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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

NICK COONS, et al.,	
Plaintiffs,	**No. 2:10-cv-1714-GMS**
v.	**Plaintiffs' L.R. 7.2(m)(2) Objections and Motion to Strike and L.R. 56(b) Controverting Statement of Facts**
TIMOTHY GEITHNER, et al.,	
Defendants.	

Plaintiffs, pursuant to Local Rules 56.1(b) and 7.2(m)(2) of the District of Arizona, move to strike Defendants' L.R. 56.1(a) Statement and present their 56.1(b) Controverting Statement of Facts, as follows:

I. PLAINTIFFS' RULE 7.2(m)(2) MOTION TO STRIKE

Despite Defendants' recognition that "[t]his case presents pure questions of law – primarily, whether Congress acted within its Article I powers" when it enacted the Individual Mandate (Defs.' Mem. Summ. J., 6-7) (Defs." Mem."), Defendants inundated the record with a L.R. 56.1(a) Statement of Facts, with 50 purported statements of fact, referencing 54 exhibits

consisting of more than 830 pages. Further, despite acknowledging that the constitutionality of the Individual Mandate is a matter of law and not fact (*id.*), Defendants claim that paragraphs 1-43[1] of their Statement "are facts that Congress considered or could have considered in determining that it had authority under Article I of the Constitution to enact [PPACA], and in particular the [Individual Mandate]." (Defs.' SOF 1.) However, whether it is true or not that Congress considered or could have considered these "facts" is of no consequence because by Defendants' own admission, they are not facts the Court needs in order to decide Defendants' Motion. *See* L.R. 56.1(a). Accordingly, they are immaterial and should be stricken.

1. Defendants Facts are Immaterial and Should be Stricken

The "materiality" of a fact is determined by the substantive law governing the claim or defense. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Harkins Amusement Enterprises, Inc. v. General Cinema Corp.*, 850 F.2d 477, 482 (9th Cir. 1988). "A material fact is one which might affect the outcome of the case under governing law." *Anderson*, 477 U.S. at 248.

Paragraphs 1-44 are immaterial because whether Congress can force individuals to purchase health insurance pursuant to its commerce authority is a legal (as Defendants recognize), not factual question, which goes directly to Congress's Article I authority to enact the Mandate. Congress cannot "find" its way into Article I authority, or evade judicial review, by dressing its legal conclusions in the garb of legislative "facts." *See e.g.*, the Patient

[1]It is unclear why Defendants did not include paragraph 44 in this list; nonetheless, Plaintiffs contend all Defendants' "facts" are immaterial.

Protection and Affordable Care Act, (PPACA or the Act), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (HCERA)[2], §1501(a)(2)(A) (finding that the Individual Mandate regulates "activity that is commercial and economic in nature: economic and financial decisions about . . . health insurance."). Indeed, the limits of Congress's authority under the Constitution are, as Defendants themselves recognize, questions of law upon which the judiciary, not Congress, must have the last word. *See generally Cooper v. Aaron*, 358 U.S. 1, 18 (1958) (noting the "permanent and indispensable feature of our constitutional system" that "the federal judiciary is supreme in the exposition of the Constitution"). *See also Lamprecht v. FCC*, 958 F.2d 382, 392 n. 2 (D.C. Cir. 1992) ("If a legislature could make a statute constitutional simply by 'finding' that black is white or freedom, slavery, judicial review would be an elaborate farce").

Perhaps by submitting paragraphs 1-43, and presumably 44, Defendants are conflating the type of deference courts afford Congress in determining whether in the aggregate an activity has a substantial effect on interstate commerce, with the question of whether an activity can be regulated as essential to a broader regulatory scheme. If that is the case, it still remains that Congress cannot expand its Commerce Clause powers by making factual findings – even extensive ones – about the ultimate economic consequences of the behavior (or absence of behavior) it seeks to control. *See United States v. Morrison*, 529 U.S. 598, 614 (2000) ("[T]he

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[2]All citations herein to PPACA are to PPACA, as amended by HCERA.

existence of congressional findings is not sufficient, by itself, to sustain the constitutionality of Commerce Clause legislation.").

Because the unconstitutionality of the Mandate rests squarely on whether Congress exceeded its Article I powers, Defendants' L.R. 56.1(a) "facts" regarding any "detailed findings" Congress made that "establish the foundation for the exercise of its commerce power," and that the Mandate "regulates activity that is commercial and economic in nature" (Defs.' Mem. 5), are irrelevant and immaterial for summary judgment purposes and should be stricken.

2. Paragraph 45 Is By Defendants' Own Concession Immaterial

In Paragraph 45, Defendants state "Plaintiff Coons does not assert that the minimum coverage provision is *currently* forcing him to rearrange his financial affairs or that the provision is currently causing him to change his behavior. . . . Specifically, unlike the plaintiffs in several other cases challenging the constitutionality of the ACA, Coons does not identify any steps he has taken in the present to enable him to comply with the minimum coverage provision when it takes effect in 2014." Inexplicably, Defendants persist in pursuing this argument despite the fact that they have "concede[d] that an injury does not have to occur immediately to qualify as an injury-in-fact." *Florida Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1145 (N.D. Fla. 2010). Accordingly, paragraph 45 is undisputedly immaterial and should be stricken.

3. Paragraphs 46-48 Are Not Facts, but Are Instead Statutory Excerpts or Paraphrases Thereof, which Are Not Proper L.R. 56.1(a) Facts and, thus, Should Be Stricken

Paragraphs 46 through 48 solely rely on and cite in part to PPACA statutory provisions. As such, these paragraphs amount to legal argument that is improper for a Rule 56.1(a) Statement. Accordingly, these paragraphs should be stricken for failing to conform to Rule 56.1(a).

4. Defendants' Rule 56.1(a) Statement Does Not Conform to Rule 56.1(a)

In addition to being immaterial, Defendants' L.R. 56.1(a) statement should be stricken in its entirety for failure to conform to L.R. 56.1(a). For the most part, each paragraph in Defendants' Rule 56.1(a) Statement does not consist of "facts," but multiple statements and argument. Defendants' Statement in fact reads more like a legal memorandum, broken into numbered paragraph containing multiple proposed facts, citing to multiple exhibits. *See e.g*, ¶ 5 consisting of six sentences and referencing four exhibits; ¶ 14 consisting of eight sentences and referencing four case opinions and an exhibit; ¶ 16 consisting of five sentences and referencing three exhibits and a statute; and ¶ 28 consisting of seven sentences and referencing and four exhibits.

Additionally, paragraphs 49 and 50 are speculative, conclusory and rely on inadmissible hearsay documents pursuant to Rule 26(2) of the Fed. R. Civ. P and Rules 701, 702, 703 and 801 of the Federal Rules of Evidence. Further, Defendants' statement contains legal argument throughout (*see e.g.*, ¶¶ 3, 14, 45-48-50), which is improper pursuant to Rule 56.1(a). *See also Kilroy v. Ruckelshaus*, 738 F.2d 1448, 1452 (9th Cir. 1984) ("Our reading of [plaintiff's]

proposed findings of fact reveals that they are actually legal conclusions … disputed by [the defendant] in its memoranda. The district court was not obligated to accept [plaintiff's] legal conclusions as true simply because he characterized them as statements of fact."). These legal arguments amount to a self-granted extension of briefing page limits, made all the more unnecessary by Defendants' already extensive and redundant briefing.

II. PLAINTIFFS' RESPONSE TO DEFENDANTS' RULE 56.1(a) STATEMENT

1. The interstate market for health care services is one of the largest and most important sectors of the United States economy. In 2009, the United States spent more than 17% of its gross domestic product – a total of $2.5 trillion – on health care. 42 U.S.C. § 18091(a)(2)(B). This amount translates to $8,086 per person. Ctrs. for Medicare & Medicaid Services ("CMS"), Nat'l Health Expenditures 2009 Highlights 1 (2011) (Ex. 1).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 1 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Plaintiffs further object to and move to strike the first statement of this paragraph, which states in part: the "interstate market for health care services is one of the largest and most important sectors . . . ," because it is self-serving argument and unsupported by the cited document.

Plaintiffs admit that 42 U.S.C. § 18091(a)(2)(B) speaks for itself but Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" the remainder of paragraph 1 in "determining" its Article I authority.

2. Before enacting the Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("Act" or "ACA"), Congress gave detailed consideration to the reforms that would be needed to fix the health care market's interrelated structural and economic problems. Congress conducted more than 50 hearings on the subject in the 110th and 111th Congresses alone. *See* H.R. Rep. No. 111-443, pt. II, at 954-68 (2010) (Ex. 2), and it marshaled the evidence it

gathered into detailed findings on the need for and operation of the regulatory measures that it adopted. These facts, and others established in the legislative record and elsewhere, provide far more than a rational basis for Congress to conclude that it had authority under Article I of the Constitution to enact the ACA, and in particular, the minimum coverage provision.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 2 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of unsupported argument (*see*, specifically, "and it marshaled the evidence it gathered into detailed findings on the need for and operation of the regulatory measures that it adopted. These facts, and others established in the legislative record and elsewhere, provide far more than a rational basis for Congress to conclude that it had authority under Article I of the Constitution to enact the ACA, and in particular, the minimum coverage provision").

Plaintiffs admit that the Congressional Record speaks for itself and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 2 in "determining" its Article I authority.

3. The interstate market for health care services is unique in several respects. First, participation in this market is nearly universal. More than 80% of adults nationwide visited a doctor or other health care professional during 2009 alone. Ctrs. for Disease Control & Prevention ("CDC"), Nat'l Ctr for Health Statistics, Summary Health Statistics for U.S. Adults: Nat'l Health Interview Survey, 2009 tbl. 35 (2010) (Ex. 3). In 2007, about one in five Americans visited the emergency room at least once. CDC, Nat'l Ctr for Health Statistics, Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? 2 (2010) (Ex. 4).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 3 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument (*see*, specifically, the first sentence of the paragraph where Defendants argue that the "interstate market for health care services is unique in several respects"). This statement is immaterial to the question of the scope of Congress's Article I authority because "uniqueness" is "not a limiting principle rooted in any constitutional understanding of the commerce power. Rather, it is an *ad hoc* factor that happens to apply to the health insurance and health care industries. Uniqueness is not a limiting principle[], but limiting [a] circumstance[]." *Florida v. United States Dep't Health and Human Servs.*, __ F.3d __, 2011 WL 3519178 *83 (11th Cir. Aug. 12, 2011).

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 3 in "determining" its Article I authority.

4. Second, although, over time, virtually everyone participates in the health care market, the extent of any given individual's participation in any given year is unpredictable. "Most medical expenses for people under 65" result "from the 'bolt-from-the-blue' event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." *Expanding Consumer Choice & Addressing "Adverse Selection" Concerns in Health Insurance*: Hearing Before the Joint Economic Comm., 108th Cong. 32 (2004) (statement of Professor Mark V. Pauly) (Ex. 5). "[E]ven the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur; the vast bulk of spending needs cannot be forecast in advance." Amicus Br. of Economic Scholars, at 8, *Commonwealth of Virginia ex rel. Cuccinelli v. Sebelius*, Nos. 11-11057 & 11-11058 (4th Cir. filed Mar. 7, 2011) ("Economic Scholars Br.") (Ex. 6) (citing Ross Winkelman & Syed Mehmud, A Comparative Analysis Of Claims-Based Tools For Health Risk Assessment, Society Of Actuaries (2007)).

What actually will happen to any given individual in a particular time period — the "frequency, timing, and magnitude" of an individual's demand for health care services — is largely unknowable. J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007) (Ex. 7).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 4 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument regarding so-called market "uniqueness." This is statement is immaterial to the question of the scope of Congress's Article I authority because "uniqueness" is "not a limiting principle rooted in any constitutional understanding of the commerce power. Rather, it is an *ad hoc* factor that happens to apply to the health insurance and health care industries. Uniqueness is not a limiting principle[], but limiting [a] circumstance[]." *Florida*, 2011 WL 3519178 *83.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 4 in "determining" its Article I authority.

5. Third, costs mount rapidly for even the most common medical procedures. For example, one in three babies is born by Caesarean delivery, the cost of which averages more than $13,000. CDC, NAT'L CTR FOR HEALTH STATISTICS, Recent Trends in Caesarean Delivery in the United States (Mar. 2010) (Ex. 8); International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country ("IFHP Comparative Price Report"), at 12 (Ex. 9). The average bill for a single hospital stay for a person who is uninsured is $22,000. U.S. Dep't of Health & Human Servs. ("HHS"), ASPE Research Brief, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills ("ASPE Research Br."), at 8 (2011) (Ex. 10). That is about the same as the loss from an average house fire, but a person is ten times more likely to be hospitalized than to experience a house fire. *Id.* at 1. The average cost of an appendectomy is $13,000; bypass surgery is nearly $60,000; and an angioplasty, $29,000. IFHP Comparative Price Report, at 14,

16, 17. An MRI scan alone costs $1,000 on average. *Id.* at 8. Drug treatment for a common form of cancer costs more than $150,000 a year. Neal J. Meropol, et al., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007). (Ex. 11).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 5 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and hearsay materials and incorporates their response to paragraph 4 herein.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 5 in "determining" its Article I authority.

6. The potential for financially ruinous burdens is plain, and well documented. A recent report concludes that, on average, families without insurance can afford to pay in full for only 12% of the cost of any hospitalizations they might require, and even families with incomes above 400% of the federal poverty line can afford to pay in full for only 37% of their hospitalizations. HHS, ASPE Research Br., at 1. Consistent with such numbers, Congress found that 62% of all personal bankruptcies are caused in part by medical expenses. 42 U.S.C. § 18091(a)(2)(G).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 6 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it is not a statement of "fact," but instead consists of self-serving argument and citation to a statute, and relies on hearsay materials.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 6 in "determining" its Article I authority.

7. As a result of these market realities, everyone is faced, one way or another, with managing the financial risks associated with unpredictable future health care costs. Katherine Baicker & Amitabh Chandra, *Myths & Misconceptions About U.S. Health Insurance*, 27 Health Affairs w533, w534 (2008) (Ex. 12).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 7 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike paragraph 7 because it consists of self-serving argument relying on hearsay material. Plaintiffs further object to this paragraph because the statement in paragraph 7 is not contained in the cited document.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 7 in "determining" its Article I authority.

8. Health insurance is not a free-standing consumer product but is, instead, a means of financing health care services that people receive. Given the unique combination of universal need, unavoidable uncertainty, and high costs in the health care market, insurance, either private or governmental, is the customary means by which people pay for health care services in the United States. In 2009, payments by private health insurers constituted 32% of national health care spending. CMS, 2009 National Health Expenditure Data tbl. 3 (2011) (Ex. 13). Payments by government programs – including government insurance programs such as Medicare and Medicaid – comprised 43% of health care spending that year. *Id.* tbls. 5 & 11. Consumers' out-of-pocket expenses — including deductibles, copayments, and payments for uncovered services — accounted for only 12% of national health care spending in 2009. *Id.* tbl. 3.\

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 8 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of unsupported, self-serving argument (*see*, specifically, "[h]ealth insurance is not a free-standing consumer product but is, instead, a means of financing health care services that people receive. Given the unique combination of universal need, unavoidable uncertainty, and high costs in the health care market, insurance, either private or governmental, is the customary means by which people pay for health care services in the United States").

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 8 in "determining" its Article I authority.

9. While some of the government program expenditures are made by state and local governments, the federal government's involvement in health care financing is pervasive. Virtually all Americans aged 65 or older are insured through the federal Medicare program. Kaiser Family Found., The Uninsured: A Primer 1 (Dec. 2010) (Ex. 14). Under current law, the Medicaid program and the Children's Health Insurance Program cover about 20% of the non-elderly population by covering four principal categories of low-income individuals – children, their parents, pregnant women, and individuals with disabilities. *Id.* at 3. In 2010, federal spending on Medicare and Medicaid was more than $790 billion, with billions more federal funds spent on other health care programs. Congressional Budget Office ("CBO"), The Long-Term Budget Outlook, at 37-39 (2011) (Ex. 15). These figures do not include the federal government's longstanding use of tax incentives to finance health care costs. CBO, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 30 (2008) ("KEY ISSUES") (Ex. 16).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 9 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it not a statement of "fact," but instead consists of self-serving argument and relies on hearsay materials.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 9 in "determining" its Article I authority.

10. Despite the fact that health insurance is the customary means of financing the consumption of health care services, there remains a notion under the current regime that individuals have the option to pay for health care out of pocket, even though as a practical matter, that notion is illusory, given the potential magnitude of health care expenses. Thus, despite the fact that an individual's risk assessment is necessarily imperfect, most people's decisions to pay for their anticipated health care needs through insurance, or to attempt (often unsuccessfully) to pay out of pocket, involve an economic calculation, assessing the relative costs, or potential costs, of each option. *See* Mark V. Pauly, *Risks and Benefits in Health Care: The View from Economics*, 26 Health Affairs 653, 657-58 (2007) (Ex. 17). Indeed, individuals regularly revisit these economic decisions. 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) (Ex. 18); *see also* CBO, Key Issues, at 11.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 10 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it not a statement of "fact," but instead consists of self-serving argument and relies on hearsay materials.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 10 in "determining" its Article I authority.

11. While such economic assessments are often a feature of a healthy market, that is not the case here. Prior to Congress's enactment of the Affordable Care Act, economists had concluded that "[t]he market for health insurance . . . is not a well-functioning market." COUNCIL OF ECONOMIC ADVISERS ("CEA"), THE ECONOMIC CASE FOR HEALTH CARE REFORM (2009) (" The Economic Case"), at 16 (submitted into the record for *The Economic Case for Health Reform: Hearing Before the H. Comm. on the Budget*, 111th Cong. 5 (2009)) (Ex. 19). In 2009, the percentage of the non-elderly with private health insurance coverage (64.2%) was significantly lower than that in 2000 (73.4%), meaning that millions more lacked insurance. John Holahan, *The 2007-09 Recession And Health Insurance Coverage, 30 Health Affairs* 145, 148 (2011) (Ex. 20). The percentage covered by employment-based plans dropped from 68.3% in 2000 to 59% in 2009. *Id.* All told, an estimated 50 million people (18.8% of the non-elderly population) had no health insurance in 2009. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2009, at 23, tbl. 8 (2010) (Ex. 21).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 11 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 11 in "determining" its Article I authority.

12. Declining insurance enrollments are both a symptom and a cause of the unique challenges associated with the health care market. As discussed above, people who have no insurance still actively participate in the interstate health care market, consuming more than $100 billion of health care services annually. Families USA Found., Hidden Health Tax: Americans Pay a Premium 2 (2009) ("Families USA, Hidden Health Tax") ($116 billion in 2008) (Ex. 22). And, on average, they cannot afford to pay for the health care they consume. HHS, ASPE Research Br., at 1.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 12 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 12 in "determining" its Article I authority.

13. One reason that this situation has persisted is that, unlike in other markets, the underlying good – medical care – is viewed by many to be a matter of right. To some extent, this view has been incorporated in the existing legal framework, and people receive expensive health care services in times of need without regard to their ability to pay, and regardless of insurance status. Under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, for example, hospitals that participate in Medicare and offer emergency services are required to stabilize any individual who arrives at the emergency department with an emergency condition, even an individual who has no insurance or other means of paying for that care. CBO, Key Issues, at 13.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 13 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 13 in "determining" its Article I authority.

14. This principle is also recognized in state law, including Arizona law. *See St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cnty.*, 688 P.2d 986, 990 (Ariz. 1984) ("[T]he private hospital may not simply release a seriously ill, indigent patient to perish on the streets."). Indeed, even before the enactment of EMTALA, many state legislatures and courts had recognized that hospitals cannot properly turn away people in need of emergency treatment. *See, e.g.*, *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961); *see also Mercy Med. Ctr. of Oshkosh v. Winnebago Cnty.*, 206 N.W.2d 198, 201 (Wis. 1973) ("It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the service."). As one of the first proponents of a national requirement to obtain health insurance put the issue:

> [The Heritage Foundation plan] assumes that there is an implicit contract between households and society, based on the notion that health insurance is not like other forms of insurance protection. If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car. But health care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. If we find that he has spent money on other things rather than insurance, we may be angry but we will not deny him services – even if that means more prudent citizens end up paying the tab.

Stuart Butler, The Heritage Lectures 218: Assuring Affordable Health Care for All Americans, at 6 (Heritage Foundation 1989) (Ex. 23).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 14 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exh. 23.) As Defendants know, or certainly should know, the Heritage Foundation filed an amicus brief in support of the plaintiffs' complaint in *Florida v. Sebelius*. In that brief, the Heritage Foundation made clear that this excerpt from a 1989 document does not reflect the policy of the Heritage Foundation or even the current beliefs of the speaker. The dissenting opinion in the *Florida* case in fact recognized:

> The Heritage Foundation has filed an amicus brief in support of the plaintiffs making clear that this excerpt does not reflect the policy of the Heritage Foundation or even the current beliefs of the speaker; both strongly dispute the efficacy and the constitutionality of the individual mandate. Brief for Heritage Found. as Amicus Curiae Supporting the Plaintiffs at 5-6. I do not doubt the sincerity of this position, and use this statement not to imply that the Heritage Foundation has blessed the individual mandate but rather only for the statement's own value as a persuasively articulated description of an important distinction between health insurance, health care, and other markets.

Florida, 2011 WL 3519178 *277 n.19.

Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 14 in "determining" its Article I authority.

15. Because of the availability of this backstop of free emergency care, many people have an incentive not to obtain insurance, knowing that they will not bear the full cost of their decision to attempt to pay for their health care needs out of pocket. CEA, The Economic Case at 17; *see also* Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 226 (2005) (Ex. 24). Yet, reliance on EMTALA and similar laws has its own risks. As noted above, while the uninsured who end up needing expensive emergency care will receive it, those individuals who cannot afford to pay after receiving care face the prospect of significant debt and possible bankruptcy. *See* 42 U.S.C. § 18091(a)(2)(G).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 15 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that 42 U.S.C. § 18091(a)(2)(G) speaks for itself and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 15 in "determining" its Article I authority.

16. The unique structural characteristics of these individual risk assessments are not the only problem of the pre-ACA regime. Another factor contributing to the broken market is that, even when people make the economic decision to obtain health insurance, the national health insurance market, and in particular the markets for individual and small-group health insurance, impose numerous barriers to the availability of coverage. CEA, The Economic Case at 16. Because of the high cost of medical procedures, insurers in the individual and small-group markets, absent regulation, have a strong market incentive to exclude those they deem most likely to incur expenses. *47 Million and Counting: Why the Health Care Marketplace Is Broken*: Hearing Before the S. Comm. on Finance, 110th Cong. 51-52 (2008) (statement of Mark Hall, Professor of Law and Public Health, Wake Forest University) (Ex. 25). Insurers have thus adopted measures designed – albeit imperfectly – to "cherry-pick healthy people and

to weed out those who are not as healthy," H.R. Rep. No. 111-443, pt. II, at 990 (internal quotation omitted), in an individualized review of insurance applicants' health status, a process known as "medical underwriting." This practice is costly, resulting in administrative fees that are responsible for 26% to 30% of the total amount charged for premiums in the individual and small group markets. 42 U.S.C. § 18091(a)(2)(J).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 16 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that the Congressional Record and 42 U.S.C. § 18091(a)(2)(J) speak for themselves and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 16 in "determining" its Article I authority.

17. The exclusionary practices of insurers also include denial of coverage because of pre-existing conditions, even minor ones; exclusion of pre-existing conditions from coverage; and higher, and often unaffordable, premiums based on the insured's medical history. H.R. Rep. No. 111-443, pt. II, at 990. These practices are often harsh and unfair for consumers, in that "many who need coverage cannot obtain it, and many more who have some type of insurance may not have adequate coverage to meet their health care needs." *Health Reform in the 21st Century: Insurance Market Reforms*: Hearing Before the H. Comm. on Ways and Means ("Health Reform in the 21st Century"), 111th Cong. 53 (2009) (Statement of Linda Blumberg, Senior Fellow, Urban Institute) (Ex. 26). Insurers often revoke coverage even for relatively minor pre-existing conditions. *Consumer Choices & Transparency in the Health Insurance Industry*: Hearing Before the S. Comm. on Commerce, Science & Transp., 111th Cong. 29-30 (2009) (Statement of Karen Pollitz, Research Professor, Georgetown University Health Policy Institute) (Ex. 27). "In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage." 47 Million and Counting, 110th Cong. 52 (statement of Prof. Hall).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 17 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that the Congressional Record speaks for itself and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 17 in "determining" its Article I authority.

18. Depending on the definition used, between 50 and 129 million non-elderly Americans (19 to 50% of the non-elderly population) have at least one pre-existing condition, and thus, absent reform, risk denial of insurance coverage or higher premiums based on a pre-existing condition. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011) (Ex. 28); Chairman Henry A. Waxman & Rep. Bart Stupak, *Memorandum on Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market* to H. Comm. on Energy & Commerce, at 1 (Oct. 12, 2010) (Ex. 29) (observing that the four largest for-profit insurers excluded more than 600,000 individuals from coverage because of such conditions in the three years before the Affordable Care Act). A recent national survey estimated that 9 million non-elderly adults – 35% of those who tried to purchase health insurance directly from an insurance company in the individual market in the previous three years – were denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition in the previous three years. Help on the Horizon: Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010, at xi (2011) (Ex. 30). These obstacles contribute to the fact that only 20% of Americans who lack employer-provided insurance, insurance through government programs, or other coverage options purchase a policy in the individual market; the remaining 80% are uninsured. CBO, Key Issues, at 9.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 18 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that the Congressional Record speaks for itself and Plaintiffs lack knowledge or

information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 18 in "determining" its Article I authority.

19. Whether uninsured individuals have chosen to forego insurance or have been denied coverage by insurance companies, they continue to participate in the interstate health care market. Empirical studies document the universal need for, and use of, health care services. Far from being inactive bystanders, most people without insurance – just like those who do have insurance – participate in the health care market by obtaining medical services. Nationwide, the uninsured consume over $100 billion of health care services annually. Families USA, Hidden Health Tax, at 2, 26 ($116 billion in 2008). In 2008, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. HHS, ASPE Research Br. at 5; *see also* CDC, Nat'l Ctr. for Health Statistics, Health, United States, 2010, at 283 tbl. 79 (2011) (Ex. 31) (80% of those under age 65 who were uninsured for any period up to 12 months had at least one visit to a doctor or emergency room in 2009); CDC, Nat'l Ctr. for Health Statistics, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2010, tbl. 16 (2011) (Ex. 32) (nearly 20% of uninsured children visited the emergency room at least once in 2009).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 19 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 19 in "determining" its Article I authority.

20. The widespread use of health care services by those without insurance not only affects those individuals, by driving them into debt or bankruptcy, 42 U.S.C. § 18091(a)(2)(G), but also has broader effects on the market as a whole. As a class, the millions of people who are uninsured pay only a small portion of the cost of the medical services they receive. *See* Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, & Incremental Costs 2008*, 27 Health Affairs w399, w401 (2008) (Ex. 33) (finding that average person without insurance for an entire year paid for only 34.5% of his total medical spending). This phenomenon is not limited to the uninsured with the lowest incomes. A 2005 study found that, even in households at or above median income, uninsured people on average pay less than half the cost of the medical care they consume. Herring, 24 J. of Health Econ., at 229-30.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 20 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that 42 U.S.C. § 18091(a)(2)(G) speaks for itself and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 20 in "determining" its Article I authority.

21. The costs of "uncompensated care" for the uninsured fall on other participants in the health care market. In the aggregate, Congress found that cost shifting amounted to at least $43 billion in 2008. 42 U.S.C. § 18091(a)(2)(F). This is the amount of care that goes unpaid, either by the uninsured themselves, or by government programs or charities. Families USA, Hidden Health Tax, at 2. CBO estimates that uncompensated care accounts for about 5 percent of overall hospital revenues. CBO, Key Issues, at 114 (citing Hadley et al., *Covering the Uninsured in 2008*, 27 Health Affairs at w401); *see also* CBO, Nonprofit Hospitals & the Provision of Community Benefits at 1-2 (2006) (Ex. 34).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 21 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 21in "determining" its Article I authority.

22. These costs are paid in part by public funds. For example, through Disproportionate Share Hospital payments, Community Health Center grants, and other mechanisms funded by tax revenues, the federal government paid for tens of billions of dollars in uncompensated care for the uninsured in 2008 alone. H.R. Rep. No. 111-443, pt. II, at 983; *see also* CEA, The Economic Case, at 8. One of Congress's goals in enacting the Affordable Care Act was to lower these taxpayer-financed public subsidies.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 22 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs admit that the Congressional Record speaks for itself and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 22 in "determining" its Article I authority.

23. The remaining costs fall in the first instance on health care providers, which in turn "pass on the cost to private insurers, which pass on the cost to families." 42 U.S.C. § 18091(a)(2)(F). This cost-shifting effectively creates a "hidden tax" reflected in fees charged by health care providers and premiums charged by insurers. CEA, Economic Report of the President 187 (Feb. 2010) (Ex. 35); Families USA, Hidden Health Tax, at 2, 6; *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010). The average annual insurance premium for insured families is over $1000 higher due to cost-shifting. 42 U.S.C. § 18091(a)(2)(F); *see also* S. Rep. No. 111-89, at 2 (2009) (Ex. 36) (an estimated 10% of the cost of health insurance premiums in California is attributable to uncompensated care consumed by people without insurance).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 23 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exh. 35.) Plaintiffs admit that the statute and the legislative history speak for themselves and Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 23 in "determining" its Article I authority.

24. When premiums increase as a result of cost-shifting by the uninsured, more people who are currently healthy make the economic calculation not to buy, or to drop, coverage. *See* CBO, Key Issues, at 12. This self-selection further narrows the risk pool, which, in turn, further

increases the price of coverage for the insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century*, at 118-19 (2009) (statement of American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985. This premium spiral particularly hurts small employers, due to their relative lack of bargaining power when negotiating rates with insurance companies. *See id.* at 986-88; CEA, The Economic Case at 37-38; *see also 47 Million and Counting*, 110th Cong. 36 (statement of Raymond Arth, National Small Business Association) (noting need for insurance reform and minimum coverage provision to stem rise of small business premiums). Small employers may cease to offer coverage, or be forced to set premiums so high that their employees opt out of coverage, and the "vicious cycle" continues because "uninsured workers turn to emergency rooms for health care which in turn increases costs for employers and families with health insurance." H.R. Rep. No. 111-443, pt. II, at 985.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 24 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 24 in "determining" its Article I authority.

25. The uncertainty that many Americans experience as to whether they can obtain insurance coverage, due to the barriers imposed by insurance companies and increasing costs of insurance premiums, also constrains the labor market. Traditionally, most Americans have financed their health care expenditures through employment-based insurance. *See* Holahan, 30 Health Affairs at 148 (2011). That number has declined significantly in recent years, due in part to the increased cost of coverage. *Id.* (percentage of non-elderly Americans with employer-based health insurance dropped from 68.3% in 2000 to 59% in 2009). Between 1999 and 2010, average premiums for employer-sponsored family coverage increased 138 percent. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY at 31, tbl. 1.11 (2010) (Ex. 37).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 25 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it consists of self-serving argument and relies on hearsay materials (Exhs. 20, 37.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 25 in "determining" its Article I authority.

26. Nevertheless, employees often value the coverage they receive from their current employer highly, compared to other options, given that insurance outside employment costs even more and may be unavailable to those with a pre-existing condition. The phenomenon of "job lock," in which employees avoid changing jobs because they fear losing coverage, is widespread. Employees are 25% less likely to change jobs where doing so places them at risk of losing health insurance coverage. CEA, The Economic Case at 36-37. Insurance industry reform to guarantee coverage would alleviate "job lock" and increase wages, in the aggregate, by more than $10 billion annually, or 0.2% of the gross domestic product. *Id.*

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 26 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exh. 19.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 26 in "determining" its Article I authority.

27. As indicated above, more than 18% of the non-elderly population went without health insurance in 2009. U.S. CENSUS BUREAU, INCOME, POVERTY, & HEALTH INSURANCE IN THE UNITED STATES: 2009, at 23 tbl 8. The number of persons without insurance has increased dramatically since 1970, when only 6% of Americans under age sixty-five had no coverage. Laura D. Hermer, The Scapegoat: EMTALA and Emergency Department Overcrowding, 14 J. Law & Policy 695, 710 (2006) (Ex. 38). Absent the Affordable Care Act, rates of insurance coverage would have continued to drop. CBO, Key Issues, at 11. The market problems that Congress identified would have continued to grow worse.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 27 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 16, 21, 38.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 27 in "determining" its Article I authority.

28. Congress determined that the problems in the interstate health care market were national in scope and required a national solution. Given that insurers operate in interstate commerce and can adjust their participation in any particular state market based on the nature of regulation in that state, Congress concluded that there was a need for regulation of health insurance at a national level. "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 Engl. J. Med. e29, at 3 (2010) (Ex. 39). "Furthermore, in a modern economy, people need to be able to move interstate in order to pursue economic opportunities and participate in a changing labor market." *Id.* The Act accordingly "provides for uniform national standards, so employers, employees or individuals moving from state-to-state won't be subject to a patchwork of requirements and protections." H.R. Rep. No. 111-443, pt. I, at 211-12 (2010); *see also State Coverage Initiatives*: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means, 110th Cong. 7 (2008) (statement of Alan R. Weil, Executive Director, National Academy of State Health Policy) (Ex. 40) ("Expecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort."). In addition, the cost-shifting problem is itself an interstate issue. For example, Pennsylvania residents cross state lines to make over 1500 emergency room visits each year to a West Virginia hospital; in fiscal year 2007, the Commonwealth owed over $820,000 in payments for these visits. Amicus Br. of the Governors of Washington, Colorado, Michigan, and Pennsylvania, *State of Florida v. HHS*, No. 3:10-cv-91 (N.D. Fla. filed Nov. 19, 2010), at 9 (Ex. 41).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 28 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 39-41.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 28 in "determining" its Article I authority.

29. Congress accordingly enacted the Affordable Care Act to address the economic effects of the market failure in the interstate health care market, and to prohibit health insurance industry practices that have prevented people from obtaining or maintaining health insurance. The Act comprehensively "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." 42 U.S.C. § 18091(a)(2)(A). The comprehensive reform has five main components.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 29 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument. Plaintiffs admit that 42 U.S.C. § 18091(a)(2)(A) speaks for itself and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 29 in "determining" its Article I authority.

30. First, to address inflated premiums in the individual and small-group 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 (internal quotation omitted). The Exchanges will allow individual and small-employer purchasers of insurance to use the leverage of collective buying power to obtain prices that are competitive with those of large-employer group plans. 42 U.S.C. § 18031.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 30 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument. Plaintiffs admit that the legislative history and 42 U.S.C. § 18091(a)(2)(A) speak for themselves and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 30 in "determining" its Article I authority.

31. Second, the Act builds on the existing system of employer-based health insurance, in which most individuals receive coverage as part of employee compensation. *See* CBO, Key Issues, at 4-5. As with previous measures designed to encourage employer-based insurance, Congress used the federal tax laws to help achieve its goal, establishing tax incentives for small businesses to purchase health insurance for their employees, 26 U.S.C. § 45R, and prescribing tax penalties under specified circumstances for certain large businesses that do not offer their full-time employees adequate coverage, 26 U.S.C. § 4980H.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 31 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving legal argument and relies on hearsay materials. (Exh. 16.) Plaintiffs admit that the statute speaks for itself and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 31 in "determining" its Article I authority.

32. Third, the Act provides financial assistance to support the purchase of coverage for a large portion of the uninsured population. As Congress understood, nearly two-thirds of the uninsured are in families with household income less than 200% of the federal poverty level, H.R. Rep. No. 111-443, pt. II, at 978; *see also* CBO, Key Issues, at 27, while only 4% of the uninsured have household income greater than 400% of the poverty level. *Id.* at 11. The Act

addresses this gap by providing premium tax credits for eligible individuals and families with household income between 133% and 400% of the federal poverty line who purchase coverage in the new health insurance Exchanges, 26 U.S.C. § 36B(a), (b), and by creating cost-sharing reductions to help cover out-of-pocket expenses such as copayments or deductibles for eligible individuals who purchase coverage in the Exchanges, 42 U.S.C. § 18081. The Act also expands eligibility for Medicaid to all individuals with income up to 133% of the federal poverty level beginning in 2014. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 32 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exh. 19.) Plaintiffs admit that the legislative history and the statute speak for themselves and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 32 in "determining" its Article I authority.

Plaintiffs further object to and move to strike paragraph 32 to the extent it relates to the PPACA's Medicaid mandate, which is immaterial to the issue of whether Congress exceeded its Article I authority when it enacted the mandate.

33. Fourth, the Act removes barriers to insurance coverage. *See* Pub. L. No. 111-148, §§ 1201, 10103 (amending 42 U.S.C. §§ 300gg et seq.). As noted above, a variety of insurance industry practices have increased premiums for or denied coverage to those with the greatest health care needs. The Act bars insurance companies from refusing to cover individuals because of a pre-existing medical condition, 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a), canceling insurance absent fraud or intentional misrepresentation of material fact, 42 U.S.C. § 300gg-12, charging higher premiums based on a person's medical condition or history, 42 U.S.C. § 300gg, or placing lifetime dollar caps on the benefits of the policyholder for which the insurer will pay, 42 U.S.C. § 300gg-11.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 33 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials.

Plaintiffs admit that the legislative history and statutes speak for themselves and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 33 in "determining" its Article I authority.

34. Finally, in the minimum coverage provision that is at issue in this case, the Act beginning in 2014 will require that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty with their annual income tax return. 26 U.S.C. § 5000A. This provision may be satisfied through enrollment in an employer-sponsored insurance plan; an individual market plan including one offered through the new Exchanges; a grandfathered health plan; certain government-sponsored health insurance programs such as Medicare, Medicaid, or TRICARE; or similar coverage recognized by the Secretary of Health and Human Services in coordination with the Secretary of the Treasury. *Id.* § 5000A(f).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 34 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument. Plaintiffs admit that the statute speaks for itself and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 34 in "determining" its Article I authority.

35. The tax penalty will not apply to individuals whose household income is insufficient to require them to file a federal income tax return, whose premium payments would exceed 8% of their household income, or who establish that the requirement would impose a

hardship. *Id.* § 5000A(e). In addition, Congress exempted from the minimum coverage requirement adherents of religious sects who are "conscientiously opposed [to] acceptance of the benefits of any private or public insurance," if the sect makes provision for their dependent members, *id.* § 5000A(d)(2)(A) (incorporating requirements of 26 U.S.C. § 1402(g)); members of "health care sharing ministry" who, for ethical or religious reasons, share medical expenses among themselves, *id.* § 5000A(d)(2)(B); unlawful aliens, *id.* § 5000A(d)(3); and persons who are incarcerated, *id.* § 5000A(d)(4).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 35 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument (*see*, specifically, Defendants' characterization of the Mandate penalty as a "tax penalty"). Plaintiffs admit that the legislative statutes speak for themselves and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 35 in "determining" its Article I authority.

36. The CBO projects that the reforms in the Act will reduce the number of uninsured Americans by approximately 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (Mar. 20, 2010) ("CBO Letter to Speaker Pelosi") (Ex. 42). 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) (Ex. 43). Without the minimum coverage provision, at least 16 million fewer Americans would gain health insurance, and the cost of premiums in the individual and small-group markets would rise by 27 percent. Jonathan Gruber, *Health Care Reform Without the Individual Mandate*, at 2 (Feb. 2011) (Ex. 44).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 36 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 42-44.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 36 in "determining" its Article I authority.

37. 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." 42 U.S.C. § 18091(a)(2)(H). Congress recognized that, without the minimum coverage provision, the reforms in the Act, specifically the ban on denying coverage or charging more 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.* § 18091(a)(2)(I). 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.*

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 37 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument. Plaintiffs admit the statutes speak for themselves and lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 37 in "determining" its Article I authority.

38. These congressional findings are amply supported. The new "guaranteed issue" and "community rating" requirements under Section 1201 of the Act ensure that Americans can obtain coverage despite any pre-existing conditions they may have when they seek to enroll, without being charged higher rates because of those conditions. 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3(a), 300gg-4(a). Because, absent the minimum coverage provision, these new insurance regulations would allow individuals to "wait to purchase health insurance until they needed care," *id.* § 18091(a)(2)(I), they would increase the incentives for individuals to "make an

economic and financial decision to forego health insurance coverage" until their health care needs become substantial, *id.* § 18091(a)(2)(A).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 38 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument (*e.g.*,"These congressional findings are amply supported"). Plaintiffs admit that government mandates cause higher costs and decreased coverage. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 38 in "determining" its Article I authority.

39. Individuals who would make that decision would take advantage of the ACA's guaranteed issue and community rating reforms after they suffer a serious illness or injury by joining a coverage pool maintained in the interim through premiums paid by other market participants. In other words, without a minimum coverage provision, many consumers "will 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: Ensuring Affordable Coverage*: Hearing Before the House Comm. on Energy and Commerce, Subcomm. on Health, at 11 (2009) (testimony of Uwe Reinhardt, Ph.D., Professor of Political Economy, Economics, and Public Affairs, Princeton University) (Ex. 45). This market timing would increase the costs of uncompensated care and the premiums for the insured pool, creating pressures that would "inexorably drive [the health insurance] market into extinction." *Health Reform in the 21st Century: Insurance Market Reforms*, at 13 (statement of Dr. Reinhardt).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 39 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials.

(Exhs. 26, 45.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 39 in "determining" its Article I authority.

40. This danger is not merely theoretical, but instead is borne out in the experience of states that have attempted "guaranteed issue" and "community rating" reforms without an accompanying minimum coverage provision. After New Jersey enacted a similar reform, its individual health insurance market experienced higher premiums and decreased coverage. *See* Alan C. Monheit et al., *Community Rating & Sustainable Individual Health Insurance Markets in New Jersey*, 23 Health Affairs 167, 168 (2004) (Ex. 46) (describing potential for "adverse-selection death spiral" in a market with guaranteed issue); *see also Health Reform in the 21st Century*, at 101-02 (statement of Dr. Reinhardt).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 40 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 26, 46.) Plaintiffs admit that government mandates cause higher costs and decreased coverage. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 40 in "determining" its Article I authority.

41. Likewise, after New York enacted a similar reform, "[t]here 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 (2000) (Ex. 47). Again, similarly, when Maine enacted legislation requiring insurers to accept all applicants and charge all policyholders in the same class the same premiums, most health insurers withdrew from the state. *Health Reform in the 21st Century*, at 117 (letter of Phil Caper, M.D., & Joe Lendvai).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 41 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 26, 47.) Plaintiffs admit that government mandates cause higher costs and decreased coverage. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 41 in "determining" its Article I authority.

42. In contrast, Massachusetts' enactment of "guaranteed issue" and "community rating" reforms was coupled with a minimum coverage provision. And its reforms have succeeded. Since 2006, the average individual premium in Massachusetts has decreased by 40%, compared to a 14% increase in the national average. Jonathan Gruber, *Mass. Inst. of Tech., The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates* 1 (Nov. 27, 2009) (Ex. 48); see also 42 U.S.C. § 18091(a)(2)(D); Letter from Mitt H. Romney, Governor of Massachusetts, to State Legislature 1-2 (Apr. 12, 2006) (Ex. 49) (signing statement for Massachusetts bill, noting need for insurance coverage requirement to prevent cost-shifting by the uninsured). Nevertheless, Massachusetts itself attests that the "interstate flow of patients (including uninsured patients) [illustrates] that individual states cannot effectively account for, let alone mitigate, the impact of healthcare trends felt on the national and interstate levels." Amicus Br. of the Commonwealth of Massachusetts in Support of Appellant, *State of Florida et al. v. U.S. Dep't of Health & Human Servs.*, No. 11-11021 (11th Cir. filed Apr. 11, 2011), at 13 (Ex. 50).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 42 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 49-50.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether

Congress "considered" or "could have considered" paragraph 42 in "determining" its Article I authority.

43. In short, "fundamental insurance-market reform is impossible" if the guaranteed issue and community rating reforms are not coupled with a minimum coverage provision. Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 316 New Eng. J. of Med. 2497, 2498 (2009) (Ex. 51). This is because "[a] health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." *47 Million and Counting*, 110th Cong. 52 (statement of Prof. Hall). Accordingly, Congress found that the minimum coverage provision is "essential" to its broader effort to regulate health insurance industry underwriting practices that have prevented many from obtaining health insurance. 42 U.S.C. § 18091(a)(2)(I), (J).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 43 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike the paragraph because it consists of self-serving argument and relies on hearsay materials. (Exhs. 25-51.) Plaintiffs further admit that government mandates cause higher costs and drive private business out of the market place. Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 43 in "determining" its Article I authority.

44. CBO estimates that the interrelated revenue and spending provisions in the Act — specifically taking into account revenue from the minimum coverage provision — will yield net savings to the federal government of more than $100 billion over the next decade. CBO Letter to Speaker Pelosi, at 2. In particular, the CBO estimates that the minimum coverage provision will produce about $4 billion in annual revenue once it is fully in effect. *Id.* at tbl. 4 at 2.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 44 because it fails to conform to L.R. 56.1(a) in that it is immaterial. Notwithstanding, Plaintiffs further object to and move to strike

the paragraph because it relies on hearsay materials. (Exh. 42.) Plaintiffs lack knowledge or information sufficient to form a belief as to whether Congress "considered" or "could have considered" paragraph 44 in "determining" its Article I authority.

45. Plaintiff Coons does not assert that the minimum coverage provision is *currently* forcing him to rearrange his financial affairs or that the provision is currently causing him to change his behavior. *See* Decl. of Nick Coons, ECF No. 50-1. Specifically, unlike the plaintiffs in several other cases challenging the constitutionality of the ACA, Coons does not identify any steps he has taken in the present to enable him to comply with the minimum coverage provision when it takes effect in 2014. *Id.*

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 45 because it fails to conform to L.R. 56.1(a) in that it is immaterial and includes self-serving argument. Defendants have "concede[d] that an injury does not have to occur immediately to qualify as an injury-in-fact." *Florida,* 716 F. Supp. 2d at 1145. Therefore, it is immaterial whether PPACA is "*currently* forcing [Mr. Coons] to rearrange his financial affairs or the provision is currently causing him to change his behavior."

46. The Independent Payment Advisory Board ("IPAB" or "the Board") will be 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).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 46 because it does not conform to L.R. 561(a) in that it is not a fact, but a purported excerpt from the Act. Plaintiffs deny that the cited record supports the first sentence of paragraph 46 but admit that § 1395kkk(g) provides that IPAB will be comprised of 15 members appointed by the President, by and with the advice and

consent of the Senate, as well as the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration. Plaintiffs further admit that subsection (g) provides that the Chairperson of the Board may appoint an executive director and other personnel as he chooses. Plaintiffs deny that the second sentence is a complete recitation of IPAB's responsibilities, and admits that the cited record states in part, "[i]t is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending."

47. 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, to the extent feasible, 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[,]" as practicable. *Id.* § 1395kkk(c)(2)(B)(ii)(I), (II).

Plaintiffs' Response:

Plaintiffs object to, deny and move to strike paragraph 47 because it fails to conform to L.R. 56.1(a) in that it contains multiple (and incomplete) excerpts from the Act. Plaintiffs further object to this paragraph because it is not factual, but is instead a recitation, albeit an incomplete recitation, of statutory provisions, not material facts. *See*, § 1395kkk(b)(2), (c)(6); § 1395kkk(c)(1)(A), (c)(2)(B)(i); and § 1395kkk(c)(2)(B)(ii)(I), (II). Plaintiffs admit PPACA *requires* IPAB to produce a "public report" containing "standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the

program under this title," § 1395kkk(n)(1), and that IPAB must include in its report "[a]ny other areas that the Board determines affect overall spending and quality of care in the *private sector*." § 1395kkk(n)(1)(E) (emphasis added). Section 1395kkk (c)(2)(B)(vii) *requires* IPAB to rely on these reports in formulating its legislative proposals. Additionally, PPACA requires IPAB to submit to Congress and the President recommendations to "slow the growth in national health expenditures" in "Non-Federal Health Care Programs" (§1395kkk(o)(1)), which includes recommendations that may "require legislation to be enacted by Congress in order to be implemented" or that may "require legislation to be enacted by State or local governments in order to be implemented." § 1395 (o)(1)(A)-(E).

48. If the IPAB is required to make a recommendation, and Congress fails to pass legislation to otherwise reduce Medicare spending, the Secretary generally implements the Board's recommendations. *See id.* § 1395kkk(e)(3)(A). Of course, nothing in the law prohibits Congress from repealing or suspending the rules that govern Senate or House changes to the IPAB recommendations, *see id.* § 1395kkk(d)(3), and then voting on superseding the legislation.

Plaintiffs' Response:

Plaintiffs object to, deny and move to strike paragraph 48 because it fails to conform to L.R. 56.1(a) in that it contains multiple (and incomplete) excerpts from the Act. Plaintiffs further object to and move to strike this paragraph because it is not factual, but is instead a recitation, albeit an incomplete recitation, of statutory provisions, not material facts.

Plaintiffs deny the alleged facts set forth in paragraph 48 because they are not supported by the cited record. Plaintiffs admit that the cited statute in fact establishes that when IPAB develops legislative proposals that are submitted to Congress, the Secretary "shall" "implement the recommendations contained in the proposal submitted to the Board or the President to

Congress pursuant to this section on August 15 of the year in which the proposal is so submitted," *see* § 1395kkk(e)(1), unless, and only unless, "prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: 'This Act supercedes the recommendations of the Board contained in the proposal submitted' [or] 'in the case of the implementation year 2020 and subsequent implementation years, a joint resolution described in (f)(1) is enacted not later than August 15, 2017.'" *See* § 1395kkk(e)(3)(A)(i) and (ii)).

Plaintiffs further object to and deny this paragraph because § 1395kkk (d)(3) restricts the Senate's power to repeal or suspend the rules that govern changes to IPAB's legislative proposals as follows:

> (d)(3)(A)provides "[i]t shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2);
> (d)(3)(B) enacts a "[l]imitation on changes[by Congress]to the Board's recommendations in other legislation;
> (d)(3)(C) enacts a limit on "changes to this subsection";
> (d)(3)(D) provides that this paragraph "may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; and
> (d)(3)(E) requires an "affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph."

Accordingly, the statutory provision Defendants cite to actually limits Congress's power by restricting its ability to do anything other than what IPAB could otherwise do, unless it is able to hurdle the super-majority vote requirement, which then must also be signed by the President. *See* § 1395kkk(d)(3).

49. 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." CBO, CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 at 26 (Mar. 30, 2011) (Ex. 52). In addition, a new CBO report—issued on June 21 of this year—also predicts that the Board will not issue proposals for at least the next ten years. CBO, 2011 Long Term Budget Outlook at 38 (June 21, 2011) (Ex. 53). It is therefore speculative whether the IPAB will issue any proposals at all on January 15, 2014.

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 49 because it is self-serving and speculative, and relies on inadmissible hearsay – Exhs. 52 and 53 - pursuant to Rules 701, 702, 703 and 801 of the Federal Rules of Evidence, and Rule 26 of the Fed.R.Civ.P. Plaintiffs further object to and move to strike this paragraph because it relies on unreliable and contradictory "projections" by the CBO, which change on a month by month basis. (*See* Exh. 52 at 26) ("In its February 2011 estimate, CBO concluded that the rate of increase in spending would probably exceed the target rate in some years, and that the IPAB, therefore, would have to intervene to reduce the growth of Medicare spending.") Moreover, Defendants' own Exhibit 54 provides that because the trigger for IPAB's reductions are required to based in part on "projections rather than actual data," "IPAB could be compelled to recommend savings that may not have been required based on what actually happens." (Exh. 54 at 15.)

Plaintiffs admit that it is undisputed that (contrary to the ever-changing CBO predictions), PPACA is clear: IPAB will begin receiving the sum of $15 million per year in 2012 (with increases annually), and IPAB will begin issuing legislative proposals in 2014. *See* § 1395kkk(m)(1). This means that PPACA requires the expenditure of more than $120 million in

taxpayer dollars for IPAB between 2012 and 2019, for IPAB to issue legislative proposals. The only thing speculative in this scenario is Defendants' speculative argument about the vagaries that could happen between 2012 and beyond. On the other hand, Congress's intent is clear: it expects IPAB to begin issuing proposals in 2014 as evinced by this massive funding.

50. It is also speculative whether the IPAB, once it begins issuing proposals, will recommend reductions in Medicare payments to orthopaedic surgeons like Dr. Eric Novack. Instead, 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 Found. Program on Medicare Policy, The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending 16 (Apr. 2011) (Ex. 54).

Plaintiffs' Response:

Plaintiffs object to and move to strike paragraph 50 because it fails to conform to L.R. 56.1(a) in that it is immaterial, self-serving and speculative argument, which relies on inadmissible hearsay - Exh. 54 - pursuant to Rules 701, 702, 703 and 801 of the Federal Rules of Evidence, and Rule 26 of the Fed. R. Civ. P.

DATED: AUGUST 29, 2011

RESPECTFULLY SUBMITTED,
s/Diane S. Cohen
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CERTIFICATE OF SERVICE

I, Diane Cohen, an attorney, hereby certify that on August 29, 2011, I electronically filed Plaintiffs' L.R. 7.2(m)(2) Objections and Motion to Strike Defendants Rule 56.1(a) Statement and L.R. 56.1(b) Controverting Statement of Facts, with the Clerk of the Court for the United States District Court, District of Arizona by using the CM/ECF system.

I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the District Court's CM/ECF system.

s/ Diane S. Cohen