity. *Lopez*, 514 U.S. at 561. Similarly, in *Morrison*, the

Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. *Morrison*, 529 U.S. at 615-16. Neither of these measures played any role in a broader regulation of economic activity. Indeed, the "noneconomic, criminal nature of the conduct at issue was central" to the Court's decisions. *Id.* at 610.

The minimum coverage provision is not a stand-alone measure. It is part of a broad economic regulation of health care financing in the massive interstate health care market, and it is essential to the Act's regulation of underwriting practices in the insurance industry. Nor does the minimum coverage provision regulate non-economic conduct. Rather, it addresses the means of payment for health care services in a market that accounts for one-sixth of the nation's GDP. Indeed, it is difficult to conceive of legislation that is more clearly economic than the regulation of the means of payment for health care services and the requirements placed on insurers, employers, and individuals who are made insurable by federal law. Far from the chain of attenuated reasoning required in *Lopez* and *Morrison* to identify any substantial effect on interstate commerce, the link to interstate commerce in this case is direct and compelling.

Plaintiffs' "slippery slope" arguments, *see* Pl. Opp. at 25, ignore the factors unique to the health care market that distinguish the exercise of Congress's commerce power in that context. Plaintiffs suggest that, if the minimum coverage provision were deemed constitutional, Congress would have unlimited power "to compel the purchase of goods and services," such as vitamin supplements. *Id.* Unlike health insurance, however, the ordinary "good" or "service" is not itself a method of payment for services that necessarily will be rendered. Those who do not buy vitamin supplements might have poorer health, which might lead to greater health care costs, but those costs

will not be shifted to others – unless the individuals who do not buy vitamins are also uninsured. Moreover, even if the failure to take vitamins might have some other attenuated impact on interstate commerce, the difference here is that Congress found that the effects of being uninsured are direct – people who do not have insurance incur billions in health care costs for which they do not pay. Congress did not need to "pile inference upon inference" to link the regulated activity and interstate commerce. *Lopez*, 514 U.S. at 567. The limitations here derive from the unique combination of features that characterize the health care market. The near universal participation in that market, the unpredictable risks of incurring enormous medical expenses at unpredictable times, the general requirement that hospitals provide emergency care regardless of ability to pay, and the prevalence and enormous impact of cost shifting yield an airtight connection between the minimum coverage provision and interstate commerce, a connection replicated in no other market.

Because the minimum coverage provision is a valid exercise of Congress's Article I authority, it does not violate the Tenth Amendment. *New York v. United States*, 505 U.S. 144, 156 (1992). Indeed, as plaintiffs' focus on their rights, as ostensibly "inactive" individuals, to be free from government-compelled purchases makes clear, their argument has nothing to do with the Tenth Amendment, despite the significant rhetorical emphasis that they place on principles of federalism. Again, plaintiffs' arguments here mirror their substantive due process claim that their "right not to enter into a contract" has been violated – a claim without legal support since the *Lochner* era, as explained below.

Finally, even if this Court entirely disregarded Congress's understanding of the relationship between health insurance and the health care market and concluded that plaintiffs themselves, who claim that they have no insurance and do not plan to acquire it, are not participants in a relevant

market and are therefore "inactive," there is no doubt that the vast majority of people subject to the minimum coverage provision already have some form of health insurance and thus could not be deemed "inactive" even under plaintiffs' theory. *See* Pl. Opp. at 26 ("It is undoubtedly true that the purchase of health insurance . . . [is] economic activity as contemplated by *Raich*."). Those individuals are also regulated by the minimum coverage provision insofar as they may (unless they qualify for an exception) be required to continue to maintain coverage, and to maintain coverage that qualifies as "minimum essential coverage" under the ACA. Indeed, even the category of the "uninsured" is not static. The same individuals who are uninsured now are likely to have been insured within the past year or to acquire insurance within the next year. CBO, *How Many Lack Health Insurance and For How Long?* at 4, 9 (May 2003), *available at* www.cbo.gov/doc.cfm?index=4210&type=1; *see also* CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 11 (Dec. 2008). Those who have recently had insurance or are planning to acquire it in the near future would also fall into the "active" category even under plaintiffs' theory. Plaintiffs therefore cannot possibly prevail in this facial challenge to the minimum coverage provision based solely on the notion that the provision regulates "inactivity" – which is the only argument that they make. Even under their theory, they cannot "establish that no set of circumstances exists under which the Act would be valid, *i.e.*, that the law is unconstitutional in all of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (internal quotation omitted).

B. The Minimum Coverage Provision Is a Reasonably Adapted Means to the Legitimate End of Increasing the Affordability and Availability of Health Care and Health Insurance and Is Therefore a Valid Exercise of Necessary and Proper Clause Authority

Plaintiffs do not dispute that people who obtain health care services without insurance shift

substantial costs to other market participants; nor do they dispute the centrality of the minimum coverage provision to the ACA's broader regulation of medical underwriting. Essentially, plaintiffs' challenge focuses narrowly on the means by which Congress determined to regulate payment in the interstate market for health care services. Governing precedent leaves no room for plaintiffs' invitation to override Congress's judgment about the appropriate means to achieve its legitimate regulatory objectives.

"[T]he Federal '[g]overnment is acknowledged by all to be one of enumerated powers,'" but "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *M'Culloch v. Maryland*, 17 U.S. (4 Wheat) 316, 405, 408 (1819)). Invoking this time-honored precept that undergirds the Necessary and Proper Clause, Justice Scalia has explained that "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co*., 315 U.S. 110, 118-19 (1942)). The "relevant inquiry" in a Necessary and Proper Clause analysis "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)). A challenged provision must be upheld if it is "rationally related to the implementation of a constitutionally enumerated power." *Id.* at 1956 (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Raich*, 545 U.S. at 22; *Lopez*, 514 U.S. at 557; and *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 (1981)).

Congress's "legitimate end," through the ACA's insurance reforms, was to increase the affordability and availability of health insurance and health care and the fairness of the process by which they are made available. That end – which ultimately focuses on pricing and related factors – is clearly justified under Congress's commerce power. *Wickard*, 317 U.S. at 128 ("It is well established by decisions of this Court that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices."); *see United States v. S.-E. Underwriters Ass'n*, 322 U.S. 533, 553 (1944) (recognizing Congress's power to regulate the "business of insurance"); *United States v. Ogba*, 526 F.3d 214, 238 (5th Cir. 2008) (recognizing Congress's power to regulate "[t]he provision of medical services").

Moreover, the minimum coverage provision is a reasonably adapted means to that end. As discussed, the ACA's insurance reforms, among other things, bar insurance companies from refusing to cover, or charging higher premiums to, individuals with pre-existing medical conditions. 42 U.S.C. §§ 300gg to 300gg-3. Those reforms are intended to regulate interstate markets by increasing the availability and affordability of health insurance and, as a result, health care services. Yet, without the minimum coverage provision, Congress determined, the ACA would amplify incentives to forgo insurance until substantial health care needs arise. 42 U.S.C. § 18091(a)(2)(I). This would result in a smaller insurance risk pool, which would only serve to accelerate the spiraling health care and health insurance costs that the current health care system is already experiencing. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 118-19 (Apr. 22, 2009) (Am. Academy of Actuaries). Thus, Congress found the minimum coverage provision "essential" to its broader effort through the ACA to increase the availability and affordability of health care. 42 U.S.C. § 18091(a)(2)(C) (provision will contribute

to increase in supply of and demand for health care services), (F) (provision will contribute to lowering health insurance premiums), (G) (provision will improve financial security), (H) (provision is essential part of "regulating health insurance"), (I) (provision is essential to "creating effective health insurance markets" that are guaranteed issue regardless of pre-existing conditions), (J) (provision is essential to eliminating underwriting and associated administrative costs).

Congress's choice of the minimum coverage provision as the means to make the ACA's guaranteed issue and community rating reforms viable was dictated by, and tailored to, the unique features of the health care market. As explained, virtually all people, including plaintiffs, participate in this market. In contrast to other markets, the timing and amount of expenditures are highly 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." *Consequences of Expanded Employee Insurance Selection: Hearing Before the Senate/House Joint Economic Committee*, 108th Cong. (Sept. 22, 2004) (Prof. Pauly), 2004 WL 2107555. When health care needs do arise unexpectedly, our system of health care allows individuals to receive extraordinarily expensive services without regard to their ability to pay.

Federal and state law reflect the widely shared understanding that access to medical treatment cannot properly be restricted in the same way as access to other goods and services. Even before the enactment of the Emergency Medical Treatment and Active Labor Act in 1986, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. The common law had long recognized limitations on a physician's ability to abandon treatment regardless of a patient's

ability to pay, but recognized no duty on the part of private physicians to provide care in the first place. *Becker v. Janinski*, 15 N.Y.S. 675 (N.Y. Sup. 1891). The common law has evolved, however, to preclude hospitals from turning away patients with emergency needs because they are unable to pay for services. 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, 735 (Mich. Ct. App. 1990). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985 "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists[.]" H.R. Rep. No. 99-241(III), at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727. These measures were not adequate, however, to prevent hospitals from diverting patients or discharging them prematurely. Congress thus enacted EMTALA in order "to prevent hospitals from dumping patients who suffered from an emergency medical condition because they lacked insurance to pay the medical bills." *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990) (citing H.R. Rep. No. 99-241(I), at 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605). The federal statute augmented the duties imposed under state law by requiring all hospitals that participate in Medicare and offer emergency services to stabilize 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 Va., Inc.*, 525 U.S. 249 (1999) (per curiam).

Insurance requirements in the health care market thus cannot be imposed as a *condition* of receiving health care services, in the same way that state laws make automobile insurance a condition of driving a vehicle. As EMTALA's enactment demonstrates, in our society, it would be entirely unacceptable to restrict emergency room access to those who can show that they are

covered by health insurance. Moreover, as noted, with health insurance, timing is critical. A health insurance market could never survive "if people could simply buy their insurance on the way to the hospital." *47 Million and Counting*, at 14 (Prof. Hall). To be practical and ethical, a requirement to obtain medical insurance must therefore apply before the medical services are actually needed. The minimum coverage provision therefore falls well within Congress's authority under the Necessary and Proper Clause.

Plaintiffs' arguments in opposition are without merit. Contrary to plaintiffs' contention, the Supreme Court's decision in *Comstock* did not change the applicable Necessary and Proper Clause analysis, which has been in place since *M'Culloch*, 17 U.S. (4 Wheat.) 316. *See United States v. DeCay*, 620 F.3d 534, 542 (5th Cir. 2010) (citing the Supreme Court's recognition in *Comstock* that the Necessary and Proper Clause vests Congress with "broad authority" to carry into execution its enumerated powers); *see also United States v. Belfast*, 611 F.3d 783, 808 (11th Cir. 2010) (citing *Comstock* as authority to apply the traditional Necessary and Proper Clause analysis).[9] While plaintiffs attempt to insert the question of state sovereignty into the analysis, the Necessary and Proper Clause does not contain any affirmative obligation that Congress "accommodate" state

[9]In failing to uphold the minimum coverage provision as a valid exercise of Congress's power under the Necessary and Proper Clause, the court in *Commonwealth of Virginia v. Sebelius*, 728 F. Supp. 2d 768, 779, 782 (E.D. Va. 2010), did not suggest that *Comstock* altered the Necessary and Proper Clause analysis. At the same time, the court did not correctly apply that analysis; rather, it appears that the *Virginia* court regarded the minimum coverage provision as both the "end" that Congress sought to achieve, and the "means" through which Congress sought to achieve it. *See id.* (concluding that the minimum coverage provision did not fall within Congress's authority under the Necessary and Proper Clause because it was "beyond the historical reach of the Commerce Clause"). Its conclusion that neither were legitimate is therefore circular. However, as explained, Congress's "end" in enacting the minimum coverage provision – to make the ACA's insurance reforms effective in order to increase the affordability and availability of both insurance and health care – was undeniably legitimate. A requirement that all qualifying participants in the health care market pay for the services they receive through insurance is a reasonably-adapted means to that end.

interests. Rather, the line between what is national and what is local is drawn at the outset, when determining whether the "end" sought is within another enumerated power, such as the Commerce Clause. Significantly, plaintiffs provide no explanation of why states should be uniquely empowered to require individuals to obtain health insurance, given the indisputable fact that the health insurance and health care services markets are interstate markets. *See S.-E. Underwriters Ass'n*, 322 U.S. at 553. The fact that Congress chose, in the McCarran-Ferguson Act, to allow states to regulate insurance as well, even though it is an interstate market, in no way weakens Congress's authority in this area. *W. & S. Life Ins. Co. v. State Bd. of Equalization*, 451 U.S. 648, 652 (1981).

Plaintiffs also suggest that defendants are attempting to employ the Necessary and Proper clause as "a bootstrap by which Congress may evade the constitutional limits on its enumerated powers." Pl. Opp. at 42. But plaintiffs get things backwards. The Court in *Comstock* recognized that whether Congress's exercise of its Necessary and Proper Clause authority is otherwise "prohibited by the Constitution" depends on the statute's "validity under provisions of the Constitution *other than* the Necessary and Proper Clause." *Comstock*, 130 S. Ct. at 1957 (emphasis added) (internal quotation omitted). The question of whether the minimum coverage provision violates some other constitutional provision, such as the Due Process Clause, is one a court would answer in considering a claim raised under that provision. But the question has no bearing on whether the provision is reasonably adapted to a legitimate end.[10] For similar reasons, plaintiffs' asserted concern that, if the

[10]Similarly, the *Virginia* court's summary conclusion that the minimum coverage provision is simply beyond "the letter and spirit of the constitution," and thus invalid under the Necessary and Proper Clause, *Virginia*, 728 F. Supp. 2d at 782, cannot be reconciled with controlling precedent. The *Virginia* court reasoned that the provision imposes an "affirmative duty to engage in private commerce," or else to pay a penalty. *Id.* However, in *Comstock* the Supreme Court implicitly recognized that the federal government can, consistent with the Constitution's "letter and spirit," impose affirmative duties, such as the duty to comport oneself in accord with the notions of

Necessary and Proper Clause empowers Congress to enact the minimum coverage provision, there is no limit to Congress's authority, Pl. Opp. at 44, is misplaced. Again, plaintiffs rely on cases – *Printz v. United States*, 521 U.S. 898 (1997), and *New York*, 505 U.S. 144 – that address the proper line between federal and state authority. But again, plaintiffs provide no explanation of how the minimum coverage provision infringes on state sovereignty. Plaintiffs' stated objection to the provision – that, in their opinion, it infringes on individual liberty by compelling "inactive" individuals to enter into a commercial transaction – has nothing to do with state sovereignty. While the Constitution undoubtedly protects individual liberties, it does so through the Bill of Rights, not through the Commerce Clause or the Necessary and Proper Clause. *Cf. Washington v. Glucksberg*, 521 U.S. 702, 719 (1997).[11] Plaintiffs' arguments as to why the minimum coverage provision cannot be sustained under the Necessary and Proper Clause merely rehash their Commerce Clause arguments, which in turn are really Due Process Clause arguments in disguise. The minimum coverage provision is a valid exercise of Congress's power under the Necessary and Proper Clause, and the question of whether it infringes on individual liberty should be analyzed separately.

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acceptable behavior that are inherent in a congressionally-defined criminal code, upon pain of criminal sanction – as long as no other constitutional provision is violated. *See Comstock*, 130 S. Ct. at 1957. Again, the proper focus of the *Virginia* court's concern, and of plaintiffs', is the Due Process Clause, not the Necessary and Proper Clause or the Commerce Clause.

[11]While the court in *City of Madison v. Bear Creek Water Ass'n*, 816 F.2d 1057, 1060-61 (5th Cir. 1987), suggested that the "critical division of power between the federal and state governments" was "a bulwark of protecting our individual liberties," it also recognized that the Tenth Amendment was not implicated unless a state's ability to regulate in an area was "essential to its sovereignty." Plaintiffs have not even attempted to argue that a state's ability to require its citizens to obtain health insurance is essential to its sovereignty.

C. Congress Had Independent Authority Under the General Welfare Clause To Enact the Minimum Coverage Provision

As discussed in defendants' opening brief, the minimum coverage provision is also a proper exercise of Congress's taxing power under the General Welfare Clause. Plaintiffs oppose Congress's authority under the General Welfare Clause on the basis that Congress did not call the § 5000A penalty a "tax" and did not expressly invoke the General Welfare Clause in the provision's enactment. Pl. Opp. at 46, 50. However, plaintiffs fail to cite any authority for the notion that the Constitution requires Congress to identify, in express terms, every enumerated power under which a specific statutory provision is enacted, and well-established Supreme Court authority is to the contrary. *See EEOC v. Wyoming*, 460 U.S. 226, 244 n.18 (1983) ("'[T]he constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise.'" (quoting *Woods v. Miller,* 333 U.S. 138, 144 (1948))); *see also Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 78-79 (2000) (holding that the ADEA was a valid exercise of Congress's power under Section 5 of the Fourteenth Amendment although Congress's findings when enacting the ADEA had only related to the Commerce Clause); *Kusjanovic v. Oregon*, 243 F. Supp. 2d 1137, 1138-39 (D. Or. 2002) (applying the same reasoning to the FLSA). The fact that Congress included express findings to support the provision's enactment under the Commerce Clause, but not the General Welfare Clause, is therefore irrelevant to the question of Congress's constitutional authority to enact the provision. Indeed, in other instances where Congress made such findings, courts have treated regulatory assessments for health coverage as valid exercises of Congress's taxing power. *See, e.g.*, *Adventure Res., Inc. v. Holland,* 137 F.3d 786, 794 (4th Cir. 1998).[12]

[12]Even if Congress's expressed intent were relevant, plaintiffs' argument would fail. In debating the minimum coverage provision, Congressional leaders repeatedly and explicitly

For purposes of determining whether the § 5000A penalty falls within Congress's taxing power, the fact that the penalty will raise public revenue is dispositive and requires the conclusion that the penalty falls within Congress's Article I authority. Plaintiffs are wrong in emphasizing the notion that "what Congress called it – a penalty – and not a tax" is determinative. *See* Pl. Opp. at 50. The semantic distinction between a "penalty" and a "tax" is not the difference between an apple and an orange. In particular, there is no absolute distinction between penalties, when established by the government, and "excise taxes," which are taxes on an event. Both government-established penalties and excise taxes raise revenue, and both are often used for regulatory purposes. *E.g.*, *United States v. Kahriger*, 345 U.S. 22, 28 (1953) (recognizing that Congress's power to impose excise taxes "is extensive and sometimes falls with crushing effect on businesses deemed unessential or inimical to the public welfare"). The overlap in meaning between these two terms is highlighted by the fact that the Joint Committee on Taxation ("JCT"), in its Technical Explanation of the Revenue Provisions of the ACA, refers to the § 5000A penalty as an "excise tax." *See* JCT, Technical Explanation, JCX-18-10 (Mar. 21, 2010), at 31-34, 2 (amending two paragraphs on page 33). Similarly, the ACA's employer responsibility provision alternatively describes the same funds owed by certain employers that fail to provide adequate coverage to their employees as a "payment," 26 U.S.C. § 4980H(a), a "tax" *id.* § 4980H(b)(2), and a "penalt[y]," *id.* § 4980H(d). Moreover, while the term "penalty" is often deemed to denote a punitive assessment, the § 5000A penalty is not truly punitive in nature. For example, as the JCT report emphasizes, the § 5000A penalty cannot be enforced through

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defended the provision as an exercise of the taxing power as well as an exercise of the commerce power. *See, e.g.*, 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (Rep. Miller); 156 Cong. Rec. H1824, H1826 (daily ed. Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (daily ed. Dec. 22, 2009) (Sen. Leahy); 155 Cong. Rec. S13,558, S13,581-82 (daily ed. Dec. 20, 2009) (Sen. Baucus).

criminal sanctions or civil liens. JCT, Technical Explanation, at 33, 2. There is no scienter requirement. And individuals whose income is below the poverty level, or who can show a "hardship," are not subject to the penalty, exceptions plainly out of place in a punitive measure. 26 U.S.C. § 5000A(e). The provision, plainly, encourages persons to obtain insurance, but it does not operate as a punishment for those who do not. *See United States v. Sanchez*, 340 U.S. 42, 45 (1950). The import of the § 5000A penalty is that individuals who fail to maintain a minimum level of health insurance, and thus continue to risk shifting the cost of the health services they receive to third parties, including the government, will at least be required to contribute revenue to the general treasury, by some amount that is no more than the cost of insurance.

Plaintiffs also argue that Congress's primary motive in enacting the minimum coverage provision was regulatory rather than to raise revenues, and thus again seek to resurrect "distinctions between regulatory and revenue-raising taxes" long abandoned by the Supreme Court. *Bob Jones Univ. v. Simon*, 416 U.S. 725, 741 n.12 (1974); *cf. Kahriger*, 345 U.S. at 28 ("a federal excise tax does not cease to be valid merely because it discourages or deters the activities taxed"). Again, there is simply no dispute that the § 5000A penalty will raise revenues, or that these revenues will be used to defray government expenses. Moreover, the minimum coverage provision as a whole cannot be deemed unrelated to raising revenue when it is aimed, to some degree, at protecting the public fisc by requiring qualifying individuals to obtain health insurance, thereby preventing them from shifting costs to third parties, including the federal government. There is no bright-line distinction between a "tax" and a "penalty" based on whether an assessment is at least 51% revenue-raising or at least 51% regulatory. *See Sanchez*, 340 U.S. at 44 (rejecting the notion that a tax clearly designed to deter trafficking in marijuana was beyond Congress's general welfare power). Rather, the only exception

to Congress's broad authority to impose a tax with regulatory purposes under the General Welfare Clause is where the object of regulation is otherwise "subject only to state regulation." *Kahriger*, 345 U.S. at 31 (citing *Child Labor Tax Case*, 259 U.S. 20, 38 (1922)). Again, plaintiffs have offered no argument that regulation of the means of payment within the interstate market for health care services is exclusively within the States' regulatory power, nor is there any basis for such a conclusion. Insofar as plaintiffs rely on the notion that the § 5000A penalty infringes on individual liberties, they must raise such a claim under other constitutional provisions, such as the Due Process Clause.[13]

Congress enacted 25 U.S.C. § 5000A as a taxing measure. It placed the provision in the Internal Revenue Code, assessed the penalty according to the "taxable year" and with reference to individuals' income over the taxable year, required "taxpayers" to pay any penalty with their income taxes when they file their tax return, and granted enforcement power to the Secretary of the Treasury. 26 U.S.C. § 5000A(b). During the debate on the ACA, opponents of the bill repeatedly attacked the minimum coverage provision as a tax, and proponents expressly defended it as an exercise of the taxing power. To claim that Congress did not intend to invoke the taxing power is to ignore the language of the statute and the legislative record that underlies it.

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[13]Plaintiffs' further argument that the § 5000A penalty is not a tax because Congress applied the assessment and collection mechanisms for taxes to the penalty, through § 5000A(g)(1) and 26 U.S.C. § 6671, but determined, in § 5000A(g)(2), that it would not impose criminal penalties, liens, or levies for failure to pay it, Pl. Opp. at 53, also makes no sense. Plaintiffs are incorrect in suggesting that these are the only enforcement mechanisms available in the Internal Revenue Code. *Id.* The Secretary of the Treasury may engage in civil collection practices, 26 U.S.C. §§ 6301-6306, and may also offset the penalty amount against tax court judgments or refunds or credits that a taxpayer would otherwise receive. JCT, Technical Explanation, at 33, 2.

D. The § 5000A Penalty Is Not an Unapportioned Capitation Tax or a Direct Tax

Plaintiffs' argument that, if the § 5000A penalty is a tax, it is invalid under Article I, Section 9, is without merit. The penalty is not a capitation tax because it is not imposed "without regard to property, profession, or any other circumstance." *Hylton v. United States*, 3 U.S. (3 Dall.) 171, 175 (1796) (opinion of Chase, J.); *see also Pac. Ins. Co. v. Soule*, 74 U.S. (7 Wall.) 433, 444 (1868). The penalty will be imposed only in certain circumstances – specifically, when a qualifying individual fails to maintain minimum essential coverage during a particular month. Moreover, the minimum coverage provision excepts individuals whose incomes are below the typical threshold for the filing of a tax return, as well as those for whom the cost of qualifying coverage would exceed 8% of their household income. 26 U.S.C. § 5000A(e)(1)-(2). The amount of the penalty varies according to the taxpayer's income, subject to a floor of a particular dollar amount and to a cap equal to the cost of qualifying coverage. *Id.* § 5000A(c)(1)-(2). Such a tax, imposed on the occurrence of an event, and varying according to individual circumstance, is an indirect tax that is not subject to Article I, Section 9. *United States v. Mfrs. Nat'l Bank of Detroit*, 363 U.S. 194, 197-98 (1960); *Tyler v. United States*, 281 U.S. 497, 502 (1930); *Murphy v. IRS*, 493 F.3d 170, 184 (D.C. Cir. 2007).

Plaintiffs' suggestion that the § 5000A penalty is based on a "decision," and is therefore not based on an "event," Pl. Opp. at 56, is without merit. The penalty is assessed when a qualifying individual fails to meet the requirements set forth in § 5000A(a). It is not based on an individual's mere existence or ownership of property, any more than a penalty for failure to fulfill any other statutory obligation. *E.g.*, 26 U.S.C. § 4974 (tax on failure of retirement plans to distribute assets); *id.* § 4980B (tax on failure of group health plan to extend coverage to beneficiary); *id.* § 4980E (tax on failure of employer to make comparable Archer MSA contributions); *id.*

§ 4942 (tax on failure of private foundation to distribute income). Plaintiffs' assertion that the penalty "falls on each American not otherwise excepted," Pl. Opp. at 57, is nothing but a tautology, equivalent to an assertion that a particular tax is imposed on everyone who is obligated to pay it. In sum, plaintiffs fail to explain how the § 5000A penalty qualifies as a direct or capitation tax, and their claim on this basis should be dismissed.

E. Because Plaintiffs Identify No Fundamental Right Implicated by the Minimum Coverage Provision, Their Substantive Due Process Claim Must Be Rejected

While the Due Process Clause is the appropriate vehicle for plaintiffs' challenge, plaintiffs nevertheless cannot prevail on this ground because the minimum coverage provision violates no fundamental individual right. In contending otherwise, plaintiffs suggest that the minimum coverage provision implicates two separate "fundamental rights" – the "right to not enter into a contract for the purchase [of] health insurance from a corporate stranger," Pl. Opp. at 62, and the "right to not share confidential medical information with a corporate stranger," *id.* at 65. Neither of these descriptions identifies a fundamental right that is implicated in this case.

Plaintiffs' first asserted "fundamental right" is plainly precluded under the Supreme Court's jurisprudence since the mid-1930s. Under that authority, the Due Process Clause requires only rational basis review when a plaintiff asserts "economic rights and liberties." *See Florida*, 716 F. Supp. 2d at 1161 (citing *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1963), and *New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 439 U.S. 96, 106-07 (1978)). Plaintiffs' contention that their asserted right "not to contract" with a health insurance company, or "not to purchase" health insurance, is different in kind from other economic rights because of its uniquely (according to plaintiffs) "coercive" quality, Pl. Opp. at 73, is meritless. Any claim of a Due Process violation is in some sense complaining of government coercion. It is well established, however, that Congress has the power to "adjust[] the

burdens and benefits of economic life" without implicating any fundamental individual liberty. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Rather, such legislation is accorded "a presumption of constitutionality." *Id.* There is no reasoned basis for plaintiffs' notion that individuals who will almost inevitably receive health care services cannot be required to use a particular payment method – one that must be set up prior to the receipt of health care but that, in Congress's rational determination, is an effective means of improving health care affordability and availability for all. The true import of plaintiffs' argument is that they have a "fundamental right" to take the risk that, at the point when they require health care, their expenses will be greater than they can afford, and these costs will be shifted to third parties, including the government, health care providers, insurers, and other individuals. There is no such fundamental right to shift one's health care costs to others, and plaintiffs' argument should therefore be rejected.

Plaintiffs have no claim with respect to their second asserted "fundamental" right – not to disclose private medical information to a health insurance company – because, for one thing, the minimum coverage provision does not, by its plain terms, require the disclosure of private medical information. Rather, it is an economic measure that seeks to impose a particular means of payment for future health care services. Significantly, plaintiffs have not alleged that they have been required to disclose private medical information. As another district court has recognized, individuals such as plaintiffs lack standing to challenge the minimum coverage provision on this ground because they "do[] not, nor can [they] at this time, allege that [they] ha[ve] been compelled by the [ACA] to provide personal information, that [their] personal information has been used improperly, or that use of [their] personal information has in any way eroded [their] physician-patient privilege." *Baldwin*, 2010 WL 3418436, at *4. To the extent plaintiffs speculate that all insurance plans available to them

in 2014 will require them to provide private medical information, they cannot establish that this is so, nor can they show that any such requirement would be particularly invasive or would result in public disclosure. *See Whalen v. Roe*, 429 U.S. 589, 602 (1977) (recognizing that disclosures to insurance companies do not constitute an impermissible invasion of privacy). Nothing in plaintiffs' Complaint supports the notion that they have sustained, or are likely to suffer, an injury-in-fact on this ground, nor that such an injury would be fairly traceable to the minimum coverage provision. *See* Def. Op. Br. at 36. To the contrary, plaintiffs' assertion that they have no intention of acquiring health insurance, whether or not the minimum coverage provision is in effect, Comp. ¶ 26, requires the conclusion that, even if others who do obtain health insurance face such a threat, no such injury is "certainly impending" for these plaintiffs. *McConnell*, 540 U.S. at 226.

In any event, even if plaintiffs had standing to raise such a claim, it must fail. As the *Florida* court explained, the Supreme Court has not recognized a fundamental right of the kind that plaintiffs seek to identify here. *Florida*, 716 F. Supp. 2d at 1162.[14] Because the minimum coverage provision easily satisfies rational basis review, plaintiffs' substantive due process claims must be dismissed.

[14]In *NASA v. Nelson*, No. 09-530, 2011 WL 148254, at *8 (U.S. Jan. 19, 2011), the Supreme Court declined to decide whether there existed a "privacy interest of constitutional significance" with respect to individuals' claims of information privacy rights. The Court held, however, that even assuming such a right, there was no violation where statutory safeguards – similar to those that HIPAA, Pub. L. No. 104-191, 110 Stat. 1936 (1996), provides for personally-identifying health information collected by an insurance company, *see Acara v. Banks*, 470 F.3d 569, 570-71 (5th Cir. 2006) – prevent public disclosure of the information at issue. *NASA*, 2011 WL 148254, at *12. Justices Scalia and Thomas would have held that "[a] federal constitutional right to 'informational privacy' does not exist." *Id.* at *15 (Scalia, J., concurring in judgment).

F. Lieutenant Governor Bryant's Tenth Amendment Claim Should Be Dismissed

1. Lt. Gov. Bryant Lacks Standing To Assert a Tenth Amendment Commandeering Claim

As explained in defendants' opening brief, Lieutenant Governor Bryant lacks standing, based merely on his status as a state employee, to assert that the ACA "commandeers" state governments and officials in violation of the Tenth Amendment. Def. Op. Br. at 41-43. The few contrary cases cited by the Lieutenant Governor in his separate opposition brief do not overcome the weight of authority cited by defendants, including authority from a member of this Court. *See id.* at 42 (citing *United States v. Johnson*, 652 F. Supp. 2d 720, 726 (S.D. Miss. 2009), as well as cases from five other Circuits). Indeed, most of the Lieutenant Governor's cited cases merely assumed standing without deciding the issue – at a time prior to the Supreme Court's instruction that courts should not proceed in such a manner – because the plaintiff's claim was "so patently without merit." *E.g., Nance v. EPA*, 645 F.2d 701, 716 (9th Cir. 1981).

In addition, the Lieutenant Governor has simply not alleged a plausible injury-in-fact that is fairly traceable to the provisions that, he apparently asserts, violate the Tenth Amendment.[15] His separate opposition brief makes no attempt to explain how he is injured by ACA provisions that require certain employers to offer particular health insurance coverage to their employees, nor does he clarify whether the State of Mississippi is included among those covered employers or whether the State of Mississippi will have to change the coverage that it already provides in order to comply with the ACA. The only injury discernible from the Lieutenant Governor's allegations – that he will

[15]As observed in defendants' opening brief, the Complaint does not actually identify the ACA provisions that relate to employers, which appear to be the only provisions potentially relevant to the lieutenant governor's Tenth Amendment claim. *See* Def. Op. Br. at 43 n.18.

be required to maintain a minimum level of health insurance coverage – is the same injury alleged by other plaintiffs, which they ascribe to the minimum coverage provision, not to the provisions directed at employers.[16] The absence of an injury-in-fact here stands in stark contrast to the two cases that the Lieutenant Governor identifies as holding that standing existed; in each of those cases, the court identified an injury-in-fact resulting from the challenged statutory provision, even if that injury had no "nexus" with the Tenth Amendment issue. *See Gillespie v. City of Indianapolis*, 185 F.3d 693, 701 (7th Cir. 1999) (plaintiff alleged that he was deprived of the ability to carry a gun due to the challenged law); *Atlanta Gas Light Co. v. U.S. Dep't of Energy*, 666 F.2d 1359, 1368 n.16 (11th Cir. 1982) (court observed that plaintiffs had demonstrated the requisite injury in fact and causal connection to the challenged provision). Because the authority cited by the Lieutenant Governor does not support his standing to assert a Tenth Amendment commandeering challenge to the ACA's employer provisions, his claim should be dismissed for lack of subject matter jurisdiction.

2. The ACA's Employer Provisions Do Not Infringe on State Sovereignty

Even if the Lieutenant Governor had standing to assert a Tenth Amendment "commandeering" claim, he fails to state a claim upon which relief may be granted. The fact that

[16]While the Lieutenant Governor claims that the employer provisions will dictate the "terms and conditions" of his employment, he points to no ACA requirement that employees accept the insurance offered by their employers. Thus, any injury he might assert could only be whatever injury might result from the minimum coverage provision. At the same time, the Complaint appears to indicate that the Lieutenant Governor has insurance through his employer, Comp. ¶ 97, and does not suggest that he has any intention of dropping it. Because the Lieutenant Governor may well already satisfy the requirements of the minimum coverage provision, 26 U.S.C. § 5000A(f)(1)(B), (2)(A), he has failed to establish that he has standing to assert any of the claims set forth in the Complaint, regardless of whether the other plaintiffs have sufficiently established standing.

the ACA provisions for "employers" do not exclude state governments does not constitute any form of commandeering. No state official is required to carry out federal policy. Rather, state employers are simply required to follow the same rules that other employers must follow. The Lieutenant Governor's citation of *Gregory v. Ashcroft*, 501 U.S. 452 (1991), is inapposite. That case suggested that a federal law that interfered with a state's ability to impose an age limit for state judges might infringe on state sovereignty because it would affect the state's ability to determine the qualifications for its highest government officials. *Id.* at 459 (ultimately concluded that no such infringement had occurred in that case because the ADEA did not, by its plain terms, apply to state judges). *Gregory* has no possible application here because, insofar as the ACA employer provisions might impact the nature of benefits provided to State of Mississippi employees (something that the Lieutenant Governor has failed to establish), such an impact would not affect the State's ability to determine the qualifications of its officers. *See Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 554 (1985) (upholding application of FLSA overtime- and minimum-wage requirements against city's Tenth Amendment challenge); *EEOC*, 460 U.S. at 239 (recognizing Congress's exercise of its commerce power could apply to states and state employees without violating the Tenth Amendment where the federal law had no direct impact on "attributes of state sovereignty"), *abrogated on other grounds by Seminole Tribe v. Florida*, 517 U.S. 44 (1996).

Indeed, the district court in the *Florida* ACA challenge rejected the same claim brought by the State of Mississippi itself: "the mere fact that the states will be required to provide the same healthcare benefits to employees as private employers does not, by itself, implicate or interfere with state functions and sovereignty." *Florida*, 716 F. Supp. 2d at 1152. As the court noted, "to some extent Congress already regulates health benefits for state employees, for example, with respect to

COBRA's temporary continuation of coverage provisions and HIPAA's restrictions on the ability of group plans to deny coverage due to preexisting conditions." *Id.* at 1153. The Lieutenant Governor's commandeering claim should therefore be dismissed.

CONCLUSION

For the foregoing reasons and those set forth in defendants' opening brief, this case should be dismissed in its entirety.

DATED this 21st day of January, 2011.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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

Dated: January 21, 2011

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