11-15-2010

Sissel v. HHS - U.S. Motion to Dismiss

United States Department of Health and Human Services

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MATT SISSEL, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Civil Action No. 1:10-cv-01263 (RJL)

DEFENDANTS' MOTION TO DISMISS

Pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6), Defendants United States Department of Health and Human Services; Kathleen Sebelius, in her official capacity as Secretary of Health and Human Services; United States Department of the Treasury; and Timothy Geithner, in his official capacity as Secretary of the Treasury, respectfully move the Court to dismiss this action. The accompanying memorandum sets forth the grounds for this motion.

Dated: November 15, 2010

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MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

INTRODUCTION

Plaintiff Matt Sissel, an individual who prefers not to purchase health insurance, seeks to overturn recently enacted federal health care reform legislation that he opposes. Federal courts, however, have limited jurisdiction and an obligation of judicial restraint. They do not referee political disputes or strain to displace judgments reached through the democratic process. They decide specific cases or controversies, brought by a party with standing to sue predicated on a concrete injury in fact. Plaintiff does not come close to satisfying this most basic prerequisite of federal court jurisdiction. The minimum coverage provision that Plaintiff assaults – Section 1501 of the Patient Protection and Affordable Care Act ("ACA" or "Act"), Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), requiring non-exempted individuals either to obtain a minimum level of health insurance or to pay a penalty – does not take effect until 2014, and when it does take effect, Plaintiff cannot show that it will adversely affect him. *See Baldwin v. Sebelius*, Civ. No. 3:10-01033, 2010 WL 3418436, at *3 (S.D. Cal. Aug. 27, 2010) (rejecting standing to challenge minimum coverage provision because "it is impossible to know now whether or not Plaintiff will be subject to or compliant with the Act in 2014").

Plaintiff asks this Court to equate his fear of future harm with current injury by alleging that he has altered his finances to prepare for 2014, but to do so would nullify the imminence requirement of Article III. Plaintiff's claims thus fail before the Court can reach the merits.

Even if Plaintiff could surmount this and other jurisdictional barriers, his claim still would fail, because Congress, in adopting the minimum coverage provision, acted well within its authority under the Commerce Clause and the Necessary and Proper Clause. Congress determined that, without the minimum coverage provision, health insurance reforms in the Act

which Congress unquestionably had authority to adopt – such as the ban on insurers denying coverage or charging more based on pre-existing medical conditions – would not work, as those reforms would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care" and thus shift even greater costs onto third parties. ACA §§ 1501(a)(2)(I), 10106(a). Congress thus found that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* As has been recognized by the only court to date that has ruled on the merits on this issue, Congress has the power under the Commerce Clause and the Necessary and Proper Clause to enact provisions to ensure the viability of its larger regulations of interstate commerce. *Thomas More Law Ctr. v. Obama*, Civ. No. 2:10-11156, 2010 WL 3952805, at *9-10 (E.D. Mich. Oct. 7, 2010).

Congress further understood that virtually everyone at some point needs to purchase medical services, which cost money. The ACA regulates economic decisions about how to pay for those services—whether to pay for the expected purchases in advance through insurance or to attempt to pay later, out of pocket, at the time of the purchases. Congress found, based on overwhelming evidence, that those decisions, "in the aggregate," substantially affect the vast, interstate health care market. *Gonzales v. Raich*, 545 U.S. 1, 22 (2005). More than 45 million Americans have neither private health insurance nor the protection of government programs such as Medicare or Medicaid. Many of these individuals are uninsured because they cannot afford coverage. Others are excluded by insurers' restrictive underwriting criteria. Still others make the economic decision to forgo health insurance altogether with the backdrop of "free" healthcare in the event of a critical illness or accident. Forgoing health insurance, however, is

not the same as forgoing health care, and health care is not really "free." When accidents or illnesses inevitably occur, the uninsured still receive medical assistance, even if they cannot pay. As Congress documented, the cost of such uncompensated health care – $43 billion in 2008 alone – is passed on to the other participants in the health care market: health care providers, insurers, the insured population, governments, and taxpayers. ACA §§ 1501(a)(2)(F), 10106(a). Congress's commerce power plainly enables it to address these substantial effects on the interstate market. *Thomas More*, 2010 WL 3952805, at *8-9. Moreover, the absence of health insurance renders Americans more hesitant to change jobs, contributes substantially to the number of personal bankruptcies, and causes premium rates to spiral. Uninsured Americans make, revisit, and revise *economic* decisions about how to finance their health care needs.

In addition, while Plaintiff's complaint looks only to the Commerce Clause, Congress has independent authority to enact the minimum coverage provision as an exercise of its power under Article I, Section 8, to lay taxes and make expenditures to promote the general welfare. *License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1867). The provision, which Congress placed in the Internal Revenue Code and treated like other tax penalties, will raise revenue. It is valid under longstanding precedent, even though Congress also had a regulatory purpose in enacting the provisions.

In sum, because Plaintiff lacks standing to sue, this case does not call upon the Court to judge the "constitutionality of an Act of Congress" – "'the gravest and most delicate duty'" a court may undertake. *Nw. Austin Mun. Util. Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009) (quoting *Blodgett v. Holden*, 275 U.S. 142, 147-48 (1927) (Holmes, J., concurring)). Even if the Court were to undertake that task, however, clear precedent establishes that the

minimum coverage provision falls within Congress's authority to regulate interstate commerce, as well as its power to collect revenue and make expenditures for the general welfare.

The Court therefore should dismiss Plaintiff's Complaint.

BACKGROUND

I. STATUTORY BACKGROUND

In 2009, the United States spent more than an estimated 17% of its gross domestic product on health care. ACA §§ 1501(a)(2)(B), 10106(a). Notwithstanding this extraordinary expenditure, 45 million people — an estimated 15% of the population — went without health insurance for some portion of 2009, and, absent the new legislation, that number would have climbed to 54 million by 2019. Cong. Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* 11 (Dec. 2008) [hereinafter *Key Issues*]; *see also* CBO, *The Long-Term Budget Outlook* 21-22 (June 2009).

The record before Congress documented the staggering costs that a broken health care system visits on individual Americans and the nation as a whole. The millions who lack health insurance coverage still receive medical care, but often cannot pay for it. The costs of that uncompensated care are shifted to the government, taxpayers, insurers, and the insured. But cost shifting is not the only harm imposed by the lack of insurance. Congress found that the "economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured," ACA §§ 1501(a)(2)(E), 10106(a), and concluded that 62 percent of all personal bankruptcies result in part from medical expenses, *id.* §§ 1501(a)(2)(G), 10106(a). All these costs, Congress determined, have a substantial effect on interstate commerce. *Id.* §§ 1501(a)(2)(F), 10106(a).

In order to remedy this enormous problem for the American economy, the Act comprehensively "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." *Id.* §§ 1501(a)(2)(A), 10106(a). First, to address inflated fees and premiums in the individual and small-business insurance market, Congress established health insurance exchanges "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare health insurance options." H.R. Rep. No. 111-443, pt. II, at 976 (2010) (internal quotation omitted). The exchanges coordinate participation and enrollment in health plans, and provide consumers with needed information. ACA § 1311.

Second, the Act builds on the existing system of health insurance, in which most individuals receive coverage as part of their employee compensation. *See* CBO, *Key Issues*, at 4-5. It creates a system of tax incentives for small businesses to encourage the purchase of health insurance for their employees, and imposes assessments, in certain circumstances, on large businesses that do not provide adequate coverage to their full-time employees. ACA §§ 1421, 1513. The employer responsibility provision of Section 1513 of the Act will prevent "employers who do not offer health insurance to their workers" from gaining "an unfair economic advantage relative to those employers who do provide coverage." H.R. Rep. No. 111-443, pt. II, at 984-85.

Third, the Act subsidizes insurance coverage for a large portion of the uninsured population. As Congress understood, nearly two-thirds of the uninsured are in families with income less than 200 percent of the federal poverty level, *id.* at 978; *see also* CBO, *Key Issues*, at 27, while 4 percent of those with income greater than 400 percent of the poverty level are uninsured, CBO, *Key Issues*, at 11. The Act reduces this gap by providing premium tax credits

and reduced cost-sharing for individuals and families with income below 400 percent of the federal poverty line, ACA §§ 1401-02, and by expanding eligibility for Medicaid to individuals with income below 133 percent of the federal poverty level beginning in 2014, *id.* § 2001.

Fourth, the Act removes barriers to insurance coverage. As noted, it prohibits widespread insurance industry practices that increase premiums – or deny coverage – to those with the greatest need for health care. For example, the Act bars insurers from refusing to cover individuals with pre-existing medical conditions. *Id.* §§ 1001, 1201, 10101(a).[1]

Finally, the Act will require that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty on their tax returns starting with tax year 2014. *Id.* §§ 1501, 10106, *as amended by* HCERA § 1002. Congress found that this provision "is an essential part of this larger regulation of economic activity," and that its absence "would undercut Federal regulation of the health insurance market." *Id.* §§ 1501(a)(2)(H), 10106(a). That judgment rested on detailed Congressional findings. Congress found that, by "significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums." *Id.* §§ 1501(a)(2)(F), 10106(a). Conversely, Congress also found that, without the minimum coverage provision, the reforms in the Act, such as the ban on denying coverage based on pre-existing conditions, would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," thereby further shifting costs onto third parties. *Id.* §§ 1501(a)(2)(I), 10106(a). Congress thus found that the minimum coverage provision "is essential to creating effective health insurance

[1] It also prevents insurers from rescinding coverage for any reason other than fraud or misrepresentation, or declining to renew coverage based on health status. ACA §§ 1001, 1201. And it prohibits caps on the amount of coverage available to a policyholder in a given year or over a lifetime. *Id.* §§ 1001, 10101(a).

markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

At the same time, Congress carefully crafted exceptions to the minimum coverage provision to accommodate those who, even with tax credits, could not afford insurance, as well as members of religious organizations that have developed alternative methods of caring for their sick and dependent. *See id.* § 1501(b) (adding 26 U.S.C. § 5000A(d), (e)).

The CBO projects that the reforms in the Act will reduce the number of uninsured Americans by approximately 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (Mar. 20, 2010) [hereinafter CBO Letter to Speaker Pelosi]. It further projects that the Act's combination of reforms and tax credits will reduce the average premium for individuals and families in the individual and small-group markets. *Id.* at 15; CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 23-25 (Nov. 30, 2009).

II. CURRENT PROCEEDINGS

Plaintiff filed this suit against federal agencies and officials charged with administering the minimum coverage provision, seeking to prevent the possible application of the provision to him beginning in 2014. Plaintiff alleges that he has been uninsured since leaving the National Guard in January 2008, and that he now "does not have, need, or want to purchase health insurance." Compl. ¶¶ 5, 24. He contends that the minimum coverage provision is unconstitutional, as it purportedly exceeds Congress's authority under the Commerce Clause, and requests declaratory and injunctive relief against the operation of the provision. *See id.*, ¶¶ 31-35, Prayer.

ARGUMENT

I. STANDARD OF REVIEW

Defendants move to dismiss Plaintiff's Complaint for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure. "'[T]he party invoking federal jurisdiction bears the burden of establishing its existence.'" *NRDC v. Pena*, 147 F.3d 1012, 1020 (D.C. Cir. 1998) (quoting *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 104 (1998)). Where, as here, the defendant challenges jurisdiction on the face of the complaint, the complaint must plead sufficient facts to establish that jurisdiction exists. This Court must determine whether it has subject matter jurisdiction before addressing the merits of the complaint. *See Steel Co.*, 523 U.S. at 94-95.

Defendants also move to dismiss the Complaint under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. In applying this Rule, "the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions. Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009); *see also Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007).[2]

II. THE COURT LACKS JURISDICTION OVER PLAINTIFF'S CHALLENGE TO THE MINIMUM COVERAGE PROVISION

Federal courts sit to decide cases and controversies, not to resolve disagreements on policy or politics. To invoke the jurisdiction of this Court, Plaintiff must have standing to sue. *E.g.*, *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992). But Plaintiff could not even arguably

[2] Because Plaintiff raises a facial challenge to the minimum coverage provision, he bears the burden of showing that "no set of circumstances exist under which the Act would be valid," *United States v. Salerno*, 481 U.S. 739, 745 (1987), that is, "that the law is unconstitutional in *all* of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (emphasis added).

suffer injury from the minimum coverage provision until 2014 at the earliest, and it is speculative whether he will suffer injury even then. Aside from standing, the length of time before the minimum coverage period takes effect renders Plaintiff's challenge unripe. And wholly apart from these jurisdictional defects, the Anti-Injunction Act independently bars Plaintiff's suit. Accordingly, the Court lacks subject matter jurisdiction.

A. Plaintiff's Alleged Injury From the Operation of the Minimum Coverage Provision in 2014 is Not Imminent

To establish standing, "the plaintiff must have suffered an injury in fact — an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Lujan*, 504 U.S. at 560 (internal citations, quotation marks, and footnote omitted). To meet this requirement, the harm must be "direct, real, and palpable." *Pub. Citizen v. NHTSA*, 489 F.3d 1279, 1292 (D.C. Cir. 2007). "Allegations of possible future injury do not satisfy the requirements of Art. III. A threatened injury must be certainly impending to constitute injury in fact." *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990) (internal quotation marks omitted). A plaintiff who "alleges only an injury at some indefinite future time" has not shown an injury in fact, particularly where "the acts necessary to make the injury happen are at least partly within the plaintiff's own control." *Lujan*, 504 U.S. at 564 n.2. In these situations, "the injury [must] proceed with a high degree of immediacy, so as to reduce the possibility of deciding a case in which no injury would have occurred at all." *Id.*

The D.C. Circuit has recognized that an individual's voluntary decision to change his behavior in anticipation of a contingent future possibility does not constitute imminent injury-in-fact or present hardship. *See, e.g.*, *Tenn. Gas Pipeline Co. v. FERC*, 736 F.2d 747, 751 (D.C. Cir. 1984) ("The planning insecurity Tennessee advances does not set its case apart from the mine run of situations in which an enterprise confronts official interpretations and policy

statements regarding projected application of regulatory or fiscal legislation. Were we to entertain anticipatory challenges pressed by parties facing no imminent threat of adverse agency action, no hard choice between compliance certain to be disadvantageous and a high probability of strong sanctions, we would venture away from the domain of judicial review into a realm more accurately described as judicial preview. No roving preview function has been assigned to courts in the federal system.") (internal citation omitted). "An injury is not 'actual, imminent, or certainly impending' for standing purposes where a party 'can only aver that any significant adverse effects . . . may occur at some point in the future.'" *Gulf Restoration Network, Inc. v. Nat'l Marine Fisheries Serv.*, Civ. No. 1:09-1883, __ F. Supp. 2d __, 2010 WL 3184327, at *8 (D.D.C. Aug. 12, 2010) (quoting *Ctr. for Biological Diversity v. U.S. Dep't of Interior*, 563 F.3d 466, 478 (D.C. Cir. 2009)); *id.* ("Plaintiffs' claims in the instant case are equally general and attenuated since they describe possible future harms instead of concrete present injury.").

Here, Plaintiff alleges that he is injured by Congress's enactment of the minimum coverage provision, as he will be forced to purchase insurance or else, "beginning on January 1, 2014, Plaintiff will incur federal penalties for each month he remains without 'minimum essential' health insurance coverage." Compl. ¶ 16. But as the U.S. District Court for the Southern District of California found as to similar claims, "it is impossible to know now whether or not Plaintiff will be subject to or compliant with the Act in 2014," when it goes into effect. *Baldwin v. Sebelius*, Civ. No. 3:10-01033, 2010 WL 3418436, at *3 (S.D. Cal. Aug. 27, 2010). The Supreme Court has instructed that such a long time gap between the filing of the lawsuit and the inception of any possible injury renders a party unable to satisfy the imminence requirement for standing pursuant to Article III. The asserted injury is simply "too remote temporally." *See McConnell v. FEC*, 540 U.S. 93, 226 (2003) (Senator lacked standing based on claimed desire to

air advertisements five years in the future), *overruled in part on other grounds*, *Citizens United v. FEC*, 130 S. Ct. 876 (2010); *Whitmore*, 495 U.S. at 159-60. This defect in Plaintiff's suit does not implicate a mere technical issue of counting intermediate days, but goes again to the fundamental limitations on the role of federal courts. The "underlying purpose of the imminence requirement is to ensure that the court in which suit is brought does not render an advisory opinion in 'a case in which no injury would have occurred at all.'" *Animal Legal Def. Fund, Inc. v. Espy*, 23 F.3d 496, 500 (D.C. Cir. 1994) (quoting *Lujan*, 504 U.S. at 564 n.2).

Although Plaintiff alleges that he is not currently insured and "cannot claim any of the exemptions" from the minimum coverage requirement, his attempts to prognosticate his future condition can neither erode the limitations of the minimum coverage provision nor stabilize the vicissitudes of personal circumstance through 2014. Plaintiff could, under a wide range of scenarios, satisfy the minimum coverage requirement in 2014. Indeed, if Plaintiff takes no action whatsoever, and remains outside the United States in Toronto, he will be exempt from the minimum coverage requirement. *See* ACA § 1501(b) (adding 26 U.S.C. § 5000A(f)(4)). If he does return to the United States, by 2014 he may well be back in Canada or elsewhere outside the United States. He might obtain insurance, as he had until 2008 through his service in National Guard. He might find other employment by 2014 that provides adequate health coverage, or find that his economic situation has deteriorated to the point where he qualifies for Medicaid or a financial hardship exemption. *See* ACA § 1501(b) (adding 26 U.S.C. § 5000A(e)). Or he might discover that he has changed his mind about the necessity of health insurance due to such possible life events as a serious illness. If none of this occurs and Plaintiff, in 2014, has not satisfied the minimum coverage provision and chooses not to purchase health insurance, he can pay the resulting penalty and challenge the provision in a suit for a refund. As

of now, however, any harm that Plaintiff might suffer is remote rather than imminent, speculative rather than concrete, and "at least partly within [his] own control." *Lujan*, 504 U.S. at 564 n.2.

Plaintiff cannot plead his way around this by alleging that he "must act now to make financial plans to satisfy the mandate's requirements," or contend that he has modified contingent future travel plans as a result of the minimum coverage provision's 2014 effective date. Compl. ¶¶ 23, 26, 27. Whatever anticipatory planning Plaintiff undertakes for this remote contingency, the possible payment of a penalty on his 2014 taxes still remains both remote and contingent. Allowing such subjective decisions about future financial risks to create standing would render the imminence requirement a hollow shell. The D.C. Circuit recognized as much in rejecting the approach of the plaintiffs in *Public Citizen*:

> [T]he Supreme Court has said that, in temporal terms, there are three kinds of harm – actual harms, imminent harms, and potential future harms that are not imminent. Treating the increased risk of future harm as an actual harm, however, would eliminate these categories. Under this approach, possible future injuries, whether or not they are imminent, would magically become concrete, particularized, and actual injuries merely because they *could* occur. That makes no sense, except as a creative way to end-run the Supreme Court's standing precedents. We decline to circumvent well-established standing law in this fashion.

489 F.3d at 1298 (internal citations omitted). Unless and until the time comes that Plaintiff imminently has to pay a penalty, the choice of what to do with his money is entirely within his own control. Whether he shifts the amount of the penalty that he anticipates paying in 2014 from checking to savings, or retains the money rather than spending it, the fact remains that these funds remain his until at least 2014. His subjective decision about how to allocate that money is not traceable to the operation of the minimum coverage provision in 2014.[3] *See McConnell*, 540

[3] The court in *Thomas More* erred in finding that the plaintiffs there had standing to challenge the provision because they are saving now to buy insurance in 2014. 2010 WL 3952805, at *3-4.

U.S. at 228; *Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 831 (D.C. Cir. 2006); *see also Ctr. for Law & Educ. v. Dep't of Educ.*, 396 F.3d 1152, 1161 (D.C. Cir. 2005) (current increased cost of lobbying by corporation due to government action that poses possible future harm does not constitute injury in fact); *Sanner v. Bd. of Trade of City of Chi.*, 62 F.3d 918, 923 (7th Cir. 1995) ("We have little difficulty concluding that the soybean farmers who refrained from selling soybeans due to the depressed price of the cash market lack standing under Article III.").

For these very reasons, the District Court in *Baldwin* dismissed a lawsuit brought by an individual challenging the minimum coverage provision, because "it is impossible to know now whether or not Plaintiff will be subject to or compliant with the Act in 2014." *Baldwin*, 2010 WL 3418436, at *3. This Court, too, should reject Plaintiff's attempt to rush to a constitutional judgment on a critical provision of the health reform legislation years before its effective date.

B. Plaintiff's Challenge is Unripe

For similar reasons, Plaintiff's challenge to the minimum coverage provision is not ripe for review. The ripeness inquiry "evaluate[s] both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." *Abbott Labs. v. Gardner*, 387 U.S. 136, 149 (1967), *overruled on other grounds*, *Califano v. Sanders*, 430 U.S. 99 (1977). Whether a case is fit for judicial resolution depends upon whether the claim "rests upon 'contingent future events that may not occur as anticipated, or indeed may not occur at all.'" *Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 17 (D.D.C. 2001) (quoting *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985)); *see also Friends of Keeseville Inc. v. FERC*, 859 F.2d 230, 235-36 (D.C. Cir. 1988). "Similarly, with

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As the *Baldwin* court correctly reasoned, if it cannot be known now whether plaintiffs will be subject to the Act in 2014, it also cannot be known now whether any planning efforts that they are taking now are traceable to the Act. *Baldwin*, 2010 WL 3418436, at *3.

respect to the 'hardship to the parties' prong, an abstract harm is not sufficient; there must be an immediate harm with a 'direct effect on the day-to-day business of the plaintiffs.'" *Grand Lodge*, 185 F. Supp. 2d at 17-18 (quoting *Texas v. United States*, 523 U.S. 296, 301 (1998)). Plaintiff's challenge satisfies neither prong of the ripeness inquiry because no injury could occur before 2014, and Plaintiff has not shown that one will occur even then.

To be sure, "[w]here the inevitability of the operation of a statute against certain individuals is patent, it is irrelevant to the existence of a justiciable controversy that there will be a time delay before the disputed provisions will come into effect." *Blanchette v. Conn. Gen. Ins. Corps.*, 419 U.S. 102, 143 (1974). However, in contrast to *Blanchette*, any injury to Plaintiff here is far from "inevitable." Nor is this a case like *Abbott Laboratories*, where plaintiffs demonstrated "a direct effect on [their] day-to-day business," and faced potential criminal sanctions for non-compliance. *Abbott Labs.*, 387 U.S. at 152. This case instead involves "contingent future events that may not occur as anticipated, or indeed may not occur at all." *Thomas*, 473 U.S. at 580-81. Even where the issue presented is "a purely legal question," such uncertainty whether a statutory provision will harm Plaintiff renders the controversy not ripe for review. *Toilet Goods Ass'n v. Gardner*, 387 U.S. 158, 163-64 (1967).[4]

C. The Anti-Injunction Act Bars Plaintiff's Claim

The Court lacks jurisdiction over Plaintiff's challenge to the minimum coverage provision for the additional reason that he seeks to restrain the federal government from collecting the penalty specified under that provision. The Anti-Injunction Act ("AIA") provides

[4] The court in *Thomas More* found the case before it to be ripe because "the imposition" of the minimum coverage provision "is highly probable." 2010 WL 3952805, at *5. But the question is not whether the statute is certain to go into effect; instead, the question is whether the provision is certain to operate to the detriment of the Plaintiff here. As noted above, it cannot be known now whether Plaintiff will be subject to the Act, or whether he will in fact benefit from it, for example, if he develops a medical condition that would render him uninsurable in the absence of the Act.

that, with exceptions inapplicable here, "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. ("I.R.C.") § 7421(a). Whether or not the penalty here is labeled a tax, it is, with exceptions not material here, "assessed and collected in the same manner" as other penalties under the Internal Revenue Code, ACA § 1501(b) (adding 26 U.S.C. § 5000A(g)(1)), and, like these other penalties, it is covered by the AIA. I.R.C. § 6671(a); *see, e.g.*, *Barr v. United States*, 736 F.2d 1134, 1135 (7th Cir. 1984) (per curiam) ("Section 6671 provides that the penalty at issue here is a tax for purposes of the Anti-Injunction Act."). That result is consistent with the purpose of the AIA, which is to preserve the Government's ability to collect such assessments expeditiously with "a minimum of preenforcement judicial interference" and "to require that the legal right to the disputed sums be determined in a suit for refund." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 736 (1974) (citation and internal quotation omitted).

District courts accordingly lack jurisdiction to order the abatement of any liability for a tax or a penalty, apart from their power to consider validly-filed claims for refunds. *See, e.g., Evans-Hoke v. Paulson*, 503 F. Supp. 2d 83, 86 (D.D.C. 2007). These jurisdictional limitations apply even where, as here, a plaintiff raises a constitutional challenge. *United States v. Clintwood Elkhorn Mining Co.*, 553 U.S. 1, 10 (2008). The AIA therefore bars Plaintiff's effort to enjoin collection of the minimum coverage penalty.[5]

[5] The court in *Thomas More* reasoned that the AIA did not apply, because the plaintiffs had brought suit before the IRS had begun assessment or collection efforts, because the suit sought only declaratory relief, and because the case raised constitutional issues. 2010 WL 3952805, at *5-6. But, as noted above: (1) the AIA extends beyond suits that specifically challenge assessment or collection efforts, and instead bars any suit that could have the effect of precluding a tax, *see Dickens v. United States*, 671 F.2d 969, 971 (6th Cir. 1982); (2) the Declaratory Judgment Act bars declaratory relief as least as broadly as the AIA bars injunctive relief, *see Bob*

III. THE MINIMUM COVERAGE PROVISION FALLS WITHIN CONGRESS'S CONSTITUTIONAL AUTHORITY UNDER THE COMMERCE CLAUSE AND, INDEPENDENTLY, THE GENERAL WELFARE CLAUSE

Even if this Court had subject-matter jurisdiction, Plaintiff's constitutional challenge to the ACA's minimum coverage provision would lack merit.[6] "Due respect for the decisions of a coordinate branch of Government demands that [this Court] invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *United States v. Morrison*, 529 U.S. 598, 607 (2000). Moreover, because Plaintiff raises a facial challenge, he must demonstrate "that no set of circumstances exists under which the Act would be valid." *United States v. Salerno*, 481 U.S. 739, 745 (1987). Plaintiff cannot make this showing. The minimum coverage provision passes muster under the Commerce Clause and the Necessary and Proper Clause, and, independently, the General Welfare Clause of the Constitution.

Jones Univ., 416 U.S. at 732 n.7; and (3) the constitutional nature of a claim is irrelevant for purposes of the AIA, *see Clintwood Elkhorn*, 553 U.S. at 10.

[6] On August 2, 2010, Judge Henry E. Hudson of the Eastern District of Virginia issued a procedural decision denying the United States' motion to dismiss in *Virginia ex rel. Cuccinelli v. Sebelius*. On the merits of the Commonwealth's claim, Judge Hudson deferred a decision, denying the motion to dismiss because there was an "arguable legal basis" for the Commonwealth of Virginia's claim for which the court desired further briefing. 702 F. Supp. 2d 598, 612. Similarly, Judge Roger Vinson of the Northern District of Florida denied the United States' motion to dismiss in *State of Florida v. U.S. Dep't of Health and Human Servs.*, stating that Rule 12(b)(6) requires the Court "to 'take a peek' at the status of the applicable existing Constitutional law." 2010 WL 4010119, at *23. *See also id.* at *35 ("In this order, I have not attempted to determine whether the line between Constitutional and extraconstitutional government has been crossed. . . . I am only saying that (with respect to two of the particular causes of action discussed above) the plaintiffs have at least stated a plausible claim that the line has been crossed."). For the reasons stated elsewhere in this brief, Plaintiff's claims here fail under well-settled law. But even if this Court considered the legal questions to be closer, it would be clear error to deny Defendants' motion to dismiss based on the reasoning of the Virginia and Florida courts. Resolving disputes of law is precisely the purpose of a Rule 12(b)(6) motion, and if the plaintiff fails to state a claim under the governing law, the court must dismiss the complaint, "without regard to whether it is based on an outlandish legal theory or on a close but ultimately unavailing one." *Neitzke v. Williams*, 490 U.S. 319, 327 (1989).

A. The Comprehensive Regulatory Measures of the ACA, Including the Minimum Coverage Provision, Are a Proper Exercise of Congress's Article I Powers Pursuant to the Commerce Clause and the Necessary and Proper Clause

1. Congress's Commerce Clause Authority is Broad

The Constitution grants Congress the power to "regulate Commerce . . . among the several States." U.S. Const., art. I, § 8, cl. 3. This authority is broad. Congress may "regulate the channels of interstate commerce"; it may "regulate and protect the instrumentalities of interstate commerce, and persons or things in interstate commerce"; and it may "regulate activities that substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005). In assessing whether an activity substantially affects interstate commerce, Congress may consider the aggregate effect of a particular form of conduct. The question is not whether any one person's conduct, considered in isolation, affects interstate commerce, but whether there is a rational basis for concluding that the *class of activities*, "taken in the aggregate," at least has some substantial effect on interstate commerce. *Id.* at 22; *see also Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942). In other words, "'[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power 'to excise, as trivial, individual instances' of the class." *Raich*, 545 U.S. at 23 (quoting *Perez v. United States*, 402 U.S. 146, 154 (1971)).

In exercising its Commerce Clause power, Congress may reach even wholly intrastate, non-commercial matters when it concludes that failure to do so would undercut the operation of a larger program regulating interstate commerce. *Id.* at 18; *see also United States v. Sullivan*, 451 F.3d 884, 891 (D.C. Cir. 2006) (upholding statute criminalizing intrastate possession of child pornography); *Navegar, Inc. v. United States*, 192 F.3d 1050, 1061 (D.C. Cir. 1999) (upholding, in light of *United States v. Lopez*, 514 U.S. 549 (1995), statute criminalizing the intrastate

possession of a semiautomatic assault weapon). Thus, when "a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence." *Raich*, 545 U.S. at 17 (internal quotation omitted); *see also id.* at 37 (Scalia, J., concurring in the judgment) (Congress's authority to make its regulation of commerce effective is "distinct" from its authority to regulate matters that substantially affect interstate commerce).

In assessing Congress's judgments regarding the impact on interstate commerce and the necessity of individual provisions to the overall scheme of reform, the task of the Court "is a modest one." *Id.* at 22. The Court need not itself measure the impact on interstate commerce of the activities Congress sought to regulate, nor need the Court calculate how integral a particular provision is to a larger regulatory program. The Court's task instead is to determine "whether a 'rational basis' exists" for Congress's conclusions. *Id.* (quoting *Lopez*, 514 U.S. at 557). Under rational basis review, this Court may not second-guess the factual record upon which Congress relied.[7]

Raich and *Wickard* illustrate the breadth of the Commerce power and the deference accorded Congress's judgments. In *Raich*, the Court sustained Congress's authority to prohibit the possession of home-grown marijuana intended solely for personal use. It was sufficient that the Controlled Substances Act "regulates the production, distribution, and consumption of commodities for which there is an established, and lucrative, interstate market." 545 U.S. at 26. In *Wickard*, the Court upheld a penalty on wheat grown for home consumption despite the farmer's protests that he did not intend to put the commodity on the market. It was sufficient that the existence of homegrown wheat, in the aggregate, could "suppl[y] a need of the man who

[7] "[L]egislative facts," Fed. R. Evid. 201 advisory committee note, may be considered on a motion to dismiss. *See Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007).

grew it which would otherwise be reflected by purchases in the open market," thus undermining the efficacy of the federal price stabilization scheme. 317 U.S. at 128. In each case, the Court upheld obligations even on individuals who claimed not to participate in interstate commerce, because those obligations were components of broad schemes regulating interstate commerce.

Raich followed *United States v. Lopez*, 514 U.S. 549 (1995), and *United States v. Morrison*, 529 U.S. 598 (2000), and thus highlights the central focus and limited scope of those decisions. Unlike *Raich*, and unlike this case, neither *Lopez* nor *Morrison* involved regulation of economic decisions. Neither case addressed a measure integral to a comprehensive scheme to regulate activities in interstate commerce. *Lopez* was a challenge to the Gun-Free School Zones Act of 1990, "a brief, single-subject statute making it a crime for an individual to possess a gun in a school zone." *Raich*, 545 U.S. at 23. Possessing a gun in a school zone did not involve an economic decision. Nor was it "'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" *Id.* at 24 (quoting *Lopez*, 514 U.S. at 561). Indeed, the argument that this provision affected interstate commerce had to posit an extended chain reaction—guns near schools lead to violent crime; such violent crime imposes costs; and insurance spreads those costs. The Court found this reasoning too attenuated to sustain the gun law "'under [the Court's] cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce.'" *Id.* (quoting *Lopez*, 514 U.S. at 561). Likewise, the statute at issue in *Morrison* simply created a civil remedy for victims of gender-motivated violent crimes. *Id.* at 25. Unlike the purchase of health care services or health care insurance, gender-motivated violent crimes do not entail economic decisions, and the statute at issue focused on violence against women, not on any broader regulation of interstate markets.

2. The ACA and Its Minimum Coverage Provision Regulate the Interstate Market in Health Insurance

Regulating a vast interstate market consuming an estimated 17.6 percent of our gross domestic product is within the compass of congressional authority under the Commerce Clause. ACA §§ 1501(a)(2)(B), 10106(a). Congress has power to regulate the interstate health insurance market, *see United States v. S.E. Underwriters Ass'n*, 322 U.S. 533, 553 (1944), and has repeatedly exercised that power, both by providing directly for government-funded health insurance through Medicare, and by adopting over the course of four decades numerous statutes regulating the content of private insurance policies.[8]

This history of federal regulation of health insurance buttressed Congress's understanding that only it, and not the States, could effectively counter the national health care crisis. Given the current scope of federal regulation – for example, through Medicare and ERISA – "[e]xpecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort." *State Coverage Initiatives: Hearing*

[8] In 1974, Congress enacted the Employee Retirement and Income Security Act, Pub L. No. 93-406, 88 Stat. 829 ("ERISA"), establishing federal requirements for health insurance plans offered by private employers. Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 ("COBRA"), allowing workers who lose their health benefits under certain circumstances the right to continue receiving certain benefits from their plans for a time. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 ("HIPAA"), to improve access to health insurance by, among other things, generally prohibiting group plans from discriminating against individual participants based on health status, requiring insurers to offer coverage to small businesses, and limiting the pre-existing condition exclusion period for group plans. I.R.C. §§ 9801-9803; 29 U.S.C. §§ 1181(a), 1182; 42 U.S.C. §§ 300gg, 300gg-1. *See also* Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (regulating limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (requiring plans that offer maternity coverage to provide at least a 48-hour hospital stay following childbirth); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (requiring certain plans to offer benefits related to mastectomies). More recently, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881, requiring parity in financial requirements and treatment limitations between mental health benefits and substance abuse disorder and medical and surgical benefits.

Before the Subcomm. on Health of the H. Comm. on Ways and Means, 110th Cong. 7 (2008) (statement of Alan R. Weil, Executive Director, National Academy of State Health Policy).

Accordingly, Congress undertook in the ACA comprehensive reform of the interstate health insurance market. To regulate health insurance provided through the workplace, the Act adopts incentives for small employers to offer or expand coverage. To regulate health insurance provided through government programs, the Act, among other things, expands Medicaid eligibility. To regulate health insurance sold to individuals or in small group markets, the Act establishes exchanges enabling individuals and small businesses to pool their purchasing power and obtain affordable insurance. And to regulate the overall scope of health insurance coverage, the Act extends tax credits to a significant portion of the uninsured; ends industry practices that have made insurance unobtainable or unaffordable for many; and, in Section 1501, requires most Americans who can afford insurance to obtain a minimum level of coverage or to pay a penalty.

Section 1501, like the Act as a whole, regulates decisions about how to pay for services in the health care market. These decisions are quintessentially economic, and within the traditional scope of the Commerce Clause. As Congress recognized, "decisions about how and when health care is paid for, and when health insurance is purchased" are "economic and financial" and thus "commercial and economic in nature." ACA §§ 1501(a)(2)(A), 10106(a); *see Thomas More*, 2010 WL 3952805, at *8 (recognizing these decisions as "plainly economic").[9]

[9] Although Congress is not required to set forth particularized findings of an activity's effect on interstate commerce, where, as here, it does so, courts "will consider congressional findings in [their] analysis." *Raich*, 545 U.S. at 21; *see also, e.g., Nat'l Ass'n of Home Builders v. Babbitt*, 130 F.3d 1041, 1051 (D.C. Cir. 1997) (holding that the existence of express congressional findings distinguished the case from *Lopez*); *Terry v. Reno*, 101 F.3d 1412, 1415 (D.C. Cir. 1996) (relying on congressional committee findings despite the lack of express findings in the challenged statute).

3. The Minimum Coverage Provision Is an Integral Part of the Larger Regulatory Scheme and Is Necessary and Proper to Congress's Regulation of the Interstate Market for Health Insurance

The ACA's reforms of the interstate insurance market – particularly its requirement that insurers guarantee coverage for all individuals, even those with pre-existing medical conditions – clearly fall within the boundaries of the Commerce Clause and could not function effectively without the minimum coverage provision. The provision is thus an essential part of a larger regulation of interstate commerce, and thus, under *Raich*, is well within Congress's Commerce Clause authority. *Raich*, 545 U.S. at 18. Analyzing the minimum coverage provision under the Necessary and Proper Clause leads to the same conclusion for fundamentally the same reason: The provision is a reasonable means to accomplish Congress's reforms of the health insurance industry – reforms that it has authority to adopt under the Commerce Clause.

The minimum coverage provision is an "essential" part of the Act's larger regulatory scheme for the interstate health care market. The Act adopts a series of measures to increase the availability and affordability of health insurance, including, in particular, measures to prohibit an array of insurance industry practices that have denied or terminated coverage, or increased premiums, for those with the greatest health care needs. Beginning in 2014, for example, the Act will bar insurers from refusing to cover or charging more for individuals with pre-existing medical conditions and will end discrimination against individuals with pre-existing medical conditions by prohibiting eligibility rules based on health-status-related factors, including medical condition, claims experience, and medical history. ACA § 1201.

Congress found that, without the minimum coverage provision, these insurance reforms would encourage more individuals to forgo insurance or drop existing coverage until they needed substantial care, at which point the ACA would obligate insurers to cover them at the same cost

as everyone else. The market distortion would make insurance less affordable for everyone, decrease the number of insured individuals, and create pressures that would "inexorably drive [the health insurance] market into extinction," precisely contrary to Congress's intent. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (2010) (statement of Uwe Reinhardt, Ph.D., Professor of Political Economy, Economics, and Public Affairs, Princeton University). Accordingly, Congress found the minimum coverage provision to be "essential" to its broader effort to regulate underwriting practices that prevented many from obtaining health insurance, ACA §§ 1501(a)(2)(H), (I), 10106(a); *see also Thomas More*, 2010 WL 3952805, at *9 (recognizing that the minimum coverage provision "operates as an essential part of a comprehensive regulatory scheme" and thus is valid under *Raich*).

In other respects as well, the minimum coverage provision is essential to the Act's comprehensive regulatory scheme to ensure that health insurance is available and affordable. The provision works in tandem with the Act's reforms to reduce the upward pressure on premiums caused by the practice of medical underwriting. This process of individualized review of an applicant's health status contributes to administrative fees that are responsible for 26 to 30 percent of the cost of premiums in the individual and small group markets.[10] ACA §§ 1501(a)(2)(J), 10106(a). The minimum coverage requirement helps to counteract these pressures by significantly increasing health insurance coverage and the size of purchasing pools, and thereby increasing economies of scale. *Id.* §§ 1501(a)(2)(J), 10106(a).

Because the minimum coverage provision is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets, it is also a valid exercise of

[10] Notably, medical underwriting yields substantially higher risk-adjusted premiums or outright denial of insurance coverage for an estimated one-fifth of applicants. *See* CBO, *Key Issues*, at 81.

Congress's authority under the Necessary and Proper Clause. U.S. Const. art. I, § 8, cl. 18. "[T]he Necessary and Proper Clause grants Congress broad authority to enact federal legislation." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010). It has been settled since *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819), that this Clause affords Congress the power to employ any means "reasonably adapted to the end permitted by the Constitution." *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 (1981) (internal quotation omitted). And when Congress legislates in furtherance of a legitimate end, its choice of means is accorded broad deference. *See Sabri v. United States*, 541 U.S. 600, 605 (2004); *see also Comstock*, 130 S. Ct. at 1956-57. "[W]here Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)). As demonstrated above, Congress reasonably found that the minimum coverage provision not only is adapted to, but is "essential" to, achieving key reforms of the interstate health care and health insurance markets.

4. The Minimum Coverage Provision Regulates Conduct with Substantial Effects on Interstate Commerce

The minimum coverage provision is a valid exercise of Congress's powers for a second reason. Congress needed no extended chain of inferences to determine that decisions about how and when to pay for health care – particularly whether to obtain health insurance or to attempt to pay for health care out of pocket at the time the services are rendered – in the aggregate substantially affect the interstate health care market. Individuals who forgo health insurance coverage do not thereby forgo health care. To the contrary, many of the uninsured will "receive treatments from traditional providers for which they either do not pay or pay very little, which is known as 'uncompensated care.'" CBO, *Key Issues*, at 13; *see also* Council of Economic

Advisers ("CEA"), *The Economic Case for Health Care Reform* 8 (June 2009) [hereinafter *The Economic Case*]. This country effectively guarantees a minimum level of health care. The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, for example, requires hospitals that participate in Medicare and offer emergency services to screen and stabilize any patient who presents with an emergency condition, regardless of whether he has insurance or otherwise can pay. CBO, *Key Issues*, at 13. In addition, most hospitals "have some obligation to provide care for free or for a minimal charge to members of their community who could not afford it otherwise." *Id.*

Uncompensated care, however, is not free. In the aggregate, that uncompensated cost amounted to $43 billion in 2008, about five percent of overall hospital revenues. CBO, *Key Issues*, at 114. Public funds subsidize these costs. Through programs such as Disproportionate Share Hospital payments, the federal government paid tens of billions of dollars for such uncompensated care in 2008 alone. H.R. Rep. No. 111-443, pt. II, at 983 (2010); *see also* CEA, *The Economic Case*, at 8. The remaining costs fall in the first instance on health care providers, which in turn "pass on the cost to private insurers, which pass on the cost to families." ACA §§ 1501(a)(2)(F), 10106(a). This cost-shifting effectively creates a "hidden tax" reflected in fees charged by providers (to the uninsured and the insured alike) and in premiums charged by insurers. CEA, *Economic Report of the President* 187 (Feb. 2010); *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010); S. Rep. No. 111-89, at 2 (2009). As premiums increase, more people decide not to buy coverage, further narrowing the risk pool and forcing upwards even more the price of coverage for the insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century*, *supra*, at 118-19 (submission of American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010). Small employers particularly suffer from

this premium spiral, due to their relative lack of bargaining power. *See* H.R. Rep. No. 111-443, pt. II, at 986-88 (2010); *47 Million and Counting: Why the Health Care Market Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 5 (2008) (statement of Raymond Arth, Nat'l Small Business Ass'n) (noting the need for insurance reform and a minimum coverage provision to limit the growth of small business premiums).

The putative right to forgo health insurance includes decisions by some to engage in market timing. These individuals will purchase insurance in later years, but choose in the short term to incur out-of-pocket costs with the backup of the emergency room services that Medicare-participating hospitals with emergency departments must provide whether or not the patient can pay. *See* CBO, *Key Issues*, at 12. By making the economic calculation to opt out of the health insurance pool during these years, these individuals skew premiums upward for the insured population. Yet when they later need care, many of these uninsured will opt back into the health insurance system, maintained in the interim by that same insured population. In the aggregate, these economic decisions by the uninsured have a substantial effect on the interstate health care market. Congress may use its Commerce Clause authority to regulate these direct and aggregate effects. *See Raich*, 545 U.S. at 16-17; *Wickard*, 317 U.S. at 127-28.

Plaintiff cannot brush aside these marketplace realities by claiming that an individual who decides to go without insurance coverage "is not engaged in commerce . . . and is not engaged in any activity that has a substantial effect on interstate commerce" and therefore beyond the reach of the Commerce Clause. Compl. ¶ 33. This assertion misunderstands both the nature of the regulated activity and the scope of Congress's power. Congress found that the decision to try to pay for health care services without reliance on insurance is "economic and financial." ACA §§ 1501(a)(2)(A), 10106(a). Individuals who make the "economic and

financial" choice to try to pay for health care services without insurance, *id.* §§ 1501(a)(2)(A), 10106(a), are not passive bystanders divorced from the health care market. To the contrary, as was recognized by the first court to reach a decision on the merits of a challenge to the ACA, the health care market is unique, because "[n]o one can guarantee his or her health, or ensure that he or she will never participate in the health care market." *Thomas More*, 2010 WL 3952805, at *9. Indeed, far from being passive bystanders, the vast majority of uninsured population actively use health care services. Nor do these persons sit passively by even with respect to insurance coverage. Instead, movement in and out of insured status is "very fluid." CBO, *How Many People Lack Health Insurance and For How Long?* 4 (May 2003). Of those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year. *Id.* at 4, 9. These persons make the decisions to add or drop coverage knowing that they will not bear the full cost of their decision to attempt to pay for their health care needs out-of-pocket. CEA, *The Economic Case*, at 17; *see also* Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. of Health Econ. 225, 226 (2005). Notwithstanding Plaintiff's attempt to characterize those economic decisions as "inactivity," they have a direct and substantial effect on the interstate health care market in which uninsured and insured alike participate, and thus are subject to federal regulation.[11]

The ACA in fact regulates economic activity far more directly than provisions the Supreme Court has previously upheld. In *Wickard*, the Court upheld a system of production

[11] The minimum coverage provision also clearly covers those who already have insurance by requiring them to obtain minimum coverage if their current plan does not provide it and to retain such coverage. Even Plaintiff must concede that these individuals are "active" in commerce and that Congress may legitimately regulate their activity. Thus, Plaintiff cannot succeed on a facial challenge to the minimum coverage provision. *See Salerno*, 481 U.S. at 745 (facial challenge requires plaintiff to show "that no set of circumstances exists under which the Act would be valid").

quotas, despite the claim that the statute "forc[ed] some farmers into the market to buy what they could provide for themselves." 317 U.S. at 129. The Court reasoned that "[h]ome-grown wheat . . . competes with wheat in commerce. The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon." *Id.* at 128; *see also Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 258-59 (1964) (Commerce Clause reaches decisions not to engage in transactions with persons with whom plaintiff did not wish to deal); *Daniel v. Paul*, 395 U.S. 298 (1969) (same). And in *Raich*, the Court likewise rejected plaintiffs' claim that their home-grown marijuana was "entirely separated from the market" and thus not subject to regulation under the Commerce Clause. 545 U.S. at 30. Similarly, the ACA regulates a class of individuals who almost certainly will participate in the health care market, who have decided to finance that participation (or not) in one particular way, and whose decisions impose substantial costs on other participants in that market. These economic decisions regarding how to pay for medical services that will inevitably be necessary substantially affect the larger market for health care services. That fact empowers Congress to regulate.

That the minimum coverage provision is a valid exercise of Congressional authority under the Commerce Clause was recognized by Judge George Steeh in the Eastern District of Michigan in *Thomas More Law Center*, 2010 WL 3952805. Like Plaintiff here, the plaintiffs in *Thomas More* argued that Congress exceeded its Article I powers in enacting the minimum coverage provision of the ACA. The district court rejected this claim, finding a rational basis for Congress's conclusion that the regulated activities, "'taken in the aggregate, substantially affect interstate commerce.'" *Id.* at *7 (quoting *Raich*, 545 U.S. at 22). The court noted that the decision whether to purchase health insurance or to attempt to pay for health care out of pocket "is plainly economic," and that these decisions in the aggregate affect interstate commerce,

because other participants in the health care market bear the cost when the uninsured receive care but cannot pay for it. *Id.* at *8. This cost-shifting had a "clear and direct" effect on other market participants, the court found, *id.*, rendering this case unlike *Lopez*, in which Congress could only link its regulated activity to interstate commerce by "pil[ing] inference upon inference." *Id.* at *7-*8.

The court in *Thomas More* sustained Congress's Article I authority to enact the minimum coverage provision for the additional reason that it is "'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" *Id.* at *10 (quoting *Raich*, 545 U.S. at 24-25 (internal quotation omitted)). It noted that Section 1201 of the ACA bars insurers from refusing to cover persons with pre-existing medical conditions. Without the minimum coverage provision, the court found, these reforms would create an incentive for individuals to wait to buy insurance until they needed care, which, in turn, would "aggravate current problems with cost-shifting and lead to even higher premiums," threatening to "driv[e] the insurance market into extinction." *Id.* The court thus held that Congress had appropriately found the minimum coverage provision to be essential to the success of the Act's insurance industry reforms. *Id.* Because the court sustained the provision under the commerce power, it found it unnecessary to decide whether the provision was also valid under the General Welfare Clause. *Id.*

B. The Minimum Coverage Provision Is a Valid Exercise of Congress's Independent Power Under the General Welfare Clause

Plaintiff's challenge fails for an additional reason. Independent of the Commerce Clause, Congress has the "Power 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."[12] U.S. Const. art. I, § 8, cl. 1. Congress's power under the General Welfare Clause is "extensive." *License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1867); *see also McCray v. United States*, 195 U.S. 27, 56-59 (1904); *United States v. Doremus*, 249 U.S. 86, 93 (1919); *Steward Mach. Co. v. Davis*, 301 U.S. 548, 581 (1937). Congress may use its authority under this Clause even for purposes beyond its powers under the other provisions of Article I. *See United States v. Sanchez*, 340 U.S. 42, 44 (1950) ("Nor does a tax statute necessarily fall because it touches on activities which Congress might not otherwise regulate."); *United States v. Butler*, 297 U.S. 1, 66 (1936); *Knowlton v. Moore*, 178 U.S. 41, 59-60 (1900) (holding that Congress can tax inheritances, even if it could not regulate them under the Commerce Clause).

To be sure, Congress must use its power under Article I, Section 8, Clause 1, to "provide for the . . . general Welfare." As the Supreme Court held 75 years ago with regard to the Social Security Act, however, decisions of how best to provide for the general welfare are for the representative branches, not for the courts. *Helvering v. Davis*, 301 U.S. 619, 640, 645 & n.10 (1937); *see South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

The minimum coverage provision falls within Congress's "extensive" General Welfare authority. *License Tax Cases*, 72 U.S. at 471. The Act requires individuals not otherwise exempt to obtain "minimum essential coverage" or pay a penalty. ACA § 1501(b) (adding I.R.C. § 5000A(a), (b)(1)). Individuals who are not required to file income tax returns for a given year are not subject to this provision. *Id.* § 1501(b), *as amended by* HCERA § 1002 (adding I.R.C. § 5000A(e)(2)). In general, the penalty is the greater of a fixed amount or a percentage of the

[12] Plaintiff suggests in his complaint that the General Welfare Clause cannot support the ACA because it was not explicitly invoked by Congress. Compl. ¶ 33. But "[t]he question of the constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise." *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948).

individual's household income, but may not exceed the national average premium for the lowest-tier plans offered through health insurance exchanges for the individual's family size. *Id.* § 1501(b) (adding I.R.C. § 5000A(c)(1), (2)). If the penalty applies, the individual must report it on the income tax return for the taxable year. *Id.* (adding I.R.C. § 5000A(b)(2)). The penalty is assessed and collected in the same manner as other assessable penalties under the Internal Revenue Code.[13]

That the provision has a regulatory purpose does not place it beyond the power of Congress under the General Welfare Clause.[14] *Sanchez*, 340 U.S. at 44 ("[A] tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed."); *see United States v. Kahriger*, 345 U.S. 22, 27-28 (1953), *overruled in part on other grounds*, *Marchetti v. United States*, 390 U.S. 39 (1968); *cf. Bob Jones Univ.*, 416 U.S. at 741 n.12 (noting that the Supreme Court has "abandoned" older "distinctions between regulatory and revenue-raising taxes").[15] So long as a statute is "productive of some revenue," courts will not second-guess Congress's exercise of this power, and "will not undertake, by collateral inquiry as to the measure of the regulatory effect of a tax, to ascribe to Congress an attempt, under the guise

[13] The Secretary of the Treasury may not collect the penalty through notice of federal liens or levies, and may not bring a criminal prosecution for a failure to pay it. ACA § 1501(b) (adding I.R.C. § 5000A(g)(2)). Revenues from the minimum coverage penalty are paid into general revenues.

[14] Congress has long used the taxing power as a regulatory tool, in particular, in regulating how health care is paid for in the national market. HIPAA, for example, imposes a tax on any group health plan that fails to comply with limits on exclusions or terminations of applicants with pre-existing conditions. I.R.C. §§ 4980D, 9801-03. In addition, the Internal Revenue Code requires group health plans to offer COBRA continuing coverage to terminated employees, and similarly imposes taxes on any plan that fails to comply. *Id.* § 4980B.

[15] Nor does the statutory label of the provision as a "penalty" matter. *See Penn Mut. Indem. Co. v. Comm'r*, 277 F.2d 16, 20 (3d Cir. 1960) ("Congress has the power to impose taxes generally, and if the particular imposition does not run afoul of any constitutional restrictions then the tax is lawful, call it what you will.") (footnote omitted).

of taxation, to exercise another power denied by the Federal Constitution." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *United States v. Spoerke*, 568 F.3d 1236, 1245 (11th Cir. 2009); *United States v. Ross*, 458 F.2d 1144, 1145 (5th Cir. 1972).

The minimum coverage provision easily meets this standard. The Joint Committee on Taxation included the provision in its review of the "Revenue Provisions" of the Act and the Reconciliation Act, analyzing it as a "tax," an "excise tax," and a "penalty," and stating that it is accounted for as "an additional amount of Federal tax owed." *See* Staff of Joint Comm. on Taxation, 111th Cong., *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in Combination with the "Patient Protection and Affordable Care Act"* 31, 33 (Mar. 21, 2010).[16] Moreover, the Joint Committee specifically incorporated the prediction of the CBO regarding how much revenue the provision would raise. The CBO estimated that the minimum coverage provision would produce about $4 billion in annual revenue. CBO Letter to Speaker Pelosi at tbl. 4 at 2. Thus, as Congress recognized, the minimum coverage provision produces revenue alongside its regulatory purpose, which is all that Article I, Section 8, Clause 1 requires.

In any event, just as a court should interpret the "words of a statute . . . in their context and with a view to their place in the overall statutory scheme," *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (internal quotation omitted), so, too, the Court should analyze the purpose and function of the minimum coverage provision in context, as an integral part of the overall statutory scheme it advances. Congress reasonably concluded that the minimum coverage provision would increase insurance coverage, permit the restrictions imposed

[16] The Joint Committee on Taxation is "a nonpartisan committee of the United States Congress, originally established under the Revenue Act of 1926," that "is closely involved with every aspect of the tax legislative process." *See* Joint Committee on Taxation, Overview, *at* http://www.jct.gov/about-us/overview.html (last visited Nov. 15, 2010); *see also* I.R.C. §§ 8001-8023.

on insurers to function efficiently, and lower insurance premiums. ACA §§ 1501(a), 10106(a). And Congress determined, also with substantial reason, that this provision was essential to its comprehensive scheme of reform. Congress acted well within its authority to integrate the provision into the interrelated revenue and spending provisions of the Act, and to treat it as necessary and proper to the overall goal of advancing the general welfare. *See Buckley v. Valeo*, 424 U.S. 1, 90 (1976) (grant of power under General Welfare Clause "is quite expansive, particularly in view of the enlargement of power by the Necessary and Proper Clause").

CONCLUSION

For the above stated reasons, the Court should dismiss Plaintiff's Complaint under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6).

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