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Florida v. HHS - U.S. Reply-Response Brief

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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CERTIFICATE OF INTERESTED PERSONS

State of Florida, et al. v. U.S. Dep't of Health & Human Servs., et al.,
Nos. 11-11021 & 11-11067 (11th Cir.)

Pursuant to 11th Cir. R. 26.1-1, the undersigned counsel certifies that, to the best of her knowledge, the list of interested persons provided in appellants' opening brief, as updated by all subsequent briefs including those of amici curiae, is complete.

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MAY 2011

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SUMMARY OF ARGUMENT

I. The minimum coverage provision of the Affordable Care Act regulates the timing and method of payment for health care services. To uphold this provision, the Court does not need to make new law or alter the established allocation of authority between state and federal government. The Court need only apply longstanding principles recognizing congressional authority to regulate economic conduct that substantially affects interstate commerce.

While plaintiffs seek to radically reshape the law and override the judgment of the elected branches of government, they acknowledge the fundamental features of the health care services market that produced the national problem Congress sought to address, generated substantial effects on interstate commerce, and shaped the regulatory structure of the Act. Unlike in other markets with general participation, such as the markets for food and housing, expenses in the health care services market are often sudden, unpredictable and too high to be reliably financed out-of-pocket. For that reason, insurance — a financial instrument — has long been the primary means of payment for health care services.

Millions of Americans, however, do not have health insurance and obtain health care services without the means to pay for them. Some lack the resources to purchase insurance. Some are denied insurance because of their medical conditions

or history. And some "make an economic and financial decision" to "attempt to self-insure." 42 U.S.C.A. § 18091(a)(2)(A). The tens of billions of dollars in annual health care costs that people without insurance fail to pay are passed on to other participants in the health care services market, *id*. § 18091(a)(2)(F) — a burden on interstate commerce that plainly qualifies as substantial.

Congress addressed these problems comprehensively in the Affordable Care Act. The Act increases the availability of insurance coverage through premium tax credits, the expansion of Medicaid, and the creation of insurance exchanges. It also regulates the insurance industry — barring insurers from denying insurance, or charging more for coverage, because of a person's medical history or condition. And, in furtherance of these consumer protections, so as not to "undercut [this] Federal regulation of the health insurance market," *id*. § 18091(a)(2)(H), the Act requires most individuals to maintain a minimum level of insurance or pay a tax penalty.

Plaintiffs do not dispute that the commerce power allows Congress to regulate how people pay for services in the vast interstate health care services market, which is quintessential economic activity. They take issue, instead, with the means that Congress chose to regulate this economic activity. Plaintiffs urge that the correct way to ensure that people pay for the medical services they consume is not by imposing an insurance requirement, but by "imposing restrictions or penalties on individuals

who attempt to consume health care services without insurance." States' Brief ("SB") 31-32. The "restrictions" that plaintiffs propose would limit access to medical care. In disregard of longstanding common law and state statutes (including the laws in many plaintiff states), plaintiffs argue that such restrictions would not contravene any shared "societal judgment." *Id*. at 37 & n.1.

Congress did not exceed its commerce power by opting to require minimum insurance coverage or the payment of a tax, instead of conditioning access to health care on the purchase of insurance and thereby denying the sick and injured access to medical care if they do not have coverage. Plaintiffs' proposed regulatory scheme disregards both the essential characteristics of the health care services market and the nature of insurance. Because the need for health care is unpredictable, plaintiffs' approach would require that individuals obtain insurance or else risk being left on the street after a car accident. Thus, under plaintiffs' scheme, the penalty for failing to maintain minimum coverage — denial of treatment — would be far more draconian than the tax penalty that Congress enacted.

Regulation of health care financing is clearly an appropriate role for the federal government, as plaintiffs conceded below. Record Excerpts ("RE") 333, 2052. If plaintiffs' proposed means to implement that regulation and address the problem of cost-shifting by the uninsured would be constitutional, then surely the means chosen

by the legislators empowered to make the choice is constitutional as well. It was eminently proper for Congress to choose not to turn away trauma victims, pregnant women in labor, and others with emergency conditions from the hospital if they cannot produce an insurance card.

In "determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court "'look[s] 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 *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010)) (this Court's emphasis). Notwithstanding plaintiffs' policy preferences, the minimum coverage provision is a rational means to accomplish Congress's legitimate Commerce Clause objectives.

II. In urging that the minimum coverage provision is not a valid exercise of the taxing power, plaintiffs recite contentions last marshaled 90 years ago to strike down child labor laws and long since laid to rest. *See* Private Plaintiffs' Br. ("PB") 58. In the modern era, the Supreme Court has repeatedly rejected claims that a provision is not a tax because its purpose is to alter conduct with the hope that the assessment will not be collected. The minimum coverage provision has none of the hallmarks of a "punitive" sanction. And although Congress may not have expressly

labeled the measure a "tax," the strong presumption that statutes are constitutional requires a court to determine whether Congress has the constitutional authority to adopt the minimum coverage provision, not whether Congress used particular terminology in doing so. In any event, it defies logic to argue that Congress eschewed the taxing power when it put the minimum coverage provision in the Internal Revenue Code, required payment of the penalty on April 15 with income taxes, employed numerous other trappings of the tax code, and justified the constitutionality of the provision as an exercise of the taxing power in the legislative debates.

III. As part of its comprehensive regulation of the means of payment for services in the health care market, Congress expanded eligibility for coverage under the Medicaid program. The federal government will bear the lion's share of the costs of this expansion, covering 100% of the costs of newly eligible individuals from 2014 through 2016, with the federal percentage in subsequent years gradually lowering to 90% in 2020 and thereafter.

Even though the federal government will shoulder an enormous share of the additional costs, the state plaintiffs insist that Congress lacks authority to expand the Medicaid program in this way. They recognize that their "participation in the Medicaid program is entirely optional," *Harris v. McRae*, 448 U.S. 297, 301 (1980),

but claim that they cannot realistically refuse to accept federal funds. On this basis, they urge that the expansion of the program is impermissibly "coercive."

No court has ever invalidated a condition on federal spending on a "coercion" theory, and several courts of appeals have rejected similar challenges to previous amendments to the Medicaid program. These decisions reflect the settled principle that Congress may "fix the terms on which it shall disburse federal money to the States," *New York v. United States*, 505 U.S. 144, 158 (1992), and that, "'[i]f a State wishes to receive any federal funding, it must accept the related, unambiguous conditions in their entirety.'" *Benning v. Georgia*, 391 F.3d 1299, 1308 (11th Cir. 2004) (citation omitted). Indeed, Congress expressly reserved its right to alter the Medicaid program, 42 U.S.C. § 1304, and the states accept federal funds subject to that reservation. *Bowen v. Public Agencies Opposed to Social Security Entrapment* ("*POSSE*"), 477 U.S. 41, 53 (1986).

IV. Plaintiffs do not seriously defend the district court's conclusion that invalidation of the minimum coverage provision would require invalidation of all provisions of the Affordable Care Act. Plaintiffs also make virtually no effort to defend the district court's conclusion that two plaintiff states have standing to challenge the minimum coverage provision on the basis of state statutes that declare that the federal law cannot be applied to their citizens. Their primary contention at

this juncture is that the plaintiff states are injured by the statute's Medicaid provisions and thus have standing to argue that the Medicaid provision cannot be severed from the minimum coverage provision. There is no doubt, however, that the Medicaid provisions are "operative" on their own and therefore severable. *New York*, 505 U.S. at 187.

ARGUMENT

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

A. The minimum coverage provision regulates the means by which people pay for health care services.

1. Congress enacted the minimum coverage provision as part of a broad scheme to regulate the payment for health care services. The legislative findings clearly expressed Congress's intent that the minimum coverage "requirement regulate[] activity that is commercial and economic in nature," including "how and when health care is paid for." 42 U.S.C.A. § 18091(a)(2)(A). Congress also identified the substantial effects on interstate commerce it was seeking to ameliorate, explaining that attempts to "self-insure" "increase[] financial risks to households and medical providers," *ibid*., and that, in 2008, "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000." *Id*. § 18091(a)(2)(F). Congress further

quantified the impact on interstate commerce, determining that "[t]his cost-shifting increases family premiums by on average over $1,000 a year." *Ibid*.

In regulating the means by which individuals pay for health care, Congress dealt with the reality that all people are at risk of injury and illness, and even those without insurance participate in the market for health care services. In 2008, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. U.S. Dep't of Health & Human Servs. ("HHS"), ASPE Research Brief, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills* ("ASPE Research"), at 5 (May 2011).[1] The two individual plaintiffs before the Court do not deny participation in the health care services market. *See* RE 924 (Brown Decl.); RE 928 (Ahlburg Decl.).

The statutory findings reflect that Congress focused on the uninsured as a class, and addressed the additional reality, not disputed here, that people without insurance do not pay for much of the health care they consume. Plaintiffs admit that the uninsured pay only "37% of their health care costs out of pocket," SB 30 (citing Families USA, Hidden Health Tax: Americans Pay a Premium, at 6, 22 (2009)), and

[1] In 2009, almost 60% of Americans under age 65 who were "uninsured for more than 12 months" had at least one visit with a doctor or to an emergency room; approximately 80% of those who were "uninsured for any period up to 12 months" did so. CDC, National Center for Health Statistics, *Health, United States, 2010*, at table 79.

that "third parties pay for another 26% of those costs on their behalf," *id*. at 30-31. These third parties include government programs that provide funding to offset the costs of care for the uninsured. Families USA, Hidden Health Tax, at 6, 22 (discussing Medicaid disproportionate share hospital payments). "The remaining amount" is "uncompensated care" that totaled "approximately $42.7 billion in 2008." *Id*. at 6. Congress found that this cost of uncompensated care increased annual insurance costs by $1,000 per insured family. 42 U.S.C.A. § 18091(a)(2)(F).

The problem of uncompensated care is not, as the private plaintiffs suggest, confined to the low-income population. *See* PB 5-6. There is no doubt that low-income individuals consume uncompensated care — a problem that Congress addressed separately by expanding eligibility for Medicaid. *See* Part III, *infra*. But even in households at or above the median income, people without insurance pay, on average, for 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, in households at or above the median income, uninsured people who consume more than $10,000 in medical services pay only 22% of their costs. *Id*. at 230; *see also* ASPE Research at 1 (uninsured families with incomes above 400% of the federal poverty level paid in full for only 37% of their hospitalizations).

Established Commerce Clause precedent confirms Congress's power to address this economic problem. In *Wickard* and *Raich*, the Supreme Court found there was a rational basis for Congress to have concluded that leaving home-grown and home-consumed commodities (wheat and marijuana respectively) outside of a comprehensive federal regulatory scheme would affect price and market conditions for those commodities. "In both cases," the Court explained, "the regulation is squarely within Congress' commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *Gonzales v. Raich*, 545 U.S. 1, 19 (2005). Given that this level of effect on interstate commerce is sufficient to justify congressional exercise of the commerce authority, it is equally clear that the regulation of the means of payment for health care services at issue here — a multi-billion dollar problem resulting from the failure of millions of uninsured patients to pay the full cost of the health care services they consume — satisfies the "substantial effects" standard and therefore is within Congress's commerce power.

2. Unable to dispute the cost-shifting attributable to the consumption of health care by the uninsured, plaintiffs nevertheless argue that Congress cannot deal with this problem by treating the uninsured as a class. They declare that "the government

cites no statistics whatsoever that would show that *all* uninsured individuals that receive medical care do not pay for the care." SB 30 (emphasis added).

This assertion is irrelevant to the commerce power. That some uninsured individuals may not generate uncompensated costs in a particular month or year provides no basis for invalidating the statute. The Supreme Court has never required Congress "to legislate with scientific exactitude," *Raich*, 545 U.S. at 17, and Congress is not required to predict, person-by-person, who among the uninsured will receive uncompensated medical services in a given month or year. *See NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 43 (1937) (despite the lack of recent labor strife in the steel industry, "Congress was entitled to foresee and to exercise its protective power to forestall" "the possibilities" of such disturbances in the future). The prevalence of insurance as the customary means of payment for health care services reflects the fact that the timing and magnitude of health care costs cannot accurately be predicted.

Given that people without insurance actively participate in the health care services market, and that, as a class, they fail to pay for 63% of the services they receive, Congress had far more than a rational basis to address the risk for individuals, and the reality for the class, that sudden and unforeseen medical costs can easily outstrip their assets. *See, e.g.*, U.S. Br. 8; *see also* ASPE Research at 3, 5.

Even before the dramatic escalation in medical costs in the last half century, Nobel laureate economist Kenneth Arrow, one of the signatories of the amicus brief of the economic scholars here,[2] observed that while food, like medical services, is a necessity, "avoidance of deprivation of food can be guaranteed with sufficient income, where the same cannot be said of avoidance of illness." Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941, 948-49 (1963) ("The most obvious distinguishing characteristics of an individual's demand for medical services is that it is not steady in origin as, for example, for food or clothing, but irregular and unpredictable.").

Plaintiffs rightly admit that "[r]egulations are 'plainly adapted' if they invoke 'the ordinary means of execution.'" PB 42. They fail to recognize, however, that, in the health care services market, insurance *is* the "ordinary means" of paying for health care services. Congress did not transgress the limits of its Commerce Clause authority by requiring non-exempted individuals to maintain minimum insurance coverage.

3. The private plaintiffs assert that the minimum coverage provision "does not regulate how individuals pay for *healthcare*, but only their failure to buy health

[2] *See* Amicus Br. of Economic Scholars (filed by 38 economists, including three Nobel laureates, two recipients of the John Bates Clark Medal, and a number of former high-ranking government economists).

insurance." PB 50 (plaintiffs' emphasis). That is incorrect. Health insurance is the ordinary means of payment for health care, and the statute requires that individuals have that means of payment available. It thus regulates how individuals pay for health care.

Plaintiffs offer two cursory statements in support of their contrary claim. First, they state that the Act "imposes monthly penalties on individuals who have not purchased insurance, even if they have not obtained healthcare during that month, let alone failed to pay for any care obtained." PB 50. But insurance requirements necessarily take effect before the need for the insurance arises. That an insurance policy is not used in a particular month does not alter its function as a means of payment, available to be drawn upon when health care is needed.

Second, plaintiffs argue that "the Act does not regulate or restrict any commerce between healthcare providers and patients, but only contracts between insurers and customers." *Ibid.* This formulation is at odds with the practical realities of the health care market. The Act necessarily regulates commerce between health care providers and patients because it requires patients to have insurance to pay those providers. Plaintiffs' argument once again exhibits a fundamental confusion between ends and means. Insurance requirements are not imposed for their own sake; they are imposed because of financial risks and costs associated with the underlying activity

that is being insured. *See United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 547 (1944) (courts must "examine the entire transaction, of which [the] contract [for insurance] is but a part, in order to determine whether there may be a chain of events which becomes interstate commerce"); *cf. Brown Shoe Co. v. United States,* 370 U.S. 294, 336-37 (1962) (Congress chose in the Clayton Act to "prescribe[] a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one").

4. Plaintiffs contend that "many healthy individuals make a rational choice to self-insure and are fully capable of paying for the care they receive," SB 30, and that an individual properly considers his "actuarial risk in self-financing his healthcare." PB 23. The assertions reveal plaintiffs' fundamental misunderstanding of the nature of insurance and its role in the health care services market.

Actuarial science is an insurance tool designed to assess risk across a broad population; it does not accurately predict the health care needs of any particular individual. Indeed, "even the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur; the vast bulk of spending needs cannot be forecast in advance." Amicus Br. of Economic Scholars, at 10-11 (citing Winkelman & Mehmud, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment, Society

of Actuaries, Apr. 20, 2007). The "frequency, timing and magnitude" of a given individual's demand for health care are unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007); *cf. Arizona Governing Comm. For Tax Deferred Annuity and Deferred Compensation Plans v. Norris,* 463 U.S. 1073, 1103 (1983) (actuaries cannot make "individual determinations of life expectancy").

The "self-insured" individual who, on plaintiffs' account, considers his "risk in self-financing his healthcare," thus places a bet that he will not incur significant health care costs in a given period. If he loses his bet, however, he will not likely be the only person to bear the costs — they will be passed on to other consumers in the health care market. The minimum coverage provision precludes him from making that bet and incurring that level of risk. Requirements of this kind are familiar tools of economic regulation.

Plaintiffs' argument boils down to the contention that Congress has no Commerce Clause power to regulate the extent of financial risk-taking in the health care services market. Whatever policy objection plaintiffs may have to such regulation, they muster no support for the claim that it exceeds Congress's commerce power. Regulation of financial risk in the health care services market would be valid even if, as plaintiffs assert, "the uninsured are *strangers* to the health-insurance

market who in no way stimulate or obstruct its operation." PB 21 (plaintiffs' emphasis).

In fact, however, plaintiffs' assertion is not accurate. First, the uninsured receive uncompensated care that inflates the premiums of insured consumers. They thus "obstruct" the operation of the insurance market. Indeed, an individual's calculation to "self-insure" may appear "rational" only because of the "backstop of uncompensated care funded by third parties." *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010).

Second, for many "self-insurers," the "actuarial" calculation is not *whether* to purchase market insurance but *when* to purchase it. *See* CBO, How Many People Lack Health Insurance and for How Long? at 4, 9 (2003) (substantial numbers move in or out of insurance coverage within a given year). The individual plaintiffs do not suggest that they have never had health insurance coverage — only that they do not carry coverage now. *See* RE 924 (Brown has "not had health insurance for the past four years"); RE 928 (Ahlburg has "not had insurance for the past six years").

Being uninsured is not, as plaintiffs suggest, a non-economic "status." PB 8. At least for the "healthy individuals" who assertedly "make a rational choice" — that is, an economic calculation — "to self-insure," SB 30, it is a choice to try to finance health care services in a particular way based on an assessment of short-term needs

for medical care. While "many healthy individuals" may make the economic choice to forgo insurance for some period of time, economic realities make it unlikely that they will do so indefinitely; at some point, their assessment of the "actuarial risk in self-financing," PB 23, is likely to change. As a general matter, "young adults move into coverage as they grow older." Glied & Stabile, *Generation Vexed: Age-Cohort Differences in Employer-Sponsored Health Insurance Coverage*, 20 Health Affairs 184, 185 (2001); *see also* Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23 table 8 (showing that, in 2009, about 30 percent of individuals ages 18 to 34 lacked coverage, compared with about 16 percent of those ages 45 to 64).

The efforts of such individuals to time their entry into the insurance pool to maximize their personal gains significantly affects the costs of premiums, and thus substantially affects interstate commerce. It may seem rational to some healthy, young individuals to postpone joining the insurance pool — as long as insurance remains available at a later date. In the meantime, their choice to "self-insure" raises premiums for the individuals who finance, and thereby maintain, the insurance plans and medical infrastructure of which the young "self-insurers" will likely later avail themselves.

The private plaintiffs cast no doubt on the validity of the minimum coverage provision by insisting that it disadvantages some consumers (those who would prefer to attempt to "self-insure") to the advantage of others (those who benefit most immediately from the reform of medical underwriting practices). PB 3-4. Plaintiffs disregard the fact that those who endeavor to "self-insure" also "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.*, 720 F. Supp. 2d at 894. But, even accepting plaintiffs' characterization for purposes of argument, their position echoes the argument that was rejected in *Wickard v. Filburn*, 317 U.S. 111 (1942). There, it was urged that "this Act, forcing some farmers into the market to buy what they could provide for themselves, is an unfair promotion of the markets and prices of specializing wheat growers." *Id*. at 129. The Supreme Court rejected that argument and explained: "It is of the essence of regulation that it lays a restraining hand on the self-interest of the regulated and that advantages from the regulation commonly fall to others. The conflicts of economic interest between the regulated and those who advantage by it are wisely left under our system to resolution by the Congress under its more flexible and responsible legislative process." *Ibid.*

Plaintiffs' attempt to isolate particular individuals would not, in any event, provide a basis for a "facial challenge" to the minimum coverage provision. SB 3.

Facial challenges are disfavored; "[a]lthough passing on the validity of a law wholesale may be efficient in the abstract, any gain is often offset by losing the lessons taught by the particular, to which the common law method normally looks." *Sabri v. United States*, 541 U.S. 600, 608-09 (2004). In a facial challenge, the plaintiff bears the burden of showing that "*no* application of the statute could be constitutional." *Id.* at 609; *see also United States v. Salerno*, 481 U.S. 739, 745 (1987). Although plaintiffs focus their argument on individuals such as plaintiffs Brown and Ahlburg — who are assertedly "strangers" to the insurance market during the periods in which they attempt to "self-insure" — the minimum coverage provision also applies to individuals who maintain insurance that does not meet minimum standards. It likewise applies to individuals who move in and out of the health insurance market during the course of a year and who are thus "active" in that market even under plaintiffs' narrow conception of that term. Accordingly, plaintiffs' facial challenge necessarily fails.

B. Requiring minimum insurance coverage is a necessary and proper means of regulating economic activity in the health care market.

1. At bottom, plaintiffs do not really dispute that the minimum coverage provision advances legitimate Commerce Clause objectives. Their quarrel, instead, is with the means of regulation. In district court, plaintiffs argued that it would be

"constitutionally unobjectionable for the government to say, at least as a structural matter — there are some Bill of Rights issues — you cannot pay for medical care out of your own pocket; you have to pay with insurance. The government could do that." RE 334. The district court agreed that "Congress plainly has the power to regulate [individuals] at the time [when they fail to pay for services] (or even at the time that they initially seek medical care)," RE 2052, and noted that this is "a fact with which the plaintiffs agree." *Ibid*.

On appeal, plaintiffs again acknowledge that "Supreme Court precedent" allows Congress to accomplish its legitimate regulatory goals by "imposing restrictions or penalties on individuals who attempt to consume health care services without insurance." SB 31-32. But they further declare: "that does not give Congress carte blanche to compel participation in that activity." *Id.* at 32. Plaintiffs identify no precedent that suggests that Congress's only permissible choice is to penalize "individuals who attempt to consume health care services without insurance," and that it cannot, instead, adopt the far more rational approach of requiring insurance in the first place. SB 31-32.[3]

[3] Plaintiffs' reference to "carte blanche to compel participation in that activity," SB 32, underscores their conflation of the activity being regulated (participation in the health care services market) and the means of regulation (maintenance of insurance). The minimum coverage provision does not, of course, require persons to "'consum[e] health care services.'" SB 31 (citation omitted).

Plaintiffs do not spell out what kind of "restrictions or penalties" they would impose "on individuals who attempt to consume health care services without insurance." SB 31-32. They imply, but do not explicitly argue, that accident victims and pregnant women in labor should be turned away from the hospital if they cannot produce an insurance certificate. And they vigorously contend that such a restriction on access to medical care would not contravene any shared "societal judgment." SB 37 & n.1.

Plaintiffs' contention is quite extraordinary and fails at every level. First, even if plaintiffs were correct to claim that uncompensated care and cost-shifting were created by EMTALA, *see* SB 36, the point would be immaterial. For purposes of the commerce power, the relevant point is that the minimum coverage provision does indeed regulate economic activity in the health care services market — the point is not whether uncompensated care and cost-shifting would exist in a hypothetical Hobbesian health care services market in which emergency rooms closed their doors to people who were uninsured.

No case has ever suggested that Congress lacks the power to regulate a market because its own regulations affected market conditions. The ban on marijuana possession at issue in *Raich*, for example, was necessary only because Congress had determined to eradicate the interstate marijuana market. Far from suggesting that the

ban was therefore suspect, the Supreme Court explained that Congress has particular latitude to enact provisions in aid of its broader regulatory programs. *Raich*, 545 U.S. at 22 & 25 n.34. Likewise, in his concurring opinion, Justice Scalia stressed that where "Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Id*. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy*, 315 U.S. 110, 118-19 (1942)); *see also Jinks v. Richland County*, 538 U.S. 456, 461-64 (2003); *Comstock,* 130 S. Ct. at 1961-62.

In any event, the requirement to provide emergency medical treatment is grounded in state law, including the law in many plaintiff states, and a widely shared sense of moral imperative. As our opening brief explained (Br. 34-35), well before EMTALA, state court rulings had imposed "a common law duty on doctors and hospitals to provide necessary emergency care." H.R. Rep. No. 99-241(III) (1985), at 5. The modern rule "is that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency." *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) (citing *Valdez v. Lyman-Roberts Hosp., Inc.*, 638 S.W.2d 111, 114 (Tex. App. 1982); Annotation: *Liability of Hospital for Refusal To Admit or Treat Patient*, 35 A.L.R. 3d 841, § 4, at 846-47). Indeed, the common-law duties extend further than EMTALA,

because they restrict a physician's ability to terminate an existing physician-patient relationship. *See*, *e.g.*, *Ricks v. Budge*, 64 P.2d 208, 210-13 (Utah 1937) (holding a physician subject to liability for refusing to continue treatment until the patient's outstanding account balance was paid).

In addition to the requirements imposed under common law, by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists." H.R. Rep. No. 99-241(III) (1985), at 5. For example, Florida law 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). "Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay." *Id*. § 395.1041(3)(k)(1). 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(A); Idaho Code Ann. § 39-1391b; Wash. Rev. Code § 70.170.060(2); Utah Code Ann. § 26-8a-501(1).

Plaintiffs do not discuss — or even cite — these state statutes and court rulings. Presumably, however, plaintiffs do not reject the longstanding judgments of their

courts and legislatures. Certainly, it was proper for Congress to take into account the moral, practical, and legal imperatives of the health care system in crafting its regulations.

2. The minimum coverage provision is valid for an independent reason, namely that it is integral to the statutory requirements that insurers extend coverage and set premiums without regard to pre-existing medical conditions. *See* U.S. Br. 28-32. Plaintiffs do not dispute that regulating the terms of insurance policies is within Congress's commerce power, *see South-Eastern Underwriters Ass'n*, 322 U.S. at 533, nor do they question Congress's judgment that these insurance regulations would not work if consumers could wait to buy insurance until they are injured or sick, *see* 42 U.S.C.A. § 18091(a)(2)(I). Instead, plaintiffs assert that if the Commerce Clause itself does not authorize the minimum coverage provision, then it cannot be within Congress's Necessary and Proper authority. SB 38; PB 35. But, under the Necessary and Proper Clause, Congress is permitted to utilize "means ... not themselves within the granted power." *United States v. Darby*, 312 U.S. 100, 121 (1941). Here the end — reform of discriminatory insurance practices — is plainly within Congress's commerce authority, and Congress's chosen means of effectuating that end — including the minimum coverage provision — is plainly adapted to it. Nothing more is required under the Necessary and Proper Clause. *Comstock*, 130 S. Ct. at 1956-57.

Plaintiffs' assertion that Congress may not "counteract" the consequences of its own regulation, SB 40, turns the settled doctrine on its head. *See* pp. 21-22, *supra*; *see also* Amicus Br. of Barry Friedman, et al., at 23-31.[4]

The private plaintiffs contend that Congress could have achieved its objectives through other means. They suggest that Congress could exclude persons who fail "to purchase insurance by a certain date or age" from the protection of the guaranteed-issue and community-rating provisions. PB 41. But such a scheme would perpetuate the cost-shifting problem, as an excluded person who developed a medical condition would be unable to obtain insurance but could still receive expensive medical care regardless of ability to pay.

Even assuming that plaintiffs could identify preferable regulatory alternatives, that would provide no basis to invalidate the statute that Congress enacted. This Court and the Supreme Court have stressed that "'in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power.'" *United States v.*

[4] The Supreme Court has not developed separate Necessary and Proper Clause jurisprudence for each enumerated power. Indeed, in *Comstock*, the Court concluded that a federal civil commitment statute was "necessary and proper" without tethering that analysis to a particular enumerated power and nowhere suggested the analysis would differ on a clause-by-clause basis. 130 S. Ct. at 1957-58.

Belfast, 611 F.3d 783, 804 (11th Cir. 2010) (quoting *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010), and citing *Raich*, 545 U.S. at 22, and *Sabri v. United States*, 541 U.S. 600, 605 (2004)) (this Court's emphasis); *United States v. Nascimento*, 491 F.3d 25, 42 (1st Cir.) ("Assuming the existence of a rational basis for the solution that Congress has devised, the court should respect the level of generality at which Congress chose to act."), *cert. denied*, 552 U.S. 1297 (2007). Indeed, the minimum coverage provision is not merely a rational means of implementing Congress's objectives; it would satisfy even the strict sense of necessity that Chief Justice Marshall recognized in *McCulloch* to be unduly restrictive of Congress's prerogatives.

C. Plaintiffs' assertions of law contradict governing Commerce Clause precedent.

1. Plaintiffs nonetheless insist that the minimum coverage requirement must await specific, commercial transactions — "attempt[s] to consume health care services without insurance." SB 32. This argument parallels the reasoning that the Supreme Court rejected in *Raich*.

The Ninth Circuit held that the possession of marijuana for medicinal purposes "is not properly characterized as commercial or economic activity" because the "class of activities does not involve sale, exchange, or distribution." *Raich v. Ashcroft*, 352 F.3d 1222, 1229 (9th Cir. 2003). "Lacking sale, exchange or distribution," the court

reasoned that "the activity does not possess the essential elements of commerce." *Id*. at 1229-30.

The Supreme Court reversed the Ninth Circuit, however, and declared that the absence of such transactions was immaterial 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. The Court explained that the Controlled Substances Act "regulates the production, distribution, and consumption of commodities for which there is an established, and lucrative, interstate market," and that "[p]rohibiting the intrastate possession or manufacture of an article of commerce is a rational (and commonly utilized) means of regulating commerce in that product." *Id*. at 25-26.

Well before *Raich*, the Supreme Court rejected the contention that the commerce power cannot be exercised until the "problematic commerce" occurs. PB 53. "It cannot be maintained that the exertion of federal power must await the disruption of ... commerce." *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 222 (1938). On the contrary, Congress may adopt "reasonable preventive measures" to avoid disruptions to interstate commerce before they occur. *Ibid*.

2. This Court has applied *Raich* in several decisions that plaintiffs ignore or brush aside. In *Garcia v. Vanguard Car Rental USA, Inc.,* 540 F.3d 1242 (11th Cir.

2008), this Court stressed that "Congress need only have a rational basis for concluding that the intrastate activity would undermine the lawful Commerce Clause goals of a federal statute if left untouched." *Id.* at 1253 (citing *Raich,* 545 U.S. at 19). The Court thus upheld a statute that preempted state tort laws making the lessor of an automobile vicariously liable for the acts of a lessee. The Court explained that, "[i]f *any* costs are passed on to customers, rental cars — a product which substantially affects commerce and which is frequently an instrumentality of commerce — become more expensive, and interstate commerce is thereby inhibited." *Ibid*. (this Court's emphasis).

Prior to *Raich*, this Court had invalidated the ban on possession of child pornography on the ground that the ban had "no clear economic purpose," and made "no effort to control national trade by regulating intrastate activity." *United States v. Maxwell*, 386 F.3d 1042, 1057 (11th Cir. 2004) ("*Maxwell I*"). Subsequently, the Court recognized that this reasoning did not survive *Raich,* which made clear that Congress has "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." *United States v. Maxwell*, 446 F.3d 1210, 1219 (11th Cir. 2006) ("*Maxwell II*").

Likewise, in *Alabama-Tombigbee Rivers Coalition v. Kempthorne*, 477 F.3d 1250, 1271 (11th Cir. 2007), this Court upheld 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." *Id*. at 1277; *see also United States v. Evans*, 476 F.3d 1176, 1179 (11th Cir. 2007) (sustaining conviction under Trafficking Victims Protection Act for enticing minor into prostitution, stressing that the provision at issue formed part of a comprehensive regulatory scheme); *United States v. Smith*, 459 F.3d 1276, 1285 (11th Cir. 2006) ("Congress could have rationally concluded that the inability to regulate intrastate possession and production of child pornography would, in the aggregate, undermine Congress's regulation of the interstate child pornography market.").

These decisions underscore plaintiffs' error in seeking to analogize regulation of the means of payment for health care services to the statutes at issue in *Lopez* and *Morrison.* Those cases did not, as plaintiffs assert, reject a "cost-shifting and insurance rationale" that is "similar" to the rationale for the minimum coverage provision. SB 36. Rather, the Supreme Court rejected "the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct's

aggregate effect on interstate commerce." *United States v. Morrison*, 529 U.S. 598, 617 (2000); *see also Raich*, 545 U.S. at 35-36 (Scalia, J., concurring in the judgment) (describing *Lopez* and *Morrison*); *Sabri v. United States*, 541 U.S. 600, 607 (2004) (*Lopez* and *Morrison* both "emphasized the noneconomic nature of the regulated conduct").

This Court has made clear that the reasoning of *Lopez* and *Morrison* does not apply where a plaintiff challenges "'a component of a broader regulatory scheme whose subject is decidedly economic,'" rather than "'a single-subject statute whose single subject is itself non-economic.'" *United States v. Paige*, 604 F.3d 1268, 1273 (11th Cir. 2010) (quoting *Maxwell II*, 446 F.3d at 1216 n.6); *see also Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981) (rejecting Commerce Clause challenge to "specific provisions" of a "complex regulatory program" where they were "an integral part of the regulatory program" and where "the regulatory scheme as a whole" was designed to "prevent[] adverse effects on interstate commerce"). The minimum coverage provision regulates economic conduct — the means of payment for health care services — and forms part of a comprehensive scheme of economic regulation. It bears no resemblance to the Gun Free School Zones Act or the Violence Against Women Act.

Moreover, it is common ground that there is no federal "police power" and that Congress may not exceed the limits of its commerce power articulated in *Morrison* and *Lopez*.[5] But whereas the Court in those cases "emphasized the noneconomic nature of the regulated conduct" and "found the effects of those activities on interstate commerce insufficiently robust," *Sabri*, 541 U.S. at 607, the minimum coverage provision regulates economic conduct with an extraordinarily robust impact on interstate commerce. Even plaintiffs do not dispute that payment for health care services is economic activity. Nor do they dispute the interstate nature of the health care market, the interstate mobility of patients seeking treatment, the barriers the current insurance system poses to interstate job changes, or the structural obstacles inherent in state-level health care reform. U.S. Br. 46-49; *see also* Amicus Br. of Mass., at 12-15; Amicus Br. of Barry Friedman, et al., at 10-18; Amicus Br. of Oregon, et al., at 1-5, 27-30; Amicus Br. of California, et al., at 24-27, 30, *Virginia v. Sebelius*, No. 11-1057 & 11-1058 (4th Cir.). These characteristics of the health care market underscore the constitutionality of the Act and confirm that it does not disrupt

[5] It is, of course, "no objection to the assertion of the power to regulate interstate commerce that its exercise is attended by the same incidents which attend the exercise of the police power of the states." *Darby*, 312 U.S. at 114; *see also Raich*, 545 U.S. at 29 n.38 (rejecting the suggestion that Congress must "cede its constitutional power to regulate commerce whenever a State opts to exercise its 'traditional police powers to define the criminal law and to protect the health, safety, and welfare of their citizens'").

the balance between "what is truly national and what is truly local." *United States v. Lopez*, 514 U.S. 549, 567-68 (1995). Indeed, the federal government has been pervasively involved in regulating health care and insurance for decades. Congress reasonably determined that a national solution to the problem was appropriate, and no judicial precedent requires this Court to disturb that judgment.

3. Rather than address the pertinent features of the statute before this Court, plaintiffs attack a variety of far-fetched hypothetical statutes that are readily distinguishable and that would not be legitimated by a decision upholding the minimum coverage provision. Plaintiffs purport to see no difference between the Affordable Care Act's minimum coverage provision and requirements "to eat more vegetables and fewer desserts, to exercise at least 45 minutes per day, to sleep at least eight hours per day, and to drink one glass of wine a day but never any beer." SB 33-34.

Despite their rhetoric, plaintiffs at least implicitly recognize a difference in kind between a requirement to get a good night's sleep and a requirement "to pay for services in a particular way." SB 34. The regulation of payment for services is paradigmatic regulation of economic activity. That is why even plaintiffs acknowledge that Congress could impose penalties on persons who attempt to purchase medical care without insurance. *Id*. at 31-32. In contrast, hypothetical

directives to "eat more vegetables," "exercise," "sleep," or "drink ... wine" do not regulate the method of payment for medical services or any other economic activity. *See, e.g.*, Amicus Br. of Am. Hospitals Ass'n, et al., at 23-25. Such hypothetical directives address noneconomic conduct that in the aggregate would affect interstate commerce only in a highly attenuated manner. *Morrison* and *Lopez* made clear that Congress may not "regulate *noneconomic* activity based solely on the effect that it may have on interstate commerce through a remote chain of inferences." *Raich*, 545 U.S. at 35-36 (Scalia, J., concurring in the judgment). Unlike plaintiffs' hypotheticals, the requirement to maintain minimum insurance coverage directly regulates the means of payment for services in an interstate market. Even plaintiffs do not suggest that is not economic activity or that such regulation is connected to interstate commerce only "though a remote chain of inferences." *Ibid*. In short, the minimum coverage provision falls well within the limits articulated in *Morrison* and *Lopez*. Plaintiffs' hypothetical statutes do not.

Moreover, unlike the minimum coverage provision, directives to eat vegetables or to drink wine would implicate due process protections applicable to state as well as federal regulation. Regulating the means of financing a purchase is fundamentally different from forced consumption of a food product. And plaintiffs have rightly abandoned their claim that the minimum coverage provision implicates a "substantive

due process" right "to eschew entering into a contract." RE 437 (internal quotation marks and citations omitted). Although "this claim would have found Constitutional support in the Supreme Court's decisions in the years prior to the New Deal legislation of the mid-1930's, when the Due Process Clause was interpreted to reach economic rights and liberties," the *Lochner*-era doctrine "has long since been discarded." RE 436 (internal quotation marks and citations omitted).

Plaintiffs' hypotheticals also fail to distinguish between simple directives to make a purchase and the regulation of the way payments are made. As plaintiffs recognize, "[t]he individual mandate does not force participation in the health care market." SB 29. Health insurance is not designed to compel the purchase of health care services; instead, it ensures that the consumer will have the means to pay for health care services when they are needed. *See German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 414-15 (1914) (insurance is "essentially different from ordinary commercial transactions"). It is one thing for plaintiffs to urge that Congress cannot tell people "what type of housing, food, and clothing to consume" SB 34; it is another matter for plaintiffs to assert that Congress also may not regulate "how to pay for them." *Ibid.* There is no question that Congress may regulate the way people pay for products and services in interstate markets. *See*, *e.g.*, 15 U.S.C. § 1639(e) (provision

of the Dodd-Frank Wall Street Reform and Consumer Protection Act that regulates the terms of mortgage financing).

The private plaintiffs assert that the minimum coverage provision does not "regulate" commerce within the meaning of the Commerce Clause. PB 14-16. But "'[t]o regulate,' in the sense intended [by the Commerce Clause], is to foster, protect, control and restrain, with appropriate regard for the welfare of those who are immediately concerned and of the public at large." *Second Employers' Liability Case*, 223 U.S. 1, 47 (1912); *see also Texas & N.O. R. Co. v. Bhd. of Ry. & Steamship Clerks*, 281 U.S. 548, 570 (1930) ("The power to regulate commerce is the power to enact all appropriate legislation for its protection or advancement.") (internal quotation marks and citation omitted). Requiring insurance as a means of financing participation in the market for health care services falls comfortably within that definition. It is a mechanism "to prescribe the rule by which commerce is to be governed," which forms part of "the power to regulate." *Gibbons v. Ogden*, 22 U.S. 1, 196 (1824).

Although the plaintiffs repeatedly invoke abstract ideals of liberty, the practical right they seek to vindicate is the ability to consume health care services without insurance and pass overwhelming costs on to other market participants. There is of course no such right in the Constitution, and the Commerce Clause provides Congress

with ample authority to prevent such practices and to curb their substantial adverse effects on interstate commerce. Just as the Framers did not include textual provisions authorizing civil commitment of sexual predators, *Comstock*, regulation of homegrown marijuana, *Raich*, or the chartering of a bank, *McCulloch*, they did not include an express enumerated power in the Constitution on insurance requirements. The Supreme Court has repeatedly observed, however, that "'[t]he Federal Government undertakes activities today that would have been unimaginable to the Framers.'" *Comstock*, 130 S. Ct. at 1965 (quoting *New York*, 505 U.S. at 157). "The Framers demonstrated considerable foresight in drafting a Constitution capable of such resilience through time." *Ibid*.

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

The minimum coverage provision is independently authorized by Congress's taxing power because it operates as a tax, and will produce billions of dollars in revenue annually. Plaintiffs' contrary position is a flawed attempt to revive "distinctions between regulatory and revenue-raising taxes" that the Supreme Court has expressly "abandoned." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 741 n.12 (1974).

A. The minimum coverage provision operates as a tax and will produce billions of dollars in annual revenue.

There is no doubt that the "practical operation" of the minimum coverage provision is as a tax. *Nelson v. Sears, Roebuck &Co.*, 312 U.S. 359, 363 (1941). The provision amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of coverage shall pay a monthly penalty for so long as he fails to maintain that minimum. 26 U.S.C.A. § 5000A. The amount of the penalty is calculated as a percentage of household income for federal income tax purposes, subject to a floor and a cap. *Id.* § 5000A(c). The payment is reported on the individual's federal income tax return for the taxable year, and is "assessed and collected in the same manner as" other specified federal tax penalties. *Id.* § 5000A(b)(2), (g). Individuals who are not required to file income tax returns for a given year are not required to pay the penalty. *Id.* § 5000A(e)(2). The taxpayer's

responsibility for family members depends on their status as dependents under the Internal Revenue Code. *Id.* § 5000A(a), (b)(3). Taxpayers filing a joint tax return are jointly liable for the penalty. *Id.* § 5000A(b)(3)(B). And the 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 v. United States*, 300 U.S. 506, 514 (1937). The Congressional Budget Office found that it will raise at least $4 billion a year in revenues for the general treasury, *see* Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, U.S. House of Representatives, table 4 (Mar. 20, 2010), and Congress adopted that finding to conclude that the provision, together with the rest of the Act, will reduce the federal deficit, *see* Pub. L. No. 111-148, § 1563(a)(1), 124 Stat. 119, 270 (2010). In short, it is an understatement to say that the provision bears "some reasonable relation" to the "raising of revenue," *United States v. Doremus*, 249 U.S. 86, 93-94 (1919), and it is therefore within Congress's taxing power. *See also Nigro v. United States*, 276 U.S. 332, 353 (1928) (any "doubt as to the character" of a tax was removed because provision raised "substantial" sum of $1 million per year).

B. Congress did not disavow its taxing power.

Plaintiffs admit, as they must, that "Congress need not specify its constitutional basis" for its enactments. PB 58 (emphasis omitted). Because the Court is obligated to uphold a federal statute if there is a basis in the Constitution for doing so, it does not matter whether Congress invoked the taxing power, or called the provision a tax. What matters is whether it *is* a tax. As discussed, it is the practical operation that determines whether a measure is a tax. Thus, Congress may use its taxing power to impose assessments that it labels as "licenses," *License Tax Cases*, 72 U.S. 462, 474-75 (1866); "premiums," *Adventure Res., Inc. v. Holland*, 137 F.3d 786, 793-94 (4th Cir. 1998); or, as here, "penalties," *United States v. Sotelo*, 436 U.S. 268, 275 (1978). *See also Mobile Republican Assembly v. United States*, 353 F.3d 1357, 1360-61 (11th Cir. 2003) (provision labeled as a "penalty" was a valid tax).

Nevertheless, plaintiffs insist that Congress "disavowed" its taxing power and somehow rendered it not a tax. PB 57. In reality, the Senate explicitly *invoked* the taxing power when the minimum coverage provision was challenged in constitutional points of order. 155 Cong. Rec. S13,830, S13,832 (Dec. 23, 2009). Moreover, during the legislative debates, congressional leaders expressly defended the provision as an exercise of the taxing power. *E.g.*, 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); *id.* at H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec.

S13,751, S13,753 (Dec. 22, 2009) (Sen. Leahy); *id.* at S13,558, S13,581-82 (Dec. 20, 2009) (Sen. Baucus).

Nor do "the plain words of the statute" show that Congress "did not intend to impose a tax." PB 58. The term "tax" (or a variant thereof) appears more than forty times in the "plain words" of the minimum coverage provision. The provision repeatedly describes the persons subject to its terms as "taxpayers," who report their liability on their income tax returns for the "taxable year," and who calculate that liability on the basis of the "taxpayer's household income." 26 U.S.C.A. § 5000A(b)(1), (c)(2)(B), (c)(4)(B). Indeed, a "taxpayer" is subject to the provision only if his gross income is sufficient to require filing an income tax return (and he is not otherwise exempted). *Id*. § 5000A(e)(2).

There is no reason to conclude that Congress's use of the term "penalty" was meant to have constitutional significance. On the contrary, Congress used the terms "tax" and "assessable penalties" interchangeably in the Act's employer responsibility provision, in describing the payments owed under specified circumstances by a large employer that does not offer full-time employees adequate coverage. 26 U.S.C.A. § 4980H(b)(2), (c)(2)(D). Although plaintiffs note that the minimum coverage provision uses the term "requirement" to describe the conditions that trigger tax consequences under the Act, *see* SB 44, PB 56, other tax statutes are similarly phrased,

and no court has suggested that the measures are thereby beyond the taxing power. *See, e.g.*, 26 U.S.C. §§ 4980B, 9801-9834. In any event, if there were any doubt as to the meaning of the terms in the Affordable Care Act, the Court properly would resolve that doubt in favor of Congress's authority. *Northwest Austin Mun. Utility Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009); *Ashwander v. TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring).

C. Congress may impose regulatory taxes.

Plaintiffs' position is an attempt to resuscitate "distinctions between regulatory and revenue-raising taxes" that the Supreme Court has expressly "abandoned." *Bob Jones*, 416 U.S. at 741 n.12.

Plaintiffs assert that "Congress wanted the 'penalty' to produce *no revenue*, because Congress wanted *everyone* eligible to purchase insurance and thereby *avoid* the penalty." PB 58 (plaintiffs' emphases). But it is "beyond serious question that a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States v. Sanchez*, 340 U.S. 42, 44 (1950). "Every tax is in some measure regulatory" in that "it interposes an economic impediment to the activity taxed as compared with others not taxed." *Sonzinsky*, 300 U.S. at 513. Accordingly, "'the courts have sustained taxes although imposed with the collateral intent of effecting ulterior ends which, considered apart, were beyond the

constitutional power of the lawmakers to realize by legislation directly addressed to their accomplishment.'" *Sanchez*, 340 U.S. at 44-45 (quoting *A. Magnano Co. v. Hamilton*, 292 U.S. 40, 47 (1934)).

Thus, in *Sonzinsky*, 300 U.S. at 512-14, the Supreme Court rejected the argument that a tax on firearms dealers "is not a true tax, but a penalty imposed for the purpose of suppressing traffic in a certain noxious type of firearms." Likewise, in *Sanchez*, 340 U.S. at 44, the Court upheld a tax on marijuana transfers against an attack that rested "on the regulatory character and prohibitive burden of the section as well as the penal nature of the imposition."

Plaintiffs' argument echoes the contention rejected by the Supreme Court in *United States v. Kahriger*, 345 U.S. 22 (1953), where it was urged that "Congress, under the pretense of exercising its power to tax has attempted to penalize illegal intrastate gambling through the regulatory features of the Act." *Id.* at 24. The *Lochner*-era cases on which plaintiffs rely, *see* PB 55, SB 54, were anomalous even at the time they were decided. *See, e.g.*, *United States v. One Ford Coupe Auto.*, 272 U.S. 321, 328 (1926) (upholding tax whose "main purpose" was to deter lawbreaking). They "produced a prompt correction in course," *Bob Jones Univ.*, 416 U.S. at 743, and the Supreme Court has long since "abandoned the view that bright-line distinctions exist between regulatory and revenue-raising taxes," *id.* at 743 n.17.

Although plaintiffs assert that the minimum coverage provision imposes "punishment," PB 55, SB 46, the provision has none of the hallmarks of a "punitive" sanction. *Dep't of Revenue v. Kurth Ranch*, 511 U.S. 767, 778-79 (1994). It does not turn on the taxpayer's scienter. *Cf. The Child Labor Tax Case*, 259 U.S. 20, 36-37 (1922). And, unlike in cases where a "highly exorbitant" tax rate showed an intent to "punish rather than to tax," *United States v. Constantine*, 296 U.S. 287, 294, 295 (1935), the penalty under the minimum coverage provision can be no greater than the cost of qualifying insurance, 26 U.S.C. § 5000A(c)(1)(B). *Cf. Sanchez*, 340 U.S. at 45 ("rational foundation" for rate of tax showed it was not punitive sanction in disguise). Moreover, the penalty is imposed on a month-by-month basis, 26 U.S.C. § 5000A(b)(1), confirming that it does not impose punishment for past unlawful acts, *cf. The Child Labor Tax Case*, 259 U.S. at 36 (assessment was punitive where "amount is not to be proportioned in any degree to the extent or frequency of the departures"). *See* Amicus Br. of Constitutional Law Professors, at 14-15; Amicus Br. of Service Employees Int'l Union, at 15-17. In addition, paying the penalty relieves the taxpayer of the obligation to purchase insurance, in contrast with instances in which an individual who violates a statute must pay a penalty and is still required to satisfy the underlying obligation.

Plaintiffs assert, in a single sentence, that the minimum coverage provision imposes a "direct exaction" that is unconstitutional because it is not apportioned among the states according to population. PB 58-59. But the provision does not impose a direct tax on property because it is not a tax imposed on property "solely by reason of its ownership." *Knowlton v. Moore*, 178 U.S. 41, 81 (1900). Nor is it a capitation tax, that is, a tax imposed on a person, "simply, without regard to property, profession, or any other circumstance." *Hylton v. United States*, 3 U.S. 171, 175 (1796) (opinion of Chase, J.). Instead, the provision imposes a tax that is contingent upon a number of factors, including income and the way an individual finances his health care. Thus, there can be no plausible contention that the minimum coverage provision imposes a direct tax.

III. The Affordable Care Act's Amendments to the Medicaid Program Fall Within Congress's Spending Power.

A. Like various prior amendments to the Medicaid program, the Affordable Care Act expands coverage eligibility.

1. The Medicaid program, which was enacted in 1965 as Title XIX of the Social Security Act, "is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). "Although participation in the program is voluntary, participating States must comply"

with the Act's requirements. *Ibid*.; *accord Harris v. McRae*, 448 U.S. 297, 301 (1980).

To be eligible for federal funds, a state must submit a plan to HHS that demonstrates that the state is in compliance with the Medicaid Act's requirements. 42 U.S.C. § 1396a. Since the inception of the program in 1965, the Medicaid Act has specified categories of individuals who must be provided medical assistance as well as kinds of medical care and services that must be covered. For example, states are required to make medical assistance available to low-income families with dependent children and to low-income individuals who are elderly, blind, or disabled. *Id*. § 1396a(a)(10)(A)(i); *see also PhRMA v. Walsh*, 538 U.S. 644, 651 & n.4 (2003) (describing categories of individuals who must be covered under state plan). States are also required to cover specified benefits for their Medicaid enrollees, such as physician, hospital, laboratory, and nursing facility services. 42 U.S.C. § 1396a(a)(10).

If a state plan is approved by the Secretary, the federal government reimburses a percentage of most Medicaid expenses that the state incurs. That percentage (the "Federal medical assistance percentage") ranges from 50 to 83 percent, depending on the state's per capita income. 42 U.S.C. § 1396d(b). The federal government also pays at least 50 percent of the costs that a state incurs in administering its Medicaid program. *Id*. § 1396b(a)(2)-(5), (7).

Congress expressly reserved the "right to alter, amend, or repeal any provision" of the Social Security Act. *Id.* § 1304. With this "language of reservation," Congress gave "special notice of its intention to retain[] full and complete power to make such alterations and amendments as come within the just scope of legislative power." *POSSE*, 477 U.S. at 53. The reservation clause "makes express what is implicit in the institutional needs of the program" — that "it was inevitable that amendment of its provisions would be necessary in response to evolving social and economic conditions." *Id*. at 51-52 (rejecting challenge to amendment that barred states from withdrawing their employees from Social Security coverage).

Congress has amended the Medicaid Act many times since its inception, and, between 1966 and 2000, Medicaid enrollment increased from four million to 33 million recipients. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 106 (Fall 2000). For example, in 1972, Congress required participating states to extend Medicaid to recipients of Supplemental Security Income, thereby significantly expanding Medicaid enrollment. Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972). In 1989, Congress again expanded enrollment by requiring states to extend Medicaid to pregnant women and children under age six who meet certain income limits. Omnibus Budget Reconciliation Act

of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989); *see also* 42 U.S.C. § 1396a Note (listing amendments).

2. Through the Affordable Care Act's amendments to the Medicaid program, Congress expanded Medicaid eligibility to include all individuals under age 65 with incomes no greater than 133% of the federal poverty level. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII). The federal government will bear nearly the entire financial cost of coverage for the individuals newly eligible for Medicaid. From 2014 through 2016, the federal government will pay 100% of the costs associated with the expansion. *Id*. § 1396d(y).[6] That amount will gradually decrease, to 95% in 2017, 94% in 2018, and 93% in 2019. *Ibid*. In 2020 and thereafter, the federal government will pay 90% of these costs. *Ibid*.; *see also* SB 7 (acknowledging that "the federal government will initially fund 100%" and that, "by 2017, States will be responsible for 5% ... with that number increasing to 10% by 2020").[7]

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[6] The federal government also will pay a substantial portion of state administrative costs. *See* 76 Fed. Reg. 21950 (Apr. 19, 2011).

[7] Although plaintiffs note that ACA § 2304 amended the Medicaid Act's definition of "medical assistance" to include "care and services themselves," SB 8, plaintiffs urged below that the contours of this amendment are "unclear" and "cannot be assessed until regulations are promulgated," and that the provision is "thus not amenable to cost projections." RE 502 n.42; RE 705 ¶ 4, 707 ¶ 6; RE 793 ¶ 12.

B. The amendments to Medicaid do not contravene the four restrictions set out in *South Dakota v. Dole*.

Plaintiffs provide no basis to invalidate the Affordable Care Act's amendments to the Medicaid program. "The Constitution empowers Congress to 'lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States.'" *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). "Incident to this power, Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.'" *Ibid*. (citations omitted). Thus, it is well settled that Congress may "fix the terms on which it shall disburse federal money to the States." *New York*, 505 U.S. at 158.

"The Supreme Court has identified four restrictions on the spending power of Congress." *Benning*, 391 F.3d at 1305. "First, conditions attached by Congress on the expenditure of federal funds must promote the general welfare." *Ibid*. (citing *Dole*, 483 U.S. at 206). "Second, conditions on the state receipt of federal funds must be unambiguous, and enable 'the States to exercise their choice knowingly, cognizant of the consequences of their participation.'" *Ibid*. (quoting *Dole*, 483 U.S. at 206). "Third, the Supreme Court has 'suggested (without significant elaboration) that

conditions on federal grants might be illegitimate if they are unrelated to the federal interest in particular national projects or programs.'" *Ibid*. (quoting *Dole*, 483 U.S. at 206). "Fourth, no condition attached to receipt of federal funds may violate other provisions of the Constitution." *Ibid*. (citing *Dole*, 483 U.S. at 208).

Plaintiffs do not contend that the Affordable Care Act's amendments to the Medicaid program contravene any of these restrictions. They do not dispute that the conditions promote the general welfare. They do not argue that the conditions are unclear. They do not urge that the conditions are unrelated to the purpose of the Medicaid program. And they do not claim that the conditions will require states to engage in activities that would themselves be unconstitutional.

C. No court has invalidated Spending Clause legislation as "coercive."

Plaintiffs also do not dispute that, under federal law, "state participation in the Medicaid program under the Act is, as it always has been, entirely voluntary." RE 429. "No state is obligated to participate in the Medicaid program," *Florida Assoc. of Rehab. Facilities v. Florida Dep't of Health & Rehab. Servs*., 225 F.3d 1208, 1211 (11th Cir. 2000), and a participating state "always retains this option" to withdraw. *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998).

Nonetheless, plaintiffs declare that their participation in the Medicaid program is not "Truly Voluntary." SB 48. They assert that "States quite literally cannot afford

to sacrifice billions in federal funds" and "therefore have no real choice as to whether to accept these new conditions." SB 52. On plaintiffs' theory, the very magnitude of the federal grants curtails Congress's prerogative to "fix the terms on which it shall disburse federal money to the States." *New York*, 505 U.S. at 158.

The district court below recognized that such a claim of "coercion" in a Spending Clause case has never before succeeded: "[E]very single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim." RE 2011. The coercion theory rests on a single sentence from *Dole*, in which the Supreme Court noted its earlier statement that "'in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 589-90 (1937)). At the same time, however, *Dole* recognized that every federal spending statute "'is in some measure a temptation.'" *Id*. at 211 (quoting *Steward Machine*, 301 U.S. at 589). The Court declared that "'to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties.'" *Ibid*. (quoting *Steward Machine*, 301 U.S. at 589-90). Indeed, in *Steward Machine* itself, the Court expressed doubt as to the viability of a "coercion" theory, finding no coercion even "if we assume that such a concept can ever be applied with fitness to the relations between state and nation." 301 U.S. at

590. *Dole* reaffirmed the assumption, founded on "'robust common sense,'" that States exercise "'the freedom of the will'" when they choose to accept the conditions attached to the receipt of federal funds. *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-90).

Accordingly, as this Court has made clear: "'Nothing within Spending Clause jurisprudence ... suggests that States are bound by the conditional grant of federal money only if the State receives or derives a certain percentage ... of its budget from federal funds.'" *Benning*, 391 F.3d at 1308 (quoting *Charles v. Verhagen*, 348 F.3d 601, 609 (7th Cir. 2003)). "'If a State wishes to receive *any* federal funding, it must accept the related, unambiguous conditions in their entirety.'" *Ibid*. (quoting *Charles*, 348 F.3d at 609) (emphasis added). A state "cannot accept federal funds and then attempt to avoid their accompanying conditions by arguing that the conditions are disproportionate in scope." *Ibid*.

The courts of appeals have consistently rejected the contention that conditions on Medicaid funds and other federal grants are impermissibly coercive because the entire federal grant is at stake. *See*, *e.g.*, *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (entire Medicaid grant); *Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996) (entire Medicaid grant); *Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981) (entire Medicaid grant); *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th

Cir. 2000) (entire federal education grant); *Kansas v. United States*, 214 F.3d 1196, 1198 (10th Cir. 2000) (entire federal welfare grant); *Van Wyhe v. Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (entire federal grant for state prisons); *Nevada v. Skinner*, 884 F.2d 445, 448-49 (9th Cir. 1989) (95% of federal highway grant).

Likewise, the courts of appeals have consistently rejected claims that funding conditions are coercive because of the importance of the grant to critical state services, including health care. *See*, *e.g.*, *California*, 104 F.3d at 1092 (no coercion despite the State's claim that it had "no choice" but to accept Medicaid grant "to prevent a collapse of its medical system"); *Schweiker*, 655 F.2d at 413 (no coercion even though the "loss of Medicaid funds" would be "drastic"); *Van Wyhe*, 581 F.3d at 652 (no coercion despite "potential loss of 100% of the federal funding for state prisons"); *Kansas*, 214 F.3d at 1202 (noting the consensus that Medicaid grants are not coercive, "even where the removal of Medicaid funding would devastate the state's medical system").

In so holding, the courts have recognized that they "are not suited to evaluating whether the states are faced ... with an offer they cannot refuse or merely a hard choice." *Schweiker*, 655 F.2d at 414. "The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state

governments." *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989). "Sovereign states are fully competent to make their own choice" whether to decline conditional federal funding, and such choices, though "politically painful," are not "unconstitutionally 'coercive.'" *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000).

Plaintiffs rely on Judge Luttig's plurality opinion in *Virginia Department of Education v. Riley*, 106 F.3d 559 (4th Cir. 1997) (*en banc*), which suggested, in *dicta*, that there would be a "substantial constitutional question" as to whether it would be coercive for a federal agency to withhold a state's $60 million education grant because of a failure to provide educational services to 126 of the state's 128,000 special education students. *Id*. at 561, 569. Judge Luttig opined that a valid Tenth Amendment claim would lie where the federal government "withholds the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some insubstantial respect." *Id*. at 570.

The holding of *Riley* was superseded by legislation, *see* Pub. L. No. 105-17, § 612, 111 Stat. 37, 60 (1997), and the Fourth Circuit has never invalidated federal Spending Clause legislation on "coercion" grounds. Instead, the court has recognized that "hard choices do not alone amount to coercion," *Madison v. Virginia*, 474 F.3d 118, 128 (4th Cir. 2006), and acknowledged the prevailing view that "the theory raises

political questions that cannot be resolved by the courts." *West Virginia v. HHS*, 289 F.3d 281, 289 (4th Cir. 2002).

In any event, the Affordable Care Act's amendments to the Medicaid program are in no sense "insubstantial." *Riley*, 106 F.3d at 570. They are expected to provide health care coverage to more than 16 million low-income individuals. PB 3 (citing CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 18 (Mar. 30, 2011)). Nor do the amendments relate to some minor appendage to the Medicaid program. They relate to the very contours of the program itself — the basic eligibility requirements. If Congress cannot change those features, it can no longer control the uses to which federal expenditures are put or the nature of its cooperative spending programs.

D. The proceedings below confirm that plaintiffs offer no principled basis to declare the Medicaid amendments "coercive."

The proceedings in this case confirm that there is no basis on which to invalidate the Medicaid amendments. Although plaintiffs deem the amendments "coercive" and seek to have them struck down, other states have defended vigorously the "Medicaid expansion as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such

populations." District Ct. Amicus Br. of the Governors of Washington, Colorado, Michigan, and Pennsylvania ("Governors Br."), at 13, Docket Entry ("DE") 133; *see also* District Ct. Amicus Br. of Oregon, Iowa, Vermont, Maryland, and Kentucky, DE 130 ("Oregon Br."); Amicus Br. of State Legislators. Plaintiffs provide no metric by which a federal court could resolve these state policy disagreements.

"Although more people are expected to enroll in Medicaid" following the Affordable Care Act, "the federal government will cover 90-100% of the total cost of that nation-wide expansion over the next 10 years, while state Medicaid spending will increase only 1.4 percent, on average, over that same period." Oregon Br. at 3-4. Moreover, the expansion of Medicaid eligibility "will provide substantial federal funding for programs in many states that cover low income adults and are currently wholly state funded." Governors Br. at 13.

The Governors' brief explains that "plaintiffs' request that this Court decide what is 'affordable' for the states proposes a far greater intrusion on state sovereignty than any of the challenged Medicaid provisions." *Id*. at 14. "'Affordability' is a quintessentially political question involving policy choices about revenues and expenditures within a state's mandatory and optional Medicaid budgets and between health care and other state programs." *Ibid*. The variation across states in terms of Medicaid coverage reflects "how the state and its localities share funding

responsibilities for public services and how much state policymakers choose to invest in health care, education, and other programs." Center on Budget & Policy Priorities, Policy Basics: Where Do Our State Tax Dollars Go?, at 3 (Apr. 12, 2011). "By seeking to block the expansion of Medicaid coverage, plaintiffs are trying to achieve their policy preferences through litigation at the expense of states that want Medicaid expanded and that worked through the democratic process to achieve that policy goal at the national level." Oregon Br. at 7-8.

IV. 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. Plaintiffs do not seriously defend the district court's pronouncement that all of the Affordable Care Act's provisions are "inextricably bound together in purpose and must stand or fall as a single unit." RE 2075. They admit, for example, that "one provision that is arguably different is ACA section 10221, which reauthorized and amended the Indian Health Care Improvement Act." SB 65 n.8. But many other Affordable Care Act provisions likewise reauthorized or extended programs already on the books. For example, Section 4204(c) reauthorized an immunization program; Section 5603 reauthorized the Wakefield Emergency Medical Services for Children Program; Section 10203 extended funding for the Children's Health Insurance Program; and Section 10503 provided enhanced funding for the National Health

Service Corps.

Similarly, many other provisions of the Act amended longstanding programs. For example, more than 20 sections of the Act made changes to Medicare payment rates for 2011. Those revisions have already been incorporated through notice and comment rulemaking into Medicare payment regulations and implemented through changes to nearly every major Medicare claims processing system, including those for inpatient services, outpatient services, and physician services. *See* 75 Fed. Reg. 73170 (Nov. 29, 2010); 75 Fed. Reg. 71800 (Nov. 24, 2010); 75 Fed. Reg. 50042 (Aug. 16, 2010). Challenges to these provisions, like a number of other provisions in the Act, are governed by exclusive judicial review procedures. *See* 42 U.S.C. § 1395oo (Medicare); *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000); *see also* 42 U.S.C. §§ 1396c & 1316(a)(3) (Medicaid).

The district court itself recognized that many of the Act's provisions "are already in effect and functioning," and can "stand alone and function independently." RE 2066-67. The Act also includes provisions, noted by the Supreme Court, that "provide[] for more rigorous enforcement" of pre-existing statutory drug pricing requirements, *Astra USA, Inc. v. Santa Clara Cnty.*, 131 S. Ct. 1342, 1346 (2011), and that "amend[] the public disclosure bar" in the False Claims Act, *Schindler Elevator Corp. v. United States ex rel. Kirk*, __ S. Ct. __ (May 16, 2011), 2011 WL 1832825,

at *3 n.1.

As plaintiffs note, the federal government acknowledged below that the guaranteed-issue and community-rating provisions due to take effect in 2014, *i.e.*, sections 2701, 2702, 2704 (regarding adults), and 2705(a) of the Public Health Service Act, as added by section 1201 of the Affordable Care Act, cannot be severed from the minimum coverage requirement. The requirement is integral to those sections that go into effect along with it in 2014 and provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions, as discussed above. *See* pp. 24-26, *supra*. But that limited concession provides no basis to invalidate any other provision of the Act. Nor is the purported "difficulty of assessing the severability of the ACA's hundreds of other miscellaneous provisions," SB 65 n.8, a ground for invalidating them all and declaring that "Congress must start over if it still desires to regulate in this field." PB 62. "Severability is a doctrine of judicial restraint." RE 2065. 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 v. Time, Inc.,* 468 U.S. 641, 652 (1984). To the extent the district court thought it difficult to assess whether provisions were severable from the minimum coverage provision, it was required to leave them in place, not void them.

B. Plaintiffs make no allegation of harm with respect to the vast majority of the Affordable Care Act's provisions. Our opening brief explained (Br. 59-60) that a court has "no business" addressing the severability of provisions that affect "the rights and obligations of parties not before the Court." *Printz v. United States*, 521 U.S. 898, 935 (1997).

The private plaintiffs do not acknowledge *Printz* in their severability argument. *See* PB 59-62. The state plaintiffs declare only that they have "alleged injury in fact resulting from ... the individual mandate, the Medicaid expansions, and the employer mandates." SB 66. Their insistence that "[s]everance is a remedy for *Congress*'s benefit, not the plaintiff's," *ibid*., disregards *Printz*'s holding and established limits on judicial power. Moreover, declaratory and injunctive relief are equitable in nature, and a court may properly decline to embark on a broad-ranging inquiry into the severability of provisions that have not themselves been held unconstitutional.

In any event, plaintiffs offer no basis for concluding that the Medicaid expansion and employer responsibility provisions are not severable from the minimum coverage provision. The Medicaid amendments will provide health care benefits for more than 16 million low-income individuals. Like the spending conditions that were at issue in *New York*, the Medicaid amendments are "operative" on their own and therefore severable. *New York*, 505 U.S. at 187. That the statute in *New York*, "like

much federal legislation, embodies a compromise among the States," *id*. at 183, formed no part of the Supreme Court's severability analysis.

Despite *New York*'s holding, plaintiffs insist that the spending conditions cannot be severed from the minimum coverage provision because "Medicaid is the *only* way that the poorest of covered persons can comply with the mandate." SB 63. This formulation misconceives of Congress's rationale for expanding Medicaid. The expansion of Medicaid is an opportunity for millions of low-income individuals to obtain desperately needed health care coverage — almost entirely at federal expense.

Plaintiffs do not even attempt to explain why the minimum coverage provision could not be severed from the employer responsibility provision. SB 66. The provision to which plaintiffs refer, 26 U.S.C.A. § 4980H, will, in specified circumstances, impose a tax penalty on large employers that fail to make adequate coverage available to their full-time employees. The district court rejected plaintiffs' constitutional challenge to that provision, *see* RE 424, and plaintiffs concede on appeal that their challenge is "foreclosed by Supreme Court precedent." SB 59 n.6. Nonetheless, they insist that the provision must be struck down. Congress, however, has long used the tax code to encourage employers to provide health insurance benefits for their employees. Plaintiffs' assertion that this provision cannot stand apart from the minimum coverage provision is inexplicable.

C. Plaintiffs make little attempt to defend the basis of the district court's conclusion that the state plaintiffs have standing to challenge the minimum coverage provision, which will apply only to individuals and impose no obligations on the states. SB 69. The district court reasoned that Idaho and Utah had created their own standing by passing laws that purport to exempt their citizens from the minimum coverage provision. RE 2017–19. But, as our opening brief explained (Br. 61-62), it is long established that a state cannot sue as *parens patriae* to exempt its citizens from federal law. A state cannot nullify this limit on its standing by enacting a statute to exempt its citizens from federal law and then suing to defend its statute. *See, e.g.*, Amicus Br. of Federal Jurisdiction Professors, at 6-32.

Plaintiffs' alternative contention — that the "injury in fact caused by the Medicaid and employer mandate reforms" also provides standing to challenge the "individual mandate," SB 69 — was not accepted by the district court and is at odds with Supreme Court precedent. "As the Court summed up the point in *Lewis* [*v. Casey*, 518 U.S. 343, 358 n.6 (1996)], 'standing is not dispensed in gross.'" *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 353 (2006). Any injury in fact from the expansion of Medicaid and the employer provisions provides standing to challenge *those* provisions, not other provisions of the Act.

CONCLUSION

The judgment in plaintiffs' favor should be reversed, and the case remanded with directions to enter judgment for defendants.

Respectfully submitted,

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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 13,977 words. The text of the brief is composed in 14-point Times New Roman typeface.

The text of the hard copy of this brief and the text of the "PDF" version of the brief filed electronically are identical. A virus check was performed on the E-brief, using Microsoft Forefront Client Security software (version 1.5.1973.0), and no virus was detected.

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CERTIFICATE OF SERVICE

I hereby certify that on May 17, 2011, I filed the foregoing Response/Reply 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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