TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney General

DENNIS K. BURKE
United States Attorney, District of Arizona

JENNIFER RICKETTS
Director

SHEILA LIEBER
Deputy Director

TAMRA T. MOORE (D.C. Bar No. 488392)
ETHAN P. DAVIS
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Ave. NW
Washington, D.C. 20001
(202) 514-8095
Tamra.Moore@usdoj.gov

Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Nick Coons; et al., Plaintiffs, vs. Timothy Geithner; et al., Defendants	Case No.: CV-10-1714-PHX-GMS **MOTION TO DISMISS**

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INTRODUCTION

Congress enacted the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") in response to a crisis in the interstate health care market. The Act includes a series of measures to address economic conduct by participants in that unique market that had contributed substantially to that crisis. It establishes new health insurance Exchanges where individuals and small businesses can pool their purchasing power to buy insurance. It creates tax incentives for small employers to offer insurance to their employees. And it offers tax credits and cost sharing reductions to eligible people who purchase health insurance in the new Exchanges. The Act also requires insurers to guarantee the issuance of policies to all applicants at non-discriminatory rates, without regard to medical condition or history. That requirement ends a harsh industry practice of denying coverage, or charging more, to individuals because of pre-existing conditions, which has prevented many from obtaining affordable insurance. The Act also, in the provision principally at issue here, requires all Americans (with exceptions) to obtain qualifying insurance or to pay a penalty with their tax return.

The lead plaintiff here—Nick Coons—contends that Congress exceeded its Article I powers in enacting this minimum coverage provision. But Coons' claim fails at the threshold, for the provision does not take effect until 2014, and Coons has failed to allege any current or impending injury as a result of the provision. Even if Coons could surmount this jurisdictional barrier, his argument fails for two principal reasons. First, Congress acted well within its authority to adopt measures that are necessary and proper

to the regulation of interstate commerce when it enacted 26 U.S.C. § 5000A (the minimum coverage provision) because Congress understood that virtually everyone at some point needs and will seek medical services. Whether or not people choose to buy health insurance, they participate in the market for health care services, and the ACA regulates how they pay for health care services. The choice of that means of payment—*i.e.*, whether to pay in advance through insurance or to attempt to do so later out-of-pocket—"in the aggregate," substantially affects the interstate health care market, *see Gonzales v. Raich*, 545 U.S. 1, 22 (2005). Those who forgo insurance do not withdraw from the health care market. To the contrary, when accidents or illnesses inevitably occur, they still receive essential medical care, even if they cannot pay. As Congress documented, the cost of such uncompensated health care, at least $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. 42 U.S.C. § 18091(a)(2)(F). Although not all the uninsured receive health care services without paying, millions of them do. Congress's commerce power plainly enables it to address economic behavior that, in the aggregate, imposes these substantial effects on the interstate market.

In addition, as mentioned above, the ACA includes a ban on denying coverage to, or charging more for, any individual based on a preexisting medical condition. This provision regulates the terms and availability of policies offered for sale by insurance companies operating in interstate commerce and, indisputably, it is within Congress's

commerce power. Congress determined that, without the minimum coverage provision, those insurance reforms would not work, as they would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," shifting even greater costs onto third parties, and making coverage less, rather than more, affordable for everyone. 42 U.S.C. § 18091(a)(2)(I). 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.* The provision falls well within Congress's authority to ensure the viability of its larger regulations of interstate commerce. *See Raich*, 545 U.S. at 22.

Second, Congress has independent authority to enact 26 U.S.C. § 5000A as an exercise of its power under the General Welfare Clause of Article I, Section 8. *See United States v. Sanchez*, 340 U.S. 42, 44 (1950). Congress treated the minimum coverage provision as an exercise of the taxing power, lodging it in the Internal Revenue Code, specifying that the penalty under the provision be assessed and collected like any other tax, using the word "tax" or some derivation of it many times in the provision, and invoking the taxing power throughout the legislative debates. The provision, moreover, bears the principal hallmark of a tax. It will raise revenue, and is therefore valid, even though Congress also had a regulatory purpose in enacting it.

Plaintiff Coons' substantive due process challenge is equally flawed. There is no "right" to forego health insurance, and nothing in the minimum coverage provision

requires him to disclose medical information to private insurers.

As they did in their recently withdrawn preliminary injunction motion, plaintiffs Jeff Flake and Trent Franks—members of the House of Representatives—also challenge the ACA provisions establishing the Independent Payment Advisory Board ("IPAB" or "Board"). But plaintiffs Flake and Franks lack standing, as they allege only institutional injuries rather than personal ones, *see Raines v. Byrd*, 521 U.S. 811, 821 (1997), and, in any event, the Board will not exist until 2012, and will not issue any proposals until 2014. As for the merits, defendants have explained that plaintiffs' claim that the fast track provision blocks repeal is incorrect; plaintiffs remain free to introduce or vote on proposed legislation to repeal the statutory provision that creates the Board.[1] Plaintiffs' attack on the procedures governing congressional review of Board proposals is wrong for similar reasons. And their assertion that the ACA does not provide an "intelligible principle" constraining the Board's discretion is contradicted by the pages of detailed guidance contained in Section 1395kkk of the Social Security Act, as added by Section 3403 of the ACA.

Adding Dr. Eric Novack, an orthopedic surgeon who alleges that he serves Medicare patients, as a plaintiff does nothing to salvage plaintiffs' standing to pursue their IPAB claims. Dr. Novack claims that the IPAB will "decrease his Medicare

[1] In accordance with this Court's March 10, 2011 order, *see* ECF No. 34, and Local Rule 7.1(d)(2), defendants incorporate by reference the background, standing, and merits arguments contained in their response to plaintiffs' motion for a preliminary injunction, *see* Defs.' Resp. Pls.' Mot. Prelim. Inj. 2-20, ECF No. 27, and the statements made in defendants' Notice regarding the votes cast by plaintiff Flake and Franks in January 2011 to repeal the ACA in its entirety, including the IPAB provisions challenged here. *See* Defs.' Notice 1-3, ECF No. 29.

reimbursement," but as explained in detail below, the Board will not exist until at least 2012, and cannot begin issuing proposals until January 2014. Even after 2014, it is speculative whether the Board would propose changing Medicare's physician payment and when it would make such proposals, as whether the Board may make a proposal depends on the rate of growth of Medicare spending. To this latter point, the Congressional Budget Office's analysis using a March 2011 baseline estimates that the Board will not issue its first proposal until 2021 or later. *See* Congressional Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*: Testimony *Before the H. S. Comm. on Health Comm. on Energy & Commerce*, 112th Cong. 26 (2011) (statement of Douglas W. Elmendorf, Dir. CBO). And even if the Board decides to issue a proposal that would reduce Medicare payments for physicians like Dr. Novack, Congress may decide to override the proposal. These contingencies show plainly that Dr. Novack lacks standing.

BACKGROUND

A. Statutory Background

In 2009, the United States spent more than 17% of its gross domestic product on health care. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a). Notwithstanding these extraordinary expenditures, about 50 million people—18.8% of the non-elderly population—went without health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. Absent the new legislation, that number would have climbed to 54 million by 2019.

Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, U.S. House of Representatives, 9, table 4 (Mar. 20, 2010) [hereinafter CBO Letter to Speaker Pelosi]. CONG. BUDGET OFFICE ("CBO"), 2008 KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 11 (Dec. 2008) [hereinafter KEY ISSUES].

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 without health insurance coverage still receive medical care, but often cannot pay for it. The costs of that uncompensated care are shifted to health care providers, insurers, the insured, governments, and taxpayers. These costs, Congress determined, have a substantial effect on interstate commerce. Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a).

To remedy this overriding problem for the American economy, the ACA 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 will coordinate participation and enrollment in health plans and bring new transparency to the market so that consumers

will be able to compare plans based on price and quality. Pub. L. No. 111-148, § 1311.

Second, the ACA builds on the existing system of employer-sponsored health insurance, in which many people 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 on certain large businesses in specified circumstances that do not provide adequate coverage to their full-time employees. Pub. L. No. 111-148, §§ 1421, 1513.

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

Fourth, the ACA removes barriers to insurance coverage. As noted, it prohibits widespread insurance industry practices that increase premiums for—or deny coverage entirely to—those with the greatest need for health care. Most significantly, the ACA bars insurers from refusing to cover or charging more for individuals because of pre-existing medical conditions. Pub. L. No. 111-148, § 1201. It also prevents insurers from

rescinding coverage for any reason other than fraud or intentional misrepresentation of material fact, or declining to renew coverage based on health status. *Id.* §§ 1001, 1201. And it prohibits dollar caps on the amount of coverage available to a policyholder over a lifetime. *Id.* §§ 1001, 10101(a).

Finally, the ACA requires that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty. *Id.* §§ 1501, 10106.[2] Congress found that this minimum coverage 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 a number of Congressional findings. Congress found that, by "significantly reducing the number of the uninsured, the requirement, together with the other provisions of [the ACA], will lower health insurance premiums." *Id.* §§ 1501(a)(2)(F), 10106(a). Conversely, and importantly, Congress also found that, without the minimum coverage provision, the reforms in the ACA, 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 determined 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.*

[2] These provisions were amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032.

The CBO projects that the ACA's reforms will reduce the number of uninsured by approximately 32 million by 2019. CBO Letter to Speaker Pelosi, 9. It further projects that the Act's combination of reforms and tax credits will reduce the average premium paid by individuals and families in the individual and small-group markets. *Id.* at 15; CBO, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION & AFFORDABLE CARE ACT 23-25 (Nov. 30, 2009). And CBO estimates that the revenue and spending provisions in the ACA—specifically taking into account revenue from the minimum coverage provision—will save the federal government more than $100 billion over the next decade. CBO Letter to Speaker Pelosi, at 2.

B. The establishment of the Independent Payment Advisory Board

In addition to the minimum coverage provision, plaintiffs challenge Congress's enactment of the provisions establishing the IPAB. Composed of fifteen members appointed by the President and confirmed by the Senate, the Board will be responsible for finding ways to "reduce the per capita rate of growth in Medicare spending[.]" 42 U.S.C. § 1395kkk(b). To this end, beginning in 2014, the Board will be required to submit proposals recommending changes to the Medicare program if the rate of growth in spending per beneficiary is expected to exceed a target growth rate. *See* 42 U.S.C. § 1395kkk(b)(2), (c)(6). The Board's proposals must be "detailed and specific" and must, to the extent feasible, give priority to recommendations that "extend Medicare solvency." *Id.* §§ 1395kkk(c)(1)(A), (c)(2)(B)(i). The Board must also include recommendations that "improve the health care delivery system and health outcomes" and "protect and

improve Medicare beneficiaries' access to necessary and evidence-based items and services[.]" *Id.* § 1395kkk(c)(2)(B)(I), (II). The Secretary of Health and Human Services will be required to implement the Board's recommendations on a yearly basis unless Congress passes legislation to supersede the Board's proposals. *See* 42 U.S.C. § 1395kkk(e)(3)(A).

ARGUMENT

Defendants move to dismiss the complaint for lack of subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1). Plaintiffs bear the burden of proving subject matter jurisdiction by a preponderance of the evidence, and the Court must determine whether it has jurisdiction before addressing the merits. *Oregon v. Legal Servs. Corp.*, 552 F.3d 965, 969 (9th Cir. 2009); *see also Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94-95 (1998). Defendants also move to dismiss the complaint for failure to state a claim under Rule 12(b)(6). Under 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).

I. PLAINTIFFS LACK STANDING

A. Plaintiff Coons lacks standing

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 v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (internal citations, quotation marks, and footnote omitted). "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.* Plaintiff Coons has not met these standards.

Plaintiff alleges that he does not currently have health insurance and thus, come 2014, he will be forced to purchase qualifying health insurance coverage or pay a penalty. Am. Compl. ¶¶ 6, 14-16, 19-23, 26, ECF No. 35. But this asserted injury is simply too speculative and "too remote temporally" to support standing. *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). Moreover, Coons does not provide sufficient factual information about his current (or probable future) economic circumstances to show that he will almost certainly be required to purchase insurance in 2014.

Indeed, this case illustrates the danger of issuing an opinion that may turn out to be

advisory. Even if plaintiff does not have insurance now, personal situations can change dramatically over three years. Although plaintiff alleges that he does not qualify for Medicaid now, in 2014, he may be eligible for Medicaid, or Medicare, either of which would satisfy the minimum coverage provision. *See* Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(f)(1)(A)). We do not know if plaintiff is currently employed or, if so, whether his employer provides insurance as part of his compensation. Even if plaintiff's employer does not provide insurance now, it may decide to do so between now and 2014, and plaintiff may decide to enroll in such coverage. If plaintiff is not currently employed, he may find employment by 2014 in which he receives health insurance as a benefit.[3] Or plaintiff may decide, due to the availability of tax credits under the ACA or for some other reason, to purchase qualifying health insurance coverage in one of the new health insurance Exchanges. Plaintiff also does not indicate what his current household income is or what he expects his household income to be in 2014. We do not know if plaintiff's household income will be above or below the income tax filing threshold or if plaintiff's required contribution toward insurance coverage will exceed eight percent of plaintiff's household income in 2014. Depending on these factors, plaintiff may qualify for one of the minimum coverage provision's exemptions, including one for those who "cannot afford coverage," and one for those who would suffer hardship if required to purchase insurance. *Id.* § 1501(b) (adding 26 U.S.C. § 5000A(e)). For now, any harm that plaintiff might suffer is remote rather than imminent, speculative rather than

[3] We also do not know if plaintiff is married or, if so, whether his spouse is employed by an entity that provides insurance for spouses.

concrete, and "at least partly within [his] own control." *Lujan*, 504 U.S. at 564 n.2.

For these reasons, several district courts have dismissed similar lawsuits brought by individuals challenging the minimum coverage provision. *See, e.g.*, *New Jersey Physicians v. Obama*, Civil Action No. 10-1489, 2010 WL 5060597, at *4 (D.N.J. Dec. 8, 2010) (dismissing a challenge brought by an individual who did "not have qualifying insurance presently and [did] not plan to purchase insurance in the future"); *Baldwin v. Sebelius*, No. 10cv1033, 2010 WL 3418436, at *3 (S.D. Cal. Aug. 27, 2010) (rejecting a challenge brought by an individual, reasoning that, "even if [plaintiff] does not have insurance at this time, he may well satisfy the minium [sic] coverage provision of the Act by 2014"); *see also* Mem. Op. and Order, *Bryant v. Holder*, Civ. No. 2:10-76, at 19, ECF No. 26, (S.D. Miss. Feb. 3, 2011) (concluding "bare legal conclusion" that the plaintiffs "will be subject to the minimum [] coverage provision" is insufficient to establish standing; the plaintiffs must allege facts to demonstrate they will certainly be subject to the provision); *Shreeve v. Obama*, 1:10cv71, 2010 WL 4628177, at *4 (E.D. Tenn. Nov. 4, 2010).

To be sure, several courts have concluded that individual plaintiffs have standing to challenge the minimum coverage provision. But the plaintiffs in these cases all made specific allegations of current injury based on their individualized circumstances. *See* Mem., *Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, Civ. No. 1:10-763, at 12-14, ECF No. 37, (M.D. Pa. Jan. 24, 2011); *Liberty Univ., Inc. v. Geithner*, No. 6:10cv00015, 2010 WL 4860299, *5-*7 (W.D. Va. Nov. 30, 2010); *Thomas More Law*

Ctr. v. Obama, 720 F. Supp. 2d 882, 887-89 (E.D. Mich. 2010). In *Goudy-Bachman*, for example, the plaintiffs alleged that they were currently "unable to finance a five-year contract on a new vehicle" because they had to "rearrange and evaluate their finances before the [minimum coverage provision] becomes effective." Memo. at 10-11. The plaintiffs in *Thomas More Law Center* similarly alleged that they had to "start saving money today." *Thomas More Law Ctr.*, 720 F. Supp. 2d at 889.

Coons, however, makes no similar allegations of current, individualized, and concrete injury. Even after three bites at the apple, Coons is still unable to articulate any present injury. In the latest version of the complaint, he alleges that "[t]he individual mandate will force him to divert resources from his business and reorder his economic circumstances." Second Am. Compl. ¶ 16, ECF No. 41. But, like the allegations contained in the first two versions of his complaint, the allegations here *still* do not show that Coons is *currently* reordering his economic affairs, let alone that he is doing so in any specific, concrete manner. And he still has not described his "resources." Instead, he predicts what will happen in the future *if* he is ultimately subject to the minimum coverage provision. As such, the allegations in this case are analogous to those found insufficient in *Bryant v. Holder*, 2:10cv76, 2011 WL 710693, at *8 n.3 (S.D. Miss. Feb. 3, 2011) (noting that, "[i]mportantly, Plaintiffs do not allege that they are presently rearranging their finances or incurring any economic harm[,]" even though the complaint alleged "threatened injuries to Petitioners of having to plan for, invest, save and exhaust the personal resources required as a result of incurring the expense of purchasing health[

]care insurance or, in the alternative, to pay a significant monetary penalty for disobeying the PPACA").

Indeed, Coons' only identified current "harm" is that he "objects to being compelled by the federal government through the passage of the Act to purchase health care coverage and objects to being compelled to share his private medical history with third parties." Second Am. Compl. ¶ 6. But Coons cannot establish Article III standing merely by objecting to the law; if he could, any plaintiff would have standing to challenge any law. Plaintiff Coons therefore lacks standing.

For similar reasons, plaintiff's challenges are 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). This case instead involves "contingent future events that may not occur as anticipated, or indeed may not occur at all[,]" *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985), and that do not cause a hardship with a "'direct effect on the day-to-day business of the plaintiffs[,]'" *Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 17-18 (D.D.C. 2001) (quoting *Texas v. United States*, 523 U.S. 296, 301 (1998)). Plaintiff's challenges are unripe because no injury could occur before 2014, and plaintiffs have not shown a strong likelihood that one will occur even then.

B. Plaintiffs Jeff Flake and Trent Franks lack standing

Nor do Representatives Jeff Flake and Trent Franks have standing to challenge the

sections of the ACA creating the IPAB. As defendants have explained in prior briefing, "[a] claim of standing . . . based on a loss of political power" is not a legally cognizable injury-in-fact. *Raines*, 521 U.S. at 821; Defs. Opp'n Mot. for Prelim. Inj. 6-12, ECF No. 27. Plaintiffs Flake and Frank do not even try to allege any personal, individualized injury as a result of the operations of the IPAB. Instead, they assert that "[t]he establishment of IPAB currently burdens and will continue to burden Plaintiff Flake and Franks and other federal legislators' liberty and quasi-sovereign interests in legislative voting, as well as their constitutional voting duties by contributing to the diminishment of their otherwise lawful scope and effectiveness." Am. Compl. ¶ 126. But, as defendants have explained, plaintiffs cannot circumvent *Raines* simply by citing the First Amendment. However plaintiffs characterize their injury, their allegations establish beyond doubt that that the injury here "runs . . . with the Member's seat," *Raines*, 521 U.S. at 821, and is therefore not cognizable. If Representatives Flake and Franks were to resign tomorrow, they "would no longer have a claim; the claim would be possessed by [their] successor instead." *Id.*[4] As such, the claim of injury here is "official, and not personal." *Thomas v. Mundell*, 572 F.3d 756, 761 (9th Cir. 2009).

C. Plaintiff Eric Novack also lacks standing

Recognizing that Representatives Flake and Franks plainly lack standing, the third iteration of the complaint adds another plaintiff to this case: an orthopedic surgeon named Eric Novack. According to plaintiffs, "[a]pproximately 12.5% of [Dr. Novack's] patients

[4] Indeed, Representative John Shadegg—a former plaintiff—was dropped from this case after deciding not to run for re-election.

are Medicare patients, the services for which are reimbursed by the federal government through rates set by Congress and signed into law by the President." Second Am. Compl. ¶ 7. Plaintiffs reason that the IPAB will "alter[] the procedure by which Dr. Novack and other physicians, including members of his practice, are reimbursed for treating Medicare patients," and contend that the ACA is "imminently likely to decrease his reimbursements for services that he renders to Medicare patients." *Id.* ¶ 128.

But adding Dr. Novack to this case does nothing to fix plaintiffs' standing problem. Contrary to plaintiffs' claim, the IPAB is not "imminently likely" to affect Dr. Novack's Medicare payments. To the contrary: the Board does not even exist yet. The President has appointed no members, and the Board's activities cannot begin until fiscal year 2012 because funding will not be available until then. *See* 42 U.S.C. § 1395kkk(m)(1)(A). And even after the Board is created, it cannot make proposals until January 15, 2014 at the earliest. *Id.* §1395kkk(c)(1)(B) and (c)(3)(A). Even then, it can only do so if the per capita growth rate in Medicare spending exceeds defined target rates.

Indeed, even after 2014, according to recent CBO estimates using the March 2011 baseline, it is possible that the Board will not actually issue proposals until at least 2021—nearly ten years from now. As explained earlier, the Board may make recommendations only if the Chief Actuary for the Centers for Medicare & Medicaid Services determines, among other things, that the per capita growth rate in Medicare expenditures exceeds a target growth rate. *Id.* § 1395kkk(c)(3)(A)(i)-(ii). As it turns out, a recent CBO analysis of the ACA using the March 2011 baseline predicts that the rate of

growth in Medicare spending per beneficiary in the 2012-2021 period will remain "below the levels at which the IPAB will be required to intervene to reduce Medicare spending." Congressional Budget Office, CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 at 26 (Mar. 30, 2011). It is therefore speculative whether the IPAB will issue any proposals at all on January 15, 2014.

Moreover, whenever the Board begins making recommendations, whether those proposals will affect Dr. Novack is also a matter of sheer speculation. We do not know how long Dr. Novack will continue in his current practice and whether he will be practicing if and when the Board were to issue recommendations affecting his practice. It is possible he will retire, take another position, or decide that he will no longer participate in Medicare. Even if Dr. Novack continues to practice orthopedic surgery and participate in Medicare when the Board begins making recommendations, it is also speculative that the Board would issue any proposal that would change Medicare's physician payment formula, let alone propose a reduction specific to orthopedic surgeons. Indeed, although plaintiffs are correct that the IPAB may propose reductions in payments to physicians, such reductions are hardly the only weapons in the Board's arsenal. Rather than propose reducing payments to orthopedic surgeons, the Board might, for example, propose making changes to the Medicare Advantage program, Medicare Part D (the prescription drug program), or other parts of the Medicare program. *See* Kaiser Family Foundation Program on Medicare Policy, The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending 16 (Apr. 2011).

Finally, even if, years from now, the Board issues a proposal that would reduce payments to orthopedic surgeons, such a proposal would be subject to Congress enacting superseding legislation under the fast track procedures established by the ACA. *See* 42 U.S.C. § 1395kkk(d) and (e)(3)(A)(i). These possibilities render the claim of future injury here "remote" and "hypothetical." *Hartman v. Summers*, 120 F.3d 157, 160 (9th Cir. 1997). Plaintiffs' attempt to replace Representatives Flake and Frank with Dr. Novack accordingly does not give this Court jurisdiction.[5]

II. THE MINIMUM COVERAGE PROVISION IS A PROPER EXERCISE OF CONGRESS'S CONSTITUTIONAL AUTHORITY TO REGULATE INTERSTATE COMMERCE

A. The minimum coverage provision regulates the means of payment for health care services, a class of economic activities that substantially affects interstate commerce

The Constitution grants Congress the power to "regulate Commerce . . . among the

[5] On the face of the complaint, Dr. Novack raises only a non-delegation challenge to the IPAB; he does not purport to challenge the parliamentary procedures whereby Congress may discontinue the Board or the fast-track provisions governing Congress's review of Board proposals. And for good reason. Dr. Novack certainly cannot show that his purported injury—*i.e.*, that the IPAB will "alter[] the procedures by which Dr. Novack and other physicians, including members of his practice, are reimbursed for treating Medicare patients" and "decrease his reimbursements for [treating] Medicare patients," Second Am. Compl. ¶ 128—would be redressed by a favorable decision on the provisions governing Congress's repeal of the IPAB or the procedures governing congressional consideration of IPAB proposals. *Lujan*, 504 U.S. at 560-61. Indeed, even if this Court were to decide in plaintiffs' favor, there would be no guarantee that both houses of Congress would actually vote to repeal the IPAB, or that the President would sign such a repeal. Nor would there be any assurance that both houses of Congress would vote to override a Board proposal, or that the President would sign such overriding legislation. *See Medina v. Clinton*, 86 F.3d 155, 157-58 (9th Cir. 1996) (holding that plaintiffs lacked standing where "the contingency of congressional action makes the redress of plaintiffs' injury not "likely" and indeed entirely 'speculative'") (quoting *Lujan*, 504 U.S. at 561).

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 to address other conduct that "substantially affect[s] interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing those substantial effects, Congress's focus is necessarily broad. Congress may consider the aggregate effect of a particular form of conduct by those subject to regulation, 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; *Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942).

In reviewing legislation enacted under the commerce power, the Court's task "is a modest one." *Raich*, 545 U.S. at 22. The Court "need not determine" whether the regulated activities, "taken in the aggregate, substantially affect interstate commerce in fact,"—which they unquestionably do in the context of the vast interstate markets for health care services and insurance—"but only whether a 'rational basis' exists for so concluding." *Id*. The courts owe "Congress' findings deference in part because the institution is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions." *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195 (1997) (internal citation and quotations omitted). "This principle has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity[.]" *Id*. at 196. "This is not the sum of the matter, however." *Id*. The courts "owe Congress' findings an additional measure of

deference out of respect for its authority to exercise the legislative power[,]" lest a court "infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Id.* Accordingly, "courts are not to scrutinize Congress's conclusions closely[]" but instead determine whether Congress had a "'rational basis'" for determining that the regulated activities "taken in the aggregate, substantially affect interstate commerce . . . ." *United States v. Stewart*, 451 F.3d 1071, 1075 (9th Cir. 2006) (internal quotation omitted).

Congress's findings and the legislative record leave no doubt that the minimum coverage provision "regulates activity that is commercial and economic in nature[,]" 42 U.S.C. § 18091(a)(2)(A), and that has an enormous impact on interstate commerce. First, the provision addresses the consumption of health care services without payment, which is indisputably an activity that shifts billions of dollars of costs annually to other participants in the interstate health care market. *Id.* § 18091(a)(2)(F). Moreover, most health insurance is sold by national or regional companies that operate interstate and that are characterized by "[i]nterrelationship, interdependence, and integration of activities in all the states in which they operate[.]" *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 541 (1944). Second, the provision is instrumental to the viability of the statute's regulation of medical underwriting, which guarantees individuals that they will be insurable regardless of illnesses or accidents, and will not be charged higher premiums on account of health status or history. 42 U.S.C. § 18091(a)(2)(I), (J).

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

The interstate nature of the market for health care services is not in dispute. Nor could it be disputed that Americans participate in that market whether or not they have health insurance. *See* pages 4-8, *supra.* The uninsured do not, however, bear the full cost of their participation. Congress's findings quantified the effect of this cost-shifting on interstate commerce—$43 billion in the aggregate cost of providing uncompensated care to the uninsured in 2008. 42 U.S.C.A. § 18091(a)(2)(F). Congress also found that these costs affect the interstate health care market; they are passed on from providers "to private insurers, which pass on the cost to families[.]" *Id.* Congress determined that this cost-shifting inflates the premiums that families must pay for their health insurance "by an average of over $1,000 a year." *Id.*; *see also* FAMILIES USA, HIDDEN HEALTH TAX, at 2, 6. "In short, those who choose not to purchase health insurance will ultimately get a 'free ride' on the backs of those Americans who have made responsible choices to provide for the illness we all must face at some point in our lives." *Mead v. Holder*, 1:10cv00950, 2011 WL 611139, at *16 n.10 (D.D.C. Feb. 22, 2011).

"The decision whether to purchase insurance or to attempt to pay for health care out of pocket, is plainly economic." *Thomas More Law Ctr.*, 720 F. Supp. 2d at 893. And, because people without insurance, as a class, do not pay for all the health care services that they consume, these economic decisions "have clear and direct impacts on health care providers, taxpayers, and the insured population who ultimately pay for the

care provided to those who go without insurance." *Id*.

The Supreme Court's precedents make clear that it is irrelevant whether a particular individual's consumption of health care without insurance will impose a substantial burden on the interstate health care market, because it is the aggregate impact that provides the basis for the exercise of the commerce power. Thus, in *Wickard* and *Raich*, it did not matter that the individuals' consumption of home-grown wheat or home-grown marijuana, respectively, had only a "trivial" impact on the interstate markets for those commodities. *Raich*, 545 U.S. at 18 (quoting *Wickard*, 317 U.S. at 127). The important point was that such consumption, "when viewed in the aggregate," had a substantial impact on the interstate markets. *Id*. at 19 (citing *Wickard*, 317 U.S. at 128).

Nor does it matter that not every uninsured person will shift health care costs in any given year. Millions will do so, and the cumulative impact of such cost-shifting is to impose a multi-billion dollar annual burden on interstate commerce—a burden that easily qualifies as "substantial." Plaintiffs cannot deny that the practice of obtaining health care without insurance, viewed in the aggregate, has clear and direct impacts on health care providers, taxpayers, and the insured population, who ultimately pay for the care provided to those who go without insurance. Congress does not have to predict, person-by-person, who among the uninsured will receive medical services and fail to pay in a given year. The Supreme Court has repeatedly held that, where "Congress decides that the 'total incidence' of a practice"—here, the practice of attempting to pay for health care without insurance—"poses a threat to a national market, it may regulate the entire class."

Raich, 545 U.S. at 17 ((quoting *Perez v. United States*, 402 U.S. 146, 154-155 (1971)).

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

The minimum coverage provision is also valid Commerce Clause legislation because it "operates as an essential part of a comprehensive regulatory scheme[,]" which requires that insurers extend coverage and set premiums without regard to pre-existing medical conditions. *Thomas More*, 720 F. Supp. 2d at 894. Learning from the experience of state regulators, Congress recognized that its "guaranteed-issue" and "community-rating" regulations of the insurance industry could not succeed if participants in the market for health care services could wait to buy insurance until an acute medical need arises. Congress accordingly concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in the regulatory scheme. *Raich*, 545 U.S. at 22. Thus, even if the means of payment for health care services were not regarded as "commercial," it would still be properly regulated because Congress concluded that the "failure to regulate that class of activity would undercut the regulation of the interstate market[.]" *Id*. at 18; *see also id.* at 37-38 (Scalia, J., concurring in the judgment); *Stewart*, 451 F.3d at 1075.

Although insurance coverage is crucial to most consumers' ability to pay for health care services, escalating costs have made insurance increasingly unaffordable. For example, between 1999 and 2010, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Found., *Employer Health Benefits 2010 Annual Survey* 31, tbl 1.11 (2010). These "[p]remium increases are driving people out of

the insurance market." *47 Million & Counting: Why the Health Care Market is Broken*, Hr'g. before the S. Comm. on Finance, 110th Cong. 49 (statement of Prof. Hall). Thus, between 2000 and 2009, the portion of the non-Medicare population covered by private insurance slipped from about 3/4 to about 2/3. Holahan, *The 2007-09 Recession And Health Insurance* Coverage, 30 HEALTH AFFAIRS 145, 148 (2011).

As described above, these trends are attributable in substantial part to the screening process known as "medical underwriting," a practice that imposes barriers to the availability of coverage for millions of Americans who have some pre-existing medical condition.[6] The Act addresses these underwriting practices by barring insurance companies from denying coverage or setting premiums based on medical condition. 42 U.S.C. § 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a). These guaranteed-issue and community-rating requirements would not work in a regulatory scheme that permits health care consumers to time their insurance purchases. Indeed, a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." *47 Million & Counting*, 110th Cong. 52 (statement of Prof. Hall).

Congress found that, absent the minimum coverage provision, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C.A. § 18091(a)(2)(I). Congress thus found that the provision "is essential to creating effective health insurance markets that do not require underwriting and eliminate its

[6] 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. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011), http://www.healthcare.gov/center/reports/preexisting.html.

associated administrative costs." *Id*. § 18091(a)(2)(J). The record showed that the lack of a minimum coverage requirement linked to guaranteed-issue and community-rating measures had undermined reform efforts in states such as New Jersey and New York. Many consumers could "go without insurance when they are healthy, but then have the privilege of throwing themselves on the mercy of community-rated premiums when they fall ill." *Making Health Care Work for American Families: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Health*, 111th Cong. at 11 (2009) (Prof. Reinhardt). Describing the New Jersey reforms, Professor 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." *Id.*; *see also* Monheit, et al., *Community Rating & Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFFAIRS 167, 168 (2004).

After similar legislation was enacted in New York, there was "a dramatic exodus of indemnity insurers from New York's individual market." Mark Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POLITICS, POL'Y & LAW 71, 91-92 (2000). And when Maine required insurers to accept all applicants and charge all policyholders in the same class the same premiums, most health insurers withdrew from the state, and rates offered by the state's remaining for-profit insurer increased. *Health Reform in the 21st Century: Insurance Market Reforms*, Hearing before the H. Comm. on Ways and Means, 111th Cong., at 117 (2009) (letter of Phil Caper, M.D., and Joe Lendvai).

In contrast, Congress found that Massachusetts avoided some of these perils by

enacting a minimum coverage provision as part of its broader insurance reforms. That provision "has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased." 42 U.S.C.A. § 18091(a)(2)(D). The legislative record thus fully supports the Congressional finding 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.* § 18091(a)(2)(I). Because "it is rational to believe the failure to regulate the uninsured would undercut the Act's larger regulatory scheme for the interstate health care market[,]" the minimum coverage provision is well within Congress's commerce power. *Liberty Univ*, 2010 WL 4860299, at *16.

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

1. The courts accord broad deference to the means adopted by Congress to advance legitimate regulatory goals

Plaintiffs do not dispute that people who obtain health care services without insurance shift substantial costs to other market participants. And plaintiffs expressly concede that the minimum coverage provision is an "essential element" of the ACA's broader regulatory scheme. Am. Compl. ¶ 27. Plaintiffs, instead, challenge the means that Congress chose to regulate payment in the interstate market for health care services. This Court, however, is not free to override Congress's judgment about the appropriate means to achieve its legitimate regulatory objectives.

"The Federal 'government is acknowledged by all to be one of enumerated powers,'" but, "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch v. Maryland*, 17 U.S. 316, 408 (1819)). Accordingly, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

Thus, "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)); *see also Kharaiti Ram Samras v. United States*, 125 F.2d 879, 881 (9th Cir. 1942). "[I]n determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court asks "whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956 (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Raich*, 545 U.S. at 22; *United States v. Lopez*, 514 U.S. 549, 557 (1995); and *Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 276 (1981)).

2. The minimum coverage requirement is plainly adapted to the unique conditions of the market for health care services

The means chosen by Congress to effectuate the ACA's regulatory goals are closely tailored to the unique features of the market for health care services. Participation in this market is essentially universal. The need for medical treatment may arise unexpectedly, and is rarely a matter of choice. The cost of care, absent insurance, may overwhelm the typical family budget. And—unlike in other markets—one can expect to receive expensive medical services in times of need without regard to his ability to pay.

A requirement to purchase insurance to avoid the externalization of costs is hardly novel. Indeed, insurance requirements are commonplace in the United States Code. *See, e.g.*, 49 U.S.C. § 13906(a)(1) (interstate motor carriers). In the case of vehicle insurance, the requirement can accompany registration of an automobile. But, while it is sensible for the government to make automobile insurance a condition for use of the highways, it would be entirely unacceptable to impose a comparable requirement on the use of an emergency room. In other words, although "society feels no obligation to repair" the Porsche of the uninsured motorist, "[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," even if that means "more prudent citizens end up paying the tab." Stuart Butler, *The Heritage Lectures 218: Assuring Affordable Health Care for All Americans*, at 6 (Heritage Found. 1989).

Even before the enactment of the Emergency Medical Treatment and Labor Act ("EMTALA") in 1986, which requires all hospitals that participate in Medicare and offer emergency services to stabilize any patient with an emergency condition without regard

to ability to pay, *see* 42 U.S.C. § 1395dd, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. The common law had evolved to preclude hospitals from turning away patients with emergency needs because they are unable to pay for services. "[T]he private hospital may not simply release a seriously ill, indigent patient to perish on the streets." *St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cty.*, 688 P.2d 986, 990 (Ariz. 1984). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists[.]" H.R. REP. NO. 99-241, pt. III, at 5 (1985), *reprinted in* 1986 U.S.C.C.A.N. 726, 727.

These measures were not adequate, however, to prevent hospitals from diverting patients or discharging them prematurely. Congress thus enacted EMTALA in "response to the growing concern about the provision of adequate medical services to individuals, particularly the indigent and the uninsured, who seek care from hospital emergency rooms." *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001) (citing H.R. REP. NO. 99-241, pt. 1, at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605).

The minimum coverage provision is adapted to these practical and moral imperatives. Congress may properly take into account both the practical realities of the national health care market and the societal judgment, reflected both in EMTALA and the common law, that it would be unconscionable to deny medical care to someone because

of the economic choices that he has made. Moreover, as noted, with health insurance, timing is critical. A health insurance market could never survive "if people could simply buy their insurance on the way to the hospital." *47 Million & Counting*, 110th Cong. 14 (statement of Prof. Hall). To be practical and ethical, a requirement to obtain medical insurance must apply before medical services are actually needed.

3. Congress can regulate participants in the interstate health care market, even if they do not currently maintain insurance coverage

Plaintiff claims that Congress may not regulate what he considers an "entirely passive" status. Am. Compl. ¶ 46. This claim disregards the nature of the regulatory scheme that Congress enacted. Plaintiff cannot dispute that "the individuals subject to [the minimum coverage provision] are either present or future participants in the national health care market." *Mead*, 2011 WL 611139, at *18. People do not remove themselves from the health care market by attempting to pay for services out of pocket rather than with insurance. Congress may regulate the conduct of participants in the health care market – by regulating how they pay for the services that they receive in that market – even if at a given moment those participants are "inactive" in the insurance market.[7]

Plaintiff's non-participant/inactivity theory repeats arguments that have been repeatedly rejected by the Supreme Court. In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana that was grown at home for

[7] Movement in and out of insured status is "very fluid." Of those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year. CBO, *How Many People Lack Health Insurance & For How Long?*, 4, 9 (May 2003); *see also* KEY ISSUES, at 11.

personal use. The Supreme Court found it irrelevant that the plaintiffs were not engaged in commercial activity and that they did not buy, sell, or distribute any portion of the marijuana that they possessed. The regulation was proper, the Court held, because "Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would . . . affect price and market conditions." *Raich*, 545 U.S. at 19. The failure to regulate such consumption would, in the aggregate, have a "substantial effect on supply and demand in the national market for that commodity." *Id.*

Raich reflected principles established more than half a century earlier in *Wickard*, 317 U.S. at 111, which upheld the federal regulation of wheat that was grown and consumed on a family farm as part of a program to control the volume and price of wheat moving in interstate commerce. The Supreme Court sustained that exercise of the commerce power even though the wheat at issue was not "sold or intended to be sold," *id.* at 119, even though the home consumption of wheat by any individual "may be trivial by itself," *id.* at 127, and even though the regulation "forc[ed] some farmers into the market to buy what they could provide for themselves," *id.* at 129.

"While the unique nature of the market for health care and the breadth of the Act present a novel set of facts for consideration, the well-settled principles expounded in *Raich* and *Wickard* control the disposition of this claim." *Liberty Univ.*, 2010 WL 4860299, at *14. The plaintiffs in *Raich* and *Wickard* could not exempt themselves from regulation by declaring themselves to be "inactive" in a market, where their behavior had concrete effects on the larger interstate market. Similarly, the claim that an individual is

"inactive" with respect to insurance coverage ignores that health insurance is not a stand-alone product, but instead is the principal means used to finance participation in the health care market. "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.*, 2010 WL 4860299, at *15.

Even if the uninsured population does not currently participate in the health *insurance* market, *but see* page 19, *supra*, it indisputably participates in the larger market for health care *services*. Thus, plaintiffs' assertion "that the Commerce Clause power does not extend to regulations which require individuals to enter a market they would otherwise choose to remain outside of is irrelevant to this case." *Mead*, 2011 WL 611139, at *19. Nothing required Congress to focus exclusively on the submarket that plaintiffs define, and nothing barred Congress from focusing on economic conduct in the health care services market. Some individuals may prefer to pay for their participation in that larger market out of pocket rather than through insurance. But that type of economic preference is plainly subject to regulation under the Commerce Clause. Congress had a rational basis to conclude that the uninsured shift billions of dollars annually on to other market participants when they use health care services for which they cannot fully pay. That gives Congress the authority to regulate.

Moreover, the currently uninsured population benefits directly from the Act's regulatory reforms. As noted, the Act prohibits insurers from denying coverage, or

charging more, for persons because of pre-existing conditions. 42 U.S.C. § 300gg, 300gg-1(a), 300gg-3(a), 300gg-4(a). The Act makes everyone insurable, and thus provides tangible protection against the risk of being left destitute by catastrophic medical expenses. *See* 42 U.S.C. § 18091(a)(2)(G) (62% of all personal bankruptcies are caused in part by medical expenses). The minimum coverage provision is addressed to the same population that will benefit from these regulatory reforms. Even apart from the other rational bases for Congress's choice of means, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Thomas More*, 720 F. Supp. 2d at 894.

Plaintiff's theory—that conduct can be exempted from federal regulation simply by attaching the label of "inactivity" to that conduct—disregards the "broad principles of economic practicality" that underlie the commerce power. *Lopez*, 514 U.S. at 571 (Kennedy, J., concurring). The Court has long held that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature" 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) ("commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962) (Congress chose in the Clayton Act to "prescribe[] a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one"). The practical reality is that all persons, whether with insurance or without, are participants in the national health care market. Congress plainly has the

authority to regulate conduct that has substantial economic effects in that market.

4. The minimum coverage provision does not depend upon attenuated links to interstate commerce

Plaintiff presumably intends to rely on the holdings of *Lopez* and *United States v. Morrison*, 529 U.S. 598 (2000), the only modern cases to invalidate federal statutes as beyond the commerce power. Both statutes were stand-alone measures that involved no economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of a handgun in a school zone because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might undermine economic productivity. Similarly, in *Morrison*, the Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. Neither of these measures played any role in a broader regulation of economic activity. *Lopez*, 514 U.S. at 561. Indeed, the "noneconomic, criminal nature of the conduct at issue was central" to the Court's decisions. *Morrison*, 529 U.S. at 610; *see also Sabri v. United States*, 541 U.S. 600, 607 (2004).

The minimum coverage provision, in contrast, addresses quintessentially economic activity by requiring health insurance as the means of financing services in the vast interstate health care market, and it is essential to the Act's regulation of underwriting practices in the health insurance industry. It does not regulate non-economic conduct; rather, it addresses the means of payment for health care services in a market that accounts for more than one sixth of the nation's GDP. Indeed, it is difficult to conceive

of legislation that is more clearly economic than the regulation of the means of payment for health care services and the requirements placed on insurers, employers, and individuals who are made insurable by federal law. Far from the chain of attenuated reasoning required in *Lopez* and *Morrison* to identify any substantial effect on interstate commerce, the link to interstate commerce in this case is direct and compelling.

Lopez and *Morrison* sought to avoid a view of economic causation so broad that it would "obliterate the distinction between what is national and what is local in the activities of commerce." *Morrison*, 529 U.S. at 616 n.6 (internal citation and quotations omitted). The problems addressed by the ACA are by no means local. "The modern health care system is highly interdependent and operates across state boundaries." Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 NEW ENG. J. MED. e29, at 3 (2010). Congress reasonably found that the Act's national standards were required to ensure that employers and individuals would not be subject to an ineffective state-by-state "patchwork of requirements and protections." H.R. REP. NO. 111-443, pt. I, at 211-12 (2010). The minimum coverage provision, a quintessentially economic regulation, addresses national problems that arise in the context of a vast interstate market.

III. CONGRESS ENACTED THE MINIMUM COVERAGE PROVISION PURSUANT TO ITS INDEPENDENT POWER UNDER THE GENERAL WELFARE CLAUSE

Plaintiff's challenge fails for an additional reason. Independent of its power under 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." U.S. CONST. art. I, § 8, cl. 1. Congress's power to collect revenue and make expenditures under the General Welfare Clause is "comprehensive." *Charles C. Steward Machine Co. v. Davis*, 301 U.S. 548, 581 (1937); *see also Veazie Bank v. Fenno*, 75 U.S. 533, 541 (1869) ("[I]t was the intention of the Convention that the whole power should be conferred …."). An exercise of the taxing power is valid so long as it bears "some reasonable relation" to the "raising of revenue." *United States v. Doremus*, 249 U.S. 86, 93-94 (1919); *see also J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 412 (1928) ("motive" and "effect" "to secure revenue" bring measure within taxing power, even if Congress announces other motives to regulate commerce).

The substance of the provision, and not its label, is dispositive on this question. "In passing on the constitutionality of a tax law [the 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) (internal quotation omitted); *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalties"); *In re Hovan, Inc.*, 96 F.3d 1254, 1257 (9th Cir. 1996) ("functional analysis" governs whether a payment is a tax).

It is settled that Congress may use this authority even for purposes beyond its powers under 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."); *Knowlton v. Moore*, 178 U.S. 41, 59-60 (1900)

(Congress may tax inheritances, even if it may not regulate them under the Commerce Clause); *Doremus*, 249 U.S. at 94. As long as a statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see also United States v. D.I. Operating Co.*, 362 F.2d 305, 308 (9th Cir. 1966).

The minimum coverage provision falls within Congress's comprehensive General Welfare Clause authority. The practical operation of the provision is as a tax, that is, as a "pecuniary burden laid upon individuals or property for the purpose of supporting the Government." *United States v. New York*, 315 U.S. 510, 515-16 (1942) (internal quotation omitted). Revenues from the provision go to the general Treasury. Congress placed the provision in the Internal Revenue Code. The ACA requires "taxpayers" not otherwise exempt to obtain "minimum essential coverage" or pay a penalty. 26 U.S.C. § 5000A(a), (b)(1). "Taxpayers" who are not required to file income tax returns for a given year are not subject to this provision. 26 U.S.C. § 5000A(e)(2)). If the penalty applies, the taxpayer must report it on his income tax return for the taxable year, as an addition to his income tax liability. 26 U.S.C. § 5000A(b)(2). The resulting penalty is the greater of a percentage of the taxpayer's household income or a fixed amount, subject to a cap of the national average premium for the lowest-tier plans offered in the new Exchanges for the taxpayer's family size. 26 U.S.C. § 5000A(c)(1), (2). The taxpayer's responsibility for his family members turns on their status as dependents under the Internal Revenue Code. 26 U.S.C. § 5000A(a), (b)(3). The Secretary of the Treasury is empowered to

enforce the provision, and he collects the penalty in the same manner as other assessable penalties under the Internal Revenue Code.[8] 26 U.S.C. § 5000A(g). In all, the word "tax" or a derivative of it appears some 48 times in the minimum coverage provision.

There is no dispute that the minimum coverage provision will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. CBO estimated that, by 2019, $4 billion in revenues will be derived each year from the provision. CBO Letter to Speaker Pelosi, at 2 tbl. 4. More recent CBO projections indicate that the provision will yield $5 billion annually by 2021. Letter from Douglas W. Elmendorf, Director, CBO, to John Boehner, Speaker, U.S. House of Representatives 9 table 3, (Feb. 18, 2011). By adding a liability that is reported in the taxpayer's annual return and is added to the taxpayer's annual tax payment, and by granting enforcement authority to the Secretary of the Treasury, the provision operates as a tax. *See In re Chateaugay Corp.*, 53 F.3d 478, 498 (2d Cir. 1995) ("Coal Act was at least partially an exercise of the taxing power," given placement in Internal Revenue Code and grant of enforcement authority to Treasury); *In re Sunnyside Coal Co.*, 146 F.3d 1273, 1276 (10th Cir. 1998) (adopting Second Circuit's reasoning).

Despite the practical operation of the minimum coverage provision as a tax, and despite the fact that the provision will produce revenue for the general Treasury, some courts have reasoned that the provision could not be justified under the taxing power because, in their view, Congress did not state its intent to exercise that power. *See, e.g.*, *Florida v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120. But "[t]he

[8] The Secretary of the Treasury may not collect the penalty through notice of federal tax liens or levies, and may not bring a criminal prosecution for a failure to pay it. 26 U.S.C. § 5000A(g)(2)).

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); *see also Clark v. California*, 123 F.3d 1267, 1271 (9th Cir. 1997). Congress may proceed under more than one grant of authority,[9] and the inclusion of findings relevant to one of those grants does not mean that a provision cannot be valid for additional reasons.

In any event, the premise of the courts that have rejected this argument—that Congress did not state its intent to exercise the taxing power—is simply false. The taxing power was expressly invoked in the Senate to defeat constitutional points of order against the provision. 155 Cong. Rec. S13,830, S13,832 (Dec. 23, 2009). The House, which previously had passed a bill in which the (otherwise materially identical) minimum coverage provision was labeled as a "tax" acceded to the bill that passed the Senate, but in doing so issued a Committee report that again explicitly described the provision as a "tax." *See* H.R. REP. NO. 111-143, pt. I, at 265 (2010). And, during the floor debates, Congressional leaders explicitly defended the provision as an exercise of the taxing power.[10]

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[9] Congress, for example, made findings relevant to the Commerce Clause when it enacted the Railroad Revitalization and Regulatory Reform Act. But that statute is also a valid exercise of Congress's Fourteenth Amendment enforcement power, despite the lack of statutory findings to that effect. *See Clark*, 123 F.3d 1276; *see also In re Sunnyside Coal Co.*, 146 F.3d at 1276 (finding "premium" on coal operators to be exercise of taxing power despite Commerce Clause findings).

[10] *See, e.g.*, 156 Cong. Rec. H1882 (Mar. 21, 2010) (statement of Rep. Miller); 156 Cong. Rec. H1824, H1826 (Mar. 21, 2010) (statement of Rep. Slaughter); 155 Cong. Rec.

IV. THE MINIMUM COVERAGE PROVISION IS CONSISTENT WITH DUE PROCESS REQUIREMENTS

In Counts Four and Five, plaintiff Coons alleges that the minimum coverage provision violates the substantive due process protections of the Fifth Amendment "by forcing him to apply limited financial resources to obtaining a health care plan he does not desire or otherwise to save income to pay a penalty," Am. Compl. ¶ 82, and his right not to disclose private medical information to insurers, Am. Compl. ¶¶ 88-91. As noted above, plaintiff lacks standing to bring these unripe challenges to the minimum coverage provision. But, even if he had standing, his challenge would fail on the merits.

A. The minimum coverage provision does not violate a purported due process right to forgo insurance

Contrary to Coons' view, there is no fundamental right not to purchase health insurance. The Due Process Clause protects only those fundamental liberty interests that are "objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (citation and internal quotation omitted). These freedoms include the "rights to marry," "to have children," "to direct the education and upbringing of one's children," "to marital privacy," "to use contraception," "to bodily integrity," "to abortion," and possibly "to refuse unwanted lifesaving medical treatment." *Id.* at 720. The Supreme Court has

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S13,751, S13,753 (Dec. 22, 2009) (statement of Sen. Leahy); 155 Cong. Rec. S13,581-82 (Dec. 20, 2009) (statement of Sen. Baucus).

cautioned against recognizing new fundamental rights, "lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court." *Id.*; *see also Christy v. Hodel*, 857 F.2d 1324, 1330 (9th Cir. 1988).

There is no "right" to forgo health insurance and, as a result, to shift one's health care costs to third parties, much less a right "deeply rooted in this Nation's history and tradition." Avoiding insurance is not a prerequisite to liberty. *Glucksberg*, 521 U.S. at 720. Indeed, plaintiff's purported interest in forgoing insurance coverage is purely economic.[11] Because any liberty or property interests the ACA may affect are not "fundamental," plaintiff's due process claim is subject to rational basis review. It is well established that laws "adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976).

The ACA as a whole, and the minimum coverage provision in particular, easily meet the rational basis standard. Under this "highly deferential" standard of review, *Flores by Galvez-Maldaonado v. Meese*, 913 F.2d 1315, 1330 (9th Cir. 1990), the statute

[11] Coons' due process claim harks back to the Court's *Lochner*-era decisions that treated contract rights as absolute, *see Adair v. United States*, 208 U.S. 161 (1908), but the Court has long since repudiated those precedents, *see, e.g.*, *Lincoln Fed. Labor Union v. Nw. Iron & Metal Co.*, 335 U.S. 525, 536 (1949) ("This Court . . . has steadily rejected the due process philosophy enunciated in the *Adair-Coppage* line of cases."); *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379, 392 (1937) ("[F]reedom of contract is a qualified, and not an absolute, right . . . . Liberty implies the absence of arbitrary restraint, not immunity from reasonable regulations."). Accordingly, the Supreme Court has not invalidated any economic or social welfare legislation on substantive due process grounds since the 1930s. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW 625 (3d ed. 2006).

"need only rationally relate," *Kahawaiolaa v. Norton*, 386 F.3d 1271, 1279 (9th Cir. 2004), to "any *conceivable* legitimate governmental interest." *Hibbs v. Dep't of Human Res.*, 273 F.3d 844, 855 (9th Cir. 2001) (emphasis added). Congress passed the ACA to address the mounting costs imposed on the economy, the government, and the public as a result of the inability of millions of Americans to obtain affordable health insurance. It also sought to eliminate cost-shifting by those who can afford insurance but opt not to obtain it and rely instead on the backstop of "free" care. These are legitimate legislative aims. And, as noted, Congress sensibly 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," Pub. L. No. 111-148, §§ 1501(a)(2)(I), 10106(a), while also helping to reduce administrative costs and lower premiums, *id.* §§ 1501(a)(2)(I), (J), 10106(a). Because Congress's objectives were plainly legitimate and its chosen means were rational, *Turner Elkhorn*, 428 U.S. at 15, the Court's inquiry ends there.

B. The minimum coverage provision does not violate a due process right of nondisclosure of medical information

Plaintiff Coons fares no better by recasting his due process theory as one asserting a right not to disclose medical information to insurers. Am. Compl. ¶¶ 79-85. Nothing in the ACA requires Coons to disclose such information, or requires insurers to seek disclosure; the ACA in no way weakens the stringent laws protecting medical privacy. Coons thus does not challenge any governmental action whatsoever, but only the possibility that private insurers will in the future ask him for personal information. But

actions by private parties may be attributed to the government, and thereby become subject to a constitutional challenge, only in narrow circumstances. *See Morse v. N. Coast Opportunities, Inc.*, 118 F.3d 1338, 1340-43 (9th Cir. 1997) (describing "public function," "compulsion," and "symbiotic relationship" tests for state action). Any hypothetical insurer that asks for personal information from its enrollees would not exercise a public function traditionally reserved to the state. *See id.* at 1343. Nor would that future insurer act under any governmental compulsion requiring it to seek personal information. *See id.* at 1342. And there could be no claim of a "symbiotic relationship" in which that insurer is acting as the government's agent in order to gather personal medical information. *See id.* at 1343; *see also Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 57-58 (1999) (challenged decisions of insurers were not state action even though insurers are "extensively regulated"). Any link between the ACA and the possibility that insurers will seek medical information is thus far too attenuated for the insurers to be deemed state actors. *See Citizens for Health v. Leavitt*, 428 F.3d 167, 182 (3d Cir. 2005) (disclosures of medical information by private insurers not state action).

In any event, Coons can only speculate as to what information insurers might seek from him in the future. This speculation demonstrates that his informational privacy claim is, at a minimum, unripe. Notably, the nature of an insurer's need for medical information in the future is unclear, given that, when § 1201 of the ACA goes fully into effect, insurers will be prohibited from denying coverage or setting premiums based on pre-existing conditions, health status, or medical history. Thus, the practices of private

insurers under current law provide no basis to believe that they will require detailed medical information from enrollees in the future when guaranteed-issue and community-rating requirements apply.[12]

V. CONGRESS'S ENACTMENT OF THE IPAB IS CONSTITUTIONALLY SOUND

A. Plaintiffs' challenges to the ACA's fast-track provisions should be rejected

In Count VI, plaintiffs Flake and Franks renew their baseless claim that the ACA's fast track provision (which establishes expedited procedures whereby Congress may repeal the IPAB) unconstitutionally "entrenches" the IPAB against repeal by a future Congress. Am. Compl. ¶¶ 104-13. As defendants have shown, the fast track provision does nothing of the sort. *See* Defs' Mem. Opp'n Mot. Prelim. Inj. 13-16. Rather, the provision establishes *one* way for Congress to repeal the Board *if* Congress wishes the repeal effort to qualify for the expedited procedures established by that provision.

[12] Further, the content of enrollment forms for plans in the Exchanges will be subject to HHS regulations. Pub. L. No. 111-148, § 1311(c)(1)(F). Neither those regulations nor those forms exists yet. There is no reason to assume that, come 2014, Coons will be unable to find an insurer that does not seek his medical information during the enrollment process. His claim thus rests upon "contingent future events that may not occur as anticipated, or indeed may not occur at all," and is not ripe. *Thomas*, 473 U.S. at 580-81; *see also Wilson v. Collins*, 517 F.3d 421, 430 (6th Cir. 2008) (rejecting due process claim where concerns about possible future disclosure of DNA sample "are purely speculative"). There also is no realistic threat of public disclosure of any information at all, because another federal statute, HIPAA, strictly limits the manner in which private insurers may use or disclose individuals' medical information. 42 U.S.C. §§ 1320d, *et seq.*; *see also* 45 C.F.R. § 164.502; *Nat'l Aeronautics & Space Admin. v. Nelson*, 131 S. Ct. 746, 763 (2011) (rejecting substantive due process challenge to agency's background check form because of, inter alia, "the protection provided by the Privacy Act's nondisclosure requirement").

Nothing prevents Congress from repealing the Board via ordinary legislation. Plaintiffs' unchallenged (albeit unsuccessful) January 19, 2011 votes to repeal the ACA in its entirety, which necessarily included a repeal of the IPAB, establish this point conclusively. *See* Defs.' Notice, ECF No. 29.

Plaintiffs' challenge to the fast-track procedures for congressional review of IPAB proposals is equally meritless. Am Compl. ¶ 103; *see generally* 42 U.S.C. § 1395kkk(d). These procedures generally require the Secretary to implement the Board's proposals unless Congress passes superseding legislation within a certain time. To allow Congress, if it wishes, to act quickly to supersede a Board proposal, the Act establishes parliamentary procedures that expedite congressional consideration of that overriding legislation. These procedures govern, among other things, when the Board proposal must be introduced, *id.* § 1395kkk(d)(1), committee consideration of the proposal, *id.* § 1395kkk(d)(2), limits on changes to the proposal, *id.* § 1395kkk(d)(3), and debate and amendment in the Senate and consideration by the other House, *id.* § 1395kkk(d)(4). The ACA expressly states that each House of Congress enacted these provisions "as an exercise of [its] rulemaking power" and "with full recognition of the constitutional right of either House to change the rules . . . at any time." *Id.* § 1395kkk(d)(5).

Despite Congress's recognition that these provisions may be repealed at any time, *see* § 1395kkk(d)(5), plaintiffs claim that these fast track provisions prevent such repeal. And, in an effort to circumvent clearly applicable restrictions on congressional standing, *see Raines*, 521 U.S. at 821, they claim that the fast-track review provisions violate the

First Amendment because they "burden and limit the ability of Representatives and Senators to review, debate, modify or reject the IPAB's proposals and recommendations before they automatically become law and must be implemented by the Secretary of Health and Human Services." Am. Compl. ¶ 102. This claim should be rejected.

Even if plaintiffs' institutional injuries were sufficient to confer standing to bring this claim, it would still be non-justiciable because the Board will not exist until 2012, *see* 42 U.S.C. 1395kkk(m)(1)(A), and will not issue any proposals until 2014 at the earliest, s*ee* 42 U.S.C. § 1395kkk(c); *see also McConnell*, 540 U.S. at 226 (Senator lacked standing based on claimed desire to air advertisements five years in the future). As for the merits, plaintiffs' claims fail for three reasons. First, as defendants have explained in earlier briefing, Article I, § 5 plainly commits the issue of internal parliamentary rules to each House of Congress, and plaintiffs' challenge therefore raises a non-justiciable political question. *See Consejo de Desarrollo Economico de Mexicali, A.C. v. United States*, 482 F.3d 1157, 1172 (9th Cir. 2007); Defs. Resp. Mot. Prelim. Inj. 12-13.

Second, parliamentary rules such as these are commonplace and may be repealed by either House---as the Act itself states.[13] It cannot be that the First Amendment is

[13] The Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, 88 Stat. 297, for example, establishes rules governing Congress's consideration of the budget. Those rules—like the ones governing congressional review of IPAB proposals—include, among other things, requirements relating to committee consideration and the germaneness of amendments. And the procedures themselves may be repealed by either House using the same procedures that would apply to any other rule of that House. The fast track provisions of the ACA are no different. Indeed, as discussed above, the ACA, like the Congressional Budget Act, expressly confirms that these parliamentary

offended each time a House of Congress adopts its own rules—which either House can change at will—that require anything other than a majority vote to pass a law. Such a result could not be reconciled with—indeed, it would swallow—Congress's constitutional authority to set and to alter its own rules. *See* U.S. Const. art. I, § 5.[14]

Third, these procedures are not the only way that Congress may enact legislation that would supersede a Board proposal; Congress may always override a Board proposal by repealing or suspending the rules that govern Senate or House changes to the IPAB recommendations, *see* 42 U.S.C. § 1395kkk(d)(3), and then voting on superseding legislation. As with any internal parliamentary rule, either House determines how its own rules will be repealed or suspended. This process raises no constitutional concerns. *See Skaggs v. Carle*, 110 F.3d 831, 835 (D.C. Cir. 1997) ("[I]f a simple majority can prevail in the House by voting first on a procedural and then on the substantive issue, then there has been no vote dilution even arguably offensive to the presentment clause.").

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procedures are enacted as "an exercise of the rulemaking power of the Senate and the House of Representatives, respectively," and "full[y] recogni[zes] . . . the constitutional right of either House to change the rules . . . at any time, in the same manner, and to the same extent as is the case of any other rule of that House." 42 U.S.C. § 1395kkk(d)(5).

[14] To be sure, 42 U.S.C. § 1395kkk(d)(3)(C) provides: "It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection." But, as discussed above, Congress expressly recognized in paragraph (d)(5) that, notwithstanding subparagraph (d)(3)(C), either House remains free to change the rule created by subparagraph (d)(3)(C) at any time. In addition, subparagraph (d)(3)(D) clarifies that all of paragraph (d)(3) "may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members," § 1395kkk(d)(3)(D), further confirming that the Senate may waive the rule at any time. This interpretation is consistent with the maxim that "Congress is presumed to act with knowledge of controlling constitutional limitations or proscriptions and with an intent and purpose to avoid their contravention." *Wells, by Gillig, v. Att'y Gen.*, 201 F.2d 556, 560 (10th Cir. 1953).

B. Plaintiffs' non-delegation doctrine claim is also baseless

Equally meritless is plaintiffs Flake and Franks' contention that, in delegating the power to issue recommendations about how to control the growth in Medicare spending to the IPAB, the ACA has delegated excessive legislative power in violation of the non-delegation doctrine. Am. Compl. ¶ 114-26.

Article I, Section 1 of the Constitution provides that "[a]ll legislative powers herein granted shall be vested in a Congress of the United States." U.S. Const. art. I, § 1. But it has long been recognized that, "in our increasingly complex society, replete with ever changing and more technical problems, Congress simply cannot do its job absent an ability to delegate power under broad general directives." *Mistretta v. United States*, 488 U.S. 361, 372 (1989). Accordingly, "[s]o long as Congress 'shall lay down by legislative act an intelligible principle to which the person or body authorized to [exercise the delegated authority] is directed to conform, such legislative action is not a forbidden delegation of legislative power.'" *Id.* (quoting *J.W. Hampton, Jr. & Co.*, 276 U.S. at 409. To provide a constitutionally sufficient "intelligible principle," Congress need only "clearly delineate[] the general policy, the public agency which is to apply it, and the boundaries of this delegated authority." *Mistretta*, 488 U.S. at 372-73 (quoting *American Power & Light Co. v. SEC*, 329 U.S. 90, 105 (1946).

This is not a difficult test to meet. In its history, the Supreme Court has held that only two statutes lacked the necessary "intelligible principle"—and that was 76 years ago. *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 474 (2001) (referring to *A.L.A.*

Schechter Poultry Corp. v. United States, 295 U.S. 495 (1935), and *Panama Ref. Co. v. Ryan*, 293 U.S. 388 (1935)). One of the statutes invalidated by the Court "provided literally no guidance for the exercise of discretion, and the other . . . conferred authority to regulate the entire economy on the basis of no more precise a standard than stimulating the economy by assuring 'fair competition.'" *Whitman*, 531 U.S. at 474.

On the other hand, the Court has repeatedly upheld broad delegations of discretionary authority to public agencies. The Court, for example, has "upheld the validity of § 11(b)(2) of the Public Utility Holding Company Act of 1935, 49 Stat. 821, which gave the Securities and Exchange Commission authority to modify the structure of holding company systems so as to ensure that they are not 'unduly or unnecessarily complicate[d]' and do not 'unfairly or inequitably distribute voting power among security holders.'" *Whitman*, 531 U.S. at 474 (referring to *American Power & Light Co. v. SEC*, 329 U.S. 90, 104 (1946)). The Court has approved the wartime delegation of authority to set prices at a level that "will be generally fair and equitable and will effectuate the purposes of th[e] Act." *Yakus v. United States*, 321 U.S. 414, 420, 423-426 (1944). And the Court has "found an 'intelligible principle" in various statutes authorizing regulation in the 'public interest.'" *Whitman*, 531 U.S. at 474 (referring to *Nat'l Broad. Co. v. United States*, 319 U.S. 190, 225-226 (1943) (Federal Communications Commission's power to regulate airwaves); *New York Cent. Sec. Corp. v. United States*, 287 U.S. 12, 24-25 (1932) (ICC's power to approve railroad consolidations)).[15]

[15] The Ninth Circuit, applying this well-established Supreme Court precedent, has been similarly permissive. *See, e.g.*, *Freedom to Travel Campaign v. Newcomb*, 82 F.3d 1431,

Measured by these accommodating standards, the ACA's delegation of policymaking authority to the IPAB easily passes constitutional muster. In contrast to many of the statutes the courts have upheld against improper delegation challenges, the section of the ACA that establishes the Board contains pages of detailed instructions that limit the Board's discretion. *See generally* 42 U.S.C. § 1395kkk. There is a general statement of purpose. *See id.* § 1395kkk(b). There is a list of "considerations" that the Board "shall, to the extent feasible," take into account, *id.* § 1395kkk(c)(2)(B), including "giv[ing] priority to recommendations that extend Medicare solvency," *id.* § 1395kkk(c)(2)(B)(i), and issuing proposals that "improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement." *Id.* § 1395kkk(c)(2)(B)(ii)(I).[16] The ACA also places specific restraints on the Board's ability to propose recommendations including, among other prohibitions,[17] any proposal not

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1436-38 (9th Cir. 1996) (approving the delegation of authority to Treasury's Office of Foreign Assets Control to promulgate regulations "in the national interest").

[16] The Board must also include recommendations that, to the extent feasible, "protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas," 42 U.S.C. § 1395kkk(c)(2)(B)(ii)(II), and "target reductions in Medicare program spending to sources of excess cost growth." *Id.* § 1395kkk(c)(2)(B)(iii). And the Board must, to the extent feasible, "consider the effects on Medicare beneficiaries of changes in payments to providers of services," "consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates," "consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program," and "develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries." *Id.* § 1395kkk(c)(2)(B)(iv)-(vii); *see also id.* § 1395kkk(c)(2)(A)(i); § 1395kkk(c)(2)(A)(v).

[17] The ACA also prohibits the Board, prior to December 21, 2018, from proposing "any recommendation that would reduce payment rates for items and services furnished . . . by

related to the Medicare program, *see id.* § 1395kkk(c)(2)(A)(vi), and any proposal to "ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing . . . or otherwise restrict benefits or modify eligibility criteria," *id.* § 1395kkk(c)(2)(A)(ii). Moreover, the ACA allows Congress to pass specific legislation to supersede Board proposals. *See* 42 U.S.C. § 1395kkk(e)(3)(A). These provisions supply far more than the required "intelligible principle."

Despite this detailed guidance, plaintiffs suggest that the intelligible principle test should include an additional element; they contend that Congress cannot confer decision-making authority on an agency unless it provides both an intelligible principle *and* judicial review of the agency's compliance with the statutory standard. Am. Compl. ¶¶ 116, 122-26. As plaintiffs point out, the ACA restricts judicial review of the Secretary's implementation of a Board proposal. 42 U.S.C. § 1395kkk(e)(5). But the Ninth Circuit has already held---squarely---that a "delegation of legislative power to the executive that is statutorily exempt from judicial review" does not violate the non-delegation doctrine. *United States v. Bozarov*, 974 F.2d 1037, 1041-45 (9th Cir. 1992). The ACA's preclusion of judicial review, moreover, applies only to "the implementation by the Secretary under this subsection of the recommendations contained in a proposal." 42 U.S.C. § 1395kkk(e)(5). Like the statute in *Bozarov*, this provision does not bar

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providers of services . . . and suppliers" already scheduled to receive a rate reduction in certain situations. *Id.* § 1395kkk(c)(2)(A)(iii). In addition, the Board must design its proposals so that implementation of the recommendations is not expected to result, over a ten-year period, "in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare spending that would have occurred absent such implementation." *Id.* § 1395kkk(c)(2)(C).

constitutional challenges (like this one) to the ACA's creation of the IPAB in the first place. *See Bozarov*, 974 F.2d at 1044. The availability of "certain limited types of judicial review" further supports the conclusion that the ACA does not unconstitutionally delegate legislative power. *Id.*

VI. PLAINTIFFS' "ALTERNATIVE" NON-PREEMPTION CLAIM IS MERITLESS

Plaintiff's claim that the ACA should not be construed to preempt the Arizona Health Care Freedom Act and the Arizona Health Care Public Policy, Am. Compl. ¶ 127-34, is also meritless.[18]

The Arizona Health Care Freedom Act, passed in November 2010, purports to "preserve the freedom of Arizonans to provide for their health care." Ariz. Const. art. XXVII, § 2. The Arizona Health Care Public Policy declares that "[t]he power to require or regulate a person's choice in the mode of securing lawful health care services, or to impose a penalty related to that choice, is . . . a power reserved to the people in the Tenth Amendment." Am. Compl. ¶ 16. To the extent these laws purport to guarantee Arizonans the right not to purchase health insurance even against a federal law to the contrary, the ACA would be entitled to preemptive force.

To be sure, this Court must "start with the assumption" that the ACA does not preempt state law "unless that was the clear and manifest purpose of Congress." *Wyeth v.*

[18] Plaintiffs' citation to Section 1555 of the ACA is misplaced. *See* Am. Compl. ¶ 129. By its terms, Section 1555 provides only that "[n]o individual, company, business, nonprofit entity, or health insurance issuer … shall be required to participate in any Federal health insurance program created under this Act …." It has nothing to do with whether the ACA preempts state laws that conflict with its provisions.

Levine, 129 S. Ct. 1187, 1194-95 (2009) (internal citations and quotation marks omitted). But it is equally true that this Court is "not free to rewrite the statute that Congress has enacted." *Dodd v. United States*, 545 U.S. 353, 359 (2005). "[W]hen the statute's language is plain, the sole function of the courts . . . is to enforce it according to its terms." *Hartford Underwriters Ins. Co. v. Union Planters Bank, N. A.*, 530 U.S. 1, 6 (2000) (internal quotation marks omitted).

Here, there is nothing ambiguous about the minimum coverage provision. The plain terms of the provision require all Americans, with certain exemptions, to purchase health insurance or to pay a penalty. *See* Pub. L. No., § 1501(b). And, as defendants have explained, the provision is essential to ensuring the viability of the ACA's guaranteed-issue and community-rating reforms. For that reason, if it were construed not to preempt state laws that purport to protect an individual's right not to purchase health insurance, the ACA's ban on denying coverage or charging more based on preexisting conditions would be undermined, thus defeating Congress's purpose to make affordable health insurance widely available. This Court should not interpret the ACA to produce a result that is flatly contrary to congressional intent.

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CONCLUSION

The motion to dismiss should be granted.

Dated: May 31, 2011

Respectfully submitted,

TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney General

DENNIS K. BURKE
United States Attorney, District of Arizona

JENNIFER RICKETTS
Director

SHEILA LIEBER
Deputy Director

/s/ *Tamra T. Moore*
TAMRA T. MOORE (D.C. Bar #488392)
ETHAN P. DAVIS (N.Y. Bar)
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Ave. NW
Washington, D.C. 20001
Phone: (202) 514-8095
E-mail: Tamra.Moore@usdoj.gov

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on May 31, 2011, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF system for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

Clint D. Bolick, Goldwater Institute, cbolick@goldwaterinstitute.org

Diane S. Cohen, Goldwater Institute, dcohen@goldwaterinstitute.org

Nicholas C. Dranias, Goldwater Institute, ndranias@goldwaterinstitute.org

s/ Tamra T. Moore
TAMRA T. MOORE