4-1-2011

Florida v. HHS - Brief for Appellants

United States Department of Health and Human Services

Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees / Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,
Defendants-Appellants / Cross-Appellees.

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

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U.S. COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

State of Florida, et al.,

v.

United States Dep't of Health & Human Svcs., et al.

Nos. 11-11021 & 11-11067

AMENDED CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to 11th Cir. R. 26.1-1, the undersigned counsel certifies that, to the best of his knowledge, the following persons, firms, and associations are the only ones that may have an interest in the outcome of this case:

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Timothy, Elizabeth M. (Magistrate Judge)

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(B) Plaintiffs and Associated Persons

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* Items marked with an asterisk have been added or amended since the prior filing of the certificate with this Court.

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APRIL 2011

STATEMENT REGARDING ORAL ARGUMENT

This Court has scheduled oral argument for Wednesday, June 8, 2011 in Atlanta, Georgia.

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STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. The court entered final judgment on January 31, 2011. Defendants and the plaintiff states filed notices of appeal on March 8, 2011 and March 10, 2011, respectively. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF ISSUES PRESENTED

1. Whether the district court erred in holding that the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") is not a valid exercise of Congress's commerce power.

2. Whether the court erred in holding that the minimum coverage provision is not independently authorized by Congress's taxing power.

3. Whether, even assuming that the minimum coverage provision was invalid, the court erred in declaring that the Affordable Care Act in its entirety is invalid and in awarding relief to plaintiffs without standing.

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 interstate market for health care services that accounts for more than 17% of the nation's gross domestic product. Millions of people without health insurance have consumed health care services for which they do not pay. They have thereby shifted the uncompensated costs of their

care — totaling $43 billion in 2008 — to health care providers regularly engaged in interstate commerce. Providers pass on much of this cost to insurance companies, which also often operate interstate. The result is higher premiums that, in turn, make insurance unaffordable to even more people. At the same time, insurers use restrictive underwriting practices to deny coverage or charge unaffordable premiums to millions because they have pre-existing medical conditions.

The Affordable Care Act addresses these national problems through measures designed to make affordable health care coverage widely available, protect consumers from restrictive underwriting, and reduce the uncompensated care obtained by the uninsured and paid for by other participants in the health care market.

The minimum coverage provision at issue here will require non-exempted individuals to maintain a minimum level of health insurance coverage or pay a tax penalty. 26 U.S.C.A. § 5000A. In enacting this provision, Congress made detailed findings establishing a foundation for the exercise of its commerce power. Congress found that the provision — which regulates how people pay for services in the interstate health care market — "regulates activity that is commercial and economic in nature," 42 U.S.C.A. § 18091(a)(2)(A); that the consumption of health care without insurance has substantial adverse effects on the interstate health care market, *id*. § 18091(a)(2)(F); that health insurance "is sold in interstate commerce" and "pays for

medical supplies, drugs, and equipment that are shipped in interstate commerce," *id.* § 18091(a)(2)(B); and 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), insurance regulation that is an unquestionably valid exercise of the commerce power.

2. Plaintiffs are 26 states, two private citizens, and the National Federation of Independent Business ("NFIB"). Their second amended complaint included six causes of action that challenged the constitutionality of several provisions of the Affordable Care Act. Record Excerpts ("RE") 1987-96.

After considering threshold issues of standing, the district court declared that the minimum coverage provision is not a valid exercise of Congress's Article I powers. Addressing the commerce power, the court recognized that, "[i]f and when the uninsured are injured or become ill, they receive treatment ... because in this country medical care is generally not denied due to lack of insurance coverage or inability to pay." RE 381. The court acknowledged that the consumption of health care without insurance imposes a substantial burden on the health care market, shifting billions of dollars of costs to other market participants. RE 2046, 2051-52. It also recognized that the minimum coverage provision is key to the Act's provisions that bar insurers from denying coverage because of a pre-existing medical condition

(the guaranteed-issue requirement) and from charging higher premiums because of a person's medical history (the community-rating requirement). RE 2057-58. Without the minimum coverage provision, the court observed, people could "delay obtaining insurance as they are now guaranteed coverage if they get sick or injured." RE 2058. Nonetheless, the court held, Congress may not require "advance purchase of health insurance based on a future contingency that will substantially affect commerce." RE 2049. While recognizing that "Congress plainly has the power" to regulate the way people pay for health care services, the court held that Congress may exercise this power only "at the time that [people] initially seek medical care." RE 2052.

With regard to the taxing power, the court did not dispute that the minimum coverage provision amends the Internal Revenue Code to provide that non-exempted individuals who fail to maintain minimum coverage shall pay a penalty that, above a flat dollar amount and subject to a cap, is calculated as a percentage of their household incomes, reported on their individual federal income tax returns for the taxable year, and assessed and collected in the same general manner as certain other federal tax penalties. Nor did the court question the Congressional Budget Office ("CBO") projection that this provision will generate billions of dollars of revenue each year. *See* Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi,

Speaker, U.S. House of Representatives, table 4 (Mar. 20, 2010). Nonetheless, the court held that the penalty is not a valid exercise by Congress of its taxing power because "Congress did not call it a tax," "state that it was acting under its taxing authority," or identify a "revenue-generating purpose" in the statute itself. RE 390, 395, 396.

The court rejected all of plaintiffs' other constitutional challenges. In addition to rejecting their substantive due process challenge to the minimum coverage provision, the court rejected plaintiffs' contention that the provision allowing states to establish health insurance exchanges, 42 U.S.C.A. § 18031, "commandeers" state governments. RE 425-28. It rejected plaintiffs' contention that provisions expanding eligibility for Medicaid are "coercive." RE 2007-14. And it rejected plaintiffs' challenge to the employer responsibility provision, 26 U.S.C.A. § 4980H, which in specified circumstances will impose a tax penalty on large employers that fail to make adequate coverage available to their full-time employees. RE 420-25.

Nevertheless, after rejecting all of these challenges except the Article I challenge to the minimum coverage provision, the court declared the Act invalid in its entirety. The court acknowledged that, "[i]n a statute that is approximately 2,700 pages long and has several hundred sections — certain of which have only a remote and tangential connection to health care — it stands to reason that some (perhaps

even most) of the remaining provisions can stand alone and function independently of the individual mandate." RE 2066. The court also recognized that, "because a ruling of unconstitutionality frustrates the intent of democratically-elected representatives of the people, the 'normal rule' — in the 'normal' case — will ordinarily require that as little of a statute be struck down as possible." RE 2072-73. Nevertheless, citing the uniqueness of this case and emphasizing the absence of an express severability clause, the court held that the minimum coverage provision is not severable from any other provision of the Act, even those with a "remote and tangential connection to health care." RE 2064-75. The court therefore declared the entire Act invalid.

Subsequently, the court clarified that it intended its judgment to be the practical equivalent of an injunction with respect to the parties to this case. RE 2142. The court recognized, however, that this would be "extremely disruptive," RE 2144, and issued a stay pending appeal contingent upon expedition, RE 2148.[1]

[1] Defendants do not dispute that plaintiff Brown's challenge to the minimum coverage provision is justiciable. *See* RE 2016 (holding that Brown has standing because she must "make financial arrangements now to ensure compliance" in 2014).

STATEMENT OF FACTS

I. Background

A. The interstate market for health care services differs from other markets in critical respects.

In responding to the crisis in the interstate health care market, Congress confronted a market different from any other. Spending in the interstate health care market accounted for 17.6% of the nation's gross domestic product in 2009. Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure 2009 Highlights, at 1 (2011). Participation is essentially universal; an individual's need for expensive medical care is unpredictable; and, across the nation, hospitals routinely provide — and are often legally required to provide — emergency care without regard to ability to pay. The market is also unique in that individuals typically pay for health care services through private or government insurance.

Although most people obtain health care services, they cannot accurately predict their need for such services. "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). Costs can mount rapidly for even the most common significant health problems. For example, the average cost of an appendectomy in 2010 was $13,123. International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country, at 13. The average cost of a day in the hospital was $3,612; of a hospital stay, $14,427; of a Caesarian-section, $13,016; of bypass surgery, $59,770; of an angioplasty, $29,055. *Id.* at 9, 10, 12, 16, 17. Drug treatment for a common form of cancer costs more than $150,000 a year. Meropol, et al., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007). Thus, the potential for financially ruinous burdens is plain, but what actually will happen to any given individual — the "frequency, timing, and magnitude" of an individual's demand for health care services — is generally unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007).

Unlike in other markets, people receive, and expect to receive, expensive health care 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, regardless of whether the person has insurance or otherwise can pay. *See* pp. 35-36, *infra*.

B. Private or government insurance is the principal means used to pay for health care services, and the federal government's involvement in health care financing is pervasive.

Unlike other markets, in the health care market, people usually pay for services through private or government insurance. In 2009, payments by private health insurers constituted 32% of national health care spending. CMS, 2009 National Health Expenditure Data, table 3 (2011). Employment-based health insurance plans accounted for most private coverage; about 59% of the non-elderly population (156.2 million people) had employer-based health insurance in 2009. Holahan, *The 2007-09 Recession and Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). In that year, about 5.2% of the non-elderly population (13.8 million people) had policies purchased in the individual insurance market. *Ibid.*

In 2009, federal, state, and local governments financed more than 43% of health care spending. CMS, 2009 National Health Expenditure Data, tables 5 & 11. The federal government provides health insurance for older and certain disabled persons under Medicare, accounting for 20% of national health care spending in 2009. *Id*., table 11. Federal and state governments provide health benefits for low-income persons through Medicaid, which constituted an additional 15% of national health care spending in 2009. *Ibid*. Another 12% of health care spending reflected government spending on other programs, such as benefits for veterans and children. *Id*., table 5.

As these figures indicate, the federal government's involvement in health care financing is pervasive. In 2009, federal spending on Medicare and Medicaid was around $750 billion, with billions more funding other federal programs. CBO, The Long-Term Budget Outlook, at 29-30 (2010). 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, at 30 (2008) ("Key Issues").[2]

C. As a class, people who endeavor 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 18.8% of the non-elderly population (approximately 50 million people) had no health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. These people nonetheless actively participate in the interstate health care market, consuming over $100 billion of health care services annually. Families USA, Hidden Health Tax: Americans Pay a Premium, at 2 (2009) ($116 billion in 2008); *see also*, *e.g.*, Centers for Disease Control and Prevention ("CDC"), National Center for Health Statistics, Health, United States, 2009, at 318, table 80 (2010) (80% of those without insurance at some point during a 12-month period visited a doctor or emergency room at least

[2] The federal government is also involved in other aspects of health care, including regulation of drugs and medical devices, 21 U.S.C. §§ 301, 351, and communicable disease, 42 U.S.C. § 264(b) (federal quarantine statute).

once); CDC, National Center for Health Statistics, Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?, at 2 (2010) (20% of uninsured adults aged 18-44 visited the emergency room in 2007); CDC, National Center for Health Statistics, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009, table 16 (2010) (18% of uninsured children visited the emergency room in 2009).

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 not paid for by the patient 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 further 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 premiums 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 that 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, 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 — 26-30% of the premiums 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 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 addressed problems in the national health care system that states individually have proven unable to solve effectively. Through comprehensive reforms, the Act will make health care coverage widely available and affordable, protect consumers from insurance underwriting practices, and reduce the uncompensated care that shifts costs to other participants in the interstate health care market and thereby increases premiums for insured consumers. In so doing, the Act also removes obstacles to interstate commerce such as "job lock," the inability or reluctance of workers to move to new jobs because of possible loss of employee health insurance benefits.

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 for a large employer if it

does not offer full-time employees adequate coverage and at least one full-time employee receives a tax credit to assist with the purchase of coverage in a health insurance exchange established under the Act. *Id*. § 4980H.

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

Third, for individuals and families with household income between 133% and 400% of the federal poverty line who purchase insurance through an exchange, Congress offered federal tax credits for payment of health insurance premiums. 26 U.S.C.A. § 36B(a), (b).[3] Congress also authorized federal payments to help cover out-of-pocket expenses such as co-payments or deductibles for eligible individuals who purchase coverage through an exchange. 42 U.S.C.A. § 18071. In addition, Congress expanded eligibility for Medicaid to cover individuals with income below 133% of the federal poverty line. *Id.* § 1396a(a)(10)(A)(i)(VIII).

Fourth, the Act regulates insurers to protect individuals from industry practices that have prevented people from obtaining and maintaining health insurance. The Act

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

bars insurers from refusing coverage because of pre-existing medical conditions, canceling insurance absent fraud or intentional misrepresentation of material fact, charging higher premiums based on a person's medical history, and placing lifetime dollar caps on benefits. *Id.* §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-11, 300gg-12.

Fifth, in the minimum coverage provision at issue here, the Act requires that non-exempted individuals pay a tax penalty if they do not maintain a minimum level of health insurance. 26 U.S.C.A. § 5000A.[4] The penalty does not apply to individuals whose household income is insufficient to require them to file a federal income tax return, whose premium payments would exceed 8% of their household income, or who establish that the requirement would impose a hardship. *Id.* § 5000A(e).

The CBO has projected that the Act will reduce the number of non-elderly people without insurance by about 33 million by 2019. Letter from Douglas W. Elmendorf to Speaker John Boehner, at 8, table 3 (Feb. 18, 2011).

[4] This insurance 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 health plan; certain government-sponsored programs such as Medicare, Medicaid, or TRICARE; or similar coverage recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. 26 U.S.C.A. § 5000A(f).

STANDARD OF REVIEW

The district court's rulings present issues of law subject to *de novo* review.

SUMMARY OF ARGUMENT

The Affordable Care Act as a whole, and the minimum coverage provision in particular, regulate the way consumers pay for health care 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 conduct that substantially affects interstate commerce. As Congress found, the minimum coverage provision regulates economic activity — how participants in the national 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 costs of their care to other participants in the health care market. Second, it is key to the viability of the Act's provisions that bar insurers from denying coverage or setting premiums based on medical condition or history.

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. The need for expensive services is unpredictable

and can easily exceed the consumer's ability to pay. And 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 cover 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, which pass it on to their customers. Rising premiums contribute in turn to the decline in the population covered by private insurance. Completing the cycle, the growing number of people without insurance 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 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 offers protection from 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 delaying their purchase of insurance until their medical costs outstrip their premiums.

In sum, the minimum coverage provision falls within Congress's commerce power because the provision is a rational means of regulating the way participants in the health care market pay for their 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 Supreme Court has long stressed the deference due to Congress's choice of means to accomplish legitimate regulatory objectives. That deference reflects the constitutional authority and institutional capacity of the political Branches to make such operational choices. Congress's power extends to regulation of even "noneconomic local activity" otherwise beyond the reach of the commerce power — "[t]he 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): "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. Consumption of health care services without insurance has demonstrable and harmful effects on other participants in the interstate health care market — what economists call "externalities." And the means that Congress selected are specifically adapted to the unique conditions of the health care market: participation is essentially universal; the need for medical treatment may arise unexpectedly; the cost of care may overwhelm the typical family budget; and individuals are legally entitled to expensive medical services in times of need without regard to their ability to pay.

The district court impermissibly substituted its own judgment for that of the elected Branches in declaring that an insurance requirement cannot be imposed until people actually seek medical care. RE 2052. Common sense, experience, and economic analysis confirm the testimony to Congress 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 is clearly "proper" for Congress to take into account the societal judgment — 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 deny medical care in an emergency because of a person's inability to pay.

C. The district court held that the constitutionality of the minimum coverage provision "turn[s] on whether the failure to buy health insurance is 'activity,'" RE 2045, and declared that "the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce," RE 2051. This reasoning disregards the teachings of the Supreme Court, which has long rejected "formalistic" distinctions between categories of economic conduct in favor of "broad principles of economic practicality." *United States v. Lopez*, 514 U.S. 549, 569, 571 (1995) (Kennedy, J., concurring).

People without insurance are not "inactive"; they actively participate in the market for health care services. Health insurance is not acquired for its own sake; it is obtained as a means to pay for health care services. Contrary to the district court's assumption, Congress was not required to cordon off one aspect of the conduct of participants in the health care market. It can regulate the conduct of participants in the overall health care market even if they are currently "inactive" in the insurance aspect of that market. The minimum coverage provision regulates how those participants pay for services in the health care market, activity that is "commercial and economic in

nature" and a subject of interstate commerce. 42 U.S.C.A. § 18091(a)(2)(A). The provision thus falls well within Congress's broad commerce power.

II. The minimum coverage provision is also independently authorized under Congress's taxing power. 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 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 is reported on the individual's tax return for the taxable year. Those who file jointly are jointly liable for the payment, and are responsible for dependents, as defined in the Internal Revenue Code. And this tax penalty is assessed and collected in the same general manner as certain other federal tax penalties. The 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 reasoning, the validity of this provision does not turn on whether it 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). This rule reflects principles of judicial restraint, which require that courts determine whether any provision of the Constitution authorized Congress to act, not whether Congress, in acting, formally invoked a particular grant of authority.

III. Even assuming *arguendo* that the minimum coverage provision was not a valid exercise of Congress's Article I powers, the district court overstepped its authority by declaring the Affordable Care Act invalid in its entirety and including parties without standing within the scope of its judgment.

A. The district court observed that the Affordable Care Act "has approximately 450 separate pieces," RE 2074, and recognized that many of these provisions, including "many [that] are already in effect and functioning," can "stand alone and function independently" of the minimum coverage provision, RE 2066-67. Indeed, many provisions, such as those amending the False Claims Act, have no relationship whatsoever to the minimum coverage provision. Others re-authorized longstanding programs. The court nevertheless declared that the Act's provisions "are all inextricably bound together in purpose and must stand or fall as a single unit." RE 2075. Nothing in the Act, committee reports, hearings, or floor debate remotely suggests such an all-encompassing bond. Because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people," the Supreme Court

has repeatedly held that a court must "refrain from invalidating more of the statute than is necessary." *Regan v. Time, Inc.,* 468 U.S. 641, 652 (1984). The district court's departure from this governing precedent cannot be sustained.

B. The court likewise disregarded basic principles of standing. Although the minimum coverage provision will place obligations only on individuals, the court held that two plaintiff states — Idaho and Utah — have standing to challenge that provision because they had enacted statutes purporting to nullify the operation of the provision with respect to their residents. RE 2017-18. That ruling is foreclosed by Supreme Court precedent establishing that a state lacks standing "to protect her citizens from the operation of federal statutes." *Massachusetts v. EPA*, 549 U.S. 497, 520 n.17 (2007). That Idaho and Utah have framed their disagreement with federal law in state statutes as well as a judicial complaint does not avoid that longstanding bar. Their claims impermissibly call upon the Court "to adjudicate, not rights of person or property, not rights of dominion over physical domain, not quasi sovereign rights actually invaded or threatened, but abstract questions of political power, of sovereignty, of government." *Massachusetts v. Mellon*, 262 U.S. 447, 484-85 (1923). Having wrongly held that two plaintiff states had standing, the district court explicitly declined to consider the standing of the remaining plaintiff states. RE 2019. Nonetheless, in a further departure from the limits on judicial power, the court

included all 26 plaintiff states within the scope of a judgment it regarded as the practical equivalent of an injunction.

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 not only to regulate interstate commerce but also to address other 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 form 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; *United States v. Maxwell*, 446 F.3d 1210, 1215 (11th Cir. 2006) ("*Maxwell II*").

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). "Not only may Congress regulate 'non-commercial' activity pursuant to its 'Commerce' Clause authority, but courts have only a limited role in second-guessing whether a 'class of [non-commercial] activity ... undercut[s]' Congress's unquestioned authority to regulate the broader interstate market." *Maxwell II*, 446 F.3d at 1215 (quoting *Raich*, 545 U.S. at 18). 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).

A. The minimum coverage provision regulates the way people pay for health care services, a class of economic activity that substantially affects interstate commerce.

Congress's findings and the legislative record leave no doubt that the minimum coverage provision — which regulates the way 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. It "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 consume health care without 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 regulation of medical underwriting, which guarantees that everyone will be insurable regardless of illnesses or accidents. *Id*. § 18091(a)(2)(I), (J).

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

The interstate nature of the market for health care services is undisputed. Nor is it controverted that individuals participate in the market for health care services whether or not they have health insurance. *See* pp. 10-11, *supra*. The uninsured do not, however, bear the full cost of their participation. A 2005 study found that, even in households at or above median income, uninsured people on average pay less than half the cost of the medical 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). Moreover, they pay a diminishing percentage of their costs as their consumption of medical services increases. *Ibid*.[5]

Congressional findings quantified this impact on interstate commerce: "The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008." 42 U.S.C.A. § 18091(a)(2)(F). Congress also made findings about how these 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* 156 Cong. Rec. E506-01, 2010 WL 1133757 (Mar. 25, 2010) (Rep. Waxman). In California, for example, uncompensated care for the uninsured accounts for an estimated 10% of premiums. S. Rep. No. 111-89, at 2 (2009).

Supreme Court precedents make clear that Congress need not show that every uninsured person, or which uninsured persons, will receive uncompensated care and shift costs. *Raich*, 545 U.S. at 18-19; *Wickard v. Filburn*, 317 U.S. 111, 127 (1942). Millions do so each year, and the cumulative impact of such cost-shifting is a multi-billion dollar annual burden on interstate commerce, which easily qualifies as

[5] In households at or above the median income, uninsured people who consume over $10,000 in medical services pay only 22% of their costs. Herring, at 230.

"substantial." Where "Congress decides that the 'total incidence' of a practice" — here, the practice of consuming health care services without insurance — "poses a threat to a national market, it may regulate the entire class." *Raich*, 545 U.S. at 17 (quoting *Perez v. United States*, 402 U.S. 146, 154-155 (1971)).

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

The minimum coverage provision is also valid Commerce Clause legislation because it is integral to broader economic regulation — the requirement that insurers extend coverage and set premiums without regard to pre-existing medical conditions. *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).

Learning from state regulators, Congress understood 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 accordingly 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, even if the way people pay for health care services were not regarded as economic activity, regulation would nevertheless be proper because Congress found that the "failure to regulate that class of activity would undercut the regulation of the interstate market." *Id*. at 18; *see also id*. at 37-38 (Scalia, J., concurring in the judgment). As

this Court stressed in upholding the federal ban on possession of child pornography, "where Congress comprehensively regulates economic activity, it may constitutionally regulate intrastate activity, whether economic or not, so long as the inability to do so would undermine Congress's ability to implement effectively the overlying economic regulatory scheme." *Maxwell II*, 446 F.3d at 1215 (footnote omitted); *accord United States v. Smith*, 459 F.3d 1276, 1285 (11th Cir. 2006).

The Nation has faced a serious shortage of affordable health insurance. More than 50 million Americans went without insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, 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).[6]

Many others are excluded from coverage by "medical underwriting," a process by which insurers establish eligibility and premiums based on individual health status or history. About 35% of non-elderly adult applicants in the individual market are

[6] The number without insurance has increased dramatically since 1970, when only 6% of Americans under age sixty-five had no coverage. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J. Law & Policy 695, 710 (2006).

denied coverage, charged a higher premium, or offered limited coverage because of pre-existing conditions. Help on the Horizon, at xi. 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).

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 end these restrictive underwriting practices. Congress found that these requirements would not

work without a minimum coverage provision to prevent health care consumers from 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. 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).

The Affordable Care Act makes everyone insurable and provides protection against ruinous medical expenses. *Id*. § 18091(a)(2)(G) (62% of personal bankruptcies are caused in part by medical expenses). "The uninsured ... benefit from the 'guaranteed issue' provision in the Act, which enables them to become insured even when they are already sick." *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010). Even apart from the other rational bases for Congress's action, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Ibid*.

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

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

The district court did not dispute that consumption of health care services without insurance imposes a substantial burden on the interstate health care market. RE 2046, 2051-52. Nor did it question the centrality of the minimum coverage

provision to the Act's broader regulation of medical underwriting. RE 2057-58. Instead, the court took issue with the means that Congress chose to regulate payment for services in the interstate health care market. While recognizing that "Congress plainly has the power" to regulate the way people pay for health care services — a point plaintiffs conceded, RE 334-35— the court held that Congress may do so only "at the time that they initially seek medical care," RE 2052, and cannot require "advance purchase of health insurance based on a future contingency that will substantially affect commerce," RE 2049.

Governing precedent does not permit a court to override Congress's judgment about the appropriate means to achieve objectives within the scope of the commerce power. The federal government is "'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.'" *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 *United States v. Wrightwood Dairy Co*., 315 U.S. 110, 118-19 (1942)).

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 determining whether a statute is "reasonably adapted" to a legitimate goal, a court looks "to see whether the statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power." *United States v. Belfast*, 611 F.3d 783, 804 (11th Cir. 2010) (quoting *Comstock*, 130 S. Ct. at 1956).

The means chosen by Congress to effectuate the Affordable Care Act's regulatory goals are tailored to the unique conditions of the interstate health care market: participation is essentially universal; the need for medical treatment may arise unexpectedly and not as a matter of choice; the cost of care may overwhelm the typical family budget; and, in times of need, individuals are entitled to obtain expensive medical services without regard to their ability to pay. The minimum coverage requirement ensures that non-exempted individuals who can afford insurance will pay for the services they consume, rather than shift their 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 vehicle insurance, the requirement accompanies registration of an automobile. The risks addressed by health insurance,

however, are always present and are not linked to a particular circumstance such as car ownership. The need for medical care is a "future contingency," RE 2049, only in the sense that the timing and extent of individual need cannot accurately be predicted.

Moreover, our society has long recognized that it would be unconscionable to deny medical care to someone in an emergency because of the economic choices he or she has made. Florida law, for example, declares it "of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care." Fla. Stat. Ann. § 395.1041(1), (3). Texas law likewise provides that "a general hospital may not deny emergency services because a person cannot establish the person's ability to pay for the services." Tex. Health & Safety Code Ann. § 311.022(a), (b); *see also*, *e.g.*, South Carolina Code Ann. § 44-7-260(E); La. Rev. Stat. Ann. § 40:2113.4; Idaho Code Ann. § 39-1391b. Even before enactment of EMTALA in 1986, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists," in addition 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, *reprinted in* 1986 U.S.C.C.A.N. 726, 727.

Finding these measures inadequate to prevent "hospital emergency 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); *Harry v. Marchant*, 291 F.3d 767, 772-73 (11th Cir. 2002) (en banc).

The minimum coverage provision is plainly adapted to these practical and moral imperatives of the health care system. Although the district court held that a health insurance requirement cannot be imposed until medical care is actually needed, 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, it is 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).

The district court saw no difference between a requirement to maintain insurance to pay for health care costs and a requirement to "buy a General Motors

automobile." RE 2047. But the difference is evident. The automotive analogy would require a fictional world in which (1) every individual is necessarily in the car market because he may develop a sudden, unforeseen need for a car, and (2) is entitled to receive the car regardless of his ability to pay. Even then, a parallel statute would not require the purchase of a car but rather the purchase of a financial instrument to finance the purchase of a car.

The Heritage Foundation stressed these distinctions decades ago in urging that the government "[m]andate all households to obtain adequate insurance." The Heritage Foundation explained: "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." But, it observed, "health care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. 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." Stuart M. Butler, *The Heritage Lectures 218: Assuring Affordable Health Care for All Americans*, at 6 (Heritage Foundation 1989).

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

a. The district court opined that the constitutionality of the minimum coverage provision "turn[s] on whether the failure to buy insurance is 'activity,'" RE 2045, and declared that "the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce," RE 2051. This mode of analysis disregards the teachings of the Supreme Court, which has rejected "formalistic" distinctions between categories of economic conduct and "committed itself to sustaining federal legislation on broad principles of economic practicality." *Lopez*, 514 U.S. at 569, 571 (Kennedy, J., concurring).

People without insurance are not "inactive"; they actively participate in the market for health care services. Indeed, millions of the uninsured participate by obtaining health care for which they cannot pay. The minimum coverage provision regulates how participants pay for services in the health care market — 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.

The district court treated 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 medical expenses. Porat, et al., *Market Insurance Versus Self Insurance*, 58 J. Risk & Ins. 657, 668 (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*, __ F. Supp. 2d __ (W.D. Va. 2010), 2010 WL 4860299, *15. Some individuals may prefer to pay for health care services out of pocket rather than through insurance. But such economic preferences are 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 Thomas More*, 720 F. Supp. 2d at 894; *Mead v. Holder*, __ F. Supp. 2d __ (D.D.C. 2011), 2011 WL 611139, *18.

The district court's holding that the exercise of the commerce power must await specific commercial transactions, RE 2052, disregards the role of health insurance as the means to pay for health care services and the practical and ethical considerations that are unique to the health care market. By the time people "seek medical care," RE 2052, it is too late to require that they have insurance to pay its costs. The district court did not suggest that people should be denied emergency treatment if they lack insurance to pay for it — a morally repugnant approach that would be at odds with the laws of plaintiff states as well as federal law. The court did not dispute that millions each year fail to pay for the health care services that they consume, nor did it dispute that where, as here, "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 (citation omitted).

The court's ruling that the exercise of the commerce power nonetheless must be linked to specific market transactions echoes arguments repeatedly rejected by the Supreme Court. 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.

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 or intended to be sold." 317 U.S. 119. The Court held that 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.

This Court in *Maxwell II* recognized that its earlier invalidation of the federal ban on possession of child pornography could not be reconciled with *Raich*. In its

initial decision, this Court had concluded that the prohibition had "no clear economic purpose," made "no effort to control national trade by regulating intrastate activity," and, instead, "attempt[ed] to regulate primary conduct directly, even within state borders." *United States v. Maxwell,* 386 F.3d 1042, 1057 (11th Cir. 2004) ("*Maxwell I*"). After the Supreme Court vacated this decision in light of *Raich*, this Court held that the prohibition was a "valid exercise of Congress's authority pursuant to the Necessary and Proper Clause to effectuate Congress's power to regulate commerce among the several states." *Maxwell II*, 446 F.3d at 1219. This Court explained that "where Congress has attempted to regulate (or eliminate) an interstate market, *Raich* grants Congress substantial leeway to regulate purely intrastate activity (whether economic or not) that it deems to have the capability, in the aggregate, of frustrating the broader regulation of interstate economic activity." *Id.* at 1215; *see also Alabama-Tombigbee Rivers Coal. v. Kempthorne*, 477 F.3d 1250, 1271, 1277 (11th Cir. 2007) (upholding the listing of the Alabama sturgeon under the Endangered Species Act although "there have been no reported commercial harvests of the fish in more than a century," because Congress could have reasonably determined "that the most effective way to safeguard the commercial benefits of biodiversity was to protect all endangered species, regardless of their geographic range").

b. The district court thus erred in analyzing the minimum coverage provision through the lens of "inactivity," rather than applying the "broad principles of economic practicality" that underlie modern Commerce Clause jurisprudence. *Lopez*, 514 U.S. at 571 (Kennedy, J., concurring). Even assuming *arguendo* that the minimum coverage provision could be thought to regulate inactivity, Congress is not regulating inactivity "as such," *Raich*, 545 U.S. at 38 (Scalia, J., concurring in the judgment), but as an aspect of its regulation of active participation in the health care market.

The Supreme Court has long held that "questions 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 Darby*, 312 U.S. at 118, 124 (referring to "practica[l] impossib[ility]" of targeting only interstate shipments and employers and holding that Congress may "resort to all means for the exercise of a granted power which are appropriate and plainly adapted to the permitted end"); *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."); *cf. 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").

Federal statutes address practical economic consequences, and need not be triggered by specific market transactions. For example, the Endangered Species Act protects even "a purely intrastate species with little, if any, commercial value." *Alabama-Tombigbee*, 477 F.3d at 1271. The Federal Access to Clinic Entrances Act prohibits physical obstruction of reproductive health clinics. *Cheffer v. Reno*, 55 F.3d 1517, 1519-21 & n.6 (11th Cir. 1995) (finding "no authority ... for the proposition that Congress' Commerce Clause authority extends only to the regulation of commercial actors"). Federal child pornography laws bar individual possession of child pornography even where "the record contained no evidence to indicate that [the] individual conduct was likely to impact interstate commerce." *Maxwell II*, 446 F.3d at 1217-18. Indeed, such laws are triggered even when an individual comes into possession of child pornography innocently, without having taken active measures. Such an individual is required to take reasonable steps to destroy the depictions or report the matter to law enforcement officials. 18 U.S.C. § 2252(c). *See also* Second Militia Act of 1792, ch. 33, § 1, 1 Stat. 271 (requiring all free men to obtain firearms, ammunition, and other equipment); *Nortz v. United States*, 294 U.S. 317, 328 (1935) (sustaining requirement that persons holding gold bullion, coin, or certificates exchange them for paper currency).

3. The minimum coverage provision regulates economic activity as part of a broad regulation of interstate commerce, and bears no resemblance to the statutes in *Lopez* and *Morrison*.

The district court attempted to derive support for its holding from *Lopez* and *Morrison*, the only modern cases to invalidate statutes as beyond the reach of the commerce power. But, as this Court has explained, in *Lopez* and *Morrison*, the Court addressed "a single-subject statute whose single subject is itself non-economic (e.g., possession of a gun in a school zone or gender-motivated violence)." *Maxwell II*, 446 F.3d at 1217 n.6. In *Lopez*, the Court struck down a ban on possession of handguns in school zones because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might ultimately undermine economic productivity. Similarly, in *Morrison*, the Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. 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. *Morrison*, 529 U.S. at 610; *accord Sabri v. United States*, 541 U.S. 600, 607 (2004).

The minimum coverage provision, in contrast, concerns intrinsically economic activity by requiring that 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 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. 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, employers, and individuals made insurable by the Act. Far from the chain of attenuated reasoning that was required in *Lopez* and *Morrison* to identify a substantial effect on interstate commerce, the link to interstate commerce here is direct and compelling.

The district court also overlooked the concern that animated the reasoning in *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 567). The district court did not suggest that the Affordable Care Act intrudes into an area of regulation reserved to the states, or that the 50 states, acting independently, could effectively solve the problems besetting our national health care system.

The modern health care system is interdependent and operates across state boundaries. Most health insurance is sold by national or regional companies that operate interstate 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. Insurance covers costs for medical supplies shipped in interstate commerce. 42 U.S.C.A. § 18091(a)(2)(B). 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); *see also Cheffer*, 55 F.3d at 1520 ("there is an interstate market with respect to both patients and doctors").

The interstate nature of the health care system has been amplified by modern transportation, which expanded the scope of commerce subject to federal regulation. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 251 (1964). Given the ease of travel, illnesses can spread rapidly and individuals can suddenly need health care services far from home.[7] 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.

[7] Interstate mobility itself facilitates the spread of disease, as Congress understood. H.R. Rep. No. 111-299(I), at 744 (2009).

RE 1579 (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).

Regulation of health care and health insurance also implicates mobility between jobs and among states, considerations absent in *Lopez* and *Morrison*. Health insurance is often an element of employee compensation, and if employees put their insurance at risk if they change jobs, they may be "reluctant to switch jobs in the first place (a phenomenon known as 'job lock')." CBO, Key Issues, at 8. Thus, the prospect of losing employee health insurance may create obstructions to interstate mobility, which the Constitution generally, and the commerce power specifically, were designed to prevent. *Heart of Atlanta*, 379 U.S. at 253 (noting that "uncertainty stemming from racial discrimination had the effect of discouraging travel").

Before the Affordable Care Act, this mobility created potential disincentives for individual states to adopt comprehensive reforms of their health care and health insurance markets.[8] A state might reasonably have resisted providing more generous benefits or broader coverage than its neighboring states out of concern that it would become "a bait to the needy and dependent elsewhere, encouraging them to migrate

[8] *See* 156 Cong. Rec. H1824, H1835 (daily ed. Mar. 21, 2010) (Rep. McGovern) (in light of the Affordable Care Act, Massachusetts "will no longer be forced to subsidize through higher premiums and higher Medicare and Medicaid costs the uncompensated care of people in other States who do not have health insurance").

and seek a haven of repose." *Helvering v. Davis*, 301 U.S. 619, 644 (1937). Moreover, as the experience of state insurance regulators showed, *see* pp. 31-32, *supra*, a state considering reform of restrictive insurance practices might have worried that insurers — mostly regional or national companies, 42 U.S.C.A. § 18091(a)(2)(B) — would respond to such regulation "simply by pulling up stakes" (particularly if the state reforms lacked a minimum coverage provision). Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New England J. Med. e29(1), e29(3) (2010). "Affordable health care is a national problem that demands a national solution." *Ibid*. This contrasts sharply with *Lopez* and *Morrison*, which involved traditional subjects of state criminal law enforcement focused on local actors.

Given these realities, it was eminently rational for Congress to address the challenges of a state-driven approach to health care by enacting national reforms. *See Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 282 (1981) (Congress acted within its "traditional role ... under the Commerce Clause" in finding that national coal mining standards were necessary because states might limit conservation efforts in response to interstate competition among coal sellers); *Darby*, 312 U.S. at 122-23; *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937).

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

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.*, 301 U.S. at 581-82, and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-83 (D.C. Cir. 2007). 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). 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." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937). 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 "penalties").

The "practical operation" of the minimum coverage provision is as a tax. *Nelson*, 312 U.S. at 363. It amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of insurance shall pay a monthly penalty for so long as he fails to do so. 26 U.S.C.A. § 5000A. The amount

of the penalty is calculated as a percentage of household income for federal income tax purposes, above a flat dollar amount and subject to a cap. *Id*. § 5000A(c). It is reported on the individual's federal income tax return for the taxable year, *ibid*., and "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 Secretary of the Treasury is empowered to enforce the penalty provision. *Id.* § 5000A(g).

There is no dispute that the minimum coverage provision will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. The CBO estimated that, by 2019, the minimum coverage provision will yield $4 billion annually. Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, U.S. House of Representatives, table 4 (Mar. 20, 2010); *see also* Pub. L. No. 111-148, § 1563(a)(1), 124 Stat. 119, 270 (adopting CBO finding that the Act "will reduce the Federal deficit"). More recent CBO projections indicate that the provision will yield $5 billion annually by 2021. Letter from Elmendorf to Boehner, table 3.

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 does not impose punishment. It does not apply retrospectively; instead, it imposes a month-to-month penalty for a failure to maintain adequate coverage, with liability ceasing when adequate coverage is obtained. 26 U.S.C.A. § 5000A(a)-(c). The tax cannot exceed the cost of qualifying insurance, *id.* § 5000A(c), does not apply to persons below a certain income level who do not need to file a federal income tax return, *id.* § 5000A(e)(2), and contains a "hardship" exemption, *id*. § 5000A(e)(5). It has no *scienter* requirement, and bars criminal prosecution for failure to pay. *Id.* § 5000A(g)(2)(A).

Contrary to the district court's understanding, Congress was not required expressly 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). As this Court stated in upholding a statute as an exercise of a power that Congress had not invoked, "'[i]n exercising the power of judicial review,' we look only at 'the *actual* powers of the national government.'" *United States v. Moghadam*, 175 F.3d 1269, 1275 n.10 (11th Cir. 1999) (citation omitted).

Nor is there any indication that Congress intended to disclaim its taxing power. To the contrary, the taxing power was expressly invoked in the Senate to defeat constitutional points of order against the minimum coverage provision. 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 Congress used terms like "excise tax" and "penalty" interchangeably. For example, at a time when the Senate bill used the term "excise tax," the accompanying Senate Report described it as a "penalty ... accounted for as an additional amount of Federal tax owed." *Compare* S. 1796 (Oct. 19, 2009), *with* S. Rep. No. 111-89, at 52 (Oct. 19, 2009). 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).[9]

[9] The evolution of the minimum coverage provision also confirms that use of the word "penalty" did not reflect any intent to disclaim the taxing power. The Senate bill, as initially introduced, used the word "penalty" to refer to a flat dollar amount owed for failure to obtain minimum coverage. H.R. 3590, 111th Cong. (2009). An amendment on the Senate floor used an alternative method of calculating the assessment as a percentage of income, insofar as the assessment was greater than the flat fee, but retained the Senate bill's terminology. H.R. 3590, Manager's Amendment (Dec. 19, 2009). That income-based approach tracks the approach in a parallel House bill, which called the assessment a "tax." H.R. 3962, 111th Cong. (2009). Nothing in the legislative history suggests that Congress, in incorporating this payment, intended to change its character as a tax.

Congress plainly did not conceal the fact that the provision operates as a tax, as the district court suggested. RE 400. Congress placed the provision in the Internal Revenue Code and required that payment be included on individual income tax returns, an entirely transparent approach. Moreover, during the legislative debates, opponents of the provision attacked it as "tax," *e.g.*, 155 Cong. Rec. S12768 (Dec. 9, 2009) (Sen. Grassley), and congressional leaders defended it 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).

III. The District Court Impermissibly Departed from Controlling Doctrine in Declaring the Affordable Care Act Invalid in Its Entirety and in Awarding Relief to Parties Without Standing.

A. The district court accepted plaintiffs' Article I challenge to the minimum coverage provision but rejected all of plaintiffs' other constitutional challenges to various provisions of the Act. The court nevertheless declared the Act invalid in its entirety, concluding that it must "stand or fall as a single unit." RE 2075.

That ruling is indefensible. The court itself recognized that its holding departs from the "'normal rule' that reviewing courts should ordinarily refrain from invalidating more than the unconstitutional part of a statute," RE 2074, and that it would have "indeterminable implications," RE 2077.

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

law," they must be sustained "[u]nless it is evident that the Legislature would not have enacted those provisions ... independently of that which is [invalid]." *Free Enterprise Fund*, 130 S. Ct. at 3161 (quoting *New York v. United States*, 505 U.S. 144, 186 (1992) (quoting *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987))).

The district court recognized that the Affordable Care Act "has approximately 450 separate pieces," RE 2074, and acknowledged that many of these provisions, including "many [that] are already in effect and functioning," can "stand alone and function independently," RE 2066-67. The court noted, for example, that "there is little doubt that the provision in the Act requiring employers to provide a 'reasonable break time' and separate room for nursing mothers to go and express breast milk can function without the individual mandate," RE 2066 (internal citation omitted), and observed that, "[i]mportantly, this provision and many others are already in effect and functioning," RE 2067.

The same is clearly the case for the Act's provisions that made multiple changes to Medicare payment rates for 2011, ACA Title III, and provisions that "provide for more rigorous enforcement" of drug pricing requirements. *Astra USA, Inc. v. Santa Clara County*, __ S. Ct. __ (Mar. 29, 2011), 2011 WL 1119021, *4. Other provisions re-authorized programs already on the books, *e.g.*, ACA §§ 4204(c), 5603, amended the False Claims Act, ACA § 10104(j)(2), and imposed requirements to eliminate

Medicaid waste and fraud, ACA §§ 6402(h)(2), 6411. Still other provisions, noted by the district court, include: "the prohibition on discrimination against providers who will not furnish assisted suicide services; an 'Independence at Home' project for chronically ill seniors; a special Medicare enrollment period for disabled veterans; Medicare reimbursement for bone-marrow density tests; and provisions devised to improve women's health, prevent abuse, and ameliorate dementia, as well as abstinence education and disease prevention." RE 2066 (internal citations omitted).

The court did not find it "evident" that these or the other "450 separate pieces" of the Act are contingent on the minimum coverage provision, which does not even take effect until 2014. RE 2074. Yet, the court declared these hundreds of pieces invalid because it believed that to determine "what Congress would want to keep is almost impossible." *Ibid*. That reasoning flies in the face of uniform Supreme Court precedent. Uncertainty about Congress's intentions or an inclination to avoid close analysis of congressional intent does not license the wholesale invalidation of statutory provisions that "stand alone and function independently." RE 2066. Because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people," a court must "refrain from invalidating more of the statute than is necessary." *Regan*, 468 U.S. at 652. Thus, "whenever an act of Congress contains unobjectionable provisions separable from those found to be

unconstitutional, it is the duty of [the] court to so declare, and to maintain the act in so far as it is valid." *Ibid.*

Following this binding precedent, the district court in *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 789 (E.D. Va. 2010) — the only other court to declare the minimum coverage provision invalid — rejected an identical request to set aside hundreds of provisions of unquestioned validity. The district court here, by contrast, attached unwarranted significance to the absence of a severability clause. RE 2068. The Supreme Court has long held that the "ultimate determination of severability will rarely turn on the presence or absence of such a clause." *United States v. Jackson*, 390 U.S. 570, 585 n.27 (1968). Thus, the Court in *Free Enterprise Fund* applied the *Alaska Airlines* standard, even though the statute at issue in *Free Enterprise Fund* had no severability clause. Likewise, the Court in *Regan* emphasized "the duty" of a court to "refrain from invalidating more of the statute than is necessary," 468 U.S. at 652, without reference to any severability provision.

The district court was equally wrong to declare the absence of a severability clause "significant because one had been included in an earlier version of the Act, but it was removed in the bill that subsequently became law." RE 2068. Even if a severability clause had been removed, the "unexplained disappearance" of text during the progress of a bill is rarely a "reliable indicator[] of congressional intent." *Mead*

Corp. v. Tilley, 490 U.S. 714, 723 (1989). That principle has particular force here because Congress legislated against the background presumption of severability. Indeed, both the Senate Legislative Drafting Manual and the House Legislative Counsel's Manual on Drafting Style "advise drafters that a 'severability clause is unnecessary' unless Congress intends to make certain portions of a statute unseverable." *Interpreting by the Book: Legislative Drafting Manuals and Statutory Interpretation*, 120 Yale L.J. 185, 190 (2010). The district court's description of the legislative history is, moreover, inaccurate. Although a bill initially adopted by the House contained a severability provision, none appeared in the bills considered by the Senate or enacted as the Affordable Care Act.[10]

The district court also noted defendants' recognition that the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions. The court did not explain, however, how that relationship could justify the invalidation of "450 separate" provisions. RE 2074. Moreover, even when particular provisions are integrally related, a court may not address provisions that do not burden parties to the litigation. The Supreme Court's decision in *Printz v. United States*, 521 U.S. 898

[10] The "earlier version of the Act" referred to by the district court is presumably H.R. 3962, a health care reform bill that the House passed in November 2009, which contained a severability provision. The Senate did not take up H.R. 3962 at that time, and instead used a different House bill as the vehicle for the Senate's version.

(1997), is illustrative. There, sheriffs challenged a scheme in which firearms dealers were required to notify local law enforcement officers of proposed gun purchases, and to delay sales for a five-day waiting period pending a background check. The Court held that the sheriffs could not be required to conduct background checks, but declined to consider the claim that the related waiting period provisions were not severable. The Court explained that "[t]hese provisions burden only firearms dealers and purchasers, and no plaintiff in either of those categories is before us here." *Id.* at 935. Although the severability claims presented "important questions," the Court had "no business answering them in these cases" and "decline[d] to speculate regarding the rights and obligations of parties not before the Court." *Ibid*.

Here, too, the multiple and varied provisions the district court declared inseverable affect the rights and obligations of parties not before the Court. Moreover, by addressing a vast array of schemes, the court disregarded a range of constraints on judicial review, such as the jurisdictional special review procedures that govern challenges to Medicare payment rates. *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000). Declaratory relief is "equitable in nature," *Abbott Labs. v. Gardner*, 387 U.S. 136, 155 (1967), and, as the district court itself recognized, "[s]everability is a doctrine of judicial restraint." RE 2065. The court clearly erred in failing to exercise that restraint.

B. The court compounded these errors by issuing a decree that applies to parties that failed to establish standing. Although the court purported to issue a judgment on behalf of all plaintiffs, the court explicitly declined to decide whether 24 of the 26 plaintiff states have standing to challenge the minimum coverage provision. RE 2019.

Moreover, the court's holding that two plaintiff states (Idaho and Utah) created their own standing to challenge the minimum coverage provision by enacting statutes that purport "to protect their citizens from forced compliance with" federal law, RE 2017-18, is clearly incorrect. The Supreme Court has long held that "[a] State does not have standing as parens patriae to bring an action against the Federal Government." *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 610 n.16 (1982) (citing *Massachusetts v. Mellon*, 262 U.S. 447, 485-86 (1923), and *Missouri v. Illinois*, 180 U.S. 208, 241 (1901)). A state cannot circumvent this bar by codifying its litigating position in a statute. Insofar as Idaho and Utah assert any cognizable rights, they are the rights of their residents.

As the Supreme Court stressed, "it is no part of [a State's] duty or power to enforce [its citizens'] rights in respect of their relations with the federal government." *Mellon*, 262 U.S. at 485-86. Here, as in *Mellon*, Idaho and Utah ask the Court "to adjudicate, not rights of person or property, not rights of dominion over physical domain, not quasi sovereign rights actually invaded or threatened, but abstract

questions of political power, of sovereignty, of government." *Id*. at 484-85. And, as the Supreme Court held in *Mellon,* such assertions do not present a justiciable issue.

CONCLUSION

The judgment of the district court should be reversed.

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CERTIFICATE OF COMPLIANCE

I hereby certify that, according to the word count provided in Corel WordPerfect 12, the foregoing brief contains 13,909 words. The text of the brief is composed in 14-point Times New Roman typeface.

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/s/Thomas M. Bondy
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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2011, I filed the foregoing Brief for Appellants by causing a copy to be electronically uploaded and by causing paper copies to be delivered to the Court by Federal Express. I also hereby certify that, by agreement with opposing counsel, I caused the brief to be served by electronic mail upon the following counsel:

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