8-12-2011

Kinder v. Geithner - Appellees Brief

Timothy Geithner
Secretary of the Treasury

No. 11-1973

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETER KINDER, et al.,
Plaintiffs-Appellants,

v.

TIMOTHY F. GEITHNER, Secretary of the United States Department of Treasury; HILDA SOLIS, Secretary of the United States Department of Labor; ERIC H. HOLDER, JR., United States Attorney General; KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services,
Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Missouri (Sippel, J.)

BRIEF FOR APPELLEES

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SUMMARY OF THE CASE

The original plaintiffs were seven Missouri citizens, including Lieutenant Governor Peter Kinder, who appears in his personal rather than his official capacity. Plaintiffs filed a nine-count amended complaint that challenged various provisions of the Patient Protection and Affordable Care Act ("Affordable Care Act") on different grounds. The district court dismissed the amended complaint for lack of standing.

Two of the plaintiffs, Kinder and Samantha Hill, have appealed. They have abandoned many of their claims, but they challenge on appeal the minimum coverage provision of the Affordable Care Act and contend that they have standing to do so. When the provision takes effect in 2014, it will require that non-exempted individuals maintain a minimum level of health insurance or pay a tax penalty. The district court held that Hill's allegations do not establish that the provision is causing or will cause her injury. The court did not consider Kinder's belated attempt to join Hill's challenge to the minimum coverage provision because Kinder did not include such a claim in the amended complaint.

Appellants have briefed standing and the merits and requested 30 minutes of oral argument time. Because the standing issue is controlling, the government respectfully submits that 15 minutes is sufficient.

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STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331. The district court dismissed the case for lack of standing on April 26, 2011. Plaintiffs filed a timely notice of appeal on April 29, 2011. This Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly dismissed this pre-enforcement challenge to the Affordable Care Act's minimum coverage provision for lack of standing.

New Jersey Physicians, Inc. v. Obama, __ F.3d __, 2011 WL 3366340 (3d Cir. August 3, 2011)

Gray v. City of Valley Park, Mo., 567 F.3d 976 (8th Cir. 2009)

2. Assuming standing, whether the minimum coverage provision is a valid exercise of Congress's commerce power.

Thomas More Law Center, et al. v. Obama, __ F.3d __, 2011 WL 2556039 (6th Cir. June 29, 2011)

Gonzales v. Raich, 545 U.S. 1 (2005)

3. Assuming standing, whether Congress's taxing power provides independent authority for the minimum coverage provision.

Nelson v. Sears, Roebuck & Co., 312 U.S. 359 (1941)

United States v. Sanchez, 340 U.S. 42 (1950)

STATEMENT OF THE CASE

1. The Affordable Care Act is a comprehensive reform of our national health care system. The Act seeks to ameliorate the crisis in the interstate market for health care services, which accounts for more than 17% of the nation's gross domestic product. Although insurance is the customary means of payment for health care services in the United States, millions of people do not have insurance. They nonetheless consume health care services for which they do not pay, shifting billions of dollars of health care costs to other participants in the health care market. The result is higher premiums that, in turn, make insurance unaffordable to even greater numbers of people. At the same time, insurance companies use restrictive underwriting practices to deny coverage to millions across the nation who have pre-existing medical conditions.

The Affordable Care Act addresses these national problems through a series of measures that will make affordable health care coverage widely available, protect consumers from restrictive insurance industry underwriting practices, and reduce the amount of care to people without insurance that is uncompensated and that increases the premiums of insured consumers.

2. The original plaintiffs in this suit were seven Missouri citizens, including Lieutenant Governor Kinder. Kinder initially purported to appear in his official

capacity, but the Missouri Attorney General objected, and Kinder amended the complaint to appear in his personal capacity instead. Add. 3-4. The nine-count amended complaint challenged various provisions of the Affordable Care Act on different grounds, many of which are abandoned on appeal.

On appeal, Kinder and Samantha Hill seek to challenge the Act's minimum coverage provision. When that provision takes effect in 2014, it will require that non-exempted individuals maintain a minimum level of insurance or pay a tax penalty. The district court held that Hill lacks standing to challenge this provision because she failed to show that it is causing or will cause her injury. Add. 9-13. The court did not consider Kinder's standing because he failed to challenge the provision in the amended complaint. Add. 11. The court thus did not reach the merits of plaintiffs' argument that the minimum coverage provision exceeds Congress's Article I powers.

STATEMENT OF FACTS

I. Background

In responding to the crisis in the health care market, Congress confronted a market different from any other. Although participation in the health care market is virtually universal, the particular nature of an individual's need for health care is unpredictable. The cost of health care is likewise unpredictable and can easily exceed

the financial means of all but the wealthiest individuals. Insurance is thus the customary means by which people pay for health care services.

Millions of people do not have insurance, however, and health care providers — unlike vendors in other markets — are often legally required to provide services in times of need without regard to the consumer's ability to pay. As a result, people without insurance collectively shift to other participants in the health care market both the ongoing financial risk that they, as uninsured, will incur costs beyond their ability to pay, and the tens of billions of dollars of actual medical costs each year that are consumed by the uninsured without payment, thereby raising the premiums of insured consumers.

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

Nearly everyone participates in the health care services market, regardless of whether they have insurance. In 2008 alone, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. U.S. Dep't of Health & Human Servs. ("HHS"), ASPE Research Brief, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills ("ASPE Research Br."), at 5 (May 2011). In 2009, almost 60% of Americans under age 65 who were "uninsured more than 12 months" had at least one visit with a doctor or to

an emergency room; approximately 80% of those who were "uninsured for any period up to 12 months" did so. Centers for Disease Control and Prevention ("CDC"), Health, United States, 2010, table 79 (2011). One out of five uninsured individuals visits the emergency room each year. *Id.* table 89; CDC, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2010, table 16 (2011).

Although the risk of illness or injury is ever-present, the timing of an individual's need for expensive medical care is unpredictable. "Most medical expenses for people under 65" result "from the 'bolt-from-the-blue' event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance, Hearing Before the Joint Economic Comm. 32 (2004) (Prof. Pauly). "[E]ven the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur; the vast bulk of spending needs cannot be forecast in advance." Amicus Br. of Economic Scholars, *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir.) ("Economic Scholars Br."), at 10-11 (citing Winkelman & Mehmud, Society of Actuaries, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment, Apr. 2007).

Costs can mount rapidly for even the most common medical procedures. For example, approximately one in three babies in the U.S. is born by Cesarean delivery, the cost of which averages more than $13,000. *See* National Vital Statistics Reports, Births: Preliminary Data for 2009 (Dec. 2010); International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees by Country ("IFHP Rep."), at 12. The average bill for a single hospital stay for an uninsured person is $22,200. ASPE Research Br. 8. The average cost of bypass surgery is nearly $60,000; of an appendectomy, $13,000; of an angioplasty, $29,000. IFHP Rep., at 16, 14, 17. An MRI scan alone costs $1,000 on average. *Id*. at 8. *See also, e.g.*, Meropol & Schulman, *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007) (one year of drug treatment for metastatic colorectal cancer can cost $150,000-$200,000).

The potential for financially ruinous burdens is plain, and 62% of all personal bankruptcies are caused in part by medical expenses. 42 U.S.C.A. § 18091(a)(2)(G). The risk we all confront can be expressed statistically for large populations, but what actually will happen to any given individual in a particular time period — the "frequency, timing and magnitude" of an individual's demand for health care services — is largely unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100

Q.J. Med. 53, 54-55 (2007); *see* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941, 948-49 (1963).

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

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

The federal government's involvement in health care financing is pervasive. Virtually all Americans aged 65 or older are insured through the federal Medicare program. The Uninsured: A Primer, Kaiser Family Foundation, at 1 (Dec. 2010). Medicaid and the Children's Health Insurance Program have covered 20% of the non-elderly population by covering categories of low-income individuals. *Id*. at 3. In 2010, federal spending on Medicare and Medicaid was more than $790 billion, with billions more spent on other health care programs. Congressional Budget Office

("CBO"), The Long-Term Budget Outlook, at 37-39 (2011). These figures do not include the federal government's longstanding use of tax incentives to finance health care costs. CBO, Key Issues in Analyzing Major Health Proposals ("CBO, Key Issues"), at 30 (2008).

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

An estimated 50 million people (18.8% of the non-elderly population) lacked health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009 ("Census Rep."), at 23 table 8. As discussed above (pp. 4-5, *supra*), these people actively participate in the interstate health care market, consuming more than $100 billion of health care services annually. Families USA, Hidden Health Tax: Americans Pay a Premium, at 2 (2009) ($116 billion in 2008).

In the health care market, unlike in other markets, people receive expensive services in times of need without regard to their ability to pay. For decades, state and federal laws have required emergency rooms to stabilize patients who arrive with an emergency condition, and common-law and ethical duties restrict a physician's ability to terminate a patient-physician relationship. *See* pp. 40-42, *infra*. As a result,

people without insurance "receive treatments from traditional providers for which they either do not pay or pay very little." CBO, Key Issues, at 13.

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

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

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

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

Medical underwriting is expensive, and insurers pass on that expense through increased premiums in the individual market. Administrative costs for private health insurance, including underwriting costs, totaled $90 billion in 2006 — 26% to 30% of the cost of the insurance premiums charged in the individual and small group markets. 42 U.S.C.A. § 18091(a)(2)(J).

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

II. The Affordable Care Act

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

First, the Act builds upon the existing nationwide system of employer-based health insurance, the principal private mechanism for health care financing. Congress established tax incentives for small businesses to purchase health insurance for their employees, 26 U.S.C.A. § 45R, and prescribed tax penalties under certain circumstances for large employers that do not offer full-time employees adequate coverage, *id*. § 4980H.

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

Third, the Act offers tax credits to assist households with incomes from 133% to 400% of the federal poverty line in purchasing insurance through the exchanges.

26 U.S.C.A. § 36B(a), (b).[1] Congress also authorized federal payments to help cover out-of-pocket expenses (e.g., co-payments or deductibles) for eligible individuals who obtain coverage through an exchange. 42 U.S.C.A. § 18071. In addition, Congress expanded eligibility for Medicaid to cover individuals with incomes up to 133% of the federal poverty line. *Id.* § 1396a(a)(10)(A)(i)(VIII).

Fourth, the Act regulates insurers to prohibit industry practices that have prevented people from obtaining and maintaining health insurance. Among other things, the Act bars insurers from refusing coverage because of pre-existing medical conditions and from charging higher premiums based on a person's medical history. *See, e.g.*, *id.* §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a).

Fifth, the Act's minimum coverage provision requires that non-exempted individuals maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C.A. § 5000A. The requirement may be satisfied through enrollment in an employer-sponsored plan; an individual market plan, including one offered through a health insurance exchange; a grandfathered plan; government-sponsored programs such as Medicare, Medicaid, or TRICARE; or similar coverage as recognized by the Secretary of HHS in coordination with the Treasury Secretary. *Id.* § 5000A(f)(1).

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

Congress exempted certain groups from the minimum coverage requirement, *id.* § 5000A(d), and made the tax penalty inapplicable to individuals whose household income is too low to require them to file a federal income tax return; whose premium payments would exceed 8% of household income; or who establish (under standards set by the HHS Secretary) that they have suffered a hardship with respect to the capability to obtain coverage. *Id.* § 5000A(e).

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

SUMMARY OF ARGUMENT

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

I. The district court correctly dismissed this challenge to the minimum coverage provision for lack of standing. This suit is a pre-enforcement challenge to the minimum coverage provision, which does not take effect until 2014. Accordingly, plaintiffs must show that the provision is having a "direct and immediate" impact on their conduct. *Gray v. City of Valley Park, Mo.*, 567 F.3d 976,

984 (8th Cir. 2009). In other Affordable Care Act cases, plaintiffs have made such a showing by representing that they have changed their spending practices in specific ways in order to have funds available to pay for insurance when the minimum coverage provision takes effect. *See*, *e.g.*, *Thomas More Law Center v. Obama*, __ F.3d __, 2011 WL 2556039, *3 (6th Cir. June 29, 2011). Plaintiff Hill failed to make such a showing, nor did she allege facts showing that she will be subject to a tax penalty in 2014 if she fails to obtain minimum coverage. Accordingly, the district court correctly held that Hill lacks standing. The court properly declined to consider plaintiff Kinder's standing because he failed to challenge the minimum coverage provision in the amended complaint. In any event, Kinder admits that he has health insurance and fails to show any actual or imminent injury attributable to the provision.

II. If the Court reaches the merits, it should uphold the minimum coverage provision as a valid exercise of Congress's commerce power for the reasons stated in the Sixth Circuit's *Thomas More* decision.

A. The minimum coverage provision is a quintessential exercise of the commerce power, which allows Congress to regulate not only interstate commerce but also economic conduct that substantially affects interstate commerce. Congress found that the minimum coverage provision regulates economic activity — how

participants in the health care market pay for their services — that substantially affects interstate commerce. The regulation furthers two principal economic goals. First, it prevents people from shifting the financial risks and actual costs of their health care to other participants in the interstate health care market. Second, it is key to the viability of the Act's regulatory provisions barring insurers from relying on medical conditions or history to deny coverage or set premiums.

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

The federal government, along with state governments, shoulders some of these costs. Health care providers pass much of the remainder on to private insurers, causing higher premiums for the insured. Rising premiums mean more people cannot afford insurance, which contributes to the decline in the privately insured population.

Completing the cycle, the growing number of uninsured persons further inflates insurance premiums for others.

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

In short, Congress had far more than a rational basis for choosing the minimum coverage provision as a means of regulating the way individuals finance health care services, of preventing consumers from shifting costs to other market participants, and of effectuating the Act's regulatory requirements of guaranteed issue and community rating. *See Gonzales v. Raich*, 545 U.S. 1, 16-17, 22 (2005).

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

Plaintiffs do not dispute that Congress can regulate the way people pay for services at the time that they obtain medical care. Plaintiffs take issue only with the timing of the minimum coverage requirement, asserting that it cannot be imposed until medical care is actually consumed. Pl. Br. 59.

This contention is premised on a deep misunderstanding of the nature of insurance and its role in the health care services market. Health insurance, by its nature, must be obtained before medical care is actually needed. Common sense, experience, and economic analysis show that a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, Hearing Before the S. Comm. on Finance, 110th Cong. 52 (2008) (Prof. Hall). Moreover, it was clearly appropriate under the Necessary and

Proper Clause for Congress to take into account the societal judgment — long reflected in state law, as well as the federal Emergency Medical Treatment and Labor Act ("EMTALA") — that it would be unconscionable to adopt an approach that would require providers to deny care in times of need because a person lacks insurance.

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

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

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

minimum coverage provision thus operates as a tax, and it is projected to raise billions of dollars in revenue each year.

Contrary to plaintiffs' contention, the validity of this provision under the taxing power does not turn on whether the assessment is labeled a "tax." The Affordable Care Act uses terms like "tax" and "assessable payment" interchangeably, and the Constitution itself uses various terms to describe the power of taxation. In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co*., 312 U.S. 359, 363 (1941). Because the minimum coverage provision operates as a tax and is projected to raise revenue, it is a valid exercise of the taxing power.

STANDARD OF REVIEW

The order of dismissal is subject to *de novo* review in this Court.

ARGUMENT

I. The District Court Correctly Dismissed This Pre-Enforcement Challenge on Standing Grounds.

The district court correctly dismissed this pre-enforcement challenge to the minimum coverage provision for lack of standing. "For purposes of standing, a plaintiff's injury must consist of 'an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or

hypothetical.'" *Young America Corp. v. Affiliated Computer Srvs., Inc.*, 424 F.3d 840, 843 (8th Cir. 2005) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). "Pre-enforcement facial challenges [to a statute] may be brought ... in certain circumstances." *Gray v. City of Valley Park, Mo.*, 567 F.3d 976, 984 (8th Cir. 2009). "Plaintiffs have standing to challenge the facial validity of a regulation notwithstanding the pre-enforcement nature of a lawsuit, where the impact of the regulation is direct and immediate and they allege an actual, well-founded fear that the law will be enforced against them." *Ibid*.

In other Affordable Care Act cases, courts have found that individuals have established such a direct and immediate impact by alleging that they must take action now in order to be in a position to obtain insurance in 2014. For example, in *Thomas More*, the Sixth Circuit relied on declarations showing that "the impending requirement to buy medical insurance on the private market has changed [the plaintiffs'] present spending and saving habits." *Thomas More*, 2011 WL 2556039, *3. Plaintiff John Ceci represented that he has delayed car repairs and computer upgrades for his office in order to have funds available for insurance in 2014. *See* No. 10-2388 (6th Cir.) (Ceci Decl. ¶¶ 7-8) (filed 5/30/11). Similarly, plaintiff Steven Hyder represented that he and his wife "have to forego making home and car repairs"

to have funds available for insurance in 2014. *See* No. 10-2388 (6th Cir.) (Hyder Decl. ¶¶ 7-8) (filed 5/30/11).[2]

By contrast, in *New Jersey Physicians, Inc. v. Obama*, __ F.3d __, 2011 WL 3366340 (3d Cir. Aug. 3, 20110), the Third Circuit held that an individual lacked standing to challenge the minimum coverage provision because he failed to allege facts showing present or imminent future injury. There were "no facts alleged to indicate that [the plaintiff] is in any way presently impacted by the Act or the mandate." *Id*. at *4. The Third Circuit thus contrasted *Thomas More* and other cases "in which the plaintiffs alleged or demonstrated that they were experiencing some current financial harm or pressure arising out of the individual mandate's looming enforcement in 2014." *Ibid*. In addition, the Third Circuit explained that the plaintiff had failed to allege facts establishing "a 'realistic danger' that [he] would be harmed

[2] *See also*, *e.g.*, *Florida v. HHS*, __ F. Supp. 2d __, 2011 WL 285683, *7-*8 (N.D. Fla. 2011) (plaintiff represented that she "must now investigate" whether "she will have to lay off employees, close her business, and seek employment that provides qualifying health insurance as a benefit"), *appeals pending*, Nos. 11-11021 & 11-11067 (11th Cir.); *Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 764 F. Supp. 2d 684, 690-92 (M.D. Pa. 2011) (plaintiffs represented that they would have to forgo a five-year contract on a new car); *Mead v. Holder,* 766 F. Supp. 2d. 16, 24-26 (D.D.C. 2011) (plaintiff alleged that she must forgo college savings), *appeal pending sub nom. Seven-Sky v. Holder*, No. 11-5047 (D.C. Cir.); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 624 (W.D. Va. 2010) (plaintiffs alleged that they "must incur the preparation costs in the near term"), *appeal pending*, No. 10-2347 (4th Cir.).

by the individual mandate" when it takes effect, noting his failure to address potential exemptions. *Ibid*.[3]

Here, as in *New Jersey Physicians*, the amended complaint fails to establish actual or imminent injury. The amended complaint does not allege that Hill is experiencing current financial pressure and taking actions now in order to save funds to pay for insurance in 2014. Even Hill's affidavit includes only vague statements declaring that Hill generally plans for future financial obligations by forgoing spending today. JA 197. That affidavit has none of the specificity of the *Thomas More* declarations and does not establish the "direct and immediate" impact required for a pre-enforcement challenge. *Gray*, 567 F.3d at 984.

Nor has Hill shown a realistic danger of injury in 2014. The amended complaint states that, "[s]hould Samantha Hill not purchase a federally-mandated health insurance policy, PPACA imposes a financial penalty upon her." JA 120 ¶ 153; JA 197 ¶ 18 (affidavit) (similar). Hill does not deny that she will obtain minimum coverage, however. Instead, she predicts, based on speculative assumptions

[3] District courts likewise have dismissed challenges to the minimum coverage provision where individuals failed to establish standing. *See, e.g.*, *Liberty Univ.*, 753 F. Supp. 2d at 621-22 & nn. 6-7; *Baldwin v. Sebelius*, No. 3:10-cv-1033, 2010 WL 3418436 (S.D. Cal. Aug. 27, 2010), *appeal pending*, No. 10-56374 (9th Cir.).

about relative costs and benefits of different policies, that she will want a policy in several years that does not meet minimum standards. JA 116 ¶ 138; JA 196 ¶ 14.

These predictions do not take into account the premium tax credits that will be available under the Affordable Care Act. They do not take in account the fact that Hill's medical needs may change over the next several years. They do not take into account the possibility of employer-provided insurance. *See Thomas More*, Pl. Letter of May 25, 2011, at 2 (admitting that, while the case was pending, plaintiff DeMars obtained employer-provided insurance at a fraction of the cost she had estimated for a policy in the individual market). Indeed, unlike the *Thomas More* plaintiffs, Hill provided no information regarding her employment. *Compare* Ceci Decl. ¶ 3 ("I am a lawyer and a solo practitioner. Consequently, I do not have employer-provided healthcare coverage."); Hyder Decl. ¶ 3 (same). Moreover, Hill's predictions about the type of policy she may want in several years assume that such policies would be available on the individual market in Missouri. The amended complaint, however, states that Missouri has "extensive statutes regulating health insurance" that require coverage of specified services. JA 105 ¶ 93; *see also*, *e.g.*, Mo. Rev. Stat. § 376.1232 (requiring coverage of prosthetic devices and services); *id.* § 376.1215 (immunizations for children under 5); *id.* § 376.1220 (newborn hearing screening and aid); *id.* § 376.1200 (certain breast cancer treatments); Bunce and Wieske, Council

for Affordable Health Insurance, Health Insurance Mandates in the States 2009 (listing 41 health insurance mandates in Missouri).

Like the plaintiffs found not to have standing in *New Jersey Physicians*, Hill also failed to show that she would be subject to a tax penalty if she does not have minimum coverage in 2014. The Third Circuit correctly noted that Congress made the tax penalty inapplicable to individuals whose household income is too low to require them to file a federal income tax return, whose premium payments would exceed 8% of household income, or who establish (under standards set by HHS) that the minimum coverage requirement would impose a hardship. *New Jersey Physicians*, 2011 WL 3366340, *1, *4 (citing 26 U.S.C.A. § 5000A(e)). Neither the amended complaint nor Hill's affidavit alleged facts relevant to those exemptions.

"Even at the motion to dismiss stage, ... '[i]t is a long-settled principle that standing cannot be inferred argumentatively from averments in the pleadings but rather must affirmatively appear in the record.'" *Id*. at *3 (quoting *FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 231 (1990)). Thus, the district court correctly held that Hill lacks standing to challenge the minimum coverage provision.[4]

[4] Hill's invocation of the "Missouri Health Care Freedom Act," Pl. Br. 29-31. adds nothing to her standing argument.

The district court properly declined to consider Kinder's standing because he did not challenge the minimum coverage provision in the amended complaint. Add. 11. In any event, Kinder admits that he has health insurance provided by the State of Missouri, JA 459-60, and thus cannot show that the minimum coverage provision is having a "direct and immediate" impact on his conduct. *Gray*, 567 F.3d at 984. Although Kinder states that his current insurance will end with his term as Lieutenant Governor, he does not claim that he will forgo insurance at that time or show that he would be subject to a tax penalty. Thus, Kinder also lacks standing to challenge the minimum coverage provision.

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

If the Court were to reach the merits, it should uphold the minimum coverage provision under the commerce power for reasons recently set out by the Sixth Circuit in *Thomas More*. The Constitution grants Congress power to "regulate Commerce ... among the several States," U.S. Const. art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. These grants of authority allow Congress to regulate not only interstate commerce but also other economic conduct that "substantially affect[s] interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing such substantial effects, Congress's focus is necessarily broad. Congress may consider the aggregate effect of a particular category of

conduct, and need not predict case by case whether and to what extent particular individuals in the class will contribute to those aggregate effects. *Id.* at 22.

In reviewing the validity of Commerce Clause legislation, a court's task "is a modest one." *Ibid*. The court "need not determine" whether the regulated conduct, "taken in the aggregate, substantially affect[s] interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Ibid*. A court is similarly deferential in reviewing the means Congress chose to achieve legitimate ends. "[T]he Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch*, 17 U.S. at 413, 418). This deference reflects separation-of-powers principles and Congress's superior capacity to make empirical and operational judgments. It "has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity." *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 196 (1997).

Congress's findings and the legislative record leave no doubt that the minimum coverage provision — which regulates how people pay for services in the interstate health care market — is a valid exercise of the commerce power under the standards established by the Supreme Court. The provision "regulates activity that is

commercial and economic in nature," 42 U.S.C.A. § 18091(a)(2)(A), and that substantially affects interstate commerce. First, Congress found that people who endeavor to pay for health care through means other than insurance shift billions of dollars of costs annually to other participants in the interstate health care market. *Id.* § 18091(a)(2)(F). Second, Congress found that the minimum coverage provision is key to the viability of the Act's insurance reforms that make individuals insurable at non-discriminatory rates regardless of illness or injury. *Id.* § 18091(a)(2)(I), (J).

A. The minimum coverage provision regulates economic activity that substantially affects interstate commerce.

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

Congress identified the substantial burden on interstate commerce that it was seeking to alleviate. Congress found that people who "forego health insurance coverage and attempt to self-insure" often fail to pay for the medical services that they consume. *Id.* § 18091(a)(2)(A), (F). Congress found that "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008." *Id.* § 18091(a)(2)(F). Congress also made findings about how these uncompensated costs

affect the interstate health care market — costs are passed on from providers "to private insurers, which pass on the cost to families." *Ibid.* Congress determined that this cost-shifting inflates family health insurance premiums "by on average over $1,000 a year." *Ibid.*; *see also* Families USA, Hidden Health Tax, at 2, 6. In California, for example, uncompensated care for the uninsured accounts for an estimated 10% of insurance premiums. S. Rep. No. 111-89, at 2 (2009).

In acting to reduce this cost-shifting, Congress dealt with the reality that all people are at risk of injury and illness, and even those without insurance actively participate in the market for health care services. *See* p. 5, *supra*. As a class, people without insurance pay only 37% of their health care costs out of pocket. Families USA, Hidden Health Tax, at 6. Third parties, including government programs that provide funding to offset the costs of care for the uninsured, pay for another 26% of the costs of care for the uninsured. *Ibid*. The remaining amount is "uncompensated care," which totaled approximately $43 billion in 2008 and raised the annual insurance premiums paid by families by an average of $1000. *Ibid*.

Even in households at or above the median income, people without insurance pay for, on average, less than half the cost of the health care they consume. Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 229-31 (2005). And, in such

households, uninsured people who consume more than $10,000 in medical services pay only 22% of the cost. *Id*. at 230.

Millions of uninsured people are hospitalized each year, and nearly 60% of these hospitalizations of the uninsured result in bills greater than $10,000. ASPE Research Br. 5. About one-third result in bills in excess of $20,000, and more than a quarter result in bills greater than $25,000. *Id*. at 5. In families with income above 400% of the federal poverty level — nearly $90,000 for a family of four — people without insurance pay in full for only 37% of their hospitalizations. *Id*. at 1. Even uninsured families at the 90th percentile of savings can afford to pay in full for only half of the hospitalizations they incur, and these bills account for just 14% of the total amount that hospitals bill the uninsured. *Id*. at 6.

2. Established Commerce Clause precedent leaves no doubt that Congress has the power to address this economic problem. In *Wickard v. Filburn*, 317 U.S. 111 (1942), and, more recently, in *Raich*, the Supreme Court found there was a rational basis for Congress to have concluded that leaving home-grown and home-consumed commodities (wheat and marijuana respectively) outside of a comprehensive federal regulatory scheme would affect the price and market conditions for those commodities. "In both cases," the Court explained, "the regulation is squarely within Congress' commerce power because production of the commodity meant for home

consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *Raich*, 545 U.S. at 19.

Given that this level of effect on interstate commerce is sufficient to justify congressional exercise of the commerce authority, there is no doubt that the regulation at issue here satisfies the "substantial effects" standard. "Faced with $43 billion in uncompensated care, Congress reasonably could require *all* covered individuals to pay for health care now so that money would be available later to pay for *all* care as the need arises." *Thomas More*, 2011 WL 2556039, *24 (Sutton, J.) (emphasis in original); *see also id*. at *11-*12 (Martin, J.).

For purposes of the commerce power, it is irrelevant that some uninsured individuals may not generate uncompensated costs in a particular month or year. *Id*. at *31 (Sutton, J.). The Supreme Court has never required Congress "to legislate with scientific exactitude," *Raich*, 545 U.S. at 17, and Congress is not required to predict, person-by-person, who among the uninsured will receive uncompensated health care services in a given period of time. Where "Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the entire class." *Raich*, 545 U.S. at 17 (quoting *Perez v. United States*, 402 U.S. 146, 154-55 (1971)). *See also Monson v. DEA*, 589 F.3d 952, 964 (8th Cir. 2009) ("The question is not whether Congress *could* have decided to regulate a narrower class of economic

activity than it chose to regulate. Rather, the question is whether Congress had any rational basis to conclude that the economic activity it chose to regulate ... substantially affects interstate commerce.") (emphasis in original).

Here, Congress found that people who "forego health insurance coverage and attempt to self-insure" often fail, with corresponding "financial risks to households and medical providers." 42 U.S.C.A. § 18091(a)(2)(A). "Given the extremely high costs of health care for all but the most routine treatments and procedures, the cost of medical care is beyond the means of all but the most wealthy Americans." Economic Scholars Br. 4; *see also* 42 U.S.C.A. § 18091(a)(2)(G) (legislative finding that 62% of personal bankruptcies are caused in part by medical expenses). People without insurance actively participate in the health care services market, and, as a class, fail to pay for 63% of the services they receive. Congress thus had far more than a rational basis to conclude that attempts to "self-insure" pose "a threat to a national market." *Raich*, 545 U.S. at 17.

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

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

or history. *Thomas More*, 2011 WL 2556039, *12-14 (Martin, J.). There is no dispute that these insurance regulations are valid exercises of Congress's commerce power. Pl. Br. 54; *see also United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944) (insurance business is interstate commerce within the meaning of the Commerce Clause). Where, as 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) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)); *see also Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981); *United States v. Howell*, 552 F.3d 709, 714 (8th Cir. 2009).

Congress found, based on the experience of state regulators, that the Act's guaranteed-issue and community-rating requirements would be unsustainable if participants in the health care market could postpone purchasing insurance until an acute need arose. Congress thus concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in that regulatory scheme. *Raich*, 545 U.S. at 22. Thus, the minimum coverage provision forms "an essential part of a broader economic regulatory scheme." *Thomas More*, 2011 WL 2556039, *15 (Martin, J.).

The Nation has faced a serious shortage of affordable health insurance. More than 50 million non-elderly Americans went without insurance in 2009. Census Rep.,

at 23 table 8. Rising premiums have priced many out of the market. Between 1999 and 2010, for example, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Foundation Employer Health Benefits, 2010 Annual Survey, at 31, table 1.11 (2010).

Many in the individual market are excluded from coverage by "medical underwriting," a process by which insurers establish eligibility and premiums based on individual health status or history. Depending on the definition used, between 50 and 129 million non-elderly Americans (19% to 50% of the non-elderly population) have at least one pre-existing condition, and the four largest for-profit insurers excluded more than 600,000 individuals from coverage because of such conditions in the three years before the Affordable Care Act. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011); Chairman Henry A. Waxman and Rep. Bart Stupak, Memorandum on Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market to H. Comm. on Energy & Commerce, at 1 (Oct. 12, 2010); *see also* Help on the Horizon, at xi (finding, during a three-year period, about 35% of non-elderly adults in the individual market were denied coverage, charged higher premiums, or offered limited coverage because of pre-existing conditions).

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

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

The legislative record demonstrated that the absence of a minimum coverage requirement linked to guaranteed-issue and community-rating requirements had undermined health care reform efforts in several states. For example, citing New Jersey's experience, Princeton University Professor Uwe Reinhardt explained that

"[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong., Prepared Testimony, at 11 (Mar. 17, 2009). In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & Law 71, 91-92 (2000). And, when Maine enacted similar legislation, most insurers withdrew from the state. Health Reform in the 21st Century: Insurance Market Reforms, Hearing Before the H. Comm. on Ways & Means, 111th Cong. 117 (2009) (Phil Caper, M.D., and Joe Lendvai). In contrast, Congress found that Massachusetts avoided these perils by enacting a minimum coverage requirement as part of broader insurance reforms. That requirement "has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased." 42 U.S.C.A. § 18091(a)(2)(D).

2. Plaintiffs assert that "the uninsured — those not buying medical insurance — do not undercut Congress's regulation of participants in the insurance market." Pl. Br. 62. Plaintiffs ignore the contrary evidence before Congress, and fail to recognize that, for many people, the question is not *whether* to obtain insurance but

when to obtain it. Substantial numbers move in or out of insurance coverage each year. CBO, How Many People Lack Health Insurance and for How Long? at 4, 9 (2003). Moreover, as a general matter, "young adults move into coverage as they grow older." Glied & Stabile, *Generation Vexed: Age-Cohort Differences in Employer-Sponsored Health Insurance Coverage*, 20 Health Affairs 184, 189 (2001); *see also* Census Rep., at 23 table 8 (showing that, in 2009, about 30% of individuals ages 18 to 34 lacked coverage, compared with about 16% of those ages 45 to 64).

It may seem rational to some healthy, young individuals to postpone joining the insurance pool — as long as insurance remains available at a later date. Many find, however, that changes in their medical condition render insurance unavailable later. Even a temporary condition as common as pregnancy can result in an automatic denial of individual health insurance coverage. *See* p. 35, *supra*. Thus, although plaintiff Hill is not now pregnant, JA 195 ¶ 10, if she were to become pregnant she could find it difficult if not impossible to obtain insurance on the individual market in the absence of the Affordable Care Act's reforms. And, when people without insurance develop significant medical needs, they resort to the "backstop" of uncompensated care funded by third parties. *Thomas More*, 2011 WL 2556039, *12.

The Affordable Care Act breaks this cycle by making all individuals insurable at non-discriminatory rates. Those without insurance benefit from the guaranteed-

issue and community-rating requirements, which allow them to obtain and maintain insurance even when they develop significant medical needs. At the same time, the minimum coverage provision ensures "that all Americans who can afford it contribute to the costs of their own health care by maintaining reasonable insurance coverage." Economic Scholars Br. 5. Accordingly, the Act's provisions work in tandem to reduce cost-shifting by the uninsured and to reform dysfunctional markets in which people who need medical care cannot get insurance.

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

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

Plaintiffs do not dispute that people who attempt to "self-insure" often fail, and collectively shift billions of dollars of costs to other participants in the health care market. Instead, plaintiffs take issue with the means that Congress chose to ensure that participants in the health care market pay for the services they obtain. Although plaintiffs do not question Congress's power to require that people have insurance at the "point of sale" of health care services, *Thomas More*, 2011 WL 2556039, *30 (Sutton, J.), they object to the timing of the insurance requirement, which, they contend, cannot be imposed before medical care is consumed. Pl. Br. 59.

Governing precedent does not permit a court to override Congress's judgment about the appropriate means to achieve objectives that are within the scope of its commerce power. The "relevant inquiry" under the Necessary and Proper Clause "is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (quoting *United States v. Darby*, 312 U.S. 100, 121 (1941))); *accord Howell*, 552 F.3d at 714; *United States v. Tom*, 565 F.3d 497, 502 (8th Cir. 2009).

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

The minimum coverage provision is just such a "reasonable preventive measure." It is reasonably adapted to the practical and moral imperatives of the health care market, which require that insurance be obtained before the need for health care is imminent. The minimum coverage provision ensures that non-

exempted individuals who can afford insurance will pay for the health care services they consume, rather than shift their risks and costs to others.

It is hardly novel for the government to require the purchase of insurance to prevent the externalization of costs. In the case of motor vehicle insurance, for example, the requirement may accompany registration or use of a vehicle. *See, e.g.*, 49 U.S.C. § 13906(a). By contrast, the risks addressed by health insurance are always present. "That is why most Americans manage the risk of not having the assets to pay for health care by purchasing medical insurance." *Thomas More*, 2011 WL 2556039, *24 (Sutton, J.) (citing 42 U.S.C.A. § 18091(a)(2)(D)). "Requiring insurance today and requiring it at a future point of sale amount to policy differences in degree, not kind, and not the sort of policy differences removed from the political branches by the word 'proper' or for that matter 'necessary' or 'regulate' or 'commerce.'" *Id*. at *30.

In enacting the minimum coverage provision, Congress understood that a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, 110th Cong. 52 (Hall). Moreover, our society has long recognized that it would be unconscionable to deny medical care to someone in an emergency because he failed to carry insurance. Well before the enactment of the federal Emergency Medical Treatment and Labor Act in 1986, state court rulings had imposed "a common law duty on

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

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

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

rooms [from] refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance," H.R. Rep. No. 99-241(I), at 27, Congress augmented state law through EMTALA in 1986. The federal statute requires all hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, without regard to ability to pay. 42 U.S.C. § 1395dd; *see also Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999); *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1136-37 (8th Cir. 1996) (en banc). In devising its legislation, it was clearly "proper" for Congress to take into account this societal judgment — reflected in state and federal law — that denying emergency care because a patient lacks insurance would be unconscionable. *Cf. Comstock*, 130 S. Ct. at 1961 (noting the "common law" duty not to release dangerous persons in one's custody, in finding it "necessary and proper" for Congress to confine a federal prisoner whose mental illness threatens others). Indeed, that judgment is reflected in the laws of the very states that are plaintiffs' *amici* here.[6]

There is no doubt that the commerce power would permit Congress to require insurance at the time that health care services are needed. Under such a scheme,

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

however, the penalty for not obtaining coverage — denial of access to medical care — would be far more draconian and coercive than the tax penalty that Congress enacted. *Thomas More*, 2011 WL 2556039, *30 (Sutton, J.). In any event, even assuming that plaintiffs could identify a preferable regulatory alternative, that would provide no basis to invalidate the statute that Congress enacted.

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

The Sixth Circuit correctly rejected the premise of plaintiffs' challenge to the minimum coverage provision, which is that the provision regulates "inactivity." People without insurance are not "inactive"; they actively participate in the market for health care services and shift substantial costs to other market participants. *Thomas More*, 2011 WL 2556039, *11-12, 14-15 (Martin, J.); *id*. at *24, 28-29 (Sutton, J.). The minimum coverage provision regulates the way participants in the health care market finance their health care services — activity that is itself "commercial and economic in nature." 42 U.S.C.A. § 18091(a)(2)(A).

As Judge Sutton explained, "[n]o one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk." *Thomas More*, 2011 WL 2556039, *29. Indeed, "[i]f done responsibly, the former requires more action (affirmatively saving money on a regular basis and managing the assets over time) than the latter (writing a check once or twice

a year or never writing one at all if the employer withholds the premiums)." *Id*. at *28.

Plaintiffs treat the minimum coverage requirement as if it were an end in itself that functioned only in the insurance market. Congress, however, viewed the requirement as a means of regulating payment for services in the health care market. That congressional judgment was not merely reasonable; it was correct. Health insurance is not bought for its own sake; it is bought to pay for health care expenses. Porat, et al., *Market Insurance Versus Self Insurance*, 58 J. Risk & Ins. 657 (1991); Martin Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. Pol. Econ. 251, 253 (1973) ("Health insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchases of health services.").

Those who resort to other options to pay medical expenses may attempt to "use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 55 (2007); *see also* Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007). "Regardless of whether one relies on an insurance policy, one's savings, or the backstop of free or reduced-cost emergency room services, one has made a choice regarding the method of payment for the health care services one expects to receive."

Liberty Univ., Inc. v. Geithner, 753 F. Supp. 2d 611, 633 (W.D. Va. 2010), *appeal pending*, No. 10-2347 (4th Cir.). Some individuals may prefer to attempt to pay for health care services out-of-pocket rather than through insurance. But such economic conduct is plainly subject to regulation under the Commerce Clause.

Although plaintiffs would divorce the insurance market from the health care market that it finances, the Supreme Court has long rejected such "formalistic" distinctions between categories of economic conduct in favor of "broad principles of economic practicality." *United States v. Lopez*, 514 U.S. 549, 569, 571 (1995) (Kennedy, J., concurring). "[Q]uestions of the power of Congress are not to be decided by reference to any formula" without regard to "the actual effects of the activity in question upon interstate commerce." *Wickard*, 317 U.S. at 120; *see also Swift Co. v. United States*, 196 U.S. 375, 398 (1905) ("[C]ommerce among the States is not a technical legal conception, but a practical one, drawn from the course of business."); *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962) (Congress in the Clayton Act "prescribed a pragmatic, factual approach to the definition of the relevant market"); *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 414-15 (1914) (observing that insurance is "essentially different from ordinary commercial transactions").

As Judge Sutton explained, plaintiffs' "action/inaction dichotomy" is neither workable nor consistent with Commerce Clause doctrine. *Thomas More*, 2011 WL 2556039, *28. "The power to regulate includes the power to prescribe and proscribe." *Ibid*. (citing *Lottery Case*, 188 U.S. 321, 359-60 (1903)). "Legislative prescriptions set forth rules of conduct, some of which require action." *Ibid*. Such requirements have never been held to present a problem under the commerce power. In *United States v. Howell*, 552 F.3d 709, 713-17 (8th Cir. 2009), for example, this Court rejected a Commerce Clause challenge to a federal statute that requires sex offenders to register. In *United States v. Faasse*, 265 F.3d 475, 486 (6th Cir. 2001) (en banc), the Sixth Circuit upheld a federal statute that requires payment of child support, declaring it "immaterial" that the statute "regulates a defendant's failure to put a thing in commerce." Similarly, the federal drug possession law upheld in *Raich* "amounts to forced inaction in some settings (those who do not have drugs must not get them), and forced action in other settings (those who have drugs must get rid of them)." *Thomas More*, 2011 WL 2556039, *28 (Sutton, J.). The federal child pornography statute likewise requires innocent recipients of child pornography to destroy the depictions or report the matter to a law enforcement agency. 18 U.S.C. § 2252(c).

In *Raich* and *Wickard*, the Supreme Court rejected "a variation on the action/inaction line — between regulating individuals already in markets and those outside of them." *Thomas More*, 2011 WL 2556039, *30 (Sutton, J.). In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana grown at home for personal use. The Court found it irrelevant that the individuals did not buy, sell, or distribute any portion of the marijuana they possessed. And, in *Wickard*, the Court upheld the federal regulation of wheat that was not "sold or intended to be sold." 317 U.S. at 119.

In any event, even on its own terms, plaintiffs' "action/inaction" dichotomy would not support this pre-enforcement facial challenge to the minimum coverage provision, because it would not show that "'no set of circumstances exists under which the Act would be valid.'" *Thomas More*, 2011 WL 2556039, *23 (Sutton, J.) (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987)); *see also Sabri v. United States*, 541 U.S. 600, 608-09 (2004). Plaintiffs' "inactivity" theory encompasses only individuals who have no insurance. Pl. Br. 54. Their theory has no application to individuals who have insurance but object to maintaining it, such as *Thomas More* plaintiff DeMars. *Thomas More*, 2011 WL 2556039, *28. It has no application to individuals living in states that require individuals to have insurance. *Id*. at *29. And it has no application to individuals with insurance that does not meet minimum

standards. Thus, on its own terms, plaintiffs' "activity/inactivity dichotomy does not work with respect to health insurance in many settings, if any of them." *Id*. at *32.

D. The minimum coverage provision bears no resemblance to the statutes at issue in *Lopez* and *Morrison* or to plaintiffs' hypothetical directives.

1. Although plaintiffs seek support for their position from *Lopez* and *Morrison*, those cases held that Congress may not "regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce." *United States v. Morrison*, 529 U.S. 598, 617 (2000). In *Lopez*, the Court struck down a ban on possession of handguns in school zones. In *Morrison*, the Court invalidated a tort cause of action for gender-motivated violence. Neither measure played any role in broader regulation of economic activity, and the "noneconomic, criminal nature of the conduct at issue was central" to the Court's rulings. *Id*. at 610; *Sabri*, 541 U.S. at 607.

"Health care and the means of paying for it are 'quintessentially economic' in a way that possessing guns near schools ... and domestic violence ... are not." *Thomas More*, 2011 WL 2556039, *25 (Sutton, J). "No one must 'pile inference upon inference,' *Lopez*, 514 U.S. at 567, to recognize that the national regulation of a $2.5 trillion industry, much of which is financed through 'health insurance ... sold by national or regional health insurance companies,' 42 U.S.C. § 18091(a)(2)(B), is

economic in nature." *Ibid.* Providers and insurers are joined in national networks; providers serve out-of-state patients, *e.g.*, *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 213 (4th Cir. 2002); and insurance companies are characterized by "[i]nterrelationship, interdependence, and integration of activities in all the states in which they operate." *South-Eastern Underwriters Ass'n*, 322 U.S. at 541.

2. Rather than address the pertinent features of the statute before the Court, plaintiffs attack a variety of far-fetched hypothetical statutes that bear no resemblance to the minimum coverage provision. Plaintiffs purport to see no difference between a requirement to maintain insurance to pay for health care costs and a requirement to buy an automobile, open a bank account, or buy a home. Pl. Br. 58-59.

As an initial matter, the far-fetched nature of plaintiffs' hypotheticals only underscores the fact that "health care is different." Stuart M. Butler, *The Heritage Lectures 218: Assuring Affordable Health Care for All Americans*, at 6 (Heritage Foundation 1989). "If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car." *Ibid.* By contrast, "[i]f a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance." *Ibid.* "If we find that he has spent money on other things rather than insurance, we may be angry but we

will not deny him services — even if that means more prudent citizens end up paying the tab." *Ibid*.

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

Although plaintiffs use the rhetoric of liberty, they do not and cannot contend that the minimum coverage provision violates any "substantive due process" right. Such a claim "would have found Constitutional support in the Supreme Court's decisions in the years prior to the New Deal legislation of the mid-1930's, when the Due Process Clause was interpreted to reach economic rights and liberties," but the *Lochner*-era doctrine "has long since been discarded." *Florida v. HHS*, 716 F. Supp. 2d 1120, 1161 (N.D. Fla. 2010).

There is no doubt that constraints on federal power play a role in safeguarding individual rights. But, stripped of rhetorical excess, the practical right that plaintiffs seek to vindicate is the ability to consume health care services without insurance and to pass costs on to other market participants. There is, of course, no such right in the

Constitution, and the commerce power vests Congress with ample authority to prevent such practices and the burdens they impose on interstate commerce.

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

A. The minimum coverage provision operates as a tax.

The minimum coverage provision is also independently authorized by Congress's power to "lay and collect Taxes." U.S. Const. art. I, § 8, cl. 1. The taxing power is "comprehensive," *Steward Mach. Co. v. Davis*, 301 U.S. 548, 581-82 (1937), and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-83 (D.C. Cir. 2007). In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson*, 312 U.S. at 363; *United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as a "penalty").

The "practical operation" of the minimum coverage provision is as a tax. *Nelson*, 312 U.S. at 363. The provision amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of coverage shall pay a monthly penalty for so long as he fails to maintain that minimum coverage. 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 penalty 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). A taxpayer's responsibility for family members depends on their status as dependents under the Internal Revenue Code. *Id.* § 5000A(a), (b)(3). Taxpayers filing a joint tax return are jointly liable for the penalty. *Id.* § 5000A(b)(3)(B). And the Treasury Secretary is empowered to enforce the penalty provision. *Id.* § 5000A(g).

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

it is therefore within Congress's taxing power. *See also Nigro v. United States*, 276 U.S. 332, 353 (1928) (any "doubt as to the character" of a tax was removed because provision raised "substantial" sum of $1 million per year).

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

Contrary to the Sixth Circuit's understanding (*Thomas More*, 2011 WL 2556039, *18), Congress was not required to invoke its taxing power expressly. "[T]he constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise." *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948). Applying the presumption of constitutionality, a court's task is "to determine whether Congress had the authority to adopt the legislation, not whether it correctly guessed the source of that power." *Usery v. Charleston Co. Sch. Dist.*, 558 F. 2d 1169, 1171 (4th Cir. 1977).

In any event, Congress did invoke its taxing power: the taxing power was expressly invoked to defeat constitutional points of order against the minimum coverage provision in the Senate. 155 Cong. Rec. S13,830, S13,832 (Dec. 23, 2009); *see also* H.R. Rep. No. 111-443(I), at 265 (2010). Moreover, during the legislative debates, congressional leaders defended the provision as an exercise of the taxing power. *E.g.*, 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); *id.* at H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753

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

It is not significant that Congress referred to the assessment as a "penalty." Congress used the terms "penalty" and "tax" interchangeably in the Affordable Care Act, as the Act's employer responsibility provision shows. *See* 26 U.S.C.A. § 4980H(b)(1), (2), (c)(2)(D), (d)(1) (alternating among the terms "tax," "assessable payment," and "assessable penalty"). Likewise, the minimum coverage provision's legislative history shows that terms like "excise tax" and "penalty" were used interchangeably in that provision as well. *Compare* S. 1796 (Oct. 19, 2009) (Senate Finance Committee bill) (using term "excise tax"), *with* S. Rep. No. 111-89, at 52 (Oct. 19, 2009) (Committee Report) (describing it as a "penalty ... accounted for as an additional amount of Federal tax owed").

Far from disclaiming its taxing power, Congress placed the minimum coverage provision in the Internal Revenue Code; required that the penalty be included on the taxpayer's income tax return; and calculated the amount owed as a percentage of income, subject to a floor and a cap. Thus, the minimum coverage provision is a tax in both administration and effect. It is enforced by the Internal Revenue Service and — in conjunction with the rest of the Act — has been determined by the CBO and Congress to reduce the budget deficit. Any doubt as to the meaning of the words in

the Affordable Care Act should be construed in favor of the statute's constitutionality. *Nw. Austin Mun. Utility Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009); *Ashwander v. TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring).

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

The Sixth Circuit concluded that the goal of the minimum coverage provision is not to raise revenue, but to "change individual behavior by requiring all qualified Americans to obtain medical insurance." *Thomas More*, 2011 WL 2556039, *18. It is settled, however, that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States v. Sanchez*, 340 U.S. 42, 44 (1950). "Every tax is in some measure regulatory" in that "it interposes an economic impediment to the activity taxed as compared with others not taxed." *Sonzinsky*, 300 U.S. at 513. As long as a statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax." *Id*. at 514; *id.* at 512 (rejecting the argument that a tax on firearms dealers was "not a true tax, but a penalty imposed for the purpose of suppressing traffic in a certain noxious type of firearms"). Accordingly, "'the courts have sustained taxes although imposed with the collateral intent of effecting ulterior ends which, considered apart, were beyond the constitutional power of the lawmakers to realize by legislation directly addressed to

their accomplishment.'" *Sanchez*, 340 U.S. at 44-45 (quoting *A. Magnano Co. v. Hamilton*, 292 U.S. 40, 47 (1934)) (rejecting challenge to tax on marijuana transfers that rested "on the regulatory character and prohibitive burden of the section as well as the penal nature of the imposition"). The Supreme Court has long "abandoned the view that bright-line distinctions exist between regulatory and revenue-raising taxes." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 743 n.17 (1974).

Congress broke no new ground in using the tax code to shape decision-making related to health care. For more than fifty years, federal tax law has pervasively regulated this area. *See, e.g.*, 26 U.S.C. §§ 35, 106, 223, 4980D, 9801-34. Indeed, the Sixth Circuit recognized that Congress could have "raised taxes on everyone in an amount equivalent to the current penalty, then offered credits to those with minimum essential insurance," or "imposed a lower tax rate on people with health insurance than those without it." *Thomas More*, 2011 WL 2556039, *17.

There undoubtedly remains a "distinction between taxes and penalties." *Id*. at *20. But the distinction does not depend on whether the assessment has a "regulatory" character, *Bob Jones*, 416 U.S. at 743 n.17; it depends on whether the assessment is "punitive." *Dep't of Revenue v. Kurth Ranch*, 511 U.S. 767, 778-79 (1994). The minimum coverage provision has none of the hallmarks of a punitive sanction. 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, 294-95 (1935), the penalty under the minimum coverage provision can be no greater than the cost of qualifying insurance, 26 U.S.C.A. § 5000A(c)(1)(B). *Cf. Sanchez*, 340 U.S. at 45 ("rational foundation" for tax rate showed it was not a punitive sanction in disguise). Moreover, the penalty is calculated on a month-by-month basis, 26 U.S.C.A. § 5000A(b)(1), and payment of the penalty relieves the taxpayer of the obligation to purchase insurance for that month, in contrast with instances in which an individual who violates a statute must pay a penalty and is still required to satisfy the underlying obligation. *See United States v. Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 224-25 (1996). Thus, the minimum coverage provision is not a punitive measure.

Nor is the assessment a "direct tax" subject to the Constitution's apportionment requirement. Pl. Br. 64-65. A direct tax is one imposed "simply, without regard to property, profession, or any other circumstance." *Hylton v. United States*, 3 U.S. 171, 175 (1796) (opinion of Chase, J.); *Pac. Ins. Co. v. Soule*, 74 U.S. 433, 444-46 (1868) (adopting Justice Chase's definition); *Veazie Bank v. Fenno*, 75 U.S. 533, 544 (1869). The minimum coverage provision does not impose a flat tax without regard to the taxpayer's circumstances. It is imposed based on whether a taxpayer maintains

minimum coverage and it is calculated monthly, based on the taxpayer's household income. *Id*. § 5000A(a), (b)(1). It thus resembles other federal taxes imposed for failures to make specified economic arrangements.[7]

[7] *See, e.g.*, 26 U.S.C. § 4974 (tax on failure of retirement plans to distribute assets); *id.* § 4980B (tax on failure of group health plan to extend coverage to beneficiary); *id.* § 4980E (tax on failure of employer to make comparable Archer MSA contributions); *id*. § 4942 (tax on failure of private foundation to distribute income).

CONCLUSION

The judgment of the district court should be affirmed.

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I hereby certify that on this 11th day of August, 2011, I filed an electronic copy of the foregoing brief through this Court's appellate CM/ECF system. The following participants in the case who are registered CM/ECF users will be served by the CM/ECF system:

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