No. _____

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, KAJ AHLBURG, AND MARY BROWN,

Petitioners,

v.

KATHLEEN SEBELIUS, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

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APPENDIX A

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Nos. 11-11021 & 11-11067

D.C. Docket No. 3:10-cv-00091-RV-EMT

STATE OF FLORIDA, by and through Attorney General, STATE OF SOUTH CAROLINA, by and through Attorney General, STATE OF NEBRASKA, by and through Attorney General, STATE OF TEXAS, by and through Attorney General, STATE OF UTAH, by and through Attorney General, et al.,

Plaintiffs - Appellees - Cross-Appellants,

versus

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY, SECRETARY OF THE UNITED STATES DEPARTMENT OF TREASURY, UNITED STATES DEPARTMENT OF LABOR, SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR,

Defendants - Appellants - Cross-Appellees.

Appeals from the United States District Court for the Northern District of Florida

(August 12, 2011)

Before DUBINA, Chief Judge, and HULL and MARCUS, Circuit Judges. DUBINA, Chief Judge, and HULL, Circuit Judge:[1]

Soon after Congress passed the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended* by Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act"), the plaintiffs brought this action challenging the Act's constitutionality. The plaintiffs are 26 states, private individuals Mary Brown and Kaj Ahlburg, and the National Federation of Independent Business ("NFIB") (collectively the "plaintiffs").[2] The defendants are the federal Health and Human Services ("HHS"), Treasury, and Labor Departments and their Secretaries (collectively the "government").

[1] This opinion was written jointly by Judges Dubina and Hull. *Cf. Waters v. Thomas*, 46 F.3d 1506, 1509 (11th Cir. 1995) (authored by Anderson and Carnes, J.J.) (citing *Peek v. Kemp*, 784 F.2d 1479 (11th Cir.) (en banc) (authored by Vance and Anderson, J.J.), *cert. denied*, 479 U.S. 939, 107 *S. Ct.* 421 (1986)).

[2] The 26 state plaintiffs are Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

The district court granted summary judgment (1) to the government on the state plaintiffs' claim that the Act's expansion of Medicaid is unconstitutional and (2) to the plaintiffs on their claim that the Act's individual mandate—that individuals purchase and continuously maintain health insurance from private companies[3]—is unconstitutional. The district court concluded that the individual mandate exceeded congressional authority under Article I of the Constitution because it was not enacted pursuant to Congress's tax power and it exceeded Congress's power under the Commerce Clause and the Necessary and Proper Clause. The district court also concluded that the individual mandate provision was not severable from the rest of the Act and declared the entire Act invalid.

The government appeals the district court's ruling that the individual mandate is unconstitutional and its severability holding. The state plaintiffs cross-appeal the district court's ruling on their Medicaid expansion claim. For the reasons that follow, we affirm in part and reverse in part.[4]

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[3] As explained later, unless the person is covered by a government-funded health program, such as Medicare, Medicaid, and others, the mandate is to purchase insurance from a private insurer.

[4] We review the district court's grant of summary judgment *de novo*. *Sammy's of Mobile, Ltd. v. City of Mobile*, 140 F.3d 993, 995 (11th Cir. 1998). We review *de novo* a constitutional challenge to a statute. *United States v. Cunningham*, 607 F.3d 1264, 1266 (11th Cir.), *cert. denied*, 131 *S. Ct.* 482 (2010).

INTRODUCTION

Legal issues concerning the constitutionality of a legislative act present important but difficult questions for the courts. Here, that importance and difficulty are heightened because (1) the Act itself is 975 pages in the format published in the Public Laws;[5] (2) the district court, agreeing with the plaintiffs, held *all* of the Act was unconstitutional; and (3) on appeal, the government argues *all* of the Act is constitutional.

We, as all federal courts, must begin with a presumption of constitutionality, meaning that "we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *United States v. Morrison*, 529 U.S. 598, 607, 120 *S. Ct.* 1740, 1748 (2000).

As an initial matter, to know whether a legislative act is constitutional requires knowing what is in the Act. Accordingly, our task is to figure out what this sweeping and comprehensive Act actually says and does. To do that, we outline the congressional findings that identify the problems the Act addresses, and the Act's legislative response and overall structure, encompassing nine Titles and hundreds of laws on a diverse array of subjects. Next, we set forth in greater depth the contents of the Act's five components most relevant to this appeal: the insurance industry reforms, the new state-run

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[5] Pub. L. No. 111-148, 124 Stat. 119 (2010), Pub. L. No. 111-152, 124 Stat. 1029 (2010). Some of the sections of the Act have not yet been codified in the U.S. Code, and for those sections we cite to the future U.S. Code provision, along with the effective date if applicable.

Exchanges, the individual mandate, the employer penalties, and the Medicaid expansion.

After that, we analyze the constitutionality of the Medicaid expansion and explain why we conclude that the Act's Medicaid expansion is constitutional.

We then review the Supreme Court's decisions on Congress's commerce power, discuss the individual mandate—which requires Americans to purchase an expensive product from a private insurance company from birth to death—and explicate how Congress exceeded its commerce power in enacting its individual mandate. We next outline why Congress's tax power does not provide an alternative constitutional basis for upholding this unprecedented individual mandate. Lastly, because of the Supreme Court's strong presumption of severability and as a matter of judicial restraint, we conclude that the individual mandate is severable from the remainder of the Act. Our opinion is organized as follows:

I. STANDING

As a threshold matter, we consider the government's challenge to the plaintiffs' standing to bring this lawsuit. "Article III of the Constitution limits the jurisdiction of federal courts to 'cases' and 'controversies.'" *Socialist Workers Party v. Leahy*, 145 F.3d 1240, 1244 (11th Cir. 1998) (citations omitted). As we have explained:

> The case-or-controversy constraint, in turn, imposes a dual limitation on federal courts commonly referred to as "justiciability." Basically, justiciability doctrine seeks to prevent the federal courts from encroaching on the powers of the other branches of government and to ensure that the courts consider only those matters that are presented in an adversarial context. Because the judiciary is unelected and unrepresentative, the Article III case-or-controversy limitation, as embodied in justiciability doctrine, presents an important restriction on the power of the federal courts.

Id. (citations omitted). Indeed, there are "three strands of justiciability doctrine—standing, ripeness, and mootness—that go to the heart of the Article III case or controversy requirement." *Harrell v. The Fla. Bar*, 608 F.3d 1241, 1247 (11th Cir. 2010) (quotation marks and alterations omitted).

As for the first strand, "[i]t is by now axiomatic that a plaintiff must have standing to invoke the jurisdiction of the federal courts." *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1266 (11th Cir. 2006). "In essence the question of standing is whether the litigant is entitled to have the court

decide the merits of the dispute or of particular issues." *Primera Iglesia Bautista Hispana of Boca Raton, Inc. v. Broward Cnty.*, 450 F.3d 1295, 1304 (11th Cir. 2006) (quotation marks omitted). To demonstrate standing, a plaintiff must show that " (1) he has suffered, or imminently will suffer, an injury-in-fact; (2) the injury is fairly traceable to [the statute]; and (3) a favorable judgment is likely to redress the injury." *Harrell*, 608 F.3d at 1253; *see also Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61, 112 *S. Ct.* 2130, 2136 (1992). "The plaintiff bears the burden of establishing each of these elements." *Elend v. Basham*, 471 F.3d 1199, 1206 (11th Cir. 2006). And standing must be established for each claim a plaintiff raises. *See Harrell*, 608 F.3d at 1253–54. "We review standing determinations *de novo*." *Bochese v. Town of Ponce Inlet*, 405 F.3d 964, 975 (11th Cir. 2005).

In fact, "[s]tanding is a threshold jurisdictional question which must be addressed prior to and independent of the merits of a party's claims." *Id. a*t 974 (quotation marks and alteration omitted). And "we are obliged to consider questions of standing regardless of whether the parties have raised them." *Id. a*t 975.

Notably, the government does not contest the standing of the individual plaintiffs or of the NFIB to challenge the individual mandate. In fact, the government expressly concedes that one of the individual plaintiffs—Mary Brown—has standing to challenge the individual mandate. See Government's Opening Br. at 6 n.1 ("Defendants do not dispute that plaintiff Brown's challenge to the minimum coverage provision is justiciable."). Nor does the government

dispute the state plaintiffs' standing to challenge the Medicaid provisions.

The only question raised by the government is whether the state plaintiffs have standing to challenge the individual mandate. The government claims that the state plaintiffs do not have standing because they are impermissibly suing the government as *parens patriae*—or as representatives of their citizens—in violation of the rule articulated in *Massachusetts v. Mellon*, 262 U.S. 447, 485–86, 43 *S. Ct.* 597, 600 (1923).[6] The state plaintiffs respond that they are not in violation of the *Mellon* rule, but rather have standing to challenge the individual mandate for three independent reasons: first, because the increased enrollment in Medicaid spurred by the individual mandate will cost the states millions of dollars in additional Medicaid funding; second, because they are injured by other provisions of the Act—such as the Medicaid expansion—from which the individual mandate cannot be severed; and finally, because the individual mandate intrudes upon their sovereign interest in enacting and enforcing state statutes that shield their citizens from the requirement to purchase health insurance. States' Opening Br. at 67–69.

Although the question of the state plaintiffs' standing to challenge the individual mandate is an interesting and difficult one, in the posture of this case, it is purely academic and one we need not

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[6] In *Mellon*, the Supreme Court held that states cannot sue the federal government in a representative capacity to protect their citizens from the operation of an allegedly unconstitutional federal law. 262 U.S. at 485–86, 43 *S. Ct.* at 600. This has come to be known as the *Mellon* rule.

confront today. The law is abundantly clear that so long as at least one plaintiff has standing to raise each claim—as is the case here—we need not address whether the remaining plaintiffs have standing. *See*, *e.g.*, *Watt v. Energy Action Educ. Found.*, 454 U.S. 151, 160, 102 *S. Ct.* 205, 212 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 264 & n.9, 97 *S. Ct.* 555, 562 & n.9 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain suit."); *ACLU of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 557 F.3d 1177, 1195 (11th Cir. 2009) ("Because Balzli has standing to raise those claims, we need not decide whether either of the organizational plaintiffs also has standing to do so."); *Jackson v. Okaloosa Cnty.*, 21 F.3d 1531, 1536 (11th Cir. 1994) ("In order for this court to have jurisdiction over the claims before us, at least one named plaintiff must have standing for each of the claims."); *Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) ("For each claim, if constitutional and prudential standing can be shown for at least one plaintiff, we need not consider the standing of the other plaintiffs to raise that claim."). Because it is beyond dispute that at least one plaintiff has standing to raise each claim here—the individual plaintiffs and the NFIB have standing to challenge the individual mandate, and the state plaintiffs undeniably have standing to challenge the Medicaid provisions—this case is justiciable, and we are permitted, indeed we are obliged, to address the merits of each. Accordingly, we turn to the constitutionality of the Act.

II. THE ACT

A. Congressional Findings

The congressional findings for the Act, including those relating to the individual mandate, are contained in two pages, now codified in 42 U.S.C. § 18091(a)(1)–(3). Approximately 50 million people are uninsured.[7] The congressional findings focus on these uninsureds, health insurance, and health care. *Id.*

1. The Uninsured and Cost-Shifting Problems

The congressional findings state that some individuals make "an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers." *Id.* § 18091(a)(2)(A). In its findings, Congress determined that the decision by the uninsured to forego insurance results in a cost-shifting scenario. *Id.* § 18091(a)(2)(F).

Congress's findings identify a multi-step process that starts with consumption of health care: (1) some uninsured persons consume health care; (2) some fail to pay the full costs; (3) in turn the unpaid costs of that health care—$43 billion in 2008—are shifted to and spread among medical providers; (4) thereafter

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[7] U.S. Census Bureau, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009* 23 tbl.8 (2010) ("*Census Report*"), *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf. Although the congressional findings do not state the precise number of the uninsured, the parties use the 50 million figure, so we will too.

Copies of the Internet materials cited in this opinion are on file in the Clerk's Office. *See* 11th Cir. R. 36, I.O.P. 10.

medical providers, by imposing higher charges, spread and shift the unpaid costs to private insurance companies; (5) then private insurance companies raise premiums for health policies and shift and spread the unpaid costs to already-insured persons; and (6) consequently already-insured persons suffer higher premiums. *Id.* § 18091(a)(2). Also, some uninsured persons continue not to buy coverage because of higher premiums. *Id.*

The findings state that this cost-shifting scenario increases family premiums on average by $1,000 per year. *Id.* § 18091(a)(2)(F). Although not in the findings, the data show the cost-shifting increases individual premiums on average by $368–410 per year.[8] The cost-shifting represents roughly 8% of average premiums.[9]

In its findings, Congress also points out that national health care spending in 2009 was approximately $2.5 trillion, or 17.6% of the national

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[8] Uncompensated care costs translate into "a surcharge of $368 for individual premiums and a surcharge of $1017 for family premiums in 2008." *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 7 (2009), *available at* http://familiesusa2.org/assets/pdfs/hiddenhealth-tax.pdf (cited by both the plaintiffs and the government).

[9] "[A] 'hidden tax' on health insurance accounts for roughly 8% of the average health insurance premium" and "[t]his cost-shift added, on average, $1,100 to each family premium in 2009 and about $410 to an individual premium." Br. of *Amici Curiae* Am. Ass'n of People with Disabilities, *et al.*, in Support of the Government at 15 (citing Ben Furnas & Peter Harbage, Ctr. for Am. Progress Action Fund, *The Cost Shift from the Uninsured* 1–2 (2009), *available at* http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf (calculations based on a 2005 analysis by Families USA)).

economy.[10] *Id.* § 18091(a)(2)(B). Thus, the $43 billion in shifted costs represents about 1.7% of total health care expenditures. Of that $2.5 trillion in national health care spending in 2009, federal, state, and local governments paid $1.1 trillion, or 44%.[11]

Private insurers still paid for 32% of health care spending in 2009,[12] *id.*, through: (1) primarily private employer-based insurance plans, or (2) the private individual insurance market. The private *employer-based* health system covers 176 million Americans. *Id.* § 18091(a)(2)(D). The private individual insurance market covers 24.7 million people.[13] Undisputedly, "[h]ealth insurance and

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[10] *See* Centers for Medicare & Medicaid Services ("CMS"), *National Health Expenditure Web Tables* tbls. 1, 5, 11, *available at* http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf (derived from calculations).

[11] *See CMS, National Health Expenditure Web Tables, supra* note 10, at tbl.5. The governments' health care spending in 2009 included $503 billion for Medicare and $374 billion for Medicaid and the Children's Health Insurance Program ("CHIP").

Projected Medicare spending is $723.1 billion in 2016 and $891.4 billion in 2019. CMS, *Nat'l Health Expenditure Projections 2009–2019* tbl.2, *available at* http://www.cms.gov/National HealthExpendData/Downloads/NHEProjections2009to2019.pdf.

With the Act's Medicaid expansion and other factors, projected Medicaid and CHIP spending is $737.5 billion in 2016 and $896.2 billion in 2019. *Id.*

[12] *See* CMS, *National Health Expenditure Web Tables, supra* note 10, at tbl.3 (derived from calculations).

[13] *See Census Report, supra* note 7, at 22–25 & 23 tbl.8 (derived from calculations).

health care services are a significant part of the national economy." *Id.* § 18091(a)(2)(B).

2. $90 Billion Private Underwriting Costs Problem

Congress also recognized that many of the uninsured desire insurance but have been denied coverage or cannot afford it. Its findings emphasize the barriers created by private insurers' underwriting practices and related administrative costs. *Id.* § 18091(a)(2)(J). Private insurers want healthy insureds and try to protect themselves against unhealthy entrants through medical underwriting, especially in the individual market. As a result of medical underwriting, many uninsured Americans—ranging from 9 million to 12.6 million—voluntarily sought health coverage in the individual market but were denied coverage, charged a higher premium, or offered only limited coverage that excludes a preexisting condition.[14]

In its findings, Congress determined that the "[a]dministrative costs for private health insurance" were $90 billion in 2006, comprising "26 to 30 percent of premiums in the current individual and small group markets." *Id.* The findings state that

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[14] HHS, Coverage Denied: *How the Current Health Insurance System Leaves Millions Behind*, http://www.healthreform.gov/reports/denied_coverage/index.html (citing Commonwealth Fund Biennial Health Insurance Survey, 2007); Sara R. Collins, *et al.*, The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* xi (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Surveys/2011/1486_Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_31611.pdf.

Congress seeks to create health insurance markets "that do not require underwriting and eliminate its associated administrative costs." *Id.* The Act requires private insurers to allow all applicants to enroll. 42 U.S.C. § 300gg-1(a). Congress stated that the Act, by eliminating underwriting costs, will lower health insurance premiums. *Id.*

3. Congress's Solutions

Given the 50 million uninsured, $43 billion in uncompensated costs, and $90 billion in underwriting costs, Congress determined these problems affect the national economy and interstate commerce. *Id.* § 18091(a)(2). The congressional findings identify what the Act regulates: (1) the "health insurance market," (2) "how and when health care is paid for," and (3) "when health insurance is purchased." *Id.* § 18091(a)(2)(A), (H). The findings also state that the Act's reforms will significantly reduce the number of the uninsured and will lower health insurance premiums. *Id.* § 18091(a)(2)(F).

To reduce the number of the uninsured, the Act employs five main tools: (1) comprehensive insurance industry reforms which alter private insurers' underwriting practices, guarantee issuance of coverage, overhaul their health insurance products, and restrict their premium pricing structure; (2) creation of state-run "Health Benefit Exchanges" as new marketplaces through which individuals, families, and small employers, now pooled together, can competitively purchase the new insurance products and obtain federal tax credits and subsidies to do so; (3) a mandate that individuals must purchase and continuously maintain health insurance or pay annual penalties; (4) penalties on

private employers who do not offer at least some type of health plan to their employees; and (5) the expansion of Medicaid eligibility and subsidies.

The Act's Medicaid expansion alone will cover 9 million of the 50 million uninsured by 2014 and 16 million by 2016.[15] The Act's health insurance reforms remove private insurers' barriers to coverage and restrict their pricing to make coverage accessible to the 9 to 12 million uninsured who were denied coverage or had their preexisting conditions excluded.[16] The Act's new Exchanges, with significant federal tax credits and subsidies, are predicted to make insurance available to 9 million in 2014 and 22 million by 2016.[17]

Congress's findings state that the Act's multiple provisions, combined together:[18]

(1) "will add millions of new consumers to the health insurance market" and "will increase the number and share of Americans who are insured";

(2) will reduce the number of the uninsured, will broaden the health insurance risk pool to include

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[15] *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*: Before the Subcomm. on Health of the H. Comm. on Energy & Commerce 112th Cong. 18 tbl.3 (2011) (Statement of Douglas Elmendorf, Director, Cong. Budget Office) [hereinafter CBO, *Analysis*], *available at* http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

[16] *See* HHS, *Coverage Denied*, and Collins, *supra* note 14.

[17] CBO, *Analysis, supra* note 15, at tbl.3.

[18] The congressional findings refer six times to the individual mandate "requirement, together with the other provisions of this Act." 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J).

additional healthy individuals, will increase economies of scale, and will significantly reduce insurance companies' administrative costs, all of which will lower health insurance premiums;

(3) will build upon and strengthen the private employer-based health insurance system, which already covers "176,000,000 Americans"; and

(4) will achieve "near-universal" coverage of the uninsured. *Id.* § 18091(a)(2).

Although the congressional findings summarily refer to "the uninsured," the parties' briefs and the 52 *amici* briefs contain, and indeed rely on, additional data about the uninsured. Before turning to the Act, we review that data.[19]

4. Data about the Uninsured and Uncompensated Care

So who are the uninsured? As to health care usage, the uninsured do not fall into a single category. Many of the uninsured do not seek health care each year. Of course, many do. In 2007, 57% of the 40 million uninsured that year used some medical services; in 2008, 56% of the 41 million uninsured that year used some medical services.[20]

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[19] There has been no evidentiary objection by any party to the data and studies cited in the parties' briefs or in any of the *amici* briefs. In fact, at times the parties cite the same data.

[20] HHS, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Household Component Summary Tables ("MEPS Summary Tables"), Table 1: Total Health Services–Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2007 & 2008, *available at* http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp (follow "Household Component summary tables" hyperlink; then

As to medical services, 50% of uninsured people had routine checkups in the past two years; 68% of uninsured people had routine checkups in the past five years.[21] In 2008, the uninsured made more than 20 million visits to emergency rooms,[22] and 2.1 million were hospitalized.[23] The medical care used by each uninsured person cost about $2,000 on average in 2007, and $1,870 on average in 2008.[24]

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select 2007 or 2008 for "year" and follow the "search" hyperlink; then follow the hyperlink next to "Table 1").

The Medical Expenditure Panel Survey ("MEPS") is a set of large-scale surveys of families and individuals, their medical providers (including doctors, hospitals, and pharmacies), and employers across the United States. It is conducted under the auspices of HHS.

[21] June E. O'Neill & Dave M. O'Neill, *Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health*, EMP'T POLICIES INSTITUTE, 21 tbl.9 (2009), *available at* http://epionline.org/studies/oneill_06-2009.pdf.

[22] Br. of *Amici Curiae* Am. Hosp. Ass'n *et al.* in Support of the Government at 11 (citing Press Release, HHS, New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits (Jul. 15, 2009), *available at* http://www.hhs.gov/news/press/2009pres/07/20090715b.html).

[23] In 2008, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. Office of the Assistant Sec'y for Planning and Evaluation, HHS, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* 5 (2011), *available at* http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.shtml.

[24] MEPS Summary Tables, supra note 20. An Economic Scholars' *amici* brief, filed in support of the government, states: "The medical care used by each uninsured person costs about $2000 per year, on average." Br. of *Amici Curiae* Economists in

When the uninsured do seek health care, what happens? Some pay in full. Some partially pay. Some pay nothing. Data show the uninsured paid on average 37% of their health care costs out of pocket in 2007, and 46.01% in 2008,[25] while third parties pay another 26% on their behalf.[26] Not surprisingly, the poorer uninsured, on average, consume more health care for which they do not pay.[27] Even in households at or above the median income level ($41,214) in 2000, the uninsured paid, on average, less than half their medical care costs.[28]

It is also undisputed that people are uninsured for a wide variety of reasons. The uninsured are spread across different income brackets:

Support of the Government at 16 (citing "Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables, Table 1" (*see* MEPS Summary Tables, *supra* note 20); Jack Hadley, *et al.*, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," 27(5) HEALTH AFFAIRS W399-415 (2008)).

In contrast, this same *amici* brief points out: "In 2007, the average person used $6,186 in personal health care services." *Id. a*t 11 (citing "Center for Medicare and Medicaid Services, National Health Expenditure Accounts"); *see* CMS, *National Expenditure Web Tables, supra* note 10, at tbl.1.

[25] *See* MEPS Summary Tables, *supra* note 20.

[26] *See* Families USA, *Hidden Health Tax*, *supra* note 8, at 2 (cited by both the plaintiffs and the government).

[27] 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, 229–31 (2005).

[28] Herring, *supra* note 27, at 231 ("[T]he median income for all household[s] in the U.S. is roughly 300% of poverty, and the poverty threshold was US$13,738 for a family of three in 2000."); *see id.* at 230 tbl.1.

(1) less than $25,000: 15.5 million uninsured, or about 31%;

(2) $25,000 to $49,999: 15.3 million uninsured, or about 30%;

(3) $50,000 to $74,999: 9.4 million uninsured, or about 18%;

(4) $75,000 or more: 10.6 million uninsured, or about 21%.[29]

As the data show, many of the uninsured have low to moderate incomes and simply cannot afford insurance. Some of the uninsured can afford insurance and tried to obtain it, but were denied coverage based on health status.[30] Some are voluntarily uninsured and self-finance because they can pay for their medical care or have modest medical care needs. Some may not have considered the issue. There is no one reason why people are uninsured. It is also not surprising, therefore, that Congress has attacked the uninsured problem through multiple reforms and numerous avenues in the Act that we outline later.

Given these identified problems, congressional findings, and data as background, we now turn to Congress's legislative response in the Act.

B. Overall Structure of Nine Titles

The sweeping and comprehensive nature of the Act is evident from its nine Titles:

I. Quality, Affordable Health Care for All Americans

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[29] *See Census Report, supra* note 7, at 23 tbl.8.

[30] *See* HHS, *Coverage Denied*, and Collins, *supra* note 14.

II. Role of Public Programs

III. Improving the Quality and Efficiency of Health Care

IV. Prevention of Chronic Disease and Improving Public Health

V. Health Care Workforce

VI. Transparency and Program Integrity

VII. Improving Access to Innovative Medical Therapies

VIII. Community Living Assistance Services and Supports

IX. Revenue Provisions[31]

The Act's provisions are spread throughout many statutes and different titles in the United States Code. As our Appendix A demonstrates, the Act's nine Titles contain hundreds of new laws about hundreds of different areas of health insurance and health care. Appendix A details most parts of the Act with section numbers. Here, we merely list the broad subject matter in each Title.

Title I contains these four components mentioned earlier: (1) the insurance industry reforms; (2) the new state-run Exchanges; (3) the individual mandate; and (4) the employer penalty. Act §§ 1001–1568. Title II shifts the Act's focus to publicly-funded programs designed to provide health care for the uninsured, such as Medicaid, CHIP, and initiatives under the Indian Health Care Improvement Act. *Id.* §§ 2001–2955. Title II contains the Medicaid

[31] There is also a tenth Title dedicated to amendments to these nine Titles.

expansion at issue here. Title II's provisions also create, or expand, other publicly-funded programs. *Id.*

Title III primarily addresses Medicare. *Id.* § 3001–3602. Title IV concentrates on prevention of illness. *Id.* §§ 4001–4402. Title V seeks to increase the supply of health care workers through education loans, training grants, and other programs. *Id.* §§ 5001–5701.

Title VI creates new transparency and anti-fraud requirements for physician-owned hospitals participating in Medicare and for nursing facilities participating in Medicare or Medicaid. *Id.* §§ 6001–6801. Title VI includes the Elder Justice Act, designed to eliminate elder abuse, neglect, and exploitation. *Id.*

Title VII extends and expands certain drug discounts in health care facilities serving low-income patients. *Id.* §§ 7001–7103. Title VIII establishes a national, voluntary long-term care insurance program for purchasing community living assistance services and support by persons with functional limitations. *Id.* §§ 8001–8002. Title IX contains revenue provisions. *Id.* §§ 9001–9023.

We include Appendix A because it documents (1) the breadth and scope of the Act; (2) the multitudinous reforms enacted to reduce the number of the uninsured; (3) the large number and diverse array of new, or expanded, federally-funded programs, grants, studies, commissions, and councils in the Act; (4) the extensive new federal requirements and regulations on myriad subjects; and (5) how many of the Act's provisions on their face operate separately and independently.

We now examine in depth the five parts of the Act largely designed to reduce the number of the uninsured. Because of the Act's comprehensive and complex regulatory scheme, it is critical to examine what the Act actually does and does not do. We start with some terms and definitions.

C. Terms and Definitions

The Act regulates three aspects of health insurance: (1) "markets," the outlets where consumers may purchase insurance products; (2) "plans," the insurance products themselves; and (3) "benefits," the health care services or items covered under an insurance plan.

1. Markets

Given its focus on making health insurance available to the uninsured, the Act recognizes and regulates four markets for health insurance products: (1) the "individual market"; (2) the "small group market"; (3) the "large group market"; and (4) the new Exchanges, to be created and run by each state.

The term "individual market" means "the market for health insurance coverage offered to individuals other than in connection with a group health plan." 42 U.S.C. §§ 300gg-91(e)(1)(A), 18024(a)(2).

The term "group market" means "the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer." *Id.* § 18024(a)(1).

Within the "group market," the Act distinguishes between the "large group market" and the "small group market." The term "large group market" refers

to the market under which individuals purchase coverage through a group plan of a "large employer." *Id.* §§ 300gg-91(e)(3), 18024(a)(3). A "large employer" is an employer with over 100 employees. *Id.* §§ 300gg-91(e)(2), 18024(b)(1).

The term "small group market" refers to the market under which individuals purchase coverage through a group plan of a "small employer," or an employer with no more than 100 employees. *Id.* §§ 300gg-91(e)(4), (5), 18024(a)(3), (b)(2).

The term "Exchanges" refers to the health benefit exchanges that each state must create and operate.[32] *Id.* 32 § 18031(b). Companies (profit and nonprofit) participating in the Exchanges will offer insurance for purchase by individuals and employees of small employers. *See id.*; *id.* § 18042. The uninsured can obtain significant federal tax credits and subsidies through the Exchanges. *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071. In 2017, the states will have the option to open the Exchanges to large employers. 42 U.S.C. § 18032(f)(2)(B).

2. "Essential Health Benefits Package" Term

Two key terms in the Act are: (1) "essential health benefits package" and (2) "minimum essential coverage." Although they sound similar, each has a different meaning.

The term "essential health benefits package" refers to the comprehensive benefits package that must be provided by plans in the individual and small group markets by 2014. *Id.* § 300gg-6(a)

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[32] The Act allows a state to opt out of creating and operating an Exchange, in which case the federal government (or a nonprofit contractor) will establish the Exchange. 42 U.S.C. § 18041(c).

(effective Jan. 1, 2014); *id.* § 18022(a). The Act does not impose the essential health benefits package on plans offered by large group employers to their employees.

An "essential health benefits package" must: (1) provide coverage for the "essential health benefits" described in § 18022(b); (2) limit the insured's cost-sharing, as provided in § 18022(c); and (3) provide "either the bronze, silver, gold, or platinum level of coverage" described in § 18022(d). *Id.* § 18022(a).

The Act leaves it to HHS to define the term "essential health benefits." *Id.* § 18022(b). However, that definition of "essential health benefits" must include at least these ten services:

> (A) Ambulatory patient services.
>
> (B) Emergency services.
>
> (C) Hospitalization.
>
> (D) Maternity and newborn care.
>
> (E) Mental health and substance use disorder services, including behavioral health treatment.
>
> (F) Prescription drugs.
>
> (G) Rehabilitative and habilitative services and devices.
>
> (H) Laboratory services.
>
> (I) Preventive and wellness services and chronic disease management.
>
> (J) Pediatric services, including oral and vision care.

Id. § 18022(b)(1).[33] The bronze, silver, gold, and platinum levels of coverage reflect the levels of cost-sharing (or actuarial value of benefits) in a plan and do not represent the level or type of services. *Id.* § 18022(d)(1)–(2). For example, a bronze plan covers 60% of the benefits' costs, and the insured pays 40% out of pocket; a platinum plan covers 90%, with the insured paying 10%. *Id.* § 18022(d)(1)(A), (D).

3. Individual Mandate's "Minimum Essential Coverage" Term

The Act uses a wholly different term—"minimum essential coverage"—in connection with the individual mandate. "Minimum essential coverage" is the type of *plan* needed to satisfy the individual mandate. A wide variety of health plans are considered "minimum essential coverage": (1) government-sponsored programs, (2) eligible employer-sponsored health plans, (3) individual market health plans, (4) grandfathered health plans, and (5) health plans that qualify for, and are offered in, a state-run Exchange. 26 U.S.C. § 5000A(a), (f)(1).

Many of these plan types will satisfy the mandate even if they do not have the "essential health benefits package" and regardless of the level of benefits or coverage. The requirement of the "essential health benefits package" is directly tied to some of the

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[33] In defining "essential health benefits," HHS must ensure that the scope of essential health benefits is "equal to the scope of benefits provided under a typical employer plan." 42 U.S.C. § 18022(b)(2). HHS must take additional elements into consideration, such as balance among the categories of benefits, discrimination based on age or disability, and the needs of diverse segments of the population. *Id.* § 18022(b)(4).

insurance product reforms, but not the individual mandate.

We turn to the Act's first component: the insurance reforms.

D. Health Insurance Reforms

To reduce the number of the uninsured, the Act heavily regulates private insurers and reforms their health insurance products. We list examples of the major reforms.

1. Guaranteed Issue. Insurers must permit every employer or individual who applies in the individual or group markets to enroll. 42 U.S.C. § 300gg-1(a) (effective Jan. 1, 2014). However, insurers "may restrict enrollment in coverage described [in subsection (a)] to open or special enrollment periods."[34] *Id.* § 300gg-1(b)(1) (effective Jan. 1, 2014).

2. Guaranteed renewability. Insurers in the individual and group markets must renew or continue coverage at the individual or plan sponsor's option in the absence of certain exceptions, such as premium nonpayment, fraud, or the insurer's discontinuation of coverage in the relevant market. *Id.* § 300gg-2(b).

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[34] The Act directs HHS to promulgate regulations with respect to enrollment periods. 42 U.S.C. § 300gg-1(b)(3) (effective Jan. 1, 2014). Insurers must establish "special enrollment periods for 'qualifying events.'" *Id.* § 300gg-1(b)(2). "Qualifying events" include, for example: (1) "[t]he death of the covered employee"; (2) "[t]he termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment"; and (3) "[t]he divorce or legal separation of the covered employee from the employee's spouse." 29 U.S.C. § 1163.

3. Waiting periods. Under group health plans, insurers may impose waiting periods of up to 90 days before a potential enrollee is eligible to be covered under the plan. *Id.* §§ 300gg-7 (effective Jan. 1, 2014), 300gg-3(b)(4). The Act places no limits on insurers' waiting periods for applications in the individual market.

4. Elimination of preexisting conditions limitations. Insurers may no longer deny or limit coverage due to an individual's preexisting medical conditions. The Act prohibits preexisting condition exclusions for children under 19 within six months of the Act's enactment, and eliminates preexisting condition exclusions for adults beginning in 2014.[35] *Id.* § 300gg-3.

5. Prohibition on health status eligibility rules. Insurers may not establish eligibility rules based on any of the health status-related factors listed in the Act.[36] *Id.* § 300gg-4 (effective Jan. 1, 2014).

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[35] For dates effective as to children and then adults, *see* Pub. L. No. 111-148, Title I, § 1255 (formerly § 1253), 124 Stat. 162 (2010) (renumbered § 1255 and amended, Pub. L. No. 111-148, Title X, § 10103(e), (f)(1), 124 Stat. 895 (2010), and codified in note to 42 U.S.C. § 300gg-3).

[36] Health status-related factors include:

> (1) Health status.
>
> (2) Medical condition (including both physical and mental illnesses).
>
> (3) Claims experience.
>
> (4) Receipt of health care.
>
> (5) Medical history.
>
> (6) Genetic information.

6. Community rating. In the individual and small group markets and the Exchanges, insurers may vary premium rates only based on (1) whether the plan covers an individual or a family; (2) "rating area"; (3) age (limited to a 3–to–1 ratio); and (4) tobacco use (limited to a 1.5–to–1 ratio). *Id.* § 300gg(a)(1). Each state must establish one or more rating areas subject to HHS review. *Id.* § 300gg(a)(2)(B). This rule prevents insurers from varying premiums within a geographic area based on gender, health status, or other factors.

7. Essential health benefits package. The individual and small group market plans must contain comprehensive coverage known as the "essential health benefits package," defined above. *Id.* §§ 300gg-6(a) (effective Jan. 1, 2014), 18022(a). The Act does not impose this requirement on large group market plans.[37]

8. Preventive service coverage. Insurers must provide coverage for certain enumerated preventive health services without any deductibles, copays, or other cost-sharing requirements. *Id.* § 300gg-13(a).

> (7) Evidence of insurability (including conditions arising out of acts of domestic violence).
>
> (8) Disability.
>
> (9) Any other health status-related factor determined appropriate by the [HHS] Secretary.

42 U.S.C. § 300gg-4(a) (effective Jan. 1, 2014).

[37] Rather, the large group market is subject to only a few coverage-reform requirements that apply broadly to either *all* insurance plans or group health plans in particular. *See* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 147 (2011).

9. Dependent coverage. Insurers must allow dependent children to remain on their parents' policies until age 26. *Id.* § 300gg-14(a).

10. Elimination of annual and lifetime limits. Insurers may no longer establish lifetime dollar limits on essential health benefits. *Id.* § 300gg-11(a)(1)(A), (b). Insurers may retain annual dollar limits on essential health benefits until 2014.[38] *Id.* § 300gg-11(a).

11. Limits on cost-sharing by insureds. "Cost-sharing"[39] includes out-of-pocket "deductibles, coinsurance, co-payments, or similar charges" and "qualified medical expenses."[40] *Id.* § 18022(c)(3)(A). Annual cost-sharing limits apply to group health plans, health plans sold in the individual market, and qualified health plans offered through an Exchange.[41] *Id.* §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(a), (c).

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[38] HHS shall determine what restricted annual limits are permitted on the dollar value of essential health benefits until 2014. 42 U.S.C. § 300gg-11(a)(1), (2). "Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits . . . ." *Id.* § 300gg-11(b).

[39] "Cost-sharing" does not include "premiums, balance billing amounts for non-network providers, or spending for non-covered services." 42 U.S.C. § 18022(c)(3)(B).

[40] "Qualified medical expense" is defined in 26 U.S.C. § 223(d)(2).

[41] Annual limits on cost-sharing are equal to the current limits on out-of-pocket spending for high-deductible health plans under the Internal Revenue Code (for 2011, $5,950 for self-only coverage and $11,900 for family coverage), adjusted after 2014

12. Deductibles. Deductibles for any plans offered in the small group market are capped at $2,000 for plans covering single individuals and $4,000 for any other plan, adjusted after 2014. *Id.* §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(c)(2). The deductible limits do not apply to individual plans or large group plans. *See id.*

13. Medical loss ratio. Insurers must maintain certain ratios of premium revenue spent on the insureds' medical care versus overhead expenses. *Id.* § 300gg-18(a), (b)(1). In the large group market, insurers must spend 85% of their premium revenue on patient care and no more than 15% on overhead. *Id.* § 300gg-18(a), (b)(1)(A)(i). In the individual and small group markets, insurers must spend 80% of their revenue on patient care and no more than 20% on overhead. *Id.* § 300gg-18(a), (b)(1)(A)(ii). This medical-loss ratio requirement applies to all plans (including grandfathered plans). *Id.* § 300gg-18(a), (b)(1). Insurers must report to HHS their ratio of incurred claims to earned premiums. *Id.* § 300gg-18(a).

14. Premium increases. HHS, along with all states, shall annually review "unreasonable" increases in premiums beginning in 2010. *Id.* § 300gg-94(a)(1). Issuers must justify any unreasonable premium increase. *Id.* § 300gg-94(a)(2).

15. Prohibition on coverage rescissions. Insurers may not rescind coverage except for fraud or

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by a "premium adjustment percentage." 42 U.S.C. §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(c)(1); 26 U.S.C. § 223(c)(2)(A)(ii), (g); I.R.S. Pub. 969 (2010), at 3.

intentional misrepresentation of material fact. *Id.* § 300gg-12.

16. Single risk pool. Insurers must consider all individual-market enrollees in their health plans (except enrollees in grandfathered plans) to be members of a single risk pool (whether enrolled privately or through an Exchange). *Id.* § 18032(c)(1). Small group market enrollees must be considered in the same risk pool. *Id.* § 18032(c)(2).

17. Temporary high risk pool program. To cover many of the uninsured immediately, the Act directs HHS to establish a "temporary high risk health insurance pool program" to offer coverage to uninsured individuals with preexisting conditions until the prohibition on preexisting condition exclusions for adults becomes effective in 2014. *Id.* § 18001(a). The premiums for persons with a preexisting condition remain what a healthy person would pay. *Id.* §§ 18001(c)(2)(C), 300gg(a)(1). The Act allocates $5 billion to HHS to cover this high-risk pool. When this temporary program ends in 2014, such individuals will be transferred to coverage through an Exchange. *Id.* § 18001(a)–(d), (g).

18. State regulation maintained. States will license insurers and enforce both federal and state insurance laws. *Id.* § 18021(a)(1)(C). The Act provides for the continued operation of state regulatory authority, even with respect to interstate "health care choice compacts," which enable qualified health plans to be offered in more than one state.[42] *Id.* § 18053(a).

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[42] Health care choice compacts allow qualified health plans to be offered in the individual markets of multiple states, yet such

In addition to reforming health insurance products, the Act requires the creation of Exchanges where the uninsured can buy the new products. We examine this second component of the Act, also designed to make insurance more accessible and affordable and thus reduce the number of the uninsured.

E. Health Benefit Exchanges

1. Establishment of State-Run Exchanges

By January 1, 2014, all states must establish "American Health Benefit Exchanges" and "Small Business Health Options Program Exchanges," which are insurance marketplaces where individuals, families, and small employers can shop for the Act's new insurance products. *Id.* § 18031(b). Consumers can compare prices and buy coverage from one of the Exchange's issuers. *Id.* § 18031(b), (c). Exchanges centralize information and facilitate the use of the Act's significant federal tax credits and other subsidies to purchase health insurance. *See* 26 U.S.C. § 36B; 42 U.S.C. §§ 18031, 18071, 18081–83. States may create and run the Exchanges through a governmental or nonprofit entity. 42 U.S.C. § 18031(d)(1).

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plans will "only be subject to the laws and regulations of the State in which the plan was written or issued." 42 U.S.C. § 18053(a)(1)(A). The issuer of such qualified health plans offered through health care choice compacts "would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards. . . . of the State in which the purchaser resides" and "would be required to be licensed in each State in which it offers the plan under the compact." *Id.* § 18053(a)(1)(B)(i)–(ii).

States may establish regional, interstate, or subsidiary Exchanges. *Id.* § 18031(f). The federal government will provide funding until January 1, 2015 to establish Exchanges. *Id.* § 18031(a). Insurers may offer their products inside or outside these Exchanges, or both. *Id.* § 18032(d).

Importantly, the Exchanges draw upon the states' significant experience regulating the health insurance industry. *See id.* § 18041. The Act allows states some flexibility in operations and enforcement, though states must either (1) directly adopt the federal requirements set forth by HHS, or (2) adopt state regulations that effectively implement the federal standards, as determined by HHS. *Id.* § 18041(b). In a subsection entitled, "No interference with State regulatory authority," the Act provides that "[n]othing in this chapter shall be construed to preempt any State law that does not prevent the application of the provisions of this chapter." *Id.* § 18041(d).

2. Qualified Individuals and Employers in the Exchanges

The Act provides that "qualified individuals" and "qualified employers" may purchase insurance through the Exchanges. *Id.* § 18031(d)(2). Although "qualified individuals" is broadly defined,[43] "qualified employers" are initially limited to small employers, but in 2017, states may allow large employers to

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[43] A "qualified individual" is a legal resident who (1) seeks to enroll in a "qualified health plan" in the individual market through the Exchange, and (2) resides in the state that established the Exchange. 42 U.S.C. § 18032(f)(1), (3). Prisoners and illegal aliens may not purchase insurance through Exchanges. *Id.* § 18032(f)(1)(B), (3).

participate in their Exchanges. *Id.* § 18032(f)(2)(A), (B). Qualified employers can purchase group plans in or out of Exchanges. *Id.* § 18032(d)(1).

3. Qualified Health Plans in the Exchanges

The Act prescribes the types of plans available in the Exchanges, known as "qualified health plans." *Id.* § 18031(d)(2)(B)(i). A "qualified health plan" is a health plan that: (1) is certified as a qualified health plan in each Exchange through which the plan is offered; (2) provides an "essential health benefits package"; and (3) is offered by an issuer that (a) is licensed and in good standing in each state where it offers coverage, and (b) complies with HHS regulations and any requirements of the Exchange. *Id.* § 18021(a)(1). The issuer must agree, *inter alia*, to offer at least one plan in the "silver" level and one in the "gold" level in each Exchange in which it participates, as described in § 18022(d). *Id.* § 18021(a)(1)(C). The issuer must charge the same premium rate regardless of whether a plan is offered in an Exchange or directly.[44] *Id.*

4. "Essential Health Benefits Package" and Catastrophic Plans

The "essential health benefits package" is required of all qualified health plans sold in the Exchanges. *Id.* § 18021(a)(1)(B). States may require

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[44] HHS establishes the criteria for certification of insurance plans as "qualified health plans" and develops a rating system to "rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price." 42 U.S.C. § 18031(c)(1), (3). States must rate each health plan offered in an Exchange (in accordance with federal standards) and certify health plans as "qualified health plans." *See id.* § 18031(e).

that a qualified health plan offered in that state cover benefits in addition to "essential health benefits," but the state must defray the costs of additional coverage through payments directly to patients or insurers. *Id.* § 18031(d)(3)(B).

One significant exception to the "essential health benefits package" requirement is the catastrophic plan in the individual market only. In and outside the Exchanges, insurers may offer catastrophic plans which provide no benefits until a certain level of out-of-pocket costs—$5,950 for self-only coverage and $11,900 for family coverage in 2011—are incurred. *Id.* § 18022(e); *see id.* § 18022(c)(1), (e)(1)(B)(i); 26 U.S.C. § 223(c)(2)(A)(ii), (g); I.R.S. Pub. 969 (2010), at 3. The level of out-of-pocket costs is equal to the current limits on outof-pocket spending for high deductible health plans adjusted after 2014. 42 U.S.C. § 18022(e), (c)(1).

This catastrophic plan exception applies only if the plan: (1) is sold in the individual market; (2) restricts enrollment to those under age 30 *or* certain persons exempted from the individual mandate; (3) provides the essential health benefits coverage *after* the out-of-pocket level is met; and (4) provides coverage for at least three primary care visits. *Id.* § 18022(e)(1), (2).

5. Federal Premium Tax Credit

To reduce the number of the uninsured, the Act also establishes considerable federal tax credits for individuals and families (1) with household incomes between 1 and 4 times the federal poverty level; (2) who do not receive health insurance through an employer; and (3) who purchase health insurance

through an Exchange.[45] 26 U.S.C. § 36B(a), (b), (c)(1)(A)–(C).

To receive the credit, eligible individuals must enroll in a plan offered through an Exchange and report their income to the Exchange. 42 U.S.C. § 18081(b). If the individual's income level qualifies, the Treasury pays the premium tax credit amount directly to the individual's insurance plan issuer. *Id.* § 18082(c)(2)(A). The individual pays only the dollar difference between the premium tax credit and the total premium charged. *Id.* § 18082(c)(2)(B). The credit amount is tied to the cost of the second-cheapest plan in the silver level offered through an

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[45] Specifically, the amount of the federal tax credit for a given month is an amount equal to the lesser of (1) the monthly premiums for the qualified health plan or plans, offered in the individual market through an Exchange, that cover the taxpayer and the members of the taxpayer's household, *or* (2) the excess of: (a) the monthly premium the taxpayer would be charged for the second lowest-cost silver plan over (b) 1/12 of the taxpayer's yearly household income multiplied by the "applicable percentage," a percentage which ranges from 2.0% to 9.5%, depending on income. 26 U.S.C. § 36B(b)(3)(A)–(C).

An example helps translate. For a family of four with an income of $33,075 per year, assuming that the premium in the second lowest-cost silver plan covering the family is $4,500 per year ($375 per month), the federal tax credit would be $3,177 per year ($264.75 per month). *See* Families USA, *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit* 8 (2010), *available at* http://www.familiesusa.org/assets/pdfs/health-reform/Premium-Tax-Credits.pdf. Without the federal tax credit, the family pays $375 per month; with the credit, the family pays $110.25 per month, or a total of $1,323, instead of the full $4,500 premium. *Id.* The federal tax credit provides a major incentive for the uninsured (in the individual market) to purchase insurance from a private insurer but through the Exchange.

Exchange where the individual resides, though the credit may be used for any plan purchased through an Exchange.[46] *See* 26 U.S.C. § 36B(b)(2).

6. Federal Cost-Sharing Subsidies

The Act also provides a variety of federal cost-sharing subsidies to reduce the out-of-pocket expenses for individuals who (1) enroll in a qualified health plan sold through an Exchange in the silver level of coverage, and (2) have a household income

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[46] Commentators have explained the operation of the tax credit for households between one and four times the federal poverty level as follows:

> For taxable years after 2013, certain low- and moderate-income individuals who purchase insurance under a health insurance exchange that the states are required to create will receive a refundable credit that subsidizes their purchase of that insurance. . . . According to the Social Security Administration, the current poverty level for a single individual is $10,830; thus a single individual can have household income of as much as $43,320 and still qualify to have his insurance cost subsidized by the government. For a family of four, the current poverty level is $22,050; such a family can have household income as large as $88,200 and still qualify for a subsidy.

Douglas A. Kahn & Jeffrey H. Kahn, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform*, 109 MICH. L. REV. FIRST IMPRESSIONS 78, 83 (2011).

HHS has since raised the poverty level for 2011 to $22,350 for a family of four and $10,890 for a single individual. 76 Fed. Reg. 3637, 3638 (Jan. 20, 2011). Thus, a single individual can have a household income of as much as $43,560 and still be eligible for a federal tax credit. A family of four can have a household income of as much as $89,400 and still be eligible for a federal tax credit. *See* 42 U.S.C. § 18071(b).

between 1 and 4 times the federal poverty level. 42 U.S.C. § 18071.

As noted earlier, the Exchanges, with significant federal tax credits and subsidies, are predicted to make insurance available to 9 million in 2014 and 22 million by 2016.[47] We now turn to the Act's third component: the individual mandate.

F. Individual Mandate

The individual mandate and its penalty are housed entirely in the Internal Revenue Code, in subtitle D, labeled "Miscellaneous Excise Taxes." 26 U.S.C. § 5000A *et seq.* The Act mandates that, after 2013, all "applicable individuals" (1) shall maintain "minimum essential coverage" for themselves and their dependents, or (2) pay a monetary penalty. *Id.* § 5000A(a)–(b). Taxpayers must include the penalty on their annual federal tax return. *Id.* § 5000A(b)(2). Married taxpayers filing a joint return are jointly liable for any penalty. *Id.* § 5000A(b)(3)(B).

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[47] CBO, *Analysis*, *supra* note 15, at 18 tbl.3. The CBO predicts that by 2019, 24 million will be insured through the Exchanges, with at least four-fifths receiving "federal subsidies to substantially reduce the cost of purchasing health insurance coverage," on average $6,460 per person. *Id. a*t 2, 18–19 tbl.3.

The CBO estimates that this 9 million increase in 2014 will be partially offset by a 3 million decrease in individual-market coverage outside the Exchanges. *Id.* The number obtaining coverage in the individual market outside the Exchanges is projected to decrease because the Act incentivizes individuals—through premium tax credits, subsidies, and otherwise—to purchase policies through the Exchanges. Similarly, the 22 million increase in Exchange-based coverage in 2016 will be partially offset by a 5 million decrease in those covered by individual-market policies obtained outside the Exchanges. *Id.*

1. "Minimum Essential Coverage"

At first glance, the term "minimum essential coverage," as used in the Internal Revenue Code, sounds like it refers to a base level of benefits or services. However, the Act uses a different term—the "essential health benefits package" in Title 42—to describe health care benefits and services. 42 U.S.C. § 300gg-6(a) (effective Jan. 1, 2014). In contrast, "minimum essential coverage" refers to a broad array of plan types that will satisfy the individual mandate. 26 U.S.C. § 5000A(f)(1).

An individual can satisfy the mandate's "minimum essential coverage" requirement through: (1) any government-funded health plan such as Medicare Part A, Medicaid, TRICARE, or CHIP; (2) any "eligible employer-sponsored plan"; (3) any health plan in the individual market; (4) any grandfathered health plan; or (5) as a catch-all, "such other health benefits coverage" that is recognized by HHS in coordination with the Treasury. *Id.* The mandate provisions in § 5000A do not specify what benefits must be in that plan. The listed plans, in many instances, satisfy the mandate regardless of the level of benefits or coverage.

2. Government-Sponsored Programs

For example, a variety of government-sponsored programs will satisfy the individual mandate. For individuals 65 or over, enrolling in Medicare Part A will suffice. *Id.* § 5000A(f)(1)(A)(i). Individuals and families may satisfy the mandate by enrolling in Medicaid, if eligible. *Id.* § 5000A(f)(1)(A)(ii). Qualifying children under age 19 can satisfy the mandate by enrolling in CHIP. *Id.* § 5000A(f)(1)(A)(iii). Government-sponsored

programs for veterans, active and former military personnel and their families, active Peace Corps volunteers, and active and retired civilian Defense Department personnel and their dependents satisfy the mandate. *Id.* § 5000A(f)(1)(A)(iv), (v), (vi).

3. Eligible Employer-Sponsored Plans

Individuals may also satisfy the mandate by purchasing coverage through any "eligible employer-sponsored plan." *Id.* § 5000A(f)(1)(B). An "eligible employer-sponsored plan" is a "group health plan or group health insurance coverage" offered "by an employer to the employee," which is defined broadly as: (1) a governmental plan established by the federal, state, or local government for its employees; (2) "any other plan or coverage offered in the small or large group market within a State"; or (3) a grandfathered health plan offered in a group market. *Id.* § 5000A(f)(2). Health plans of large employers satisfy the individual mandate whatever the nature of the benefits offered to the employee.[48]

Whether a "self-insured health plan" of large employers satisfies the mandate is another story.[49] The mandate's § 5000A(f)(2) refers to plans in the

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[48] Because of these looser restrictions, some commentators have found it surprising that employer-sponsored coverage qualifies as "minimum essential coverage" under the Act. *See* Monahan & Schwarcz, *supra* note 37, at 157 ("Surprisingly, . . . [the Act] appears to define employer-provided coverage as automatically constituting minimum essential coverage for individuals, despite the minimal requirements applicable to such plans.").

[49] The Act defines an "applicable self-insured health plan" to include self-insured plans providing health care coverage where "any portion of such coverage is provided other than through an insurance policy." 26 U.S.C. § 4376(c).

"small or large group *market*." *Id.* § 5000A(f)(2). A "self-insured health plan," by definition, is not sold or offered in a "market." It is thus not clear whether large employers' self-insured plans will constitute "eligible employer-sponsored plans" in § 5000A(f)(2) and thereby satisfy the mandate. It may be that HHS will later recognize "self-insured plans" under the "other coverage" or "grandfathered plan" categories in the mandate's § 5000A(f)(2).

4. Plans in the Individual Market

Individuals can also satisfy the mandate by purchasing insurance in the individual market through Exchanges or directly from issuers. *Id.* § 5000A(f)(1)(C). The Act imposes the "essential health benefits package" requirement on plans sold in the individual and small group markets. 42 U.S.C. § 300gg-6 (effective Jan. 1, 2014). However, in the individual market, insurers can offer catastrophic plans to persons under age 30 or certain persons exempted from the mandate. *Id.* § 18022(e).

5. Grandfathered Plans

An already-insured individual can fulfill the individual mandate by being covered by any "grandfathered health plan," 26 U.S.C. § 5000A(f)(1)(D), which is any group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010.[50] 42 U.S.C. § 18011(a)(1), (e).

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[50] The Act also allows the enrollment of family members and newly hired employees in grandfathered plans without losing the plans' grandfathered status. 42 U.S.C. § 18011(b), (c). Under the "interim final regulations" issued by HHS, "[a] group health plan or group health insurance coverage does not cease to

While not subject to many of the Act's product reforms, grandfathered plans must comply with some provisions, among them the extension of dependent coverage until age 26, the medical-loss ratio requirements, and the prohibitions on (1) preexisting condition exclusions, (2) lifetime limits on coverage, (3) excessive waiting periods, and (4) unfair rescissions of coverage. *Id.* § 18011(a)(2)–(4), (e). Under the "interim final regulations" issued by HHS, plans will lose their grandfathered status if they choose to significantly (1) cut or eliminate benefits; (2) increase co-payments, deductibles, or out-of-pocket costs for their enrollees; (3) decrease the share of premiums employers contribute for workers in group plans; or (4) decrease annual limits.[51] 45 C.F.R. § 147.140(g)

6. "Other Coverage Recognized" by HHS

The individual mandate even provides a catch-all that leaves open the door to other health coverage. The "minimum essential coverage" requirement may be met by any other coverage that HHS, in coordination with the Treasury, recognizes for

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be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person)." 45 C.F.R. § 147.140(a)(1)(i).

[51] *See also* HealthReform.gov, *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html; Families USA, *Grandfathered Plans under the Patient Protection and Affordable Care Act* (2010), available at http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf.

purposes of meeting this requirement. 26 U.S.C. § 5000A(f)(1)(E).

7. Exemptions and Exceptions to Individual Mandate

The individual mandate, however, does not apply to eight broad categories of persons, either by virtue of an exemption from the mandate or an exception to the mandate's penalty. The Act carves out these three exemptions from the individual mandate: (1) persons with religious exemptions; (2) aliens not legally present in the country; and (3) incarcerated persons. *Id.* § 5000A(d).

The Act also excepts five additional categories of persons from the individual mandate penalty: (1) individuals whose required annual premium contribution exceeds 8% of their household income for the taxable year;[52] (2) individuals whose household income for the taxable year is below the federal income tax filing threshold in 26 U.S.C. § 6012(a)(1); (3) members of Indian tribes; (4) individuals whose gaps in health insurance coverage last less than three months; and (5) as a catch-all, individuals who, as determined by HHS, have suffered a "hardship" regarding their ability to obtain coverage under a qualified health plan. *Id.* § 5000A(e).

8. Calculation of Individual Mandate Penalty

If an applicable individual fails to purchase an insurance plan in one of the many ways allowed, the individual must pay a penalty. *Id.* § 5000A(b)(1).

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[52] The required contribution for coverage means, generally, the amount required to maintain coverage either in an employer-sponsored health plan or in a bronze-level plan offered on an Exchange. *See* 26 U.S.C. § 5000A(e)(1)(A).

The annual penalty will be either: (1) a flat dollar amount, or (2) a percentage of the individual's income if higher than the flat rate. *Id.* § 5000A(c)(1). However, the percentage-of-income figure is capped at the national average premium amount for bronze-level plans in the Exchanges.[53] *Id.*

The flat dollar penalty amount, which sets the floor, is equal to $95 in 2014, $325 in 2015, and $695 in 2016. *Id.* § 5000A(c)(2)(A), (c)(3)(A)–(C). Beyond 2016, it remains $695, except for inflation adjustments.[54] *Id.* § 5000A(c)(3)(D).

The percentage-of-income number that will apply, if higher than the flat dollar amount, is a set percentage of the taxpayer's income that is in excess of the tax-filing threshold (defined in 26 U.S.C. § 6012(a)(1)).[55] *Id.* § 5000A(c)(2). In any event, the total penalty for the taxable year cannot exceed the national average premium of a bronze-level qualified health plan. *Id.* § 5000A(c)(1).

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[53] If the individual fails to fulfill the mandate requirement for only certain months as opposed to a full year, the penalty for each month of no coverage is equal to one-twelfth of the greater of these figures. 26 U.S.C. § 5000A(c)(2)–(3).

[54] The flat dollar amount applies to each individual and dependent in the taxpayer's household without minimum essential coverage, but will not exceed three times the flat dollar amount (even if more than three persons are in the household). 26 U.S.C. § 5000A(c)(2)(A). A family's flat dollar penalty in 2016 would not exceed $2,085 ($695 multiplied by 3).

[55] The percentage by which the taxpayer's household income exceeds the filing threshold is phased in over three years: 1% in 2014, 2% in 2015, and 2.5% in 2016 and thereafter. 26 U.S.C. § 5000A(c)(2)(B)(i)–(iii).

9. Collection of Individual Mandate Penalty

An individual who fails to pay the penalty is not subject to criminal or additional civil penalties. *Id.* § 5000A(g)(2)(A), (B). The IRS's authority to use liens or levies does not apply to the penalty. *Id.* § 5000A(g)(2)(B). No interest accrues on the penalty. The Act contains no enforcement mechanism. *See id.* All the IRS, practically speaking, can do is offset any tax refund owed to the uninsured taxpayer.[56]

We now review the Act's fourth component aimed at reducing the number of the uninsured: the employer penalty.

G. Employer Penalty

The Act imposes a penalty, also housed in the Internal Revenue Code, on certain employers if they do not offer coverage, or offer inadequate coverage, to their employees. *Id.* § 4980H(a), (b). The penalty applies to employers with an average of at least 50 full-time employees. *Id.* § 4980H(a), (b), (c)(2). The employer must pay a penalty if the employer: (1) does not offer its full-time employees the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" as defined in § 5000(A)(f)(2); *or* (2) offers minimum essential coverage (i) that is "unaffordable," or (ii) that consists of a plan whose share of the total cost of benefits is less than 60% (*i.e.*, does not provide "minimum value"); *and* (3) at least one full-time employee purchases a qualified health plan through an Exchange and is allowed a premium tax credit or a subsidy. *Id.* § 4980H(a), (c).

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[56] Of course, the government can always file a civil lawsuit, but the cost of that suit would exceed the modest penalty amount.

The employer penalty is tied to an employer's failure to offer "minimum essential coverage." *Id.* § 4980H(a), (b). Recall that "minimum essential coverage" is not the same thing as the "essential health benefits package." Thus, a large employer may avoid the penalty so long as it offers any plan in the large group market in the state, and the plan is "affordable" and provides "minimum value." *Id.* § 4980H(b)(1), (c)(3).

A small employer's plan, however, must include an "essential health benefits package" and also be "affordable" and provide "minimum value." 42 U.S.C. §§ 300gg-6(a) (effective Jan. 1, 2014), 18022(a)(1)–(3). The Act also provides tax incentives for certain small employers (up to 25 employees) to purchase health insurance for their workers. 26 U.S.C. § 45R.

1. Calculation of Penalty Amount

The penalty amount depends on whether the employee went to the Exchange because the employer's plan (1) was not "minimum essential coverage" or (2) was either "unaffordable" or did not provide "minimum value." The penalty translates to $2,000 to $3,000 per employee annually. *Id.* § 4980H.

An employer that does not offer "minimum essential coverage" to all fulltime employees faces a tax penalty of $166.67 per month (one-twelfth of $2,000) for each of its full-time employees, until the employer offers such coverage (subject to an exemption for the first 30 full-time employees). *Id.* § 4980H(a),(c)(1), (c)(2)(D). This particular penalty applies for as long as at least one employee, eligible for a premium tax credit or a subsidy, enrolls in a qualified health plan through an Exchange. *Id.*

In the "unaffordable coverage"[57] or "no minimum value" scenarios, the employer faces a tax penalty of $250 per month (one-twelfth of $3,000) for each employee who (1) turns down the employer-sponsored plan; (2) purchases a qualified health plan in an Exchange; and (3) is eligible for a federal premium tax credit or subsidy in an Exchange.[58] *Id.* § 4980H(b)(1).

2. Automatic Enrollment

An automatic enrollment requirement applies to employers who (1) have more than 200 employees and (2) elect to offer coverage to their employees. *Id.* § 218a. Such employers must automatically enroll new and current full-time employees, who do not opt out, in one of the employer's plans. *Id.* The maximum 90-day waiting period rule applies,

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[57] Employer-sponsored coverage that is not "affordable" is defined as coverage where the employee's required annual contribution to the premium is more than 9.5% of the employee's household income (as defined for purposes of the premium tax credits in the Exchanges). 26 U.S.C. § 36B(c)(2)(C)(i). This percentage of the employee's income is indexed to the per capita growth in premiums for the insurance market as determined by HHS. *Id.* § 36B(c)(2)(C)(iv). Note that the definition of "unaffordable" for the purposes of obtaining a federal tax credit or subsidy is *not* the same standard that is used to determine whether an individual is exempt from the individual mandate because that individual cannot afford coverage. *Compare id.* § 36B(c)(2)(C)(i), *with id.* § 5000A(e)(1).

[58] The employer's penalty, in this instance, does not exceed the maximum penalty for offering no coverage at all. The penalty for any month is capped at an amount equal to the number of full-time employees during the month multiplied by one-twelfth of $2,000, or $166.67 (subject to the exemption for the first 30 full-time employees). *See* 26 U.S.C. § 4980H(b)(2), (c).

however. *Id.*; 42 U.S.C. § 300gg-7 (effective Jan. 1, 2014).

3. Temporary Reinsurance Program for Employers' Early Retirees

To reduce the number of the uninsured, the Act provides for immediate coverage for even retired employees 55 years and older who are not yet eligible for Medicare. A federal temporary reinsurance program will reimburse former employers who allow their early retirees and the retirees' dependents and spouses to participate in their employment-based plans. The federal government will reimburse a portion of the plan's cost.[59] 42 U.S.C. § 18002(a)(1), (a)(2)(C).

We turn to the Act's fifth component: the Medicaid expansion, which alone will cover millions of the uninsured.

H. Medicaid Expansion

The Act expands Medicaid eligibility and subsidies by amending 42 U.S.C. § 1396a, the section of the Medicaid Act outlining what states must offer in their coverage plans. The Act imposes these substantive requirements on the states' plans, starting in 2014, unless otherwise noted:

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[59] The plan shall submit claims for reimbursement to HHS, and HHS shall reimburse the plan for 80% of the costs of claims in excess of $15,000 but not greater than $90,000. 42 U.S.C. § 18002(c)(2). The reimbursements will be available until January 1, 2014. *Id.* § 18002(a)(1). This federally-subsidized temporary program closes the gap between now and 2014, when the Exchanges, with their federal tax credits and subsidies, become operational.

(1) States will be required to cover adults under age 65 (who are not pregnant and not already covered) with incomes up to 133% of the federal poverty level ("FPL"). *Id.* § 1396a(a)(10)(A)(i)(VIII). This is a significant change, because previously the Medicaid Act did not set a baseline income level for mandatory eligibility. Thus, many states currently do not provide Medicaid to childless adults and cover parents only at much lower income levels.

(2) States will be required to provide Medicaid to all children whose families earn up to 133% of the FPL, including children currently covered through separate CHIP programs. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 1396a(l)(2)(C). States currently must provide Medicaid to children under age 6 with family income up to 133% of the FPL and children ages 6 through 18 with family income up to 100% of the FPL. *Id.* §§ 1396a(a)(10)(A)(i)(IV), (VI), (VII), 1396a(l)(1)(B)–(D), 1396a(l)(2)(A)–(C).

(3) States are required to at least maintain existing Medicaid eligibility levels for adults and children (that were in place as of March 23, 2010) until a state's Exchange is fully operational. *Id.* § 1396a(gg)(1). Whereas states previously had the option to raise or lower their eligibility levels, states cannot institute more restrictive eligibility standards until the new policies take place. *Id.*

(4) Children under age 26 who were receiving Medicaid but were "aged out" of foster care will be newly eligible to continue receiving Medicaid. *Id.* § 1396a(a)(10)(A)(i)(IX) (effective Jan. 1, 2014).

(5) The new law will increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rates for

2013 and 2014. *Id.* § 1396a(a)(13)(C). States will receive 100% federal funding for the cost of the increasing payment rates for 2013 and 2014.[60] *Id.* § 1396d(dd).

Having covered the Act's five major components, we examine the two components challenged as unconstitutional: (1) the Medicaid expansion and (2) the individual mandate.

III. CONSTITUTIONALITY OF MEDICAID EXPANSION

The state plaintiffs challenge the district court's grant of summary judgment in favor of the government on the state plaintiffs' claim that the Act's expansion of the Medicaid program, enacted pursuant to the Spending Clause, is unduly coercive under *South Dakota v. Dole*, 483 U.S. 203, 211, 107 *S. Ct.* 2793, 2798 (1987). For the reasons given below, we conclude that it is not.

A. History of the Medicaid Program

Medicaid is a long-standing partnership between the national and state sovereigns that has been in place for nearly half a century. "In 1965, Congress enacted the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, as Title XIX of the Social Security Act." *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011); *see also Harris v. McRae*, 448 U.S. 297, 301, 100 *S. Ct.* 2671, 2680 (1980). "Medicaid is a jointly financed federal-state cooperative program, designed to help states furnish medical treatment to their needy citizens." *Reese*, 637 F.3d at 1232. The

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[60] *See also* Julie Stone, *et al.*, Cong. Research Serv., R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in the PPACA* 2–4 (2010).

Medicaid Act "prescribes substantive requirements governing the scope of each state's program." *Curtis v. Taylor*, 625 F.2d 645, 649 (5th Cir. 1980).[61] "Section 1396a provides that a 'State plan for medical assistance' must meet various guidelines, including the provision of certain categories of care and services." *Reese*, 637 F.3d at 1232 (citing 42 U.S.C. § 1396a). "Some of these categories are discretionary, while others are mandatory for participating states." *Id.* (citing 42 U.S.C. § 1396a(a)(10)).

Under the Act, the Medicaid program serves as a cornerstone for expanded health care coverage. As explained above in Section II(H), the Act expands Medicaid eligibility and provides significant Medicaid subsidies to the impoverished. As a result of the Act's Medicaid expansion, an estimated 9 million of the 50 million uninsured will be covered for health care by 2014 (and 16 million by 2016 and 17 million by 2021).[62]

The federal government will pay 100% of the fees associated with the increased Medicaid eligibility and subsidies beginning in 2014 and until 2016; that percentage will then drop gradually each year until reaching 90% in 2020. 42 U.S.C. § 1396d(y)(1). The federal government will not cover administrative expenses associated with implementing the new Medicaid policies. *See id.* Under 42 U.S.C. § 1396c, a state whose plan does not comply with the

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[61] In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), this Court adopted as binding precedent all decisions of the former Fifth Circuit issued before the close of business on September 30, 1981.

[62] CBO, *Analysis*, *supra* note 15, at 18 tbl.3.

requirements under § 1396a will be notified by HHS of its noncompliance, and "further payments will not be made to the State (or, in [HHS's] discretion . . . payments will be limited to categories under or parts of the State plan not affected by such failure), until [HHS] is satisfied that there will no longer be any such failure to comply." *Id.* § 1396c.

B. Congress's Power under the Spending Clause

The Spending Clause provides that "Congress shall have Power . . . 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. The Spending Clause permits Congress to "fix the terms on which it shall disburse federal money to the States." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 101 *S. Ct.* 1531, 1539 (1981). "[L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." *Id. a*t 17, 101 *S. Ct.* at 1540.

There are four primary restrictions on legislation enacted pursuant to the Spending Clause. First, the exercise of the spending power must be in pursuit of the general welfare. *See Helvering v. Davis*, 301 U.S. 619, 640, 57 *S. Ct.* 904, 908 (1937). Second, the conditions on the receipt of federal funds must be reasonably related to the legislation's stated goal. *Dole*, 483 U.S. at 207, 107 *S. Ct.* at 2796. Third, Congress's intent to condition funds on a particular action must be unambiguous and must enable the states to knowingly exercise their choice whether to participate. *Pennhurst*, 451 U.S. at 17, 101 *S. Ct.* at 1540. Finally, the federal legislation cannot "induce

the States to engage in activities that would themselves be unconstitutional." *Dole*, 483 U.S. at 210, 107 *S. Ct.* at 2798. The state plaintiffs do not contend the Act's Medicaid expansion violates any of these restrictions.[63]

Rather, the state plaintiffs argue that the Medicaid expansion violates an additional limitation on the use of the spending power to encourage state legislation, one that derives not from the spending power alone, but also from the Tenth Amendment's reservation of certain powers to the states. U.S. Const. amend. X; *see Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 585, 57 *S. Ct.* 883, 890 (1937); *West Virginia v. HHS*, 289 F.3d 281, 286–87 (4th Cir. 2002). Congress may not employ the spending power in such a way as to "coerce" the states into compliance with the federal objective. *See Dole*, 483

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[63] The state plaintiffs suggest that the conditions imposed here violated the second *Dole* restriction because they have no reasonable relationship to the size of the federal inducement. States' Opening Br. at 48, 53. In so arguing, the plaintiffs misinterpret *Dole*. The Supreme Court made clear that the required relationship is between the conditions imposed and "the federal interest in particular national projects or programs," *Dole*, 483 U.S. at 207, 107 *S. Ct.* at 2796 (quotation marks omitted)—that is, "the purpose of federal spending." *New York v. United States*, 505 U.S. 144, 167, 122 *S. Ct.* 2408, 2423 (1992). The state plaintiffs mistakenly assert that the required relationship is between the conditions imposed and "the size of the federal inducement." States' Opening Br. at 53. The condition Congress imposes here on the receipt of federal funds—requiring Medicaid coverage of certain newly eligible individuals—is undeniably related to the purpose of the Medicaid Act, which is to "provid[e] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *McRae*, 448 U.S. at 301, 100 *S. Ct.* at 2680.

U.S. at 211, 107 *S. Ct.* at 2798; *Steward Mach.*, 301 U.S. at 589–91, 57 *S. Ct.* at 892–93; *cf. Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687, 119 *S. Ct.* 2219, 2231 (1999) (holding that a state's waiver of its sovereign immunity is not voluntary where Congress has made it a condition of the state's participation in an otherwise lawful activity). This restriction is different from the restrictions stemming from the spending power because it addresses whether the legislation, while perhaps an appropriate use of the spending power, goes beyond the Spending Clause by forcing the states to participate in a federal program. *Cf. Printz v. United States*, 521 U.S. 898, 117 *S. Ct.* 2365 (1997) (holding that Congress may not enact a law pursuant to one of its enumerated powers and then compel state officers to execute those federal laws); *see also Steward Mach.*, 301 U.S. at 585, 57 *S. Ct.* at 890. That is, the coercion test asks whether the federal scheme removes state choice and compels the state to act because the state, in fact, has no other option.

The coercion doctrine was first discussed at length by the Supreme Court in *Charles C. Steward Machine Co. v. Davis*. In that case, a corporation challenged the imposition of an employment tax under the newly enacted Social Security Act. Addressing the corporation's argument that the federal government improperly coerced states into participation in the Social Security program, the Supreme Court stated:

> The difficulty with the petitioner's contention is that it confuses motive with coercion. Every tax is in some measure regulatory. To

> some extent it interposes an economic impediment to the activity taxed as compared with others not taxed. In like manner every rebate from a tax when conditioned upon conduct is in some measure a temptation. But to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties. The outcome of such a doctrine is the acceptance of a philosophical determinism by which choice becomes impossible. Till now the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems. . . . Nothing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with fitness to the relations between state and nation*. Even on that assumption the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact.

301 U.S. at 589–90, 57 *S. Ct.* at 892 (quotation marks and citation omitted) (emphasis added).

This discussion of the coercion doctrine was later revived by the Supreme Court in *South Dakota v. Dole*. In *Dole*, the state of South Dakota challenged 23 U.S.C. § 158, which directed the Secretary of Transportation to withhold a percentage of federal highway funds otherwise allocable to the states if states failed to maintain a minimum drinking-age requirement of 21 years. 483 U.S. at 205, 107 *S. Ct.* at 2795. The Court noted that Congress may attach conditions on the receipt of federal funds to meet

certain policy objectives, including those that Congress could not otherwise meet through direct regulation. *Id. a*t 206–07, 107 *S. Ct.* at 2795–96. After analyzing whether the minimum drinking-age condition met the four restrictions on the Spending Clause discussed above, the Court noted, "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id. a*t 211, 107 *S. Ct.* at 2798 (quoting *Steward Mach.*, 301 U.S. at 590, 57 *S. Ct.* at 892). It further opined:

> When we consider, for a moment, that all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds otherwise obtainable under specified highway grant programs, the argument as to coercion is shown to be more rhetoric than fact. . . .
>
> Here Congress has offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose. But the enactment of such laws remains the prerogative of the States *not merely in theory but in fact*.

Id. (emphasis added). Thus, the Court once again recognized the coercion doctrine, but found no violation.

The limited case law on the doctrine of coercion and the fact that the Supreme Court has never devised a test to apply it has left many circuits with the conclusion that the doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation. *See*, *e.g.*, *Pace v.*

Bogalusa City Sch. Bd., 403 F.3d 272, 278 (5th Cir. 2005) (en banc) ("It goes without saying that, because states have the independent power to lay and collect taxes, they retain the ability to avoid the imposition of unwanted federal regulation simply by rejecting federal funds."); *A.W. v. Jersey City Pub. Schs.*, 341 F.3d 234, 243–44 (3d Cir. 2003) (noting that the state's freedom to tax makes it difficult to find a federal law coercive, even when that law threatens to withhold all federal funding in a particular area); *Kansas v. United States*, 214 F.3d 1196, 1201–02 (10th Cir. 2000) ("The cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court's discussion of a coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it." (footnote omitted)); *Id. a*t 1202 (observing that the theory is "unclear, suspect, and has little precedent to support its application"); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (noting in a Medicaid expansion case that "to the extent that there is any viability left in the coercion theory, it is not reflected in the facts of this record"); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments."); *Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981) ("The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice. . . . We therefore follow the lead of other courts that have explicitly declined to enter this

thicket when similar funding conditions have been at issue.") (pre-*Dole*); *N.H. Dep't of Emp't Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980) ("Petitioners argue, however, that this option of the state to refuse to participate in the program is illusory, since the severe financial consequences that would follow such refusal negate any real choice. . . . We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stakes that controls, but the rules of the game.") (pre-*Dole*).

Even in those circuits that do recognize the coercion doctrine, it has had little success. *See West Virginia v. HHS*, 289 F.3d at 290, 294–95 (rejecting a coercion doctrine challenge to previous Medicaid Act amendments on the ground that the Secretary may choose to withhold only some funds); *Jim C. v. United States*, 235 F.3d 1079, 1081–82 (8th Cir. 2000) (en banc) (holding that loss of all federal education funds, in that case amounting to 12% of the state's education budget, was "politically painful" but not coercive). Indeed, our review of the relevant case law indicates that no court has ever struck down a law such as this one as unduly coercive.

There are two cases in which the Supreme Court has struck down a statute because it violated the Tenth Amendment's prohibition on commandeering state legislators and executive officials to perform the federal government's work.

While not Spending Clause cases, these cases do give us an understanding of when a law may be considered so coercive as to violate the Tenth Amendment. In *New York v. United States*, the Court struck down as unduly coercive a portion of the

Low-Level Radioactive Waste Policy Amendments Act that required states to "take title" to waste created within the state, noting that Congress has ample opportunity to create incentives for states to act the way that Congress desires. 505 U.S. 144, 176–77, 112 *S. Ct.* 2408, 2428–29 (1992); *see also Printz*, 521 U.S. 898, 117 *S. Ct.* 2365 (holding, in accord with *New York*, that Congress cannot compel states to enact or administer federal regulatory programs).[64] It is clear from these two cases that Congress cannot directly compel a state to act, nor can Congress hinge the state's right to regulate in an area that the state has a constitutional right to regulate on the state's participation in a federal program. Either act is clearly unconstitutionally coercive.

If anything can be said of the coercion doctrine in the Spending Clause context, however, it is that it is an amorphous one, honest in theory but complicated in application. But this does not mean that we can cast aside our duty to apply it; indeed, it is a mystery to us why so many of our sister circuits have done so. To say that the coercion doctrine is not viable or does

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[64] The Supreme Court has also briefly discussed coercion in another context. In *Florida Prepaid*, the Court held that federal courts lack jurisdiction over a Lanham Act suit against a state, despite a law purporting to abrogate the states' sovereign immunity under the Lanham Act. 527 U.S. at 691, 119 *S. Ct.* at 2233. While the holding rested on Eleventh Amendment immunity grounds, Justice Scalia noted: "[W]e think where the constitutionally guaranteed protection of the States' sovereign immunity is involved, the point of coercion is automatically passed—and the voluntariness of waiver destroyed—when what is attached to the refusal to waive is the exclusion of the State from otherwise lawful activity." *Id. a*t 687, 119 *S. Ct.* at 2231.

not exist is to ignore Supreme Court precedent, an exercise this Court will not do. As the district court noted, "The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court." *Florida ex rel. McCollum v. HHS*, 716 F. Supp. 2d 1120, 1160 (N.D. Fla. 2010).[65] If the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it.

For now, we find it a reasonable conclusion that *Dole* instructs that the Tenth Amendment places certain limitations on congressional spending; namely, that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the "optional" legislation. This is the point where "'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211, 107 *S. Ct.* at

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[65] In *Florida ex rel. McCollum v. HHS*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010), the district court granted in part and denied in part the government's motion to dismiss. In *Florida ex rel. Bondi v. HHS*, No. 3:10-CV-91-RV/EMT, __ F. Supp. 2d __, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011), the district court ruled that (1) the Medicaid expansion did not exceed Congress's Spending Clause powers and (2) the individual mandate is beyond Congress's commerce powers and is inseverable from the rest of the Act.

2798 (quoting *Steward Mach.*, 301 U.S. at 590, 57 *S. Ct.* at 892).

And so it is not without serious thought and some hesitation that we conclude that the Act's expansion of Medicaid is not unduly coercive under *Dole* and *Steward Machine*. There are several factors, which, for us, are determinative. First, the Medicaid-participating states were warned from the beginning of the Medicaid program that Congress reserved the right to make changes to the program. *See* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress."); *McRae*, 448 U.S. at 301, 100 *S. Ct.* at 2680 (noting "[a]lthough participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements" that Congress sees fit to impose). Indeed, Congress has made numerous amendments to the program since its inception in 1965. 42 U.S.C. § 1396a Note (listing amendments).[66] In each of

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[66] The government discusses the various Medicaid expansions at length:

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

these previous amendments, the states were given the option to comply with the changes, or lose all or part of their funding. *Id.* § 1396c. None of these amendments has been struck down as unduly coercive.

Second, the federal government will bear nearly all of the costs associated with the expansion. The states will only have to pay incidental administrative costs associated with the expansion until 2016; after which, they will bear an increasing percentage of the cost, capping at 10% in 2020.[67] *Id.* § 1396d(y)(1). If states bear little of the cost of expansion, the idea that states are being coerced into spending money in an ever-growing program seems to us to be "more rhetoric than fact." *Dole*, 483 U.S. at 211, 107 *S. Ct.* at 2798.

Third, states have plenty of notice—nearly four years from the date the bill was signed into law—to decide whether they will continue to participate in Medicaid by adopting the expansions or not. This gives states the opportunity to develop new budgets (indeed, Congress allocated the cost of the entire

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> children under age six who meet certain income limits. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989).

Government's Reply Br. at 46–47.

[67] At oral argument, the state plaintiffs expressed a concern that Medicaid costs would be even larger because the individual mandate would greatly increase the number of persons in Medicaid who are currently eligible but for one reason or another do not choose to participate. This argument is not persuasive, however, as to whether the expansions themselves are coercive, because the increase in enrollment would still occur if the mandate were upheld, even if the Medicaid expansions were struck down.

expansion to the federal government initially, with the cost slowly shifting to the states over a period of six years) to deal with the expansion, or to develop a replacement program in their own states if they decide to do so. Fourth, like our sister circuits, we cannot ignore the fact that the states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress's terms. *See Pace*, 403 F.3d at 278; *Jersey City Pub. Schs.*, 341 F.3d at 243–44.

Finally, we note that while the state plaintiffs vociferously argue that states who choose not to participate in the expansion will lose all of their Medicaid funding, nothing in the Medicaid Act states that this is a foregone conclusion. Indeed, the Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state. 42 U.S.C. § 1396c; *see also West Virginia v. HHS*, 289 F.3d at 291–92; *Dole*, 483 U.S. at 211, 107 *S. Ct.* at 2798 (finding no coercion when "all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds otherwise obtainable under specified highway grant programs").

Taken together, these factors convince us that the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act's Medicaid expansion. *See Dole*, 483 U.S. at 211, 107 *S. Ct.* at 2798. Where an entity has a real choice, there can be no coercion. *See Steward Mach.*, 301 U.S. at 590, 57 *S. Ct.* at 892 (noting that in the absence of undue influence, "the law has been guided by a robust common sense which assumes the

freedom of the will as a working hypothesis in the solution of its problems").

Accordingly, the district court's grant of summary judgment to the government on the Medicaid expansion issue is affirmed.

We now turn to the constitutionality of the Act's fourth component: the individual mandate. We begin with the relevant constitutional clauses and Supreme Court precedent.

IV. SUPREME COURT'S COMMERCE CLAUSE DECISIONS

Two constitutional provisions govern our analysis of whether Congress acted within its commerce authority in enacting the individual mandate: the Commerce Clause and the Necessary and Proper Clause. U.S. Const. art. I, § 8, cls. 3, 18.

Seven words in the Commerce Clause—"[t]o regulate Commerce . . . among the several States," *id.* art. I, § 8, cl. 3—have spawned a 200-year debate over the permissible scope of this enumerated power. For many years, the Supreme Court described Congress's commerce power as regulating "traffic"—the "buying and selling, or the interchange of commodities"—and "intercourse" among states, including transportation. *See Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 189–90 (1824). Under this early understanding of the Clause, Congress could not reach commerce that was strictly internal to a state. *See Id. a*t 194–95 ("The enumeration presupposes something not enumerated; and that something, if we regard the language or the subject of the sentence, must be the exclusively internal commerce of a State.").

Ultimately, in recognition of a modern and integrated national economy and society, the New Deal decisions of the Supreme Court charted an expansive doctrinal path. *See*, *e.g.*, *United States v. Darby*, 312 U.S. 100, 61 *S. Ct.* 451 (1941); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 *S. Ct.* 615 (1937). These Supreme Court decisions adopted a broad view of the Commerce Clause, in tandem with the Necessary and Proper Clause, and permitted Congress to regulate purely local, intrastate economic activities that substantially affect interstate commerce. The "substantial effects" doctrine, along with the related "aggregation" doctrine, expanded the reach of Congress's commerce power exponentially. Nonetheless, the Supreme Court has staunchly maintained that the commerce power contains outer limits which are necessary to preserve the federal-state balance in the Constitution.

We therefore review the principal Commerce Clause precedents that inform our analysis of the difficult question before us. Although extensive, this survey is necessary to understanding the rudiments of the Supreme Court's existing Commerce Clause doctrines that we, as an inferior Article III court, must apply.

A. *Wickard v. Filburn*

One of the early "substantial effects" decisions is *Wickard v. Filburn*, 317 U.S. 111, 63 *S. Ct.* 82 (1942), where the Supreme Court held that Congress's wheat production quotas were constitutional as applied to a plaintiff farmer's home-grown and home-consumed wheat. The Agricultural Adjustment Act of 1938 ("AAA") sought to control the volume of wheat in interstate and foreign commerce by placing acreage

limits on farmers. *Id. a*t 115, 63 *S. Ct.* at 84. This scheme was intended to prevent wheat surpluses and shortages, attendant price instability, and obstructions to commerce. *Id.*

Plaintiff Filburn operated a small farm raising wheat. *Id. a*t 114, 63 *S. Ct.* at 84. Filburn sold some of this wheat crop, allocated a portion as feed for livestock and poultry on his farm, used another portion as flour for home consumption, and preserved the remainder for future seedings. *Id.* Although his AAA allotment was only 11.1 acres, Filburn sowed and harvested 23 acres of wheat—11.9 excess acres that the Supreme Court treated as home-consumed wheat.[68] *Id. a*t 114–15, 63 *S. Ct.* at 84. This violation subjected him to a penalty of 49 cents a bushel.[69] *Id.* Filburn sued, claiming that Congress's acreage quotas on his home-consumed wheat exceeded its commerce power because the regulated activities were local in nature and their effects upon interstate commerce were "indirect." *Id. a*t 119, 63 *S. Ct.* at 86.

The Supreme Court examined the factors of home-consumed wheat that impinged on interstate commerce—factors which could potentially frustrate Congress's regulatory scheme if not controlled. The Court declared that home-consumed wheat "constitutes the most variable factor in the disappearance of the wheat crop," since

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[68] *See also Gonzales v. Raich*, 545 U.S. 1, 20, 125 *S. Ct.* 2195, 2207 (2005) (noting that *Wickard* Court treated Filburn's wheat as home-consumed, not part of commercial farming operation).

[69] These penalties were levied regardless of "whether any part of the wheat either within or without the quota, is sold or intended to be sold." *Wickard*, 317 U.S. at 119, 63 *S. Ct.* at 86.

"[c]onsumption on the farm where grown appears to vary in an amount greater than 20 per cent of average production." *Id. a*t 127, 63 *S. Ct.* at 90. Filburn's home-consumed wheat therefore "compete[d]" with wheat sold in commerce, since "it supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market." *Id. a*t 128, 63 *S. Ct.* at 91.

The *Wickard* Court recognized that "the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices" and "it can hardly be denied that a factor of such volume and variability as home-consumed wheat would have a substantial influence on price and market conditions." *Id. a*t 128, 63 *S. Ct.* at 90–91. Therefore, the objectives of the AAA acreage quotas—"to increase the market price of wheat and to that end to limit the volume thereof that could affect the market"— constituted appropriate regulatory goals. *Id.*

Despite the fact that Congress's commerce power "has been held to have great latitude," *id.* at 120, 63 *S. Ct.* at 86, the Supreme Court recognized the novelty of its decision, remarking that "there is no decision of this Court that such activities may be regulated where no part of the product is intended for interstate commerce or intermingled with the subjects thereof." *Id. a*t 120, 63 *S. Ct.* at 86–87. However, the *Wickard* Court concluded that "even if [Filburn's] activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce

and this irrespective of whether such effect is what might at some earlier time have been defined as 'direct' or 'indirect.'" *Id. a*t 125, 63 *S. Ct.* at 89. The Court declared that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce." *Id. a*t 120, 63 *S. Ct.* at 87; *see also Id. a*t 123–24, 63 *S. Ct.* at 88 (stating that "the relevance of the economic effects in the application of the Commerce Clause . . . has made the mechanical application of legal formulas no longer feasible").

Even though Filburn's own contribution to wheat demand "may be trivial by itself," this was "not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial." *Id. a*t 127–28, 63 *S. Ct.* at 90. Since Filburn's homegrown wheat slackened demand for market-based wheat and placed downward pressures on price, "Congress may properly have considered that wheat consumed on the farm where grown if wholly outside the scheme of regulation would have a substantial effect in defeating and obstructing its purpose to stimulate trade therein at increased prices." *Id. a*t 128–29, 63 *S. Ct.* at 91.

The Supreme Court noted that restricting Filburn's acreage could have the effect of forcing Filburn to buy wheat in the market: "It is said, however, that this Act, forcing some farmers into the market to buy what they could provide for themselves, is an unfair promotion of the markets

and prices of specializing wheat growers." *Id. a*t 129, 63 *S. Ct.* at 91. Rejecting this, the Supreme Court stated, "It is of the essence of regulation that it lays a restraining hand on the self-interest of the regulated and that advantages from the regulation commonly fall to others." *Id.*

B. *United States v. South-Eastern Underwriters Association*

Although not concerning the "substantial effects" doctrine, the 1944 case *United States v. South-Eastern Underwriters Association*, 322 U.S. 533, 64 *S. Ct.* 1162 (1944), is important to our analysis, as it marked the Supreme Court's first recognition that the insurance business *is commerce*—and where it is conducted across state borders, it constitutes interstate commerce capable of being regulated by Congress.[70] *Id. a*t 553, 64 *S. Ct.* at 1173. The Supreme Court emphasized the interstate character of insurance business practices, which resulted in a "continuous and indivisible stream of intercourse

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[70] Prior to 1944, the Supreme Court consistently upheld the power of the states to regulate insurance. During those early years, Congress had not regulated insurance, but the states had. The operative question concerned whether Congress's power to regulate interstate commerce deprived states of the power to regulate the insurance business themselves. Since Congress had not sought to regulate insurance, an invalidation of the states' statutes would entail that insurance companies could operate without any regulation. The earlier Supreme Court decisions held that insurance is not commerce, thereby skirting any constitutional problem arising from the Constitution's grant of power to Congress to regulate interstate commerce. *See Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868); *see also N.Y. Life Ins. Co. v. Deer Lodge Cnty.*, 231 U.S. 495, 34 *S. Ct.* 167 (1913); *Hooper v. California*, 155 U.S. 648, 15 *S. Ct.* 207 (1895).

among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts." *Id. a*t 541, 64 *S. Ct.* at 1167. The defendants' insurances policies "covered not only all kinds of fixed local properties, but also. . . movable goods of all types carried in interstate and foreign commerce by every media of transportation." *Id. a*t 542, 64 *S. Ct.* at 1168.

The *South-Eastern Underwriters* Court rejected the notion that, if any components of the insurance business constitute interstate commerce, the states may not exercise regulatory control over the industry. *Id. a*t 548, 64 *S. Ct.* at 1171. Nevertheless, the Court pronounced that "[n]o commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." *Id. a*t 553, 64 *S. Ct.* at 1173.

C. *Heart of Atlanta Motel v. United States*

In another landmark Commerce Clause case, *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 85 *S. Ct.* 348 (1964), the Supreme Court held that Congress acted within its commerce authority in enacting Title II of the Civil Rights Act of 1964, which prohibited discrimination in public accommodations. The plaintiff owned and operated a 216-room motel whose guests were primarily out-of-state visitors. *Id. a*t 243, 85 *S. Ct.* at 350–51. The motel refused to rent rooms to black patrons. *Id. a*t 243, 85 *S. Ct.* at 351.

The Supreme Court detailed the "overwhelming evidence that discrimination by hotels and motels impedes interstate travel." *Id. a*t 253, 85 *S. Ct.* at 355. The Court noted that it had "long been settled" that transportation of persons in interstate commerce is within Congress's regulatory power, regardless of "whether the transportation is commercial in character." *Id. a*t 256, 85 *S. Ct.* at 357. Additionally, Supreme Court precedents confirmed that "the power of Congress to promote interstate commerce also includes the power to regulate the local incidents thereof . . . which might have a substantial and harmful effect upon that commerce." *Id. a*t 258, 85 *S. Ct.* at 358. Thus, "Congress may—as it has—prohibit racial discrimination by motels serving travelers, however 'local' their operations may appear." *Id.*

The *Heart of Atlanta Motel* Court acknowledged that "Congress could have pursued other methods to eliminate the obstructions it found in interstate commerce caused by racial discrimination," but the means employed in removing such obstructions are "within the sound and exclusive discretion of the Congress" and are "subject only to one caveat—that the means chosen by it must be reasonably adapted to the end permitted by the Constitution." *Id. a*t 261–62, 85 *S. Ct.* at 360. The means chosen by Congress in Title II clearly met this standard.[71]

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[71] In *Katzenbach v. McClung*, 379 U.S. 294, 85 *S. Ct.* 377 (1964), a companion case, the Court also upheld Title II's prohibition on discrimination in restaurants serving food to interstate travelers or serving food that had moved in interstate commerce.

D. *United States v. Lopez*

For the next thirty years, the Supreme Court applied an expansive interpretation of Congress's commerce power and upheld a wide variety of statutes. *See*, *e.g.*, *Preseault v. ICC*, 494 U.S. 1, 110 *S. Ct.* 914 (1990) (upholding statute amending National Trails System Act in facial challenge); *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 101 *S. Ct.* 2352 (1981) (sustaining Surface Mining Control and Reclamation Act in facial challenge); *Perez v. United States*, 402 U.S. 146, 91 *S. Ct.* 1357 (1971) (sustaining Title II of Consumer Credit Protection Act in as-applied challenge); *Maryland v. Wirtz*, 392 U.S. 183, 88 *S. Ct.* 2017 (1968) (upholding validity of amendments to Fair Labor Standards Act of 1938 in facial challenge), *overruled on other grounds*, *Nat'l League of Cities v. Usery*, 426 U.S. 833, 96 *S. Ct.* 2465 (1976), *overruled by Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 105 *S. Ct.* 1005 (1985). These cases reflect a practical need to allow federal regulation of a growing and unified national economy.

In 1995, the Supreme Court decided *United States v. Lopez*, 514 U.S. 549, 115 *S. Ct.* 1624 (1995), the first Supreme Court decision since the 1930s to rule that Congress had exceeded its commerce power. *Lopez* concerned the Gun-Free School Zones Act of 1990, which made it a federal offense "for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone." 18 U.S.C. § 922(q)(1)(A) (1993). The defendant Alfonso *Lopez*, a twelfth-grade student, was convicted of carrying a concealed

handgun to his Texas school. *Lopez*, 514 U.S. at 551, 115 *S. Ct.* at 1626.

In a 5–4 opinion, the *Lopez* Court invalidated § 922(q). The *Lopez* Court first observed that the Constitution created a federal government of enumerated, delegated, and thus limited powers. *Id. a*t 552, 115 *S. Ct.* at 1626. Although the Supreme Court's New Deal precedents expanded Congress's commerce power, the *Lopez* Court recognized that "this power is subject to outer limits." *Id. a*t 557, 115 *S. Ct.* at 1628. The *Lopez* Court then enumerated the "three broad categories of activity that Congress may regulate under its commerce power": (1) "the use of the channels of interstate commerce"; (2) "the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities"; and (3) "those activities that substantially affect interstate commerce."[72] *Id. a*t 558–59, 115 *S. Ct.* at 1629–30. After determining that § 922(q) could be sustained only under this third category, the *Lopez* Court identified four factors influencing its analysis of whether gun possession in school zones substantially affects interstate commerce.

First, the *Lopez* Court differentiated between economic and non-economic activity, stressing how prior cases utilizing the substantial effects test to reach intrastate conduct had all involved economic activity. The Supreme Court stated that "Section 922(q) is a criminal statute that by its terms has

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[72] The "third *Lopez* prong is the broadest expression of Congress' commerce power." *United States v. Ballinger*, 395 F.3d 1218, 1226 (11th Cir. 2005) (en banc).

nothing to do with 'commerce' or any sort of economic enterprise" and was "not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Id. a*t 561, 115 *S. Ct.* at 1630–31. The Court opined that "[e]ven *Wickard*, which is perhaps the most far reaching example of Commerce Clause authority over intrastate activity, involved *economic activity* in a way that the possession of a gun in a school zone does not." *Id. a*t 560, 115 *S. Ct.* at 1630 (emphasis added). The *Lopez* Court acknowledged that "a determination whether an intrastate activity is commercial or noncommercial may in some cases result in legal uncertainty," yet "so long as [Congress's] enumerated powers are interpreted as having judicially enforceable outer limits, congressional legislation under the Commerce Clause always will engender 'legal uncertainty.'" *Id. a*t 566, 115 *S. Ct.* at 1633.

Second, the *Lopez* Court found it significant that § 922(q) did not contain a "jurisdictional element" to "ensure, through case-by-case inquiry, that the firearm possession in question affects interstate commerce." *Id. a*t 561, 115 *S. Ct.* at 1631. Instead, the Act penalized "mere possession" and lacked any requirement that there be "an explicit connection with or effect on interstate commerce."[73] *Id. a*t 562, 115 *S. Ct.* at 1631.

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[73] In this respect, the *Lopez* Court contrasted the Gun-Free School Zones Act of 1990 with the firearm possession statute at issue in *United States v. Bass*, 404 U.S. 336, 92 *S. Ct.* 515 (1971). In *Bass*, the Supreme Court construed legislation making it a federal crime for a felon to "receiv[e], posses[s], or transpor[t] *in commerce or affecting commerce* . . . any firearm."

Third, the Court noted that Congress provided no legislative findings demonstrating the purported nexus between gun possession around schools and its effects on interstate commerce. *Id. a*t 562–63, 115 *S. Ct.* at 1631–32.

Fourth, the *Lopez* Court examined the actual relationship between gun possession in a school zone and its effects on interstate commerce. The government posited three effects: (1) violent crime, even when purely local, generates substantial costs that are spread to the wider populace through insurance; (2) individuals are deterred from traveling to areas beset by violent crime; and (3) guns in schools imperil the learning environment, which in turn adversely impacts national productivity. *Id. a*t 563–64, 115 *S. Ct.* at 1632.

The *Lopez* Court declared that the government's arguments yielded no limiting principles. For example, under the government's proffered "costs of crime" theory, "Congress could regulate not only all violent crime, but all activities that might lead to violent crime, regardless of how tenuously they relate to interstate commerce." *Id. a*t 564, 115 *S. Ct.* at 1632. Likewise, the "national productivity" rationale afforded no bounds, either. If Congress could employ its Commerce Clause authority to "regulate activities that adversely affect the learning environment, then,

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Lopez, 514 U.S. at 561–62, 115 *S. Ct.* at 1631 (emphasis added) (quoting former 18 U.S.C. § 1202(a)). The *Lopez* Court stated that "[u]nlike the statute in *Bass*, § 922(q) has no express jurisdictional element which might limit its reach to a discrete set of firearm possessions that additionally have an explicit connection with or effect on interstate commerce." *Id. a*t 562, 115 *S. Ct.* at 1631.

a fortiori, it also can regulate the educational process directly." *Id. a*t 566, 115 *S. Ct.* at 1633. Indeed, "Congress could regulate any activity that it found was related to the economic productivity of individual citizens," including "marriage, divorce, and child custody." *Id. a*t 564, 115 *S. Ct.* at 1632.

The Supreme Court pronounced that these links were too attenuated to conclude that the regulated activity "substantially affects" interstate commerce: "[I]f we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *Id.* "To uphold the Government's contentions," the Supreme Court continued, "we would have to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States." *Id. a*t 567, 115 *S. Ct.* at 1634.

Lastly, the *Lopez* Court acknowledged that some of the Supreme Court's precedents gave "great deference to congressional action" but refused to expand the "broad language" of these precedents any further, since "[t]o do so would require us to conclude that the Constitution's enumeration of powers does not presuppose something not enumerated." *Id.* Such judicial abdication would dissolve the "distinction between what is truly national and what is truly local" and subvert constitutional notions of federalism. *Id. a*t 567–68, 115 *S. Ct.* at 1634.

Although both joined the majority opinion in full, two justices wrote separately and echoed the majority's emphasis on the significance of the federal-state balance in the structure of the Constitution,

and the need for judicial intervention when Congress has "tipped the scales too far." *See Id. a*t 568–83, 115 *S. Ct.* at 1634–42 (Kennedy, J., concurring);[74] *Id. a*t 584–602, 115 *S. Ct.* at 1642–51 (Thomas, J., concurring).[75]

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[74] In a concurring opinion, Justice Kennedy explained why he joined the *Lopez* majority opinion in full and what he characterized as its "necessary though limited holding." 514 U.S. at 568, 115 *S. Ct.* at 1634 (Kennedy, J., concurring). Justice Kennedy noted "the imprecision of content-based boundaries used without more to define the limits of the Commerce Clause," referring to earlier dichotomies that distinguished between "manufacturing and commerce," "direct and indirect effects," and other formalistic categories. *Id. a*t 574, 115 *S. Ct.* at 1637. He stressed that the Supreme Court is "often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines." *Id. a*t 579, 115 *S. Ct.* at 1640.

Justice Kennedy found that § 922(q) "upsets the federal balance to a degree that renders it an unconstitutional assertion of the commerce power, and our intervention is required." *Id. a*t 580, 115 *S. Ct.* at 1640. Much like the majority opinion, Justice Kennedy emphasized the far-reaching implications of the government's position: "In a sense any conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we have not yet said the commerce power may reach so far. If Congress attempts that extension, then at the least we must inquire whether the exercise of national power seeks to intrude upon an area of traditional state concern." *Id.* Such an interference was present in *Lopez*, as "it is well established that education is a traditional concern of the States." *Id.* Justice Kennedy added that courts have a "duty to recognize meaningful limits on the commerce power of Congress." *Id.*

[75] *See* discussion of Justice Thomas's concurring opinion *infra* note 78.

E. *United States v. Morrison*

In another 5–4 decision, the Supreme Court in *United States v. Morrison*, 529 U.S. 598, 120 *S. Ct.* 1740 (2000), reapplied the *Lopez* principles and invalidated a section of the Violence Against Women Act of 1994 ("VAWA"), 42 U.S.C. § 13981, which provided a federal civil remedy for victims of gender-motivated violence.[76]

In enacting the VAWA, Congress made specific findings about the relationship between gender-motivated violence and its substantial effects on interstate commerce. Congress declared its objectives were "to protect victims of gender motivated violence" and "to promote public safety, health, and activities affecting interstate commerce."[77] *Id.* § 13981(a).

The *Morrison* Court observed that since the New Deal case of *Jones & Laughlin Steel*, "Congress has had considerably greater latitude in regulating conduct and transactions under the Commerce Clause than our previous case law permitted."

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[76] The VAWA provided that a person who "commits a crime of violence motivated by gender . . . shall be liable to the party injured, in an action for the recovery of compensatory and punitive damages, injunctive and declaratory relief, and such other relief as a court may deem appropriate." 42 U.S.C. § 13981(c).

[77] The *Morrison* plaintiff was a college student allegedly raped by two football players. 529 U.S. at 602, 120 *S. Ct.* at 1745–46. The plaintiff filed suit in federal court under § 13981(c). *Id. a*t 604, 120 *S. Ct.* at 1746. The defendant's motion to dismiss argued that Congress lacked authority to enact the VAWA's federal civil remedy provision under either the Commerce Clause or § 5 of the Fourteenth Amendment. *Id. a*t 604, 120 *S. Ct.* at 1746–47.

Morrison, 529 U.S. at 608, 120 *S. Ct.* at 1748. *Lopez* clarified, however, that "Congress' regulatory authority is not without effective bounds." *Id.*

The Supreme Court stated that "a fair reading of *Lopez* shows that the noneconomic, criminal nature of the conduct at issue was central to our decision in that case." *Id. a*t 610, 120 *S. Ct.* at 1750. The *Morrison* Court pointed out that "[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity." *Id. a*t 613, 120 *S. Ct.* at 1751. "While we need not adopt a categorical rule against aggregating the effects of any noneconomic activity in order to decide these cases," the Supreme Court reiterated that "our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature." *Id.*

The Supreme Court next noted that § 13981 contained no jurisdictional element. It commented that another provision of the VAWA, which similarly provided a federal remedy for gender-motivated crime, *did* contain a jurisdictional hook. *Id. a*t 613 n.5, 120 *S. Ct.* at 1752 n.5 (discussing 18 U.S.C. § 2261(a)(1), which at the time applied only to an individual "who travels across a State line or enters or leaves Indian country").

Unlike § 922(q) in *Lopez*, § 13981 was "supported by numerous findings regarding the serious impact that gender-motivated violence has on victims and their families." *Id. a*t 614, 120 *S. Ct.* at 1752. Nonetheless, the *Morrison* Court stated that congressional findings were not dispositive, echoing *Lopez*'s statement that "[s]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily

make it so." *Id.* (alteration in original) (quoting *Lopez*, 514 U.S. at 557 n.2, 115 *S. Ct.* at 1624 n.2).

The *Morrison* Court determined that "Congress' findings are substantially weakened by the fact that they rely so heavily on a method of reasoning that we have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Id. a*t 615, 120 *S. Ct.* at 1752. The congressional findings in Morrison asserted that gender-motivated violence deterred potential victims from interstate travel and employment in interstate business, decreased national productivity, and increased medical costs. *Id.* According to the *Morrison* Court, "[t]he reasoning that petitioners advance seeks to follow the but-for causal chain from the initial occurrence of violent crime (the suppression of which has always been the prime object of the States' police power) to every attenuated effect upon interstate commerce." *Id.* The logical entailment of this "but-for causal chain" of reasoning "would allow Congress to regulate any crime as long as the nationwide, aggregated impact of that crime has substantial effects on employment, production, transit, or consumption." *Id. a*t 615, 120 *S. Ct.* at 1752–53. Such arguments suggested no stopping point, and Congress could thereby exercise powers traditionally reposed in the states.[78] *Id. a*t 615–16, 120 *S. Ct.* at 1753.

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[78] Although joining the majority opinion in full in both *Lopez* and *Morrison*, Justice Thomas wrote separately in both cases to reject the substantial effects doctrine. In *Morrison*, Justice Thomas wrote "only to express my view that the very notion of a 'substantial effects' test under the Commerce Clause is inconsistent with the original understanding of Congress'

F. *Gonzales v. Raich*

Next came *Gonzales v. Raich*, 545 U.S. 1, 125 *S. Ct.* 2195 (2005), where the Supreme Court, in a 6–3 vote, concluded that Congress acted within its commerce power in prohibiting the plaintiffs' wholly intrastate production and possession of marijuana, even though California state law approved the drug's use for medical purposes. The legislation at issue was the Controlled Substances Act ("CSA"), 21 U.S.C. § 801 *et seq.*, in which Congress sought to "conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances" and "prevent the diversion of drugs from legitimate to illicit channels." *Raich*, 545 U.S. at 12–13, 125 *S. Ct.* at 2203. Congress consequently "devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the CSA." *Id. a*t 13, 125 *S. Ct.* at 2203. Under the CSA, marijuana is classified as a "Schedule I" drug, meaning that the manufacture, distribution, or possession of marijuana constitutes a criminal offense. *Id. a*t 14, 125 *S. Ct.* at 2204.

In 1996, California voters passed Proposition 215, which exempted from criminal prosecution

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powers and with this Court's early Commerce Clause cases." 529 U.S. at 627, 120 *S. Ct.* at 1759 (Thomas, J., concurring). Characterizing the substantial effects test as a "rootless and malleable standard," Justice Thomas remarked that the Supreme Court's present Commerce Clause jurisprudence had encouraged the federal government to operate under the misguided belief that the Clause "has virtually no limits." *Id.* Unless the Supreme Court reversed its course, "we will continue to see Congress appropriating state police powers under the guise of regulating commerce." *Id.*

physicians who recommend marijuana to a patient for medical purposes, as well as patients and primary caregivers who possess and cultivate marijuana for doctor-approved medical purposes.[79] *Id. a*t 5–6, 125 *S. Ct*. at 2199. The two California plaintiffs, Angel Raich and Diane Monson, suffered from serious medical conditions and used marijuana as medication for several years, as recommended by their physicians. *Id. a*t 6–7, 125 *S. Ct*. at 2199–2200. Monson cultivated her own marijuana, while Raich relied upon two caregivers to provide her with locally grown marijuana at no cost. *Id. a*t 7, 125 *S. Ct*. at 2200.

After federal agents seized and destroyed Monson's cannabis plants, the *Raich* plaintiffs sued. *Id.* They acknowledged that the CSA was within Congress's commerce authority and did not contend that any section of the CSA was unconstitutional. *Id. a*t 15, 125 *S. Ct*. at 2204. Instead, they argued solely that the CSA was unconstitutional *as applied to* their manufacture, possession, and consumption of cannabis for personal medical use. *Id. a*t 7–8, 125 *S. Ct*. at 2200.

In rejecting the plaintiffs' "quite limited" as-applied challenge, the Raich Court stated that its case law "firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Id. a*t 15, 17, 125 *S. Ct*. at 2204–05. The Supreme Court emphasized that, in assessing Congress's commerce power, its

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[79] Proposition 215 is codified as the Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5.

review was a "modest one": "We need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Id. a*t 22, 125 *S. Ct.* at 2208. The *Raich* Court commented that "[w]hen Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the entire class," and it need not "legislate with scientific exactitude." *Id. a*t 17, 125 *S. Ct.* at 2206 (quotation marks omitted). "[W]e have reiterated," the Supreme Court continued, "that when 'a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence.'" *Id.* (quotation marks omitted) (quoting *Lopez*, 514 U.S. at 558, 115 *S. Ct.* at 1629).

The Supreme Court found similar regulatory concerns underlying both the CSA in *Raich* and the AAA wheat provisions in *Wickard*. Just as rising market prices could draw wheat grown for home consumption into the interstate market and depress prices, a "parallel concern making it appropriate to include marijuana grown for home consumption in the CSA is the likelihood that the high demand in the interstate market will draw such marijuana into that market." *Id. a*t 19, 125 *S. Ct.* at 2207. In both cases, there was a threat of unwanted commodity diversion that could disrupt Congress's regulatory control over interstate commerce. *Id.*

According to the *Raich* Court, *Wickard* established that "Congress can regulate purely intrastate activity that is not itself 'commercial,' in that it is not produced for sale, if it concludes that

failure to regulate that class of activity would undercut the regulation of the interstate market in that commodity." *Id. a*t 18, 125 *S. Ct.* at 2206. Characterizing the similarities between the plaintiffs' case and *Wickard* as "striking," the *Raich* Court explained that "[i]n both cases, the regulation is squarely within Congress' commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *Id. a*t 18–19, 125 *S. Ct.* at 2206–07.

The *Raich* Court opined that the failure to regulate intrastate production and possession of marijuana would leave a "gaping hole" in the CSA's regulatory scheme: CSA enforcement would be frustrated by the difficulty in distinguishing between locally cultivated marijuana and out-of-state marijuana, and the marijuana authorized by state law could be diverted into "illicit channels." *Id. a*t 22, 125 S. Ct. at 2209. The Raich Court rejected the notion that California had "surgically excised a discrete activity that is hermetically sealed off from the larger interstate marijuana market." *Id. a*t 30, 125 *S. Ct.* at 2213. Accordingly, even though the CSA "ensnares some purely intrastate activity," the *Raich* Court "refuse[d] to excise individual components of that larger scheme." *Id.* Instead, "congressional judgment that an exemption for such a significant segment of the total market would undermine the orderly enforcement of the entire regulatory scheme is entitled to a strong presumption of validity." *Id. a*t 28, 125 *S. Ct.* at 2212.

The *Raich* Court concluded that the statutory challenges in *Lopez* and *Morrison* were "markedly different" from the plaintiffs' statutory challenge to the CSA. *Id. a*t 23, 125 *S. Ct.* at 2209. Whereas the *Raich* plaintiffs sought to "excise individual applications of a concededly valid statutory scheme," the Supreme Court noted that "in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its entirety." *Id.* The *Raich* Court considered this distinction between facial and as-applied challenges "pivotal" because "[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class." *Id.* (alteration in original) (quoting *Perez*, 402 U.S. at 154, 91 *S. Ct.* at 1361). Additionally, since the CSA was a "lengthy and detailed statute creating a comprehensive framework," its statutory scheme was "at the opposite end of the regulatory spectrum" from the statutes in *Lopez* and Morrison. *Id. a*t 24, 125 *S. Ct.* at 2210.

Once again central to the Court's analysis was whether the regulated activities were economic or noneconomic. The *Raich* Court defined "[e]conomics" as referring to "the production, distribution, and consumption of commodities." *Id. a*t 25–26, 125 *S. Ct.* at 2211 (quoting WEBSTER'S THIRD NEW INT'L DICTIONARY 720 (1966)). In contrast to the activities regulated in *Lopez* and *Morrison*, the *Raich* Court concluded that "the activities regulated by the CSA are quintessentially economic." *Id. a*t 25, 125 *S. Ct.* at 2211. Indeed, the activities engaged in by the plaintiffs themselves fit the Court's definition of

economic, since they involved the production, distribution, and consumption of marijuana.

Concurring in only the *Raich* judgment, Justice Scalia commented that under his understanding of the commerce power, "the authority to enact laws necessary and proper for the regulation of interstate commerce is not limited to laws governing intrastate activities that substantially affect interstate commerce. Where necessary to make a regulation of interstate commerce effective, Congress may regulate even those intrastate activities that do not themselves substantially affect interstate commerce." *Id. a*t 34–35, 125 *S. Ct.* at 2216 (Scalia, J., concurring).

Justice Scalia cited "two general circumstances" in which the regulation of intrastate activities may be "necessary to and proper for the regulation of interstate commerce." *Id. a*t 35, 125 *S. Ct.* at 2216. First, "the commerce power permits Congress not only to devise rules for the governance of commerce between States but also to facilitate interstate commerce by eliminating potential obstructions, and to restrict it by eliminating potential stimulants." *Id. a*t 35, 125 *S. Ct.* at 2216. Yet, "[t]his principle is not without limitation," as the cases of *Lopez* and *Morrison* made clear. *Id. a*t 35–36, 125 *S. Ct.* at 2216–17. Second, Justice Scalia submitted that "Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce." *Id. a*t 37, 125 *S. Ct.* at 2217. The "relevant question" then becomes "whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Id.*

In addition to relying on these Commerce Clause cases, both parties and the district court conducted a separate analysis of the Necessary and Proper Clause's implications for the Act. We review some foundational principles relating to that Clause, focusing our attention on *United States v. Comstock*, 560 U.S. __, 130 *S. Ct.* 1949 (2010).

G. Necessary and Proper Clause: *United States v. Comstock*

Congress has the power "[t]o make all Laws which shall be necessary and proper for carrying into Execution" its enumerated power. U.S. Const. art. I, § 8, cl. 18. The Necessary and Proper Clause is intimately tied to the enumerated power it effectuates. The Supreme Court has recognized that the Necessary and Proper Clause "is not the delegation of a new and independent power, but simply provision for making effective the powers theretofore mentioned." *Kansas v. Colorado*, 206 U.S. 46, 88, 27 *S. Ct.* 655, 663 (1907). It is "merely a declaration, for the removal of all uncertainty, that the means of carrying into execution those [powers] otherwise granted are included in the grant." *Kinsella v. United States*, 361 U.S. 234, 247, 80 *S. Ct.* 297, 304 (1960) (alterations in original) (quoting VI WRITINGS OF JAMES MADISON 383 (Gaillard Hunt ed., 1906)). It reaffirms that Congress has the incidental powers necessary to carry its enumerated powers into effect.

The Supreme Court's most definitive statement of the Necessary and Proper Clause's function remains Chief Justice Marshall's articulation in *McCulloch v. Maryland*: "Let the end be legitimate, let it be within the scope of the constitution, and all means which are

appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional." 17 U.S. (4 Wheat.) 316, 421 (1819). Thus, when legislating within its enumerated powers, Congress has broad authority: "the Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1956 (quoting *McCulloch*, 17 U.S. at 413, 418).

As it relates to the commerce power, the Supreme Court has essentially bound up the Necessary and Proper Clause with its substantial effects analysis.[80] As Justice Scalia noted in *Raich*, "Congress's regulatory authority over intrastate activities that are not themselves part of interstate commerce (including activities that have a substantial effect on interstate commerce) derives from the Necessary and Proper Clause." 545 U.S. at 34, 125 *S. Ct.* at 2216 (Scalia, J., concurring).

Comstock represents the Supreme Court's most recent, detailed application of Necessary and Proper Clause doctrine. In *Comstock*, the Supreme Court

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[80] For instance, the Court formulated the question in *Raich* as "whether the power vested in Congress by Article I, § 8, of the Constitution 'to make all Laws which shall be necessary and proper for carrying into Execution' its authority to 'regulate Commerce with foreign Nations, and among the several States' includes the power [asserted]." 545 U.S. at 5, 125 *S. Ct.* at 2198–99 (alteration omitted). Although the *Wickard* Court did not expressly invoke the Necessary and Proper Clause, the *Raich* Court clearly assumed as much. *See Id. a*t 22, 125 *S. Ct.* at 2209.

held that Congress acted pursuant to its Article I powers in enacting a federal civil-commitment statute, 18 U.S.C. § 4248, that authorized the Department of Justice to detain mentally ill, sexually dangerous prisoners beyond the term of their sentences. The majority opinion enumerated five "considerations" that supported the statute's constitutional validity: "(1) the breadth of the Necessary and Proper Clause, (2) the long history of federal involvement in this arena, (3) the sound reasons for the statute's enactment in light of the Government's custodial interest in safeguarding the public from dangers posed by those in federal custody, (4) the statute's accommodation of state interests, and (5) the statute's narrow scope." *Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1965.

On the breadth of the Necessary and Proper Clause, the *Comstock* Court noted that (1) the federal government is a government of enumerated powers, but (2) is also vested "'with ample means'" for the execution of those powers. *Id.* (quoting *McCulloch*, 17 U.S. at 408). The Supreme Court must determine whether a federal statute "constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id.* "[T]he relevant inquiry 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." *Id. a*t __, 130 *S. Ct.* at 1957 (quotation marks omitted) (quoting *Raich*, 545 U.S. at 37, 125 *S. Ct.* at 2217 (Scalia, J., concurring)).

Turning to the second factor—the history of federal involvement—the Supreme Court recognized

that, beginning in 1855, persons charged with or convicted of federal offenses could be confined to a federal mental institution for the duration of their sentences. *Id. a*t __, 130 *S. Ct.* at 1959. Since 1949, Congress had also "authorized the postsentence detention of federal prisoners who suffer from a mental illness and who are thereby dangerous." *Id. a*t __, 130 *S. Ct.* at 1961. The Supreme Court observed that "[a]side from its specific focus on sexually dangerous persons, § 4248 is similar to the provisions first enacted in 1949" and therefore represented "a modest addition to a longstanding federal statutory framework, which has been in place since 1855." *Id.*

As to the third factor—reasons for enactment in light of the government's interest—the Supreme Court concluded that "Congress reasonably extended its longstanding civil-commitment system to cover mentally ill and sexually dangerous persons who are already in federal custody, even if doing so detains them beyond the termination of their criminal sentence." *Id.* The federal government: (1) is the custodian of its prisoners and (2) has the power to protect the public from the threats posed by the prisoners in its charge. *Id.*

Turning to the fourth factor—accommodation of state interests—the *Comstock* Court ruled that § 4248 "properly accounts for state interests." *Id. a*t __, 130 *S. Ct.* at 1962. The Supreme Court found persuasive that the statute required the Attorney General (1) to allow (and indeed encourage) the state in which the prisoner was domiciled or tried to take

custody and (2) to immediately release the prisoner if the state seeks to assert authority over him.[81] *Id.*

On the fifth and final factor—the statute's narrow scope—the *Comstock* Court found the statute not "too sweeping in its scope" and the link between § 4248 and an enumerated Article I power "not too attenuated." *Id. a*t __, 130 *S. Ct.* at 1963. The Supreme Court concluded that *Lopez*'s admonition that courts should not "pile inference upon inference" did not present any problems with respect to the civil-commitment statute. *Id.* (quoting *Lopez*, 514 U.S. at 567, 115 *S. Ct.* at 1634). Specifically, the *Comstock* Court discerned that "the same enumerated power that justifies the creation of a federal criminal statute, and that justifies the additional implied federal powers that the dissent considers legitimate, justifies civil commitment under § 4248 as well." *Id. a*t __, 130 *S. Ct.* at 1964. The Supreme Court rejected the notion that "Congress's authority can be no more than one step removed from a specifically enumerated power." *Id. a*t __, 130 *S. Ct.* at 1963.

Lastly, the Supreme Court emphasized that § 4248 had been applied to "only a small fraction of

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[81] The Attorney General must "make all reasonable efforts to cause" the state in which the prisoner is domiciled or tried to "assume responsibility for his custody, care, and treatment." *Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1954 (quoting 18 U.S.C. § 4248(d)). If the state consents, the prisoner will be released to the appropriate official in that state. *Id. a*t __, 130 *S. Ct.* at 1954–55. If the state declines to take custody, the Attorney General will "place the person for treatment in a suitable facility" until the state assumes the role or until the person no longer poses a sexually dangerous threat. *Id. a*t __, 130 *S. Ct.* at 1955 (quoting 18 U.S.C. § 4248(d)).

federal prisoners." *Id. a*t __, 130 *S. Ct.* at 1964 (citing evidence that "105 individuals have been subject to § 4248 out of over 188,000 federal inmates"). The Supreme Court concluded that "§ 4248 is a reasonably adapted and narrowly tailored means of pursuing the Government's legitimate interest as a federal custodian in the responsible administration of its prison system" and thus did not endow Congress with a general police power. *Id. a*t __, 130 *S. Ct.* at 1965.

Although concurring in the judgment, Justice Kennedy and Justice Alito[82] did not join the Court's majority opinion. Because Justice Kennedy's concurring opinion focuses on Commerce Clause and federalism issues, we provide extended treatment of it here.

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[82] Justice Alito wrote separately to express "concern[] about the breadth of the Court's language, and the ambiguity of the standard that the Court applies." 560 U.S. at __, 130 *S. Ct.* at 1968 (Alito, J., concurring) (citation omitted). Justice Alito stressed that "the Necessary and Proper Clause does not give Congress *carte blanche*." *Id. a*t __, 130 *S. Ct.* at 1970. While the word "necessary" need not connote that the means employed by Congress be "absolutely necessary" or "indispensable," "the term requires an 'appropriate' link between a power conferred by the Constitution and the law enacted by Congress." *Id.* It is the Supreme Court's duty, he declared, "to enforce compliance with that limitation." *Id.* Like Justice Kennedy, Justice Alito suggested that the Necessary and Proper Clause context of the case did not warrant an analysis "in which it is merely possible for a court to think of a rational basis on which Congress might have perceived an attenuated link between the powers underlying the federal criminal statutes and the challenged civil commitment provision." *Id.* In *Comstock*, by contrast, the government had demonstrated "a substantial link to Congress' constitutional powers." *Id.*

Justice Kennedy's primary disagreement with the majority concerned its application of a "means-ends rationality" test. He advised that "[t]he terms 'rationally related' and 'rational basis' must be employed with care, particularly if either is to be used as a stand-alone test." *Id. a*t __, 130 *S. Ct*. at 1966 (Kennedy, J., concurring). Justice Kennedy observed that the phrase "rational basis" is typically employed in Due Process Clause contexts, where the Court adopts a very deferential review of congressional acts. *Id.* Under the *Lee Optical* test applied in such due process settings, the Court merely asks whether "'it might be thought that the particular legislative measure was a rational way to correct'" an evil. *Id.* (quoting *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487–88, 75 *S. Ct.* 461, 464 (1955)). By contrast, Justice Kennedy asserted, "under the Necessary and Proper Clause, application of a 'rational basis' test should be at least as exacting as it has been in the Commerce Clause cases, if not more so." *Id.*

The Commerce Clause precedents of *Raich*, *Lopez*, and *Hodel* "require a tangible link to commerce, not a mere conceivable rational relation, as in *Lee Optical*." *Id. a*t __, 130 *S. Ct*. at 1967. "The rational basis referred to in the Commerce Clause context is a demonstrated link in fact, based on empirical demonstration." *Id.* Justice Kennedy reiterated *Lopez*'s admonition that "'[s]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so.'" *Id.* (quoting *Lopez*, 514 U.S. at 557 n.2, 115 *S. Ct*. at 1629 n.2). In this regard, "[w]hen the inquiry is whether a federal law has sufficient links to an enumerated power to be within

the scope of federal authority, the analysis depends not on the number of links in the congressional-power chain but on the strength of the chain." *Id. a*t __, 130 *S. Ct*. at 1966.

In summary, these landmark Supreme Court decisions—*Wickard*, *South-Eastern Underwriters*, *Heart of Atlanta Motel*, *Lopez*, *Morrison*, *Raich*, and *Comstock*—together set forth the governing principles and analytical framework we must apply to the commerce power issues presented here.

V. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE COMMERCE POWER

With a firm understanding of the Act's provisions, the congressional findings, and the Supreme Court's Commerce Clause precedents, we turn to the central question at hand: whether the individual mandate is beyond the constitutional power granted to Congress under the Commerce Clause and Necessary and Proper Clause.

In this Section, we begin with first principles. We then examine the subject matter the individual mandate seeks to regulate, and whether it can be readily categorized under the classes of activity the Supreme Court has previously identified. We follow with a discussion of the unprecedented nature of the individual mandate. Next, we analyze whether the individual mandate is a valid exercise of Congress's power to regulate activities that substantially affect interstate commerce. In this regard, we appraise whether the government's argument furnishes judicially enforceable limiting principles and address the individual mandate's far-reaching implications for our federalist structure. Lastly, we consider the government's alternative argument that the

individual mandate is an essential part of a larger regulation of economic activity.

We conclude that the individual mandate exceeds Congress's commerce power.

A. First Principles

As the Supreme Court has observed, "The judicial authority to determine the constitutionality of laws, in cases and controversies, is based on the premise that the 'powers of the legislature are defined and limited; and that those limits may not be mistaken, or forgotten, the constitution is written.'" *City of Boerne v. Flores*, 521 U.S. 507, 516, 117 *S. Ct.* 2157, 2162 (1997) (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 176 (1803)). The judiciary is called upon not only to interpret the laws, but at times to enforce the Constitution's limits on the power of Congress, even when that power is used to address an intractable problem.

In enforcing these limits, we recognize that the Constitution established a federal government that is "'acknowledged by all to be one of enumerated powers.'" *Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1956 (quoting *McCulloch*, 17 U.S. at 405). In describing this constitutional structure, the Supreme Court has emphasized James Madison's exposition in The Federalist No. 45: "'The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite.'" *Gregory v. Ashcroft*, 501 U.S. 452, 458, 111 *S. Ct.* 2395, 2399 (1991) (quoting THE FEDERALIST NO. 45, at 292–93 (James Madison) (Clinton Rossiter ed., 1961)); *see also Lopez*, 514 U.S. at 552, 115 *S. Ct.* at 1626 (quoting same). In that same essay, Madison

noted that the commerce power was one such enumerated power: "The regulation of commerce, it is true, is a new power; but that seems to be an addition which few oppose, and from which no apprehensions are entertained." THE FEDERALIST NO. 45, at 289 (James Madison) (E.H. Scott ed., 1898). The commerce power has since come to dominate federal legislation.

The power to regulate commerce is the power "to prescribe the rule by which commerce is to be governed." *Gibbons*, 22 U.S. at 196. As the Supreme Court instructs us, "The power of Congress in this field is broad and sweeping; where it keeps within its sphere and violates no express constitutional limitation it has been the rule of this Court, going back almost to the founding days of the Republic, not to interfere." *Katzenbach v. McClung*, 379 U.S. 294, 305, 85 *S. Ct.* 377, 384 (1964). In fact, if the object of congressional legislation falls within the sphere contemplated by the Commerce Clause, "[t]hat power is plenary and may be exerted to protect interstate commerce no matter what the source of the dangers which threaten it." *Jones & Laughlin Steel Corp.*, 301 U.S. at 37, 57 *S. Ct.* at 624 (citation and quotation marks omitted).

It is because of the breadth and depth of this power that even when the Supreme Court has blessed Congress's most expansive invocations of the Commerce Clause, it has done so with a word of warning: "Undoubtedly the scope of this power must be considered in the light of our dual system of government and may not be extended so as to embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our

complex society, would effectually obliterate the distinction between what is national and what is local and create a completely centralized government." *Id.* It is this dualistic nature of the Commerce Clause power—necessarily broad yet potentially dangerous to the fundamental structure of our government—that has led the Court to adopt a flexible approach to its application, one that is often difficult to apply. As Chief Justice Hughes noted,

> Whatever terminology is used, the criterion is necessarily one of degree and must be so defined. This does not satisfy those [who] seek for mathematical or rigid formulas. But such formulas are not provided by the great concepts of the Constitution such as 'interstate commerce,' 'due process,' 'equal protection.' In maintaining the balance of the constitutional grants and limitations, it is inevitable that we should define their applications in the gradual process of inclusion and exclusion.

Santa Cruz Fruit Packing Co. v. NLRB., 303 U.S. 453, 467, 58 *S. Ct.* 656, 660 (1938); *see also Lopez*, 514 U.S. at 566, 115 *S. Ct.* at 1633 ("But, so long as Congress' authority is limited to those powers enumerated in the Constitution, and so long as those enumerated powers are interpreted as having judicially enforceable outer limits, congressional legislation under the Commerce Clause always will engender 'legal uncertainty.'").

Thus, it is not surprising that *Lopez* begins not with categories or substantial effects tests, but rather "first principles," reaffirming the "constitutionally mandated division of authority [that] 'was adopted by

the Framers to ensure protection of our fundamental liberties.'" 514 U.S. at 553, 115 *S. Ct.* at 1626 (citing *Gregory*, 501 U.S. at 458, 111 *S. Ct.* at 2400). While the substantial growth and development of Congress's power under the Commerce Clause has been well-documented, the Court has often reiterated that the power therein granted remains "subject to outer limits." *Id. a*t 557, 115 *S. Ct.* at 1628. When Congress oversteps those outer limits, the Constitution requires judicial engagement, not judicial abdication.

The Supreme Court has placed two broad limitations on congressional power under the Commerce Clause. First, Congress's regulation must accommodate the Constitution's federalist structure and preserve "a distinction between what is truly national and what is truly local." *Id. a*t 567–68, 115 *S. Ct.* at 1634. Second, the Court has repeatedly warned that courts may not interpret the Commerce Clause in a way that would grant to Congress a general police power, "which the Founders denied the National Government and reposed in the States." *Morrison*, 529 U.S. at 618, 120 *S. Ct.* at 1754; *see also Lopez*, 514 U.S. at 584, 115 *S. Ct.* at 1642 (Thomas, J., concurring) ("[W]e *always* have rejected readings of the Commerce Clause and the scope of federal power that would permit Congress to exercise a police power; our cases are quite clear that there are real limits to federal power.").

Therefore, in determining if a congressional action is within the limits of the Commerce Clause, we must look not only to the action itself but also its implications for our constitutional structure. *See Lopez*, 514 U.S. at 563–68, 115 *S. Ct.* at 1632–34.

While these structural limitations are often discussed in terms of federalism, their ultimate goal is the protection of individual liberty. *See Bond v. United States*, 564 U.S. __, __, 131 *S. Ct.* 2355, 2363 (2011) ("Federalism secures the freedom of the individual."); *New York v. United States*, 505 U.S. at 181, 112 *S. Ct.* at 2431 ("The Constitution does not protect the sovereignty of States for the benefit of the States or state governments as abstract political entities . . . . To the contrary, the Constitution divides authority between federal and state governments for the protection of individuals.").

With this at stake, we examine whether Congress legislated within its constitutional boundaries in enacting the individual mandate.[83] We begin this analysis with a "presumption of constitutionality," meaning that "we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *Morrison*, 529 U.S. at 607, 120 *S. Ct.* at 1748.

B. Dichotomies and Nomenclature

The parties contend that the answer to the question of the individual mandate's constitutionality is straightforward. The government emphasizes that Congress intended to regulate the health insurance and health care markets to ameliorate the cost-shifting problem created by individuals who forego insurance yet at some time in the future seek health

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[83] As a preliminary matter, we note that the parties appear to agree that if the individual mandate is to be sustained, it must be under the third category of activities that Congress may regulate under its commerce power: *i.e.*, "those activities that substantially affect interstate commerce." *Lopez*, 514 U.S. at 559, 115 *S. Ct.* at 1630.

care for which they cannot pay. 42 U.S.C. § 18091(a)(1)(A), (H). One of the tools Congress employed to solve that problem is an economic mandate requiring Americans to purchase and continuously maintain health insurance. The government argues that the individual mandate is constitutional because it regulates "quintessentially economic" activity related to an industry of near universal participation, whereas the regulations in *Lopez* and *Morrison* touched on criminal conduct, which is not "in any sense of the phrase, economic activity." *Morrison*, 529 U.S. at 613, 120 *S. Ct.* at 1751. The government submits that Congress has mandated only how Americans finance their inevitable health care needs.

The plaintiffs respond that the plain text of the Constitution and Supreme Court precedent support the conclusion that "activity" is a prerequisite to valid congressional regulation under the commerce power. The plaintiffs stress that Congress's authority is to "regulate" commerce, not to compel individuals to *enter into* commerce so that the federal government may regulate them. The plaintiffs point out that by choosing not to purchase insurance, the uninsured are outside the stream of commerce. Indeed, the nature of the conduct is marked by the *absence* of a commercial transaction. Since they are not engaged in commerce, or activities associated with commerce, they cannot be regulated pursuant to the Commerce Clause. The plaintiffs emphasize that, in 220 years of constitutional history, Congress has never exercised its commerce power in this manner.

Whereas the parties and many commentators have focused on this distinction between activity and

inactivity, we find it useful only to a point. Beginning with the plain language of the text, the Commerce Clause gives Congress the power to "regulate Commerce." U.S. Const. art. I, § 8, cl. 3. The power to regulate commerce, of course, presupposes that something exists to regulate. In its first comprehensive discussion of the Commerce Clause, the Supreme Court in *Gibbons* attempted to define commerce, stating, "Commerce, undoubtedly, is traffic, but it is something more: it is *intercourse*. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and *is regulated by prescribing rules for carrying on that intercourse*." *Gibbons*, 22 U.S. at 189–90 (emphasis added). The nature of Chief Justice Marshall's formulation presaged the Supreme Court's tendency to describe commerce in very general terms, since an attempt to formulate a precise and all-encompassing definition would prove impractical.

However, the Supreme Court has always described the commerce power as operating on already existing or ongoing activity. The *Gibbons* Court stated, "If Congress has the power to regulate it, that power must be exercised whenever the subject *exists*. If it exists within the States, if a foreign voyage may commence or terminate at a port within a State, then the power of Congress may be exercised within a State." *Id. a*t 195 (emphasis added). In its recent cases, the Supreme Court has continued to articulate Congress's commerce authority in terms of "activity." In *Lopez*, the Court identified "three broad *categories of activity* that Congress may regulate under its commerce power" and concluded that "possession of a gun in a local school zone is in no sense an *economic activity*." 514 U.S. at 558, 567,

115 *S. Ct.* at 1629, 1634 (emphasis added); *see also Raich*, 545 U.S. at 26, 125 *S. Ct.* at 2211 ("[T]he CSA is a statute that directly regulates *economic*, *commercial activity*." (emphasis added)); *Morrison*, 529 U.S. at 611, 120 *S. Ct.* at 1750 ("*Lopez*'s review of Commerce Clause case law demonstrates that in those cases where we have sustained federal regulation of intrastate *activity* based upon the *activity's* substantial effects on interstate commerce, the activity in question has been some sort of *economic endeavor*." (emphasis added)).

As our extensive discussion of the Supreme Court's precedent reveals, Commerce Clause cases run the gamut of possible regulation. But the diverse fact patterns of *Wickard*, *South-Eastern Underwriters*, *Heart of Atlanta Motel*, *Lopez*, *Morrison*, and *Raich* share at least one commonality: they all involved attempts by Congress to regulate preexisting, freely chosen classes of activities.

Nevertheless, we are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case. Although the Supreme Court's Commerce Clause cases frequently speak in activity-laden terms, the Court has never expressly held that activity is a precondition for Congress's ability to regulate commerce—perhaps, in part, because it has never been faced with the type of regulation at issue here.

We therefore must refine our understanding of the nature of the individual mandate and the subject matter it seeks to regulate. The uninsured have made a decision, either consciously or by default, to direct their financial resources to some other item or

need than health insurance. Congress described "the activity" it sought to regulate as "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) (emphasis added). It deemed such decisions as activity that is "commercial and economic in nature." *Id.* Congress linked the individual mandate to this decision: "In the absence of th[is] requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure . . . ." *Id.*

That Congress casts the individual mandate as regulating economic activity is not surprising. In *Morrison*, the Supreme Court acknowledged that "thus far in our Nation's history our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature." 529 U.S. at 613, 120 *S. Ct.* at 1751. *Raich* confirmed the continued viability of this distinction between economic and noneconomic activity in assessing Congress's commerce authority. *See* 545 U.S. at 25–26, 125 *S. Ct.* at 2210–11.

The parties here disagree about where the individual mandate falls within this "economic versus noneconomic activity" framework. On one hand, a decision not to purchase insurance and to self-insure for health care is a financial decision that has more of an economic patina than the gun possession in *Lopez* or the gender-motivated violence in *Morrison*. But whether such an economic decision constitutes economic *activity* as previously conceptualized by the Supreme Court is not so clear, nor do we find this sort of categorical thinking particularly helpful in

assessing the constitutionality of such an unprecedented congressional action. After all, in choosing not to purchase health insurance, the individuals regulated by the individual mandate are hardly involved in the "production, distribution, and consumption of commodities," which was the broad definition of economics provided by the *Raich* Court.[84] 545 U.S. at 25, 125 *S. Ct.* at 2211 (citation and quotation marks omitted). Rather, to the extent the uninsured can be said to be "active," their activity consists of the *absence* of such behavior, at least with respect to health insurance.[85] Simply put, the individual mandate cannot be neatly classified under either the "economic activity" or "noneconomic activity" headings.

This confirms the wisdom in the conclusion that the Court's attempts throughout history to define by "semantic or formalistic categories those activities that were commerce and those that were not" are doomed to fail. *Lopez*, 514 U.S. at 569, 115 *S. Ct.* at

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[84] The fact that conduct may be said to have economic *effects* does not, by that fact alone, render the conduct "economic activity," at least as defined by the Supreme Court. *Lopez* and *Morrison* make this observation apparent. Even the fact that conduct in some way *relates* to commerce does not, by itself, convert that conduct into economic activity. Indeed, the regulated activity in *Lopez* (firearm possession) directly related to an article of commerce (the firearm being possessed). The Supreme Court has emphasized that the relevant inquiry is the *link* between the regulated activity and its effects on interstate commerce.

[85] The government correctly notes that many of the uninsured do actively consume health care, even though they are not participants in the health insurance market. We address this point at length later.

1635 (Kennedy, J., concurring). *Compare United States v. E.C. Knight Co.*, 156 U.S. 1, 13, 15 *S. Ct.* 249, 254 (1895) (approving manufacturing-commerce dichotomy), *with Standard Oil Co. v. United States*, 221 U.S. 1, 68–69, 31 *S. Ct.* 502, 519 (1911) (declaring manufacturing-commerce dichotomy "unsound"). *See also Lopez*, 514 U.S. at 572, 115 *S. Ct.* at 1636 (Kennedy, J., concurring) (noting "the Court's recognition of the importance of a practical conception of the commerce power"); *Wickard*, 317 U.S. at 120, 63 *S. Ct.* at 87 (stating that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect'"); *Swift & Co. v. United States*, 196 U.S. 375, 398, 25 *S. Ct.* 276, 280 (1905) (observing that "commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"). Yet, confusing though these dichotomies and doctrinal vacillations have been, they appear animated by one overarching goal: to provide courts with meaningful, judicially administrable limiting principles by which to assess Congress's exercise of its Commerce Clause power.

Properly formulated, we perceive the question before us to be whether the federal government can issue a mandate that Americans purchase and maintain health insurance from a private company for the entirety of their lives.[86] These types of

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[86] Whether one describes the regulated individual's decision as the financing of health care, self-insurance, or risk retention, the congressional mandate is to acquire and continuously maintain health coverage. And unless the person is covered by

purchasing decisions are legion. Every day, Americans decide what products to buy, where to invest or save, and how to pay for future contingencies such as their retirement, their children's education, and their health care. The government contends that embedded in the Commerce Clause is the power to override these ordinary decisions and redirect those funds to other purposes. Under this theory, because Americans have money to spend and must inevitably make decisions on where to spend it, the Commerce Clause gives Congress the power to direct and compel an individual's spending in order to further its overarching regulatory goals, such as reducing the number of uninsureds and the amount of uncompensated health care.

In answering whether the federal government may exercise this asserted power to issue a mandate for Americans to purchase health insurance from private companies, we next examine a number of issues: (1) the unprecedented nature of the individual mandate; (2) whether Congress's exercise of its commerce authority affords sufficient and meaningful limiting principles; and (3) the far-reaching implications for our federalist structure.

C. Unprecedented Nature of the Individual Mandate

Both parties have cited extensively to previous Supreme Court opinions defining the scope of the Commerce Clause. Economic mandates such as the one contained in the Act are so unprecedented,

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a government-financed health program, the mandate is to purchase insurance from a private insurer.

however, that the government has been unable, either in its briefs or at oral argument, to point this Court to Supreme Court precedent that addresses their constitutionality. Nor does our independent review reveal such a precedent.

The Supreme Court has sustained Congress's authority to regulate steamboat traffic, *Gibbons*, 22 U.S. 1; trafficking of lottery tickets across state lines, *The Lottery Case*, 188 U.S. 321, 23 *S. Ct.* 321 (1903); and carrying a woman across state lines for "immoral purposes," *Hoke v. United States*, 227 U.S. 308, 320, 33 *S. Ct.* 281, 283 (1913). Through the Commerce Clause, Congress may prevent the interstate transportation of liquor, *United States v. Simpson*, 252 U.S. 465, 40 *S. Ct.* 364 (1920); punish an automobile thief who crosses state lines, *Brooks v. United States*, 267 U.S. 432, 45 *S. Ct.* 345 (1925); and prevent diseased herds of cattle from bringing their contagion from Georgia to Florida, *Thornton v. United States*, 271 U.S. 414, 46 *S. Ct.* 585 (1926).

In the modern era, the Commerce Clause has been used to regulate labor practices, *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 *S. Ct.* 615; impose minimum working conditions, *Darby*, 312 U.S. 100, 61 *S. Ct.* 451; limit the production of wheat for home consumption, *Wickard*, 317 U.S. 111, 63 *S. Ct.* 82; regulate the terms of insurance contracts, *South-Eastern Underwriters*, 322 U.S. 533, 64 *S. Ct.* 1162; prevent discrimination in hotel accommodations, *Heart of Atlanta Motel*, 379 U.S. 241, 85 *S. Ct.* 348, and restaurant services, *Katzenbach*, 379 U.S. 294, 85 *S. Ct.* 377; and prevent the home production of marijuana for medical purposes, *Raich*, 545 U.S. 1, 125 *S. Ct.* 2195. What

the Court has never done is interpret the Commerce Clause to allow Congress to dictate the financial decisions of Americans through an economic mandate.

Both the Congressional Budget Office ("CBO") and the Congressional Research Service ("CRS") have commented on the unprecedented nature of the individual mandate. When the idea of an individual mandate to purchase health insurance was first floated in 1994, the CBO stated that a "mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action." SPEC. STUDIES DIV., CONG. BUDGET OFFICE, THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE 1 (1994) [hereinafter CBO MANDATE MEMO]. The CBO observed that Congress "has never required people to buy any good or service as a condition of lawful residence in the United States," noting that "mandates typically apply to people as parties to economic transactions, rather than as members of society." *Id. a*t 1–2. Meanwhile, in reviewing the present legislation in 2009, the CRS warned:

> Despite the breadth of powers that have been exercised under the Commerce Clause, it is unclear whether the clause would provide a solid constitutional foundation for legislation containing a requirement to have health insurance. Whether such a requirement would be constitutional under the Commerce Clause is perhaps the most challenging question posed by such a proposal, as it is a novel issue whether Congress may use this

> clause to require an individual to purchase a good or a service.

JENNIFER STAMAN & CYNTHIA BROUGHER, CONG. RESEARCH SERV., R. 40725, REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS 3 (2009).

The fact that Congress has never before exercised this supposed authority is telling. As the Supreme Court has noted, "the utter lack of statutes imposing obligations on the States' executive (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power." *Printz*, 521 U.S. at 907–08, 117 *S. Ct.* at 2371; *see also Va. Office for Prot. & Advocacy v. Stewart*, 563 U.S. __, __, 131 *S. Ct.* 1632, 1641 (2011) ("Lack of historical precedent can indicate a constitutional infirmity."); *Alden v. Maine*, 527 U.S. 706, 743–44, 119 *S. Ct.* 2240, 2261 (1999). Few powers, if any, could be more attractive to Congress than compelling the purchase of certain products. Yet even if we focus on the modern era, when congressional power under the Commerce Clause has been at its height, Congress still has not asserted this authority. Even in the face of a Great Depression, a World War, a Cold War, recessions, oil shocks, inflation, and unemployment, Congress never sought to require the purchase of wheat or war bonds, force a higher savings rate or greater consumption of American goods, or require every American to purchase a more fuel efficient vehicle.[87] *See Printz*, 521 U.S. at 905, 117 *S. Ct.* at 2370 ("[I]f . . . earlier Congresses avoided use of this

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[87] Compare the lack of legislation compelling activity to the long history of Congress forbidding activity.

highly attractive power, we would have reason to believe that the power was thought not to exist.").

Traditionally, Congress has sought to encourage commercial activity it favors while discouraging what it does not. This is instructive. Not only have prior congressional actions not asserted the power now claimed, they "contain some indication of precisely the opposite assumption." *Id. a*t 910, 117 *S. Ct.* at 2372. Instead of requiring action, Congress has sought to encourage it. The instances of such encouragement are ubiquitous, but the example of flood insurance provides a particularly relevant illustration of how the individual mandate departs from conventional exercises of congressional power.

In passing the National Flood Insurance Act of 1968, Congress recognized that "from time to time flood disasters have created personal hardships and economic distress which have required unforeseen disaster relief measures and have placed an increasing burden on the Nation's resources." 42 U.S.C. § 4001(a)(1). Despite considerable expenditures on public programs designed to prevent floods, those programs had "not been sufficient to protect adequately against growing exposure to future flood losses." *Id.* § 4001(a)(2). In response to this problem, however, Congress did not require everyone who owns a house in a flood plain to purchase flood insurance. In fact, Congress did not even require anyone who chooses to build a new house in a flood plain to buy insurance. Rather, Congress created a series of incentives designed to encourage voluntary purchase of flood insurance. These incentives included requiring flood insurance before the home owner could receive federal financial

assistance or federally regulated loans. *See id.* § 4012a(a), (b)(1).

Without an "individual mandate," the flood insurance program has largely been a failure. *See* Bryant J. Spann, Note, *Going Down for the Third Time: Senator Kerry's Reform Bill Could Save the Drowning National Flood Insurance Program*, 28 GA. L. REV. 593, 597 (1994) ("One of the most astounding facts to surface from the Midwestern flood of 1993 was that so few homeowners eligible for flood insurance actually had it. Of the states impacted by the flood, Illinois had the highest percentage of eligible households covered, with 8.7%."). One key reason for this low participation is not surprising. "Disaster relief, as a political issue, is almost invincible. No politician wants to be on record as opposing disaster relief, particularly for his or her own constituents." *Id. a*t 602. People living in a flood plain know that even if they do not have insurance, they can count on the virtually guaranteed availability of federal funds.[88] Nevertheless, despite the unpredictability of flooding, the inevitability that floods will strike flood plains, and the cost shifting inherent in uninsured property owners seeking disaster relief funds, Congress has never taken the obvious and expedient step of invoking the power the government now argues it has and forcing all

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[88] Compare this with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, which ensures public access to emergency medical services without regard to one's ability to pay.

property owners in flood plains to purchase insurance.[89]

Contrast flood insurance with the very few instances of activity in which Congress has compelled Americans to engage solely as a consequence of being citizens living in the United States. Given the attractiveness of the power to compel behavior in order to solve important problems, we find it illuminating that Americans have, historically, been subject only to a limited set of personal mandates: serving on juries, registering for the draft, filing tax returns, and responding to the census. These mandates are in the nature of duties owed to the government attendant to citizenship, and they contain clear foundations in the constitutional text.[90] Additionally, all these mandates involve a citizen directly interacting with the government, whereas the individual mandate requires an individual to enter into a compulsory contract with a private company. In these respects, the individual mandate is a sharp departure from all prior exercises of federal power.

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[89] The contrast with the individual mandate is even more stark when we consider that property owners in flood plains have actually entered the housing market.

[90] *See*, *e.g.*, U.S. Const. art. I, § 2 ("[An] Enumeration shall be made within three Years after the first Meeting of the Congress of the United States, and within every subsequent Term of ten Years, in such Manner as they shall by Law direct."); *id.* art. I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes"); *id.* art. I, § 8, cl. 12 (providing Congress with power "[t]o raise and support Armies"); *id.* art. III, § 2 ("The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury.").

The draft is an excellent example of this sort of duty, particularly as it is one upon which the Supreme Court has spoken. In the *Selective Draft Law Cases*, the Supreme Court reviewed challenges to the draft instituted in 1917 upon the entry of the United States into World War I. 245 U.S. 366, 38 *S. Ct.* 159 (1918). The Court rejected these challenges on several grounds, primarily based on the long history of the draft both in the United States and other nations. *Id. a*t 379–87, 38 *S. Ct*. at 162–64. But it also pointed to the relationship between citizens and government: "It may not be doubted that the very [c]onception of a just government and its duty to the citizen includes the reciprocal obligation of the citizen to render military service in case of need and the right to compel it." *Id. a*t 378, 38 *S. Ct*. at 161.

It is striking by comparison how very different this economic mandate is from the draft. First, it does not represent the solution to a duty owed to the government as a condition of citizenship. Moreover, unlike the draft, it has no basis in the history of our nation, much less a long and storied one. Until Congress passed the Act, the power to regulate commerce had not included the authority to issue an economic mandate. Now Congress seeks not only the power to reach a new class of "activity"—financial decisions whose effects are felt some time in the future—but it wishes to do so through a heretofore untested power: an economic mandate.

Having established the unprecedented nature of the individual mandate and the lack of any Supreme Court case addressing this issue, we are left to apply

some basic Commerce Clause principles derived largely from *Wickard*, *Lopez*, *Morrison*, and *Raich*.

D. *Wickard* and Aggregation

It is not surprising that *Wickard*, which the *Lopez* Court considered "perhaps the most far reaching example of Commerce Clause authority over intrastate activity,"[91] 514 U.S. at 560, 115 *S. Ct.* at 1630, provides perhaps the best perspective on an economic mandate. Congress's restrictions on Roscoe Filburn's wheat acreage potentially forced him to purchase wheat on the open market. In doing so, Congress was able to artificially inflate the price of wheat by simultaneously decreasing supply and increasing demand. But *Wickard* is striking not for its similarity to our present case, but in how different it is. Although *Wickard* represents the zenith of Congress's powers under the Commerce Clause, the wheat regulation therein is remarkably less intrusive than the individual mandate.

Despite the fact that Filburn was a commercial farmer[92] and thus far more amenable to Congress's commerce power than an ordinary citizen, the legislative act did not require him to purchase more

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[91] Some have argued that *Raich* now represents the high-water mark of Congress's commerce authority. We discuss *Raich* in more detail below.

[92] In enacting the Agricultural Adjustment Act at issue in *Wickard*, Congress apparently sought to avoid reaching subsistence farmers whose production did not leave surplus for sale. Thus, it exempted small farms from the quota. *See Wickard*, 317 U.S. at 130 n.30, 63 *S. Ct.* at 92 n.30. In other words, Congress's regulation only applied to suppliers operating in the stream of commerce, even though some of those market suppliers also consumed a portion of wheat at home.

wheat. Instead, Filburn had any number of other options open to him. He could have decided to make do with the amount of wheat he was allowed to grow. He could have redirected his efforts to agricultural endeavors that required less wheat. He could have even ceased part of his farming operations. The wheat-acreage regulation imposed by Congress, even though it lies at the outer bounds of the commerce power, was a limitation—not a mandate—and left Filburn with a choice. The Act's economic mandate to purchase insurance, on the contrary, leaves no choice and is more far-reaching.

Although this distinction appears, at first blush, to implicate liberty concerns not at issue on appeal,[93] in truth it strikes at the heart of whether Congress has acted within its enumerated power. Individuals subjected to this economic mandate have not made a voluntary choice to enter the stream of commerce, but instead are having that choice imposed upon them by the federal government. This suggests that they are removed from the traditional subjects of Congress's commerce authority, in the same manner that the regulated actors in *Lopez* and *Morrison* were removed from the traditional subjects of Congress's commerce authority by virtue of the noneconomic cast of their activity.

This departure from commerce power norms is made all the more salient when we consider principles of aggregation, the chief addition of *Wickard* to the Commerce Clause canon.

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[93] Among other counts, the district court dismissed the plaintiffs' substantive due process challenge under the Fifth Amendment. *Florida v. HHS*, 716 F. Supp. 2d at 1161–62. That ruling is not on appeal.

Aggregation may suffice to bring otherwise nonregulable, "trivial" instances of intrastate activity within Congress's reach if the cumulative effect of this class of activity (*i.e.*, the intrastate activity "taken together with that of many others similarly situated") substantially affects interstate commerce. *Wickard*, 317 U.S. at 127–28, 63 *S. Ct.* at 90. Aggregation is a doctrine that allows Congress to apply an otherwise valid regulation to a class of intrastate activity it might not be able to reach in isolation.[94]

In *Morrison* and *Lopez*, the Supreme Court declined to apply aggregation to the noneconomic activity at issue, reasoning that "in every case where we have sustained federal regulation under the aggregation principle in [*Wickard*], the regulated activity was of an apparent commercial character." *Morrison*, 529 U.S. at 611 n.4, 120 *S. Ct.* at 1750 n.4. The Court thereby resisted "additional expansion" of the substantial effects and aggregation doctrines. *Lopez*, 514 U.S. at 567, 115 *S. Ct.* at 1634.

The question before us is whether Congress may regulate individuals outside the stream of commerce, on the theory that those "economic and financial decisions" to avoid commerce *themselves* substantially affect interstate commerce. Applying aggregation principles to an individual's decision not to purchase a product would expand the substantial

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[94] Although not made explicit in *Wickard*, the courts have come to recognize aggregation as flowing from Congress's powers to enact laws necessary and proper to effectuate its power under the Commerce Clause. *See*, *e.g.*, *Raich*, 545 U.S. at 22, 125 *S. Ct.* at 2209; *Id. a*t 34, 125 *S. Ct.* at 2216 (Scalia, J., concurring); *Katzenbach*, 379 U.S. at 301–302, 85 *S. Ct.* at 382.

effects doctrine to one of unlimited scope. Given the economic reality of our national marketplace, any person's decision not to purchase a good would, when aggregated, substantially affect interstate commerce in that good.[95] From a doctrinal standpoint, we see no way to cabin the government's theory only to decisions not to purchase *health insurance*. If an individual's mere decision not to purchase insurance were subject to *Wickard*'s aggregation principle, we are unable to conceive of *any* product whose purchase Congress could not mandate under this line of argument.[96] Although any decision not to purchase a good or service entails commercial consequences, this does not warrant the facile conclusion that Congress may therefore regulate these decisions pursuant to the Commerce Clause. *See id. a*t 580, 115 *S. Ct.* at 1640 (Kennedy, J., concurring) ("In a sense any conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we

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[95] Perhaps we can conceive of a purely intrastate good that is wholly insulated from the interstate market and, therefore, whose purchase Congress may not mandate even under the government's sweeping extension of *Wickard*'s aggregation principle. To the extent such hypothetical goods exist, their number is vanishingly small.

[96] The CBO suggested the possibility of this perilous course when it warned that an individual mandate to buy health insurance could "open the door to a mandate-issuing government taking control of virtually any resource allocation decision that would otherwise be left to the private sector . . . . In the extreme, a command economy, in which the President and the Congress dictated how much each individual and family spent on all goods and services, could be instituted without any change in total federal receipts or outlays." CBO MANDATE MEMO, *supra* p.115, at 9.

have not yet said the commerce power may reach so far.").

Thus, even assuming that decisions *not* to buy insurance substantially affect interstate commerce, that fact alone hardly renders them a suitable subject for regulation. *See*, *e.g.*, *Morrison*, 529 U.S. at 617, 120 *S. Ct.* at 1754 ("We accordingly reject the argument that Congress may regulate noneconomic, violent criminal conduct *based solely on that conduct's aggregate effect on interstate commerce*." (emphasis added)). Instead, what matters is the regulated subject matter's connection to interstate commerce. That nexus is lacking here. It is immaterial whether we perceive Congress to be regulating inactivity or a financial decision to forego insurance. Under any framing, the regulated conduct is defined by the *absence* of both commerce or even the "the production, distribution, and consumption of commodities"—the broad definition of economics in *Raich*. 545 U.S. at 25, 125 *S. Ct.* at 2211. To connect this conduct to interstate commerce would require a "but-for causal chain" that the Supreme Court has rejected, as it would allow Congress to regulate anything. *Morrison*, 529 U.S. at 615, 120 *S. Ct.* at 1752.

E. Broad Scope of Congress's Regulation

The scope of Congress's regulation also affects the constitutional inquiry. Indisputably, the health insurance and health care industries involve, and substantially affect, interstate commerce, and Congress can regulate broadly in both those realms. Nonetheless, Congress, in exercising its commerce authority, must be careful not to sweep too broadly by including within the ambit of its regulation

activities that bear an insufficient nexus with interstate commerce. *See Morrison*, 529 U.S. at 613 & n.5, 120 *S. Ct.* at 1751–52 & n.5 (distinguishing invalidated statute from analogous statute requiring explicit interstate nexus); *Lopez*, 514 U.S. at 561–62, 115 *S. Ct.* at 1631 (same).

In this regard, the individual mandate's attempt to reduce the number of the uninsured and correct the cost-shifting problem is woefully overinclusive. The language of the mandate is not tied to those who do not pay for a portion of their health care (*i.e.*, the cost-shifters). It is not even tied to those who consume health care. Rather, the language of the mandate is unlimited, and covers even those who do not enter the health care market at all. Although overinclusiveness may not be fatal for constitutional purposes, the Supreme Court has indicated that it is a factor to be added to the constitutional equation.

For example, in *Lopez* the vast majority of the regulated behavior (firearm possession) *did* possess an interstate character.[97] However, the Supreme

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[97] A staggering proportion of the firearms in America have been transported across state lines, and thus the possessions at issue in *Lopez* likely *did* have a sufficient nexus to interstate commerce—and thus, were within Congress's regulatory authority. In the wake of *Lopez*, many defendants challenged their prosecutions under the felons-with-firearms statute—18 U.S.C. § 1202(a), later recodified as 18 U.S.C. § 922(g)—that the Supreme Court distinguished from § 922(q) by virtue of its jurisdictional element. In one such case, the government's own expert witness testified that 95% of the firearms in the United States were transported across state lines. *See* Brent E. Newton, *Felons, Firearms, and Federalism: Reconsidering* Scarborough *in Light of Lopez*, 3 J. APP. PRAC. & PROCESS 671, 681–82 & n.53 (2001).

Court ultimately found this fact insufficient to save the statute. Rather, the Supreme Court commented that an interstate-tying element in the statute itself "would ensure, through case-by-case inquiry, that the [activity] in question affects interstate commerce."[98] *Lopez*, 514 U.S. at 561, 115 *S. Ct.* at 1631.

Here, the decision to forego insurance similarly lacks an established interstate tie or any "case-by-case inquiry." *See id.* Aside from the categories of exempted individuals, the individual mandate is applied across-the-board without regard to whether the regulated individuals receive, or have ever received, uncompensated care—or, indeed, seek any care at all, either now or in the future.[99] Thus, the Act contains no language "which might limit its reach to a discrete set of [activities] that additionally have

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Instructively, Congress took its cue from the Supreme Court after *Lopez* and amended the Gun-Free School Zones Act to require an explicit interstate nexus on an individualized basis. Specifically, Congress added a jurisdictional element to ensure that the charged individual's particular firearm had moved in interstate or foreign commerce (or otherwise affected such commerce). *See* 18 U.S.C. § 922(q)(2)(A) ("It shall be unlawful for any individual knowingly to possess a firearm *that has moved in or that otherwise affects interstate or foreign commerce* at a place that the individual knows, or has reasonable cause to believe, is a school zone." (emphasis added)).

[98] The *Lopez* Court never stated that such an element was *required*, and nor do we. However, it is clearly a relevant constitutional factor that the Supreme Court instructs us to consider. The government's argument ignores it completely.

[99] Although health care consumption is pervasive, the plaintiffs correctly note that participation in the market for health care is far less inevitable than participation in markets for basic necessities like food or clothing.

an explicit connection with or effect on interstate commerce." *See id. a*t 562, 115 *S. Ct.* at 1631.

The individual mandate sweeps too broadly in another way. Because the Supreme Court's prior Commerce Clause cases all deal with already-existing activity—not the mere *possibility* of *future* activity (in this case, health care consumption) that could implicate interstate commerce—the Court never had to address any temporal aspects of congressional regulation. However, the premise of the government's position—that most people will, *at some point in the future*, consume health care—reveals that the individual mandate is even further removed from traditional exercises of Congress's commerce power.[100]

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[100] The dissent attempts to sidestep the temporal leap problem by citing *Consolidated Edison Co. v. NLRB* for the proposition that Congress may take "reasonable preventive measures" to avoid future disruptions to interstate commerce. 305 U.S. 197, 222, 59 *S. Ct.* 206, 213 (1938). *Consolidated Edison*, of course, is wholly inapposite to this case, since Congress was regulating the labor practices of *utility companies* (1) fully engaged in the stream of commerce and (2) *presently* supplying economic services to instrumentalities of interstate commerce, such as railroads and steamships. *Id. a*t 220–22, 59 *S. Ct.* at 213. Even so, the dissent's argument proves far too much. After all, by the dissent's reasoning, Congress could clearly reach the gun possession at issue in *Lopez*, since firearms are (1) objects of everyday commercial transactions and (2) are daily used to disrupt interstate commerce. *See Lopez*, 514 U.S. at 602–03, 115 *S. Ct.* at 1651 (Stevens, J., dissenting) ("Guns are both articles of commerce and articles that can be used to restrain commerce. Their possession is the consequence, either directly or indirectly, of commercial activity."). Indeed, Antonio *Lopez* himself was paid $40 to traffic the gun for which he was charged under § 922(q). *United States v. Lopez*, 2 F.3d 1342, 1345 (5th Cir. 1995).

It is true that Congress may, in some instances, regulate individuals who are consuming health care but not themselves causing the cost-shifting problem. *Cf. Raich*, 545 U.S. at 17, 125 *S. Ct.* at 2206 ("We have never required Congress to legislate with scientific exactitude."); *id. a*t 22, 125 *S. Ct.* at 2209 ("That the regulation ensnares some purely intrastate activity is of no moment."). As the plaintiffs acknowledged at oral argument, when the uninsured actually enter the stream of commerce and consume health care, Congress may regulate their activity at the point of consumption.

But the individual mandate does *not* regulate behavior at the point of consumption. Indeed, the language of the individual mandate does not truly regulate "how and when health care is paid for." 42 U.S.C. § 18091(a)(2)(A). It does not even require those who consume health care to pay for it with insurance when doing so. Instead, the language of the individual mandate in fact regulates a related, but different, subject matter: "when health insurance is purchased." *Id.* If an individual's participation in the health care market is uncertain, their participation in the insurance market is even more so.

In sum, the individual mandate is breathtaking in its expansive scope. It regulates those who have not entered the health care market at all. It regulates those who have entered the health care market, but have not entered the insurance market (and have no intention of doing so). It is overinclusive in when it regulates: it conflates those who presently consume health care with those who will not consume health care for many years into the

future. The government's position amounts to an argument that the mere fact of an individual's existence substantially affects interstate commerce, and therefore Congress may regulate them at every point of their life. This theory affords no limiting principles in which to confine Congress's enumerated power.

F. Government's Proposed Limiting Principles

"We pause to consider the implications of the Government's arguments." *Lopez*, 514 U.S. at 564, 115 *S. Ct.* at 1632. The government clearly appreciates the far-reaching implications of the individual mandate. The government has struggled to avoid the conclusion that Congress may order Americans' other economic decisions through the use of economic mandates. At oral argument, the government's counsel specifically disclaimed the argument that Congress could compel a person to purchase insurance solely on the basis of his financial decision to spend his money elsewhere. Rather, the government seems to view an economic mandate as an emergency tool of sorts, for use in extreme and unique situations and only to the extent the underlying regulated conduct meets a number of fact-based criteria.

The government submits that health care and health insurance are factually unique and not susceptible of replication due to: (1) the inevitability of health care need; (2) the unpredictability of need; (3) the high costs of health care; (4) the federal requirement that hospitals treat, until stabilized, individuals with emergency medical conditions,

regardless of their ability to pay;[101] (5) and associated cost-shifting.

The first problem with the government's proposed limiting factors is their lack of *constitutional* relevance.[102] These five factual criteria comprising the government's "uniqueness" argument are not limiting principles rooted in any constitutional understanding of the commerce power. Rather, they are *ad hoc* factors that—fortuitously—happen to apply to the health insurance and health care industries. They speak more to the complexity of the

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[101] *See* EMTALA, 42 U.S.C. § 1395dd. In this regard, the plaintiffs point out that the government's contention amounts to a bootstrapping argument. Under the government's theory, Congress can enlarge its own powers under the Commerce Clause by legislating a market externality into existence, and then claiming an extra-constitutional fix is required.

[102] The Supreme Court has rejected similar calls for a reprieve from Commerce Clause restraints based upon the ostensible uniqueness or gravity of the problem being regulated. For instance, Justice Breyer's dissent in *Lopez* attempted to deflect the majority's focus on limiting principles—specifically, its statement that upholding § 922(q) would enable the federal government to "regulate any activity that it found was related to the economic productivity of individual citizens," 514 U.S. at 564, 115 *S. Ct.* at 1632—by arguing that § 922(q) "is aimed at curbing a *particularly acute threat*" and that "guns and education are incompatible" in a "*special way*." *Id. a*t 624, 115 *S. Ct.* at 1661 (Breyer, J., dissenting) (emphasis added). The dissent further opined that gun possession in schools embodied "*the rare case* . . . [when] a statute strikes at conduct that (when considered in the abstract) seems so removed from commerce, but which (practically speaking) has so significant an impact upon commerce." *Id. a*t 624, 115 *S. Ct.* at 1662 (emphasis added). The majority dismissed these "suggested limitations," however, characterizing them as "devoid of substance." *Id. a*t 564, 115 *S. Ct.* at 1632 (majority opinion).

problem being regulated than the regulated decision's relation to interstate commerce. They are not limiting principles, but limiting circumstances.

Apparently recognizing that these factors appear in many subjects worthy of regulation, the government acknowledged at oral argument that the mere presence of many of these factors is not sufficient. Presented with three examples of industries characterized by some or all of these market deficiencies—elder care, other types of insurance, and the energy market—the government argued that an economic mandate in these three settings is distinguishable.

However, virtually all forms of insurance entail decisions about timing and planning for unpredictable events with high associated costs—insurance protecting against loss of life, disability from employment, business interruption, theft, flood, tornado, and other natural disasters, long-term nursing care requirements, and burial costs. Under the government's proposed limiting principles, there is no reason why Congress could not similarly compel Americans to insure against any number of unforeseeable but serious risks.[103] High costs and

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[103] The government essentially argues that anyone creates a cost-shifting risk by virtue of being alive, since they may one day be injured or sick and seek care that they do not pay for. Therefore, Congress can compel the purchase of health insurance, from birth to death, to protect against such risks. This expansive theory could justify the compelled purchase of innumerable forms of insurance, however. To give but one example, Congress could undoubtedly require every American to purchase liability insurance, lest the consequences of their negligence or inattention lead to unfunded costs (medical and otherwise) passed on to others in the future.

cost-shifting in premiums are simply not limited to hospital care, but occur when individuals are disabled, cannot work, experience an accident, need nursing care, die, and myriad other insurance-related contingencies.

This gives rise to a second fatal problem with the government's proposed limits: administrability. We are at a loss as to how such fact-based criteria can serve as the sort of "judicially enforceable" limitations on the commerce power that the Supreme Court has repeatedly emphasized as necessary to that *enumerated* power. *Lopez*, 514 U.S. at 566, 115 *S. Ct.* at 1633; *see also Morrison*, 529 U.S. at 608 n.3, 120 *S. Ct.* at 1749 n.3 (rejecting dissent's "remarkable theory that the commerce power is without judicially enforceable boundaries"). We are loath to invalidate an act of Congress, and do so only after extensive circumspection. But the role that the Court would take were we to adopt the position of the government is far more troublesome. Were we to adopt the "limiting principles" proffered by the government, courts would sit in judgment over every economic mandate issued by Congress, determining whether the level of participation in the underlying market, the amount of cost-shifting, the unpredictability of need, or the strength of the moral imperative were enough to justify the mandate.

But the commerce power does not admit such limitations; rather it "is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons*, 22 U.S. at 196. If Congress may compel individuals to purchase health insurance from a private company, it may similarly compel the

purchase of other products from private industry, regardless of the "unique conditions" the government cites as warrant for Congress's regulation here. *See* Government's Opening Br. at 19.

Moreover, the government's insistence that we defer to Congress's fact findings underscores the lack of any judicially enforceable stopping point to the government's "uniqueness" argument. Presumably, a future Congress similarly would be able to articulate a unique problem requiring a legislative fix that entailed compelling Americans to purchase a certain product from a private company. The government apparently seeks to set the terms of the limiting principles courts should apply, and then asks that we defer to Congress's judgment about whether those conditions have been met. The Supreme Court has firmly rejected such calls for judicial abdication in the Commerce Clause realm. *See Lopez*, 514 U.S. at 557 n.2, 115 *S. Ct.* at 1629 n.2 ("'[W]hether particular operations affect interstate commerce sufficiently to come under the constitutional power of Congress to regulate them is ultimately a judicial rather than a legislative question, and can be settled finally only by this Court.'" (quoting *Heart of Atlanta Motel*, 379 U.S. at 273, 85 *S. Ct.* at 366 (Black, J., concurring))).

At root, the government's uniqueness argument relies upon a convenient sleight of hand to deflect attention from the central issue in the case: what is the nature of the conduct being regulated by the individual mandate, and may Congress reach it? Because an individual's decision to forego purchasing a product is so incongruent with the "activities" previously reached by Congress's commerce power, the government attempts to limit the individual

mandate's far-reaching implications. Accordingly, the government adroitly and narrowly redefines the regulated activity as the uninsured's health care *consumption* and attendant *cost-shifting*, or the *timing and method of payment* for such consumption.[104] The government's reluctance to define the conduct being regulated as the decision to forego insurance is understandable. After all, if the decision to forego purchasing a product is deemed "economic activity" (merely because it is inevitable that an individual in the future will consume in a related market), then decisions not to purchase a product would be subject to the sweeping doctrine of aggregation, and such no-purchase decisions of all Americans would fall within the federal commerce power. Consequently, the government could no longer fall back on "uniqueness" as a limiting factor, since Congress could enact purchase mandates no matter how pedestrian the relevant product market.

As an inferior court, we may not craft new dichotomies—"uniqueness" versus "non-uniqueness," or "cost-shifting" versus "non-cost-shifting"—not recognized by Supreme Court doctrine. To do so would require us to fabricate out of whole cloth a five-factor test that lacks any antecedent in the Supreme

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[104] The dissent adopts the government's position. *See* Dissenting Op. at 227 (describing "the relevant conduct targeted by Congress" as "the uncompensated consumption of health care services by the uninsured"); *id. a*t 235 (stating that "many of the[] uninsured currently consume health care services for which they cannot or do not pay" and "[t]his is, in every real and meaningful sense, classic economic *activity*"); *id. a*t 214 ("In other words, the individual mandate is the means Congress adopted to regulate the *timing* and *method* of individuals' payment for the consumption of health care services.").

Court's Commerce Clause jurisprudence. Thus, not only do the "uniqueness" factors lack judicial administrability, present Commerce Clause doctrine prohibits inferior courts, like us, from applying them anyway.

Ultimately, the government's struggle to articulate cognizable, judicially administrable limiting principles only reiterates the conclusion we reach today: there are none.

G. Congressional Findings

This brings us to the congressional findings. *See* 42 U.S.C. § 18091(a)(1)–(3). We look to congressional findings to help us "evaluate the legislative judgment that the activity in question substantially affected interstate commerce." *Lopez*, 514 U.S. at 549, 115 *S. Ct.* at 1632.

Here, tracking the language of Supreme Court decisions, the congressional findings begin with the statement that the individual insurance mandate "is commercial and economic in nature" and "substantially affects interstate commerce." 42 U.S.C. § 18091(a)(1). Of course, the relevant inquiry is not whether the regulation itself substantially affects interstate commerce but rather whether *the underlying activity* being regulated substantially affects interstate commerce.

Later on, the findings do ground the individual mandate in Congress's effort to address this multi-step cost-shifting scenario: (1) some uninsureds consume health care; (2) in turn, some of them do not pay their full medical costs and instead shift them to medical providers; (3) medical providers thereafter shift these costs to "private insurers"; and (4) private insurers then shift them to insureds through higher

premiums.[105] *Id.* § 18091(a)(2). The average annual premium increase is $1,000 for insured families, *id.*, and $400 for individuals.[106] The findings state that the mandate will reduce the number of the uninsured and the $43 billion cost-shifting and thereby "lower health insurance premiums."[107] *Id.* § 18091(a)(2)(F).

Of course, "the existence of congressional findings is not sufficient, by itself, to sustain the constitutionality of Commerce Clause legislation." *Morrison*, 529 U.S. at 614, 120 *S. Ct.* at 1752. Rather, the Supreme Court has insisted that courts examine congressional findings regarding substantial effects. *See Lopez*, 514 U.S. at 557 n.2, 115 *S. Ct.* at 1629 n.2 ("'[S]imply because Congress may conclude that a particular activity substantially affects

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[105] The parties and *amici* use the shorthand terms "cost-shifting," "cost-shifters," or "freeriders" to describe these problems.

[106] *See* Families USA, *supra* note 8.

[107] Experts debate whether the Act will accomplish its premium-lowering objective. According to even the CBO, "Under PPACA and the Reconciliation Act, premiums for health insurance in the individual market will be somewhat higher than they would otherwise be . . . mostly because the average insurance policy in that market will cover a larger share of enrollees' costs for health care and provide a slightly wider range of benefits." CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 8 (2009).

The CBO estimates the Act will cause costs for health insurance in the individual market to rise by 27% to 30% over current levels in 2016, due to the broadened coverage achieved by the insurance market reforms. *Id. a*t 6. For the purpose of our analysis, however, we accept the congressional finding that cost-shifters lead to higher premiums.

interstate commerce does not necessarily make it so.'" (quoting *Hodel,* 452 U.S. at 311, 101 *S. Ct.* at 2391 (Rehnquist, J., concurring))).

As a preliminary matter, we recount what the record reveals regarding the cost-shifting effects of the uninsured. To the extent the data show anything, the data demonstrate that the cost-shifters are largely persons who either (1) are exempted from the mandate, (2) are excepted from the mandate penalty, or (3) are now covered by the Act's Medicaid expansion.

For example, illegal aliens and other nonresidents are cost-shifters ($8.1 billion, or 18.9% of the $43 billion),[108] but they are exempted from the individual mandate entirely. 26 U.S.C. § 5000A(d)(3). Low-income persons are the largest segment of cost-shifters ($15 billion, or 34.8% of the $43 billion),[109] but they are covered by the Act's Medicaid expansion or excepted from the mandate penalty. *Id.* § 5000A(e)(1), (2) (excepting individuals (1) whose premium contribution exceeds 8% of household income or (2) whose household income is below the specified income tax filing threshold). Previously, the uninsured with preexisting health conditions sought, but were denied, coverage and ended up in the past cost-shifting pool ($8.7 billion, or

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[108] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[109] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

20.1%).[110] However, the Act's insurance reforms now guarantee them coverage and move them out of the future cost-shifting pool. Already-insured persons who do not pay their out-of-pocket costs (such as co-payments and deductibles) are cost-shifters ($3.3 billion, or 7.6%),[111] but they are already covered by insurance without the mandate. In addition, the cost-shifter uninsureds who cannot pay the average $2,000 medical bill also cannot pay the average $4,500 premium,[112] yielding another disconnect.

In reality, the primary persons regulated by the individual mandate are not cost-shifters but *healthy individuals* who forego purchasing insurance. The Act confirms as much. To help private insurers, the congressional findings acknowledge that the individual mandate seeks to "broaden the health insurance risk pool to include healthy individuals," to

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[110] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[111] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[112] As noted earlier, the uninsureds' average medical care costs were $2,000 in 2007 and $1,870 in 2008. Some uninsureds incur a larger expense, some a smaller expense, and some no expense at all. We use the average cited in the Brief of the *Amici Curiae* Economists in Support of the Government, at 16, which is based on the MEPS tables. The CBO estimates that in 2016 the annual premium for a bronze level plan, even in the Exchanges, will average $4,500–5,000 for individuals and $12,000–12,500 for a family policy. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Olympia Snowe, U.S. Senator (Jan. 11, 2010), *available at* http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf.

"minimize adverse selection,"[113] to increase "the size of purchasing pools," and to promote "economies of scale." 42 U.S.C. § 18091(a)(2)(I), (J). The individual mandate forces healthy and voluntarily uninsured individuals to purchase insurance from private insurers and pay premiums *now* in order to subsidize the private insurers' costs in covering more unhealthy individuals under the Act's reforms. Congress sought to mitigate its reforms' regulatory costs on private insurers[114] by compelling healthy Americans *outside the insurance market* to enter the private insurance market and buy the insurers' products. This starkly evinces how the Act is forcing market entry by those outside the market.

Nevertheless, we need not, and do not, rely on the factual disparity between the persons regulated by the individual mandate and the cost-shifting problem. After all, courts "need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce

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[113] Distinguished economists have filed helpful briefs on both sides of the case. While they disagree on some things, they agree about the theory of adverse selection. They agree some relatively healthy people refrain from, or opt out of, buying health insurance more often than people who are unhealthy or sick seek insurance. This results in a smaller and less healthy pool of insured persons for private insurance companies. Br. of *Amici Curiae* Economists in Support of the Government at 17–18; Br. of *Amici Curiae* Economists in Support of Plaintiffs at 13–16.

[114] As explained above, the Act requires private insurers (1) to cover the unhealthy and (2) *to price that coverage*, not on actuarial risks or basic economic pricing decisions, but on community-rated premiums without regard to health status. 42 U.S.C. § 300gg-1(a).

in fact, but only whether a '*rational basis*' exists for so concluding."[115] *Raich*, 545 U.S. at 22, 125 *S. Ct.* at 2208 (emphasis added). The government would have this be the end of the constitutional inquiry.

But the government skips important analytical steps. Rational basis review is not triggered by the mere fact of Congress's invocation of Article I power; rather, the Supreme Court has applied rational basis review to a more specific question under the Commerce Clause: whether Congress has a "rational basis" for concluding that the regulated "activities, *when taken in the aggregate*, substantially affect interstate commerce."[116] *Id.* (emphasis added). As discussed in subsection D, *supra*, courts must

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[115] Notably, the *Lopez* Court recognized the same "rational basis" level of review as *Raich*. *See Lopez*, 514 U.S. at 557, 115 *S. Ct.* at 1629 (stating that, since the New Deal, the Supreme Court has "undertaken to decide whether a rational basis existed for concluding that a regulated activity sufficiently affected interstate commerce"). *Raich* did not adopt a more deferential review of congressional legislation than prior cases, as the Supreme Court itself acknowledged. *See* 545 U.S. at 22, 125 *S. Ct.* at 2208 (collecting cases).

[116] Every case the *Raich* Court cited for rational basis review is a substantial effects case. *See* 545 U.S. at 22, 125 *S. Ct.* at 2208 (citing *Lopez*, 514 U.S. at 557, 115 *S. Ct.* 1624; *Hodel*, 452 U.S. at 276–80, 101 *S. Ct.* 2352; *Perez*, 402 U.S. at 155–56, 91 *S. Ct.* 1357; *Katzenbach*, 379 U.S. at 299–301, 85 *S. Ct.* 377; *Heart of Atlanta Motel*, 379 U.S. at 252–53, 85 *S. Ct.* 348). In such contexts, courts will accord significant deference to Congress's assessment of whether an activity's cumulative effect on interstate commerce is "substantial" or some lesser quantum. This is an altogether separate question from (1) whether a regulated activity is amenable to aggregation analysis at all and (2) the extent of the inferential leap needed to connect the regulated activity to the effects on interstate commerce.

initially assess whether the subject matter targeted by the regulation is suitable for aggregation in the first place. Relatedly, courts, in the rational basis inquiry, must also examine whether the link between the regulated activity and interstate commerce is too attenuated, lest there be no discernible stopping point to Congress's commerce power.[117] *See Lopez*, 514 U.S. at 562–68, 115 *S. Ct.* at 1630–34.

The wholesale deference the government would have us apply here cannot be squared with the Supreme Court's decisions in *Morrison* and *Lopez*. Here, "Congress' findings are substantially weakened by the fact that they rely so heavily on a method of reasoning that [courts] have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Morrison*, 529 U.S. at 615, 120 *S. Ct.* at 1752. It is highly instructive that the *Lopez* and *Morrison* Courts rejected a similar cost-shifting theory now propounded by the government.

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[117] Compare *Raich*, 545 U.S. at 22, 125 *S. Ct.* at 2209 ("[W]e have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA."), *Heart of Atlanta Motel*, 379 U.S. at 253, 85 *S. Ct.* at 355 (referring to "overwhelming evidence that discrimination by hotels and motels impedes interstate travel"), *and Wickard*, 317 U.S. at 128, 63 *S. Ct.* at 91 ("[A] factor of such volume and variability as home-consumed wheat would have a substantial influence on price and market conditions."), *with Morrison*, 529 U.S. at 615, 120 *S. Ct.* at 1752 (rejecting the government's invitation "to follow the but-for causal chain from the initial occurrence of violent crime . . . to every attenuated effect upon interstate commerce"), *and Lopez*, 514 U.S. at 564, 115 *S. Ct.* at 1632 ("[I]f we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate.").

In examining the actual relationship between gun possession and interstate commerce, the *Lopez* Court refused to accept what it referred to as the government's "cost of crime" theory. 514 U.S. at 564, 115 *S. Ct.* at 1632. It did so despite the government's argument that the "costs of violent crime are substantial, and, *through the mechanism of insurance, those costs are spread throughout the population*." *Id. a*t 563–64, 115 *S. Ct.* at 1632 (emphasis added).

Similarly, in *Morrison* the Supreme Court considered a stockpile[118] of congressional findings attesting to the link between domestic violence and medical costs frequently borne by third parties. *See*, *e.g.*, 529 U.S. at 629–36, 120 S. Ct at 1760–64 (Souter, J., dissenting); *see also id. a*t 632, 120 *S. Ct.* at 1762 ("'Over 1 million women in the United States seek medical assistance each year for injuries sustained [from] their husbands or other partners.'" (quoting S. Rep. No. 101-545, at 37 (1990))); *id.* ("'[E]stimates suggest that we spend $5 to $10 billion a year on health care, criminal justice, and other social costs of domestic violence.'" (quoting S. Rep. No. 103-138, at 41 (1993))).

In *Morrison*, the Supreme Court also recounted Congress's express finding that gender-motivated

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[118] In *Morrison*, "[t]he congressional findings that accompanied VAWA were so voluminous that they were removed from the text of the statute and placed in a conference report to avoid cluttering the United States Code." Melissa Irr, Note, United States v. *Morrison*; *An Analysis of the Diminished Effect of Congressional Findings in Commerce Clause Jurisprudence and a Criticism of the Abandonment of the Rational Basis Test*, 62 U. PITT. L. REV. 815, 824 (2001).

violence substantially affected interstate commerce "'by deterring potential victims from traveling interstate, from engaging in employment in interstate business, and from transacting with business, and in places involved in interstate commerce; . . . by diminishing national productivity, *increasing medical and other costs*, and decreasing the supply of and the demand for interstate products.'" *Id. a*t 615, 120 *S. Ct.* at 1752 (majority opinion) (emphasis added) (quoting H.R. Conf. Rep. No. 103-711, at 385 (1994)). The *Morrison* Court did not dispute the above figures about medical costs, but instead considered them largely extraneous to the threshold question of whether the subject matter of the regulation had a sufficient nexus to interstate commerce. *See Id. a*t 617, 120 *S. Ct.* at 1754.

In both *Lopez* and *Morrison*, the Supreme Court determined that the government's cost-shifting argument provided too attenuated a link to Congress's commerce power. Under such a cost-shifting theory, "it is difficult to perceive any limitation on federal power, even in areas such as criminal law enforcement or education where States historically have been sovereign." *Lopez*, 514 U.S. at 564, 115 *S. Ct.* at 1632.

For example, we harbor few doubts that an individual's decisions about "marriage, divorce, and child custody," if aggregated, would have substantial effects on interstate commerce. *See Id. a*t 564, 115 *S. Ct.* at 1632. Yet, the mere fact of an activity's substantial effects on interstate commerce does not thereby render that activity an appropriate subject for Congress's plenary commerce authority. Such a

holding would require the Supreme Court to overturn *Lopez* and *Morrison*.

We see no reason why the inferential leaps in this case are any less attenuated than those in *Lopez* and *Morrison*. The cost-shifting accompanying the criminal acts of violence at issue in *Lopez* and *Morrison*—hospital bills borne by third parties, property damage and insurance consequences, law enforcement expenditures and incarceration costs—is at least as apparent as the multi-step costshifting scenario associated with the medically uninsured. Meanwhile, in all three cases, the regulated conduct giving rise to the cost-shifting is divorced from a commercial transaction or the "production, distribution, and consumption of commodities." *Raich*, 545 U.S. at 26, 125 *S. Ct.* at 2211.

At best, we can say that the uninsured may, at some point in the *unforeseeable future*, create that cost-shifting consequence. Yet this readily leads to a scenario where we must "pile inference upon inference" to sustain Congress's legislation, a practice the Supreme Court admonishes us to avoid. *See Lopez*, 514 U.S. at 567, 115 *S. Ct.* at 1634. If anything, the temporal aspects present here, but not in *Lopez* or *Morrison*, render the regulated "activity" even further remote.[119]

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[119] The dissent identifies an economic effect—cost-shifting—and essentially defines that as the activity being regulated. But the dissent's conflation of activity and effect is sheer question begging. It is no wonder, then, that the dissent makes the breathtaking assertion that there is not even a single inferential step needed to link the regulated activity here to an impact on commerce. As the dissent frames the issue, there is no lack of

We next explain how the individual mandate impairs important federalism concerns.

H. Areas of Traditional State Concern

Before examining the states' traditional role in regulating insurance and health care, we fully recognize that Congress has the power under the Commerce Clause to regulate broadly in those arenas. In fact, Congress has legislated expansively and constitutionally in the fields of insurance and health care. *See*, *e.g.*, Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996); Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986);

Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. 93-406, 88 Stat. 829 (1974); Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (establishing Medicare and Medicaid); Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938). It is clear that Congress has enacted comprehensive legislation

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nexus between the regulated activity and its effects on interstate commerce because they are one and the same!

To the extent the dissent describes the conduct being regulated as the uncompensated consumption of health care services, the language of the mandate refers only to insurance and contains no reference to health care services, much less how health care services are consumed or paid for. The dissent can find no inferential leap because it has assumed away the very problem in this case, effectively treating the mandate as operating at the point of consumption. Under the dissent's re-framing of the issue, the VAWA's civil-remedy provision in *Morrison* could be regarded as regulating the "consumption of health care services," because such consumption inevitably and empirically flows from gender-motivated violence.

regarding health insurance and health care. The Act is another such example. Yet, the narrow constitutional question here is whether one provision—§ 5000A—in that massive regulation goes too far.

For the individual mandate to be sustained, it must be enacted pursuant to a valid exercise of Article I power. It simply will not suffice to say that, because Congress has regulated broadly in a field, it may regulate in any fashion it pleases.

The Constitution supplies Congress with various tools to effectuate its legislative power, but it also denies others. In assessing Congress's exercise of power, courts recognize that the *structural* limits embedded in the Constitution are of equal dignity to the express prohibitions—and may even be a more prevalent source of limitation. *See*, *e.g.*, *Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1968 (Kennedy, J., concurring) (rejecting notion that "the Constitution's express prohibitions" are "the only, *or even the principal*, constraints on the exercise of congressional power" (emphasis added)).[120]

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[120] The Supreme Court reminds us that "the federal structure serves to grant and delimit the prerogatives and responsibilities of the States and the National Government vis-à-vis one another" and "action that exceeds the National Government's enumerated powers undermines the sovereign interests of States." *Bond*, 564 U.S. at __, __, 131 *S. Ct.* at 2364, 2366; *see also* Gregory, 501 U.S. at 458, 111 *S. Ct.* at 2399 ("This federalist structure of joint sovereigns preserves to the people numerous advantages. It assures a decentralized government that will be more sensitive to the diverse needs of a heterogenous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes

The Supreme Court's Commerce Clause jurisprudence emphasizes that, in assessing the constitutionality of Congress's exercise of its commerce authority, a relevant factor is whether a particular federal regulation trenches on an area of traditional state concern. *See Morrison*, 529 U.S. at 611, 613, 615–16, 120 *S. Ct.* at 1750–51, 1753; *Lopez*, 514 U.S. at 561 n.3, 564–68, 115 *S. Ct.* at 1631 n.3, 1632–34. The Supreme Court has expressed concern that "Congress might use the Commerce Clause to completely obliterate the Constitution's distinction between national and local authority." *Morrison*, 529 U.S. at 615, 120 *S. Ct.* at 1752; *see also Raich*, 545 U.S. at 35–36, 125 *S. Ct.* at 2216–17 (Scalia, J., concurring); *Lopez*, 514 U.S. at 557, 567–68, 115 *S. Ct.* at 1628–29, 1634; *Id. a*t 577, 115 *S. Ct.* at 1638–39 (Kennedy, J., concurring) (stating that if Congress were to assume control over areas of traditional state concern, "the boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory. The resultant inability to hold either branch of the government answerable to the citizens is more dangerous even than devolving too much authority to the remote central power" (citation omitted)). Coupled with this consideration, the Supreme Court recognizes that the Constitution "withhold[s] from Congress a plenary police power." *Lopez*, 514 U.S. at 566, 115 *S. Ct.* at 1633; *see also Morrison*, 529 U.S. at 618–19, 120 *S. Ct.* at 1754; *cf. Comstock*, 560 U.S. at __, 130 *S. Ct.* at 1964; *Id. a*t __, 130 *S. Ct.* at 1967

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government more responsive by putting the States in competition for a mobile citizenry.").

(Kennedy, J., concurring) (stating that the police power "belongs to the States and the States alone").

In addition, whether the regulated subject matter is an area of traditional state concern impacts three of the five *Comstock* factors pertinent to a Necessary and Proper Clause analysis: (1) whether there is a long history of federal involvement in this arena, (2) whether the statute accommodates or supplants state interests, and (3) the statute's narrow scope. 560 U.S. at __, 130 *S. Ct.* at 1965.

With these principles in mind, we examine whether insurance and health care qualify as areas of traditional state concern. Prior to the Supreme Court's 1944 decision in *South-Eastern Underwriters*, "the States enjoyed a virtually exclusive domain over the insurance industry." *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 539, 98 *S. Ct.* 2923, 2928 (1978). Thus, *South-Eastern Underwriters* was "widely perceived as a threat to state power to tax and regulate the insurance industry." *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 499–500, 113 *S. Ct.* 2202, 2207 (1993); *see also Cantor v. Detroit Edison Co.*, 428 U.S. 579, 608 n.4, 96 *S. Ct.* 3110, 3126 n.4 (1976) (Blackmun, J., concurring) ("Congress' expressed concern [was that the result in *South-Eastern Underwriters*] would 'greatly impair or nullify the regulation of insurance by the States,' bringing to a halt their 'experimentation and investigation in the area.'"). "To allay those fears, Congress moved quickly to restore *the supremacy of the States in the realm of insurance regulation*." *Fabe*, 508 U.S. at 500, 113 *S. Ct.* at 2207 (emphasis added).

In 1945, a year after *South-Eastern Underwriters*, Congress passed the McCarran-Ferguson Act, 59 Stat. 33, ch. 20, 15 U.S.C. §§ 1011–1015.[121] The McCarran-Ferguson Act preserved state regulatory control over insurance, which was largely considered by Congress to be a "local matter." *W. & S. Life Ins. Co. v. State Bd. of Equalization*, 451 U.S. 648, 653, 101 *S. Ct.* 2070, 2075 (1981) (quoting H.R. Rep. No. 143, at 2 (1945)). The passage of the McCarran-Ferguson Act signaled Congress's recognition of the states' historical role in regulating insurance within their boundaries—and its unwillingness to supplant their vital function as a source of experimentation. *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429, 66 *S. Ct.* 1142, 1155 (1946) ("Obviously Congress' purpose [in passing the McCarran-Ferguson Act] was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."); *see also Ne. Bancorp, Inc. v. Bd. of Governors of Fed. Reserve Sys.*, 472 U.S. 159, 179, 105 *S. Ct.* 2545, 2556 (1985) (O'Connor, J., concurring) ("The business of insurance is also of uniquely local concern . . . . [and] historically ha[s] been regulated by the States in recognition of the critical part [it] play[s] in securing the financial well-being of local citizens and

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[121] The McCarran-Ferguson Act states: (1) "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," 15 U.S.C. § 1012(a), and (2) "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance," *id.* § 1012(b).

businesses." (citations omitted)). Our Circuit has reached a similar conclusion. *Blue Cross & Blue Shield v. Nielsen,* 116 F.3d 1406, 1413 (11th Cir. 1997) ("Adjustment of the rights and interests of insurers, health care providers, and insureds is a subject matter that falls squarely within the zone of traditional state regulatory concerns.").

Thus, insurance qualifies as an area of traditional state regulation. This recognition counsels caution, and supplies reviewing courts with even greater cause for doubt when faced with an unprecedented economic mandate of dubious constitutional status. *Cf. Lopez*, 514 U.S. at 583, 115 *S. Ct.* at 1641 (Kennedy, J., concurring) ("The statute now before us forecloses the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise, and it does so by regulating an activity beyond the realm of commerce in the ordinary and usual sense of that term.").

The health care industry also falls within the sphere of traditional state regulation. A state's role in safeguarding the health of its citizens is a quintessential component of its sovereign powers. The Supreme Court has declared that the "structure and limitations of federalism . . . allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Gonzales v. Oregon*, 546 U.S. 243, 270, 126 *S. Ct.* 904, 923 (2006) (quotation marks and citation omitted). Numerous Supreme Court decisions have identified the regulation of health matters as a core facet of a state's police powers. *See*, *e.g.*, *Hill v. Colorado*, 530

U.S. 703, 715, 120 *S. Ct.* 2480, 2489 (2000) ("It is a traditional exercise of the States' police powers to protect the health and safety of their citizens." (quotation marks and citation omitted)); *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 569, 111 *S. Ct.* 2456, 2462 (1991) ("The traditional police power of the States is defined as the authority to provide for the public health, safety, and morals."); *Head v. N.M. Bd. of Exam'rs in Optometry*, 374 U.S. 424, 428, 83 *S. Ct.* 1759, 1762 (1963) ("[T]he statute here involved is a measure directly addressed to protection of the public health, and the statute thus falls within the most traditional concept of what is compendiously known as the police power."); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449, 74 *S. Ct.* 650, 654 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power."); *Jacobson v. Massachusetts*, 197 U.S. 11, 25, 25 *S. Ct.* 358, 360 (1905) ("According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety."); *see also Raich*, 545 U.S. at 42, 125 *S. Ct.* at 2221 (O'Connor, J., dissenting) ("This case exemplifies the role of States as laboratories. The States' core police powers have always included authority to define criminal law and to protect the health, safety, and welfare of their citizens.").[122]

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[122] *Gibbons*, which represents one of the Supreme Court's earliest articulations of the states' reserved police powers, also provides insight into the traditionally local nature of health

Although the states and the federal government both play indispensable roles in regulating matters of health, modern Supreme Court precedents have confirmed the view that the health of a state's citizens is predominantly a state-based concern: "the regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719, 105 *S. Ct.* 2371, 2378 (1985). The Supreme Court similarly has stated that the narrower category of "health care" is an area of traditional state concern. *See*, *e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387, 122 *S. Ct.* 2151, 2171 (2002) (referring to "'the field of health care'" as "'a subject of traditional state regulation'" (quoting *Pegram v. Herdrich*, 530 U.S. 211, 237, 120 *S. Ct.* 2143, 2158 (2000))); *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661, 115 *S. Ct.* 1671, 1680 (1995) ("[G]eneral health care regulation . . . historically has been a matter of local concern.").

Here, it is undisputed that the individual mandate supersedes a multitude of the states' policy choices in these key areas of traditional state concern. Congress's encroachment upon these areas of traditional state concern is yet another factor that weighs in the plaintiffs' favor, and strengthens the

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laws. In *Gibbons*, Chief Justice Marshall remarked that "[i]nspection laws, quarantine laws, *health laws of every description*, as well as laws for regulating the internal commerce of a State" together "form a portion of that immense mass of legislation, which embraces everything within the territory of a State, not surrendered to the general government: all which can be most advantageously exercised by the States themselves." 22 U.S. at 203 (emphasis added).

inference that the individual mandate exceeds constitutional boundaries. The inference is particularly compelling here, where Congress has used an economic mandate to compel Americans to purchase and continuously maintain insurance from a private company.

We recognize the argument that, if states can issue economic mandates, Congress should be able to do so as well. Yes, some states have exercised their general police power to require their citizens to buy certain products—most pertinently, for our purposes, health insurance itself.[123] But if anything, this gives us greater constitutional concern, not less. Indeed, if the federal government possesses the asserted power to compel individuals to purchase insurance from a private company forever, it may impose such a mandate on individuals in states that have elected not to employ their police power in this manner.[124]

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[123] *See*, *e.g.*, MASS. GEN. LAWS ch. 111M § 2 (Massachusetts law requiring residents 18 years and older to "obtain and maintain creditable coverage so long as it is deemed affordable"); N.J. STAT. ANN. § 26:15-2 (New Jersey law requiring residents 18 years and younger to "obtain and maintain health care coverage that provides hospital and medical benefits").

[124] Some states have even passed legislation providing that their citizens may not be required to obtain or maintain health insurance. *See*, *e.g.*, Utah Code Ann. § 63M-1-2505.5; Va. Code Ann. § 38.2-3430.1:1; *see also* ARIZ. CONST. Art. XXVII, § 2 ("A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system."). The American Legislative Exchange Council, a nonprofit membership association of state legislators, filed a helpful *amicus* brief documenting the diverse array of policies implemented by states to provide their citizens with health

After all, if and when Congress actually operates within its enumerated commerce power, Congress, by virtue of the Supremacy Clause, may ultimately supplant the states. When this occurs, a state is no longer permitted to tailor its policymaking goals to the specific needs of its citizenry. This is precisely why it is critical that courts preserve constitutional boundaries and ensure that Congress only operates within the proper scope of its enumerated commerce power.

In sum, the fact that Congress has enacted this insurance mandate in an area of traditional state concern is a factor that strengthens the inference of a constitutional violation. When this federalism factor is added to the numerous indicia of constitutional infirmity delineated above, we must conclude that the individual mandate cannot be sustained as a valid exercise of Congress's power to regulate activities that substantially affect interstate commerce.

We do not reach this conclusion lightly, and we recognize that "[d]ue respect for the decisions of a coordinate branch of Government demands that we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *Morrison*, 529 U.S. at 607, 120 *S. Ct.* at 1748. But we believe a compelling showing has been made here, and "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for us to admit inability to intervene when

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coverage. *See* Br. of *Amicus Curiae* American Legislative Exchange Council in Support of Plaintiffs at 21–28.

one or the other level of Government has tipped the scales too far." *Lopez*, 514 U.S. at 578, 115 *S. Ct.* at 1639 (Kennedy, J., concurring) (citations omitted).

I. Essential to a Larger Regulatory Scheme

We lastly consider the government's separate contention that the individual mandate is a necessary and proper exercise of Congress's commerce power because it is essential to Congress's broader regulation of the insurance and health care markets.

The government's argument derives from a Commerce Clause doctrine of recent vintage. In 1995, the *Lopez* Court commented that the Gun-Free School Zones Act was "not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Id. a*t 561, 115 *S. Ct.* at 1631 (majority opinion). Ten years later in *Raich*, although plainly operating within the economic-noneconomic rubric adopted in *Lopez* and *Morrison*, the Supreme Court adverted to the "essential part of a larger regulation of economic activity" language in *Lopez* as a further reason to sustain Congress's action.[125] However, several features of the individual mandate materially

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[125] In a concurring opinion, Justice Scalia stated that "Congress may regulate even *noneconomic local activity* if that regulation is a necessary part of a more general regulation of interstate commerce." *Raich*, 545 U.S. at 37, 125 *S. Ct.* at 2217 (Scalia, J., concurring) (emphasis added). As noted earlier, however, the majority opinion in *Raich* described the regulated activity as "the production, distribution, and consumption of commodities" and thus "quintessentially economic." *Id. a*t 26, 125 *S. Ct.* at 2211 (majority opinion).

distinguish this case from *Raich* and demonstrate why the government's "essential to a broader regulation of commerce" argument fails here.

First, the Supreme Court has implied that the "larger regulatory scheme" doctrine primarily implicates as-applied challenges as opposed to the facial challenge at issue here. For instance, the Supreme Court has employed the "larger regulatory scheme" doctrine when a plaintiff asserts that, although Congress's statute is a permissible regulation within its commerce power, the statute cannot be validly applied to his particular intrastate activity. *Raich*, 545 U.S. at 15, 23–24, 125 *S. Ct.* at 2204, 2209–10. In such an instance, the Supreme Court may determine that the failure to reach a plaintiff's intrastate activities would undermine Congress's efforts to police the interstate market. *Id. a*t 28, 125 *S. Ct.* at 2212. However, the Supreme Court has to date never sustained a statute on the basis of the "larger regulatory scheme" doctrine in a facial challenge, where plaintiffs contend that the entire class of activity is outside the reach of congressional power.[126]

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[126] Although the *Lopez* Court was the first to recognize the "larger regulatory scheme" doctrine, it is arguable whether they actually applied it, in any real sense, in that case. Rather, the Supreme Court summarily stated that § 922(q) did not implicate that doctrine at all and "cannot, therefore, be sustained under our cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce." *Lopez*, 514 U.S. at 561, 115 *S. Ct.* at 1631. Here, it would strain credulity to suggest that the plaintiffs' conduct "arises out of or is connected with a commercial transaction," since the very

On this facial versus as-applied point, the *Raich* Court declared that "the statutory challenges at issue in [*Lopez* and *Morrison*] were markedly different from the challenge respondents pursue in the case at hand. Here, respondents ask us to excise individual applications of a concededly valid statutory scheme. In contrast, in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its entirety." *Id. a*t 23, 125 *S. Ct*. at 2209. The Court deemed this facial versus as-applied distinction "pivotal," as "we have often reiterated that '[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class.'" *Id.* (quoting *Perez*, 402 U.S. at 154, 91 *S. Ct*. at 1361). The plaintiffs here, of course, are not asking for courts to excise, as trivial, individual instances of a class—rather, the plaintiffs contend the mandate to purchase insurance from a private company falls outside of Congress's commerce power in its entirety.

But even accepting that this larger regulatory scheme doctrine fully applies in facial challenges, the government's argument still fails here. To see why, we discuss how the Supreme Court utilized the doctrine in the as-applied setting of *Raich*, the only instance in which a statute has been sustained by the larger regulatory scheme doctrine. The Supreme Court in *Raich* observed that, in enacting the CSA, "Congress devised a *closed regulatory system* making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner

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nature of their conduct is marked by the absence of a commercial transaction.

authorized by the CSA." *Id. a*t 13, 125 *S. Ct.* at 2203 (emphasis added). By classifying marijuana as a Schedule I drug, Congress sought to eliminate *all* interstate traffic in the commodity. The Supreme Court concluded that "the diversion of homegrown marijuana tends to frustrate the federal interest in eliminating commercial transactions in the interstate market *in their entirety*." *Id. a*t 19, 125 *S. Ct.* at 2207 (emphasis added).

Additionally, the fungible nature of the commodity—*i.e.*, the inability to distinguish intrastate marijuana from interstate marijuana—also undermined Congress's ability to enforce its concededly valid total CSA ban on commercial transactions in the interstate market. The *Raich* Court stated that "[g]iven the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a *gaping hole* in the CSA."[127]

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[127] The "gaping hole" identified by the Supreme Court was thrown into sharp relief by the *Raich* plaintiffs' lack of limiting principles. If Congress could not reach intrastate marijuana used for medical purposes, the *Raich* Court reasoned that it must also be true that intrastate marijuana used for recreational purposes could not be regulated either. 545 U.S. at 28, 125 *S. Ct.* at 2212. And if Congress could not reach intrastate marijuana authorized by state law, neither could it reach intrastate marijuana unauthorized by state law. *Id.* Moreover, if Congress could not reach intrastate marijuana when it is authorized by state law, then Congress's ability to police the interstate marijuana market would be wholly contingent on state decisions about whether or not to authorize

*Id. a*t 22, 125 *S. Ct.* at 2209 (citation omitted) (emphasis added). Consequently, the *Raich* Court determined that Congress's regulation was justified by the possibility that the plaintiffs' intrastate activities could frustrate or impede a validly enacted congressional statute regulating interstate commerce.

In this case, the government contends that the individual mandate is essential to its broader regulation of the insurance market. For example, the government submits that Congress's insurance industry reforms—specifically, its community-rating and guaranteed-issue reforms—will encourage individuals to delay purchasing private insurance until an acute medical need arises. Therefore, the government argues that unless the individual mandate forces individuals into the private insurance pool before they get sick or injured, Congress's insurance industry reforms will be unsustainable by the private insurance companies. The government emphasizes that the congressional findings state that the individual mandate "is essential to creating

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marijuana use. Congress would effectively be at the mercy of states, even though "state action cannot circumscribe Congress' plenary commerce power." *Id. a*t 29, 125 *S. Ct.* at 2213. It is easy to see how the *Raich* plaintiffs' arguments threatened to completely undermine the CSA's regulation of the interstate marijuana market, not to mention "turn the Supremacy Clause on its head." *Id. a*t 29 n.38, 125 *S. Ct.* at 2213 n.38.

This stands in marked contrast with the case before us, where neither state law nor the plaintiffs' uninsured status undermine the ability of Congress to enforce its regulation of interstate commerce. Even without the mandate, the integrity of all other statutory provisions is maintained, and Congress's ability to enforce the Act is in no way jeopardized.

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." 42 U.S.C. § 18091(a)(2)(I).

We first note the truism that the mere placement of a particular regulation in a broader regulatory scheme does not, *ipso facto*, somehow render that regulation *essential* to that scheme. It would be nonsensical to suggest that, in announcing its "larger regulatory scheme" doctrine, the Supreme Court gave Congress *carte blanche* to enact unconstitutional regulations so long as such enactments were part of a broader, comprehensive regulatory scheme. We do not construe the Supreme Court's "larger regulatory scheme" doctrine as a magic words test, where Congress's statement that a regulation is "essential" thereby immunizes its enactment from constitutional inquiry. Such a reading would eviscerate the Constitution's enumeration of powers and vest Congress with a general police power.

Ultimately, we conclude that the Supreme Court's "larger regulatory scheme" doctrine embodies an observation put forth in the New Deal case of *Jones & Laughlin Steel Corp.*: "Although activities may be intrastate in character when separately considered, if they have such a close and substantial relation to interstate commerce that *their control is essential or appropriate to protect that commerce from burdens and obstructions*, Congress cannot be denied the power to exercise that control." 301 U.S. at 37, 57 *S. Ct.* at 624 (emphasis added). Justice Scalia's concurring opinion in *Raich* suggests a similar interpretation. There, he stated that the

"larger regulatory scheme" statement in *Lopez* "referred to those cases permitting the regulation of intrastate activities 'which *in a substantial way* interfere with or obstruct the exercise of the granted power.'" *Raich*, 545 U.S. at 36, 125 *S. Ct.* at 2217 (Scalia, J., concurring) (emphasis added) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 119, 62 *S. Ct.* 523, 526 (1942)). In other words, the Necessary and Proper Clause enables Congress in some instances to reach intrastate activities that markedly burden or obstruct Congress's ability to regulate interstate commerce.

In *Raich*, the plaintiffs' intrastate activities—growing and consuming marijuana—obstructed and burdened Congress's total CSA ban on interstate marijuana traffic, both because the fungible nature of marijuana frustrated Congress's ability to police the interstate market and because evidence indicated that intrastate marijuana is often diverted into the interstate market. Yet it is evident that the conduct regulated by the individual mandate—an individual's decision not to purchase health insurance and the concomitant absence of a commercial transaction—in no way "burdens" or "obstructs" Congress's ability to enforce its regulation of the insurance industry. Congress's statutory reforms of health insurance products—such as guaranteed issue and community rating—do not reference or make their implementation in any way dependent on the individual mandate.

The individual mandate does not remove an obstacle to Congress's regulation of insurance companies. An individual's uninsured status in no way interferes with Congress's ability to regulate

insurance companies. The uninsured and the individual mandate also do not prevent insurance companies' regulatory compliance with the Act's insurance reforms. At best, the individual mandate is designed *not* to enable the execution of the Act's regulations, but to counteract the significant regulatory costs on insurance companies and adverse consequences stemming from the fully executed reforms. That may be a relevant political consideration, but it does not convert an unconstitutional regulation (of an individual's decision to forego purchasing an expensive product) into a constitutional means to ameliorate adverse cost consequences on private insurance companies engendered by Congress's broader regulatory reform of their health insurance products.[128]

The government's assertion that the individual mandate is "essential" to Congress's broader economic regulation is further undermined by components of the Act itself. In *Raich*, Congress devised a "closed regulatory system," *id. a*t 13, 125 *S. Ct.* at 2203, designed to eliminate all interstate marijuana traffic. Here, by contrast, Congress itself

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[128] The government argues that Congress has broad authority to select the means by which it enforces its comprehensive regulatory scheme. But this hardly entails that Congress may choose any and all means whatsoever. Indeed, Congress might have employed other unconstitutional means to render its community-rating and guaranteed-issue reforms more "effective." For example, it might order unreasonable searches and seizures of corporate documents to ensure that insurance companies were not discriminating against applicants with preexisting conditions. Surely this action would not cease being a Fourth Amendment violation merely because it is deemed essential to a broader regulatory scheme.

carved out eight broad exemptions and exceptions to the individual mandate (and its penalty) that impair its scope and functionality. *See* 26 U.S.C. § 5000A(d)–(e). Even if the individual mandate remained intact, the "adverse selection" problem identified by Congress would persist not only with respect to these eight broad exemptions, but also with respect to *those healthy persons who choose to pay the mandate penalty*. Those who pay the penalty one year instead of purchasing insurance may still get sick the next year and *then* decide to purchase insurance, for which they could not be denied.

Additionally, Congress has hamstrung its own efforts to ensure compliance with the mandate by opting for toothless enforcement mechanisms. Eschewing the IRS's traditional enforcement tools, the Act waives all criminal penalties for noncompliance and prevents the IRS from using liens or levies to collect the penalty. *Id.* § 5000A(g)(2). Thus, to the extent the uninsureds' ability to delay insurance purchases would leave a "gaping hole" in Congress's efforts to reform the insurance market, Congress has seen fit to bore the hole itself.

J. Conclusion

For these reasons, we conclude that the individual mandate contained in the Act exceeds Congress's enumerated commerce power. This conclusion is limited in scope. The power that Congress has wielded via the Commerce Clause for the life of this country remains undiminished. Congress may regulate commercial actors. It may forbid certain commercial activity. It may enact hundreds of new laws and federally-funded programs, as it has elected to do in this massive 975-

page Act. But what Congress cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die.

It cannot be denied that the individual mandate is an unprecedented exercise of congressional power. As the CBO observed, Congress "has never required people to buy any good or service as a condition of lawful residence in the United States." CBO MANDATE MEMO, *supra* p. 115, at 1. Never before has Congress sought to *regulate* commerce by compelling non-market participants to *enter into* commerce so that Congress may regulate them. The statutory language of the mandate is not tied to health care consumption—past, present, or in the future. Rather, the mandate is to buy insurance now and forever. The individual mandate does not wait for market entry.

Because the Commerce Clause is an enumerated power, the Supreme Court's decisions all emphasize the need for judicially enforceable limitations on its exercise. The individual mandate embodies no such limitations, at least none recognized by extant Commerce Clause doctrine. If an individual's decision *not* to purchase an expensive product is subject to the sweeping doctrine of aggregation, then that purchase decision will almost always substantially affect interstate commerce. The government's five factual elements of "uniqueness," proposed as constitutional limiting principles, are nowhere to be found in Supreme Court precedent. Rather, they are *ad hoc*, devoid of constitutional substance, incapable of judicial administration—and,

consequently, illusory. The government's fact-based criteria would lead to expansive involvement by the courts in congressional legislation, requiring us to sit in judgment over when the situation is serious enough to justify an economic mandate.

This lack of limiting principles also implicates two overarching considerations within the Supreme Court's Commerce Clause jurisprudence: (1) preserving the federal-state balance and (2) withholding from Congress a general police power. *Morrison*, 529 U.S. at 617–19, 120 *S. Ct.* at 1754; *Lopez*, 514 U.S. at 566–68, 115 *S. Ct.* at 1633–34; *Jones & Laughlin Steel Corp.*, 301 U.S. at 30, 57 *S. Ct.* at 621. These concerns undergird the Constitution's dual sovereignty structure, ensuring that the federal government remains a government of enumerated powers.

As demonstrated at length throughout our opinion, Congress has broad power to deal with the problems of the uninsured, and it wielded that power pervasively in this comprehensive and sweeping Act. As to the individual mandate provision, however, Congress exceeded its enumerated commerce power. The structure of the Constitution interposes obstacles by design, in order to prevent the arrogation of power by one branch or one sovereign. *See Gregory*, 501 U.S. at 458, 111 *S. Ct.* at 2400 ("Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front."). We cannot ignore these structural limits on the

Commerce Clause because of the seriousness and intractability of the problem Congress sought to resolve in the Act.

The Supreme Court has often found itself forced to strike down congressional enactments even when the law is designed to address particularly difficult and universally acknowledged problems. For instance, in *Clinton v. City of New York*, 524 U.S. 417, 118 *S. Ct.* 2091 (1998), the Supreme Court addressed a problem of Congress's own creation—deficit spending. The Line Item Veto Act was "of first importance, for it seems undeniable the Act will tend to restrain persistent excessive spending." *Id. a*t 449, 118 *S. Ct.* at 2108 (Kennedy, J., concurring). The problem the act addressed was momentous: "A nation cannot plunder its own treasury without putting its Constitution and its survival in peril." *Id.*

Nevertheless, the Supreme Court invalidated the Line Item Veto Act, recognizing that the Constitution establishes restraints on the power of Congress to act, even in regards to the mechanism by which it withholds or allocates funding. The fact that constitutional tools sometimes "prove insufficient[] cannot validate an otherwise unconstitutional device" because "[t]he Constitution's structure requires a stability which transcends the convenience of the moment." *Id. a*t 453, 118 *S. Ct.* at 2110; *see also New York v. United States*, 505 U.S. at 178, 112 *S. Ct.* at 2429 (noting that "[n]o matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority" to supersede its constitutionally imposed boundaries); *INS v. Chadha*, 462 U.S. 919, 958–59, 103 *S. Ct.* 2764, 2788 (1983) ("In purely practical terms, it is obviously easier for

action to be taken by one House without submission to the President; but it is crystal clear from the records of the Convention, contemporaneous writings and debates, that the Framers ranked other values higher than efficiency.").

In the same way, the difficulties posed by the insurance market and health care cannot justify extra-constitutional legislation. *See Printz*, 521 U.S. at 935, 117 *S. Ct.* at 2385 ("It matters not whether policymaking is involved, and no case-by-case weighing of the burdens or benefits is necessary; such [federal] commands are fundamentally incompatible with our constitutional system of dual sovereignty.").

The federal government's assertion of power, under the Commerce Clause, to issue an economic mandate for Americans to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits, and imperils our federalist structure. We recognize that "[t]hese are not precise formulations, and in the nature of things they cannot be." *Lopez*, 514 U.S. at 567, 115 *S. Ct.* at 1634. That an economic mandate to purchase insurance from a private company is an expedient solution to pressing public needs is not sufficient. As the Supreme Court counseled in *New York v. United States*,

> The result may appear 'formalistic' in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist

> the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

505 U.S. at 187, 112 *S. Ct.* at 2434. Although courts must give due consideration to the policy choices of the political branches, the judiciary owes its ultimate deference to the Constitution.[129]

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[129] We are at a loss as to why the dissent spends a considerable portion of its opinion on the Fifth and Tenth Amendments. As mentioned earlier, the district court dismissed the plaintiffs' Fifth Amendment claim. *Florida v. HHS*, 716 F. Supp. 2d at 1161–62. That ruling is not on appeal.

Furthermore, the plaintiffs' briefs on appeal raise no free-standing Tenth Amendment claim *as to the individual mandate*. Although the state plaintiffs' brief makes a single passing reference to the Tenth Amendment in the introduction, *see* States' Opening Br. at 3, the fact remains that the Tenth Amendment is not once cited or argued in the state plaintiffs' *individual mandate* discussion. *See* States' Opening Br. at 19–47. The private plaintiffs' brief also makes a single passing reference to the Tenth Amendment, but only in relation to how principles of federalism inform a Necessary and Proper Clause analysis. *See* Private Plaintiffs' Br. at 46.

Accordingly, we cannot consider a free-standing Tenth Amendment claim. *See*, *e.g.*, *Tanner Adver. Grp., L.L.C. v. Fayette Cnty.*, 451 F.3d 777, 785 (11th Cir. 2006) ("'The law is by now well settled in this Circuit that a legal claim or argument that has not been briefed before the court is deemed abandoned and its merits will not be addressed.'" (quoting *Access Now, Inc. v. Sw. Airlines Co.*, 385 F.3d 1324, 1330 (11th Cir. 2004)) (brackets omitted)); *United States v. Jernigan*, 341 F.3d 1273, 1283 n.8 (11th Cir. 2003) (finding issue waived, despite "four passing references" in Appellant's brief, because "a party seeking to raise a claim or issue on appeal must plainly and prominently so indicate").

VI. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE TAX POWER

The government claims in the alternative that the individual mandate is a tax validly enacted pursuant to the Taxing and Spending Clause. The Clause provides in relevant part that "Congress shall have 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. 1, § 8, cl. 1. The government claims that the taxing power is comprehensive and plenary, and the fact that the individual mandate also has a concededly regulatory purpose is irrelevant, because "a tax 'does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed.'" Government's Opening Br. at 50 (quoting *United States v. Sanchez*, 340 U.S. 42, 44, 71 *S. Ct.* 108, 110 (1950)). The government claims that as long as a statute is "productive of some revenue," Congress may enact it under its taxing power. *Id.* (quoting *Sonzinsky v. United States*, 300 U.S. 506, 514, 57 *S. Ct.* 554, 556 (1937)). Furthermore, the government contends our review is limited because "the constitutional restraints on taxing are few" and "[t]he remedy for excessive taxation is in the hands of Congress, not the courts." *United States v. Kahriger*, 345 U.S. 22, 28, 73 *S. Ct.* 510, 513 (1953), *overruled on other grounds by Marchetti v. United States*, 390 U.S. 39, 88 *S. Ct.* 697 (1968); see also Kahriger, 345 U.S. at 31, 73 *S. Ct.* at 515 ("Unless there are provisions, extraneous to any tax need, courts are without authority to limit the exercise of the taxing power."). Like every other court that has addressed this claim, we remain unpersuaded.

It is not surprising to us that all of the federal courts, which have otherwise reached sharply divergent conclusions on the constitutionality of the individual mandate, have spoken on this issue with clarion uniformity. Beginning with the district court in this case, all have found, without exception, that the individual mandate operates as a regulatory penalty, not a tax. *Florida v. HHS*, 716 F. Supp. 2d at 1143–44 ("I conclude that the individual mandate penalty is not a 'tax.' It is (as the Act itself says) a penalty."); *U.S. Citizens Ass'n v. Sebelius*, 754 F. Supp. 2d 903, 909 (N.D. Ohio 2010) (concluding that the individual mandate is a penalty, "agree[ing] with the thoughtful and careful analysis of Judge Vinson"); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 629 (W.D. Va. 2010) ("After considering the prevailing case law, I conclude that the better characterization of the exactions imposed under the Act for violations of the employer and individual coverage provisions is that of regulatory penalties, not taxes."); *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 782–88 (E.D. Va. 2010) (concluding that the individual mandate "is, in form and substance, a penalty as opposed to a tax"); *Goudy-Bachman v. HHS*, 764 F. Supp. 2d 684, 695 (M.D. Pa. 2011) ("The court finds that the individual mandate itself is not a tax . . . ."); *Mead v. Holder*, 766 F. Supp. 2d 16, 41 (D.D.C. 2011) ("[T]he Court concludes that Congress did not intend [the individual mandate] to operate as a tax, and therefore Defendants cannot rely on the General Welfare Clause as authority for its enactment.").

For good reason. The breadth of the taxing power, well noted by the government and its *amici*, fails to resolve the question we face: whether the

individual mandate is a tax in the first place. The plain language of the statute and well-settled principles of statutory construction overwhelmingly establish that the individual mandate is not a tax, but rather a penalty. The legislative history of the Act further supports this conclusion. And as the Supreme Court has repeatedly recognized, there is a firm distinction between a tax and a penalty. See, *e.g.*, *United States. v. La Franca*, 282 U.S. 568, 572, 51 *S. Ct.* 278, 280 (1931) ("The two words are not interchangeable one for the other.").

The government would have us ignore all of this and instead hold that any provision found in the Internal Revenue Code that will produce revenue may be characterized as a tax. This we are unwilling to do.

A. Repeated Use of the Term "Penalty" in the Individual Mandate

"As in any case involving statutory construction, we begin with the plain language of the statute." *Hemispherx Biopharma, Inc. v. Johannesburg Consol. Invs.*, 553 F.3d 1351, 1362 (11th Cir. 2008) (citing *Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108, 100 *S. Ct.* 2051, 2056 (1980)). The plain language of the individual mandate is clear that the individual mandate is not a tax, but rather, as the statute itself repeatedly states, a "penalty" imposed on an individual for failing to maintain a minimum level of health insurance coverage in any month beginning in 2014. Title 26 U.S.C. § 5000A(a) requires "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage." 26 U.S.C. § 5000A(a). In order to enforce this

requirement, Congress stated that "[i]f a taxpayer who is an applicable individual . . . fails to meet the requirement of subsection (a) for 1 or more months, then . . . there is hereby imposed on the taxpayer a *penalty* with respect to such failures." *Id.* § 5000A(b)(1) (emphasis added).

Nor could we construe Congress's choice of language as a careless one-time invocation of the word "penalty," because the remainder of the relevant provisions in § 5000A uses the same term over and over again, without exception and without ever describing the penalty as a "tax." *See*, *e.g.*, *id.* § 5000A(b)(3)(B) (individual "with respect to whom a *penalty* is imposed by this section" who files joint tax return "shall [along with individual's spouse] be jointly liable for such *penalty*" (emphasis added)); *id.* § 5000A(c)(1) (describing "[t]he amount of the penalty imposed by this section on any taxpayer for any taxable year" (emphasis added)); *id.* § 5000A(c)(2) (describing "the monthly *penalty* amount with respect to any taxpayer" (emphasis added)); *id.* § 5000A(g)(1) ("The *penalty* provided by this section shall be paid upon notice and demand by the Secretary . . . ." (emphasis added)); *id.* § 5000A(g)(2)(A) (providing that taxpayer "shall not be subject to any criminal prosecution or penalty" for failure "to timely pay any *penalty* imposed by this section" (emphasis added)); *id.* § 5000A(g)(2)(B) (providing that the Secretary shall not "file notice of lien" or "levy" on "any property of a taxpayer by reason of any failure to pay the *penalty* imposed by this section" (emphasis added)).

Thus, the text of the individual mandate unambiguously provides that it imposes a *penalty*.

The penalty encourages compliance with the Act's requirement to obtain "minimum essential coverage" by imposing a monetary sanction on conduct that violates that requirement. The text is not unclear and was carefully selected to denote a specific meaning. As the Supreme Court most recently recognized in *United States v. Reorganized CF & I Fabricators of Utah, Inc.*, 518 U.S. 213, 116 *S. Ct.* 2106 (1996), "'[a] tax is an enforced contribution to provide for the support of government; a penalty . . . is an exaction imposed by statute as punishment for an unlawful act.'" *Id. a*t 224, 116 *S. Ct.* at 2113 (quoting *La Franca*, 282 U.S. at 572, 51 *S. Ct.* at 280). The Court further expounded upon *La Franca*: "We take *La Franca*'s statement of the distinction [between a tax and penalty] to be sufficient for the decision of this case; if the concept of penalty means anything, it means punishment for an unlawful act or omission. . . ." *Id.*; *see also Dep't of Revenue of Mont. v. Kurth Ranch*, 511 U.S. 767, 779–80, 114 *S. Ct.* 1937, 1946 (1994) ("Whereas fines, penalties, and forfeitures are readily characterized as sanctions, taxes are typically different because they are usually motivated by revenue-raising, rather than punitive, purposes."). It is clear that the terms "tax" and "penalty" "are not interchangeable one for the other . . . . and if an exaction be clearly a penalty it cannot be converted into a tax by the simple expedient of calling it such." *La Franca*, 282 U.S. at 572, 51 *S. Ct.* at 280.

B. Designation of Numerous Other Provisions in the Act as "Taxes"

We add the truism that Congress knows full well how to enact a tax when it chooses to do so. And the

Act contains several provisions that are unmistakably taxes. The point is amply made by simply looking at four different provisions: (1) an Excise Tax on Medical Device Manufacturers, 26 U.S.C. § 4191(a) ("There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a *tax* equal to 2.3 percent of the price for which so sold." (emphasis added)); (2) an Excise Tax on High Cost Employer-Sponsored Health Coverage, *id.* § 4980I(a)(1)–(2) (if an employee receives "excess benefit," as defined in the statute, from employer-sponsored health coverage, "there is hereby imposed a *tax* equal to 40 percent of the excess benefit" (emphasis added)); (3) an Additional Hospital Insurance Tax for High-Income Taxpayers, amending *id.* § 3101(b) (as part of Federal Insurance Contributions Act, providing that "there is hereby imposed on the income of every individual a *tax* equal to 1.45 percent of the wages . . . received by him with respect to employment" (emphasis added));[130] and (4) an Excise Tax on Indoor Tanning Services, *id.* § 5000B(a) ("There is hereby imposed on any indoor tanning service a *tax* equal to 10 percent of the amount paid for such service . . . whether paid by insurance or otherwise" (emphasis added)).

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[130] Indeed, this provision, which takes effect in 2013, is a 0.9% flat tax increase on an individual's wages, applicable to those earning annual wages over $200,000 ($250,000 in the case of a jointly-filed return, or $125,000 in the case of a married taxpayer filing a separate tax return). Act §§ 9015(a)(1), 10906(a), (c); HCERA, Pub. L. No. 111-152, § 1402(b)(1)(A), (3), 124 Stat. 1029, 1063 (2010), to be codified in 26 U.S.C. § 3101(b) (effective Jan. 1, 2013).

It is an unremarkable matter of statutory construction that we presume Congress did not indiscriminately use the term "tax" in some provisions but not in others. *See Duncan v. Walker*, 533 U.S. 167, 173, 121 *S. Ct.* 2120, 2125 (2001) ("It is well settled that where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." (quotation marks and alteration omitted)). We have little difficulty concluding that Congress intended § 5000A to operate as a penalty.

The very nature of congressional findings about the individual mandate further amplifies that Congress designed and intended to design a penalty for the failure to comply and not a tax. The source of the power, asserted by Congress, to create the mandate is directly pegged to the Commerce Clause. *See*, *e.g.*, 42 U.S.C. § 18091(a)(1) ("The individual responsibility requirement provided for in this section . . . is commercial and economic in nature, and substantially affects interstate commerce . . . ."); *id.* § 18091(a)(2)(B) ("Health insurance and health care services are a significant part of the national economy . . . . Private health insurance spending . . . pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.").

Indeed, the findings make clear that the goal of the individual mandate is not to raise revenue for the

public fisc, but rather to, among other things, reduce the number of the uninsured and to create what Congress perceived to be effective health insurance markets that make health insurance more widely available. *Id.* § 18091(a)(2)(C)–(I); *see also id.* § 18091(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

The argument that Congress need not employ the label of "tax" or expressly invoke the Taxing and Spending Clause in order to enact a valid tax is surely true, insofar as it goes. *See Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144, 68 *S. Ct.* 421, 424 (1948) ("[T]he constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise."). The problem with the claim, however, is not that Congress simply failed to use the term "tax," or declined to invoke the Taxing and Spending Clause when explaining the constitutional basis for enacting the individual mandate. Rather, Congress repeatedly told us that the individual mandate is a "penalty" and expressly invoked its Commerce Clause power as the foundation for the mandate. The two are not the same thing. Ultimately, we are hard pressed to construe the statute in a manner that would require us to ignore the plain text of the statute, the words repeatedly employed by Congress, well-settled principles of statutory construction, and well-settled law emphasizing the substantive distinction between a tax and a penalty.

C. Legislative History of the Individual Mandate

Even if the text were unclear—although it is not—and we were to resort to an examination of the legislative history, we would still find more of the same thing: Congress intended to impose a penalty for the failure to maintain health insurance.

Prior to the passage of the Act, earlier bills in both houses of Congress proposed an individual mandate accompanied by a "tax," as the district court noted. *See Florida v. HHS*, 716 F. Supp. 2d at 1134. Thus, for example, Section 401 of the "America's Affordable Choices Act of 2009," H.R. 3200, 111th Cong. (2009), which was introduced in the House of Representatives on July 14, 2009, provided that "there is hereby imposed a tax" on "any individual who does not meet the requirements of [maintaining minimum health insurance coverage] at any time during the taxable year." A later version of the House bill, the "Affordable Health Care for America Act," H.R. 3962, 111th Cong. § 501 (2009), passed the House of Representatives on November 7, 2009, and similarly referred to the individual mandate's enforcement mechanism as a "tax." On the Senate side, the "America's Healthy Future Act," a precursor to the Act, also used the term "tax." *See* S. 1796, 111th Cong. § 1301 (2009) ("If an applicable individual fails to [maintain minimum health insurance coverage] there is hereby imposed a tax. . . .").

Notably, however, the final version of the Act abandoned the term "tax" in favor of the term "penalty." This is no mere semantic distinction, as "[f]ew principles of statutory construction are more compelling than the proposition that Congress does

not intend *sub silentio* to enact statutory language that it has earlier discarded *in favor of other language*." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442–43, 107 *S. Ct.* 1207, 1218 (1987) (emphasis added) (quotation marks omitted).

The government relies on different pieces of the legislative history, particularly the statements of individual legislators, speaking both for and against the Act, who at various times referred to the individual mandate as a "tax." *See* Government's Opening Br. at 54 (citing 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (statement of Rep. Miller); 156 Cong. Rec. H1824, H1826 (daily ed. Mar. 21, 2010) (statement of Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (daily ed. Dec. 22, 2009) (statement of Sen. Leahy); 155 Cong. Rec. S13,558, S13,581–82 (daily ed. Dec. 20, 2009) (statement of Sen. Baucus); 155 Cong. Rec. S12,768 (daily ed. Dec. 9, 2009) (statement of Sen. Grassley)). These assorted statements of individual legislators are of precious little value, because they are in conflict with the plain text of the statute and with more reliable indicators of congressional intent. *See Huff v. DeKalb Cnty., Ga.*, 516 F.3d 1273, 1280 (11th Cir. 2008) ("'The best evidence of [legislative] purpose is the statutory text adopted by both Houses of Congress and submitted to the President. Where that contains a phrase that is unambiguous—that has a clearly accepted meaning in both legislative and judicial practice—we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process.'" (alteration in original) (quoting *W. Va. Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 98–99, 111 *S. Ct.* 1138, 1147 (1991))).

The government argues nevertheless that the individual mandate is still "a tax in both administration and effect." Government's Opening Br. at 54. It claims that in "passing on the constitutionality of a tax law," we should be "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Id.* (quoting *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363, 61 *S. Ct.* 586, 588 (1941)). That the individual mandate will produce some revenue and will be enforced by the Internal Revenue Service is enough, they say, to transmute the individual mandate's penalty provision into a tax.

We remain unpersuaded. Even on the government's own terms, the individual mandate does not in "practical operation" act as a tax. *See Nelson*, 312 U.S. at 363, 61 *S. Ct.* at 588. The government specifically claims that the individual mandate has the character of a tax because it will produce revenue. This argument—which relies on undisputed projections by the CBO that the individual mandate will generate some four to five billion dollars in annual revenue by the end of this decade[131]—does little to address the distinction between a penalty and a tax. This is because "[c]riminal fines, civil penalties, civil forfeitures, and taxes all share certain features: They generate government revenues, impose fiscal burdens on

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[131] CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* 3 (rev. Apr. 30, 2010) [hereinafter CBO, *Payments*], *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/Individual_Mandate_ Penalties-04-30.pdf.

individuals, and deter certain behavior." *Kurth Ranch*, 511 U.S. at 778, 114 *S. Ct.* at 1945. The Supreme Court has thus recognized, as indeed we must, that in our world of less than perfect compliance, penalties generate revenue just as surely as taxes.

Nor does the amount of projected revenue that will be collected under the individual mandate—a significant sum, to be sure—render the mandate a tax. The Supreme Court has never understood the *amount* of revenue generated by a statutory provision to have definitional value. In *Sonzinsky*, the Court considered a converse of the situation we face here, where a provision imposing a "$200 annual license tax" on firearms dealers was challenged as "not a true tax, but a penalty imposed for the purpose of suppressing traffic in a certain noxious type of firearms." 300 U.S. at 511–12, 57 *S. Ct.* at 554–55. The tax was "productive of some revenue," but not much. *Id. a*t 514 & n.1, 57 *S. Ct.* at 556 & n.1 (observing that 27 dealers paid the tax in 1934, and 22 paid in 1935). That did not stop the Supreme Court from upholding the provision as a tax. The Supreme Court later interpreted *Sonzinsky* as standing for the proposition that "a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed," and that proposition "applies even though *the revenue obtained is obviously negligible*." *Sanchez*, 340 U.S. at 44, 71 *S. Ct.* at 110 (emphasis added).

While the government views these cases as supportive of its argument, because they demonstrate the breadth of Congress's taxing power, the cases merely hold "that an Act of Congress which *on its*

face purports to be an exercise of the taxing power is not any the less so because the tax is burdensome or tends to restrict or suppress the thing taxed." *Sonzinsky*, 300 U.S. at 513, 57 *S. Ct.* at 556 (emphasis added). Thus, once Congress has expressly and unmistakably indicated that a provision is a tax, courts will not "[i]nquir[e] into the hidden motives which may move Congress to exercise a power constitutionally conferred upon it." *Id. a*t 513–14; 57 *S. Ct.* at 556. But that is not this case. Here we confront a statute that is not "on its face" a tax, but rather a penalty. What's more, the district court correctly noted that the government lacks any case precedent squarely on point. *Florida v. HHS*, 716 F. Supp. 2d at 1140.

Even ignoring Congress's deliberate choice of the term "penalty," the individual mandate on its face imposes a monetary sanction on an individual who "fails to meet the requirement" to maintain "minimum essential coverage." 26 U.S.C. § 5000A(b)(1). As we see it, such an exaction appears in every important respect to be "punishment for an unlawful act or omission," which defines the very "concept of penalty." *CF & I Fabricators*, 518 U.S. at 224, 116 *S. Ct.* at 2113; *see also Virginia v. Sebelius*, 728 F. Supp. 2d at 786 ("The only revenue generated under the [individual mandate] is incidental to a citizen's failure to obey the law by requiring the minimum level of insurance coverage. The resulting revenue is 'extraneous to any tax need.'" (quoting *Kahriger*, 345 U.S. at 31, 73 *S. Ct.* at 515)).

The government also suggests that the individual mandate operates as a tax because it is housed in the Internal Revenue Code and is collected through

taxpayers' annual returns. It is true that the individual mandate is located under the section of the Code titled "Miscellaneous Excise Taxes." Yet the Code itself makes clear that Congress's choice of where to place a provision in the Internal Revenue Code has no interpretive value: "No inference, implication, or presumption of legislative construction shall be drawn or made by reason of the location or grouping of any particular section or provision or portion of this title. . . ." 26 U.S.C. § 7806(b); *see also Florida v. HHS*, 716 F. Supp. 2d at 1137 (citing same).

More significantly, not every provision in the Internal Revenue Code is a tax. Indeed, Congress placed in Chapter 68 of the Internal Revenue Code a panoply of civil *penalties*, running the gamut from broadly applicable (filing frivolous tax returns[132] or making unreasonable erroneous claims for a tax refund or credit[133]) to highly industry-specific (tampering with or failing to maintain security requirements for mechanical dye injection systems,[134]

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[132] *See* 26 U.S.C. § 6702(a) (imposing "penalty of $5,000" on person who files "what purports to be a return of a tax imposed by this title" which either lacks "information on which the substantial correctness of the self-assessment may be judged" or "contains information that on its face indicates that the self-assessment is substantially incorrect").

[133] *See* 26 U.S.C. § 6676(a) ("If a claim for refund or credit with respect to income tax . . . is made for an excessive amount, unless it is shown that the claim for such excessive amount has a reasonable basis, the person making such claim shall be liable for a penalty in an amount equal to 20 percent of the excessive amount.").

[134] *See* 26 U.S.C. § 6715A(a)(1) ("If any person tampers with a mechanical dye injection system used to indelibly dye fuel . . .

or selling or reselling adulterated diesel fuel that violates environmental standards[135]). In addition, the mandate's penalty is not treated like a tax because, as noted above, the IRS may not place liens, or levy or initiate criminal prosecution or impose any interest or criminal sanctions. All the IRS, practically speaking, may do is to offset the penalty against a tax refund. 26 U.S.C. § 5000A(g)(2)(A)–(B).

Although it is irrelevant for our purposes precisely where in the Internal Revenue Code Congress decided to place the individual mandate, *id.* § 7806(b), we observe that other chapters of the Internal Revenue Code include penalty provisions as well. *See*, *e.g.*, *id.* § 5761(a) (imposing "a penalty of $1,000" on any person—primarily manufacturers, importers, and retailers—who willfully fails to comply with a variety of statutory duties and taxes under Chapter 52 of the Internal Revenue Code related to tobacco products and cigarettes). And Chapter 75 of the Internal Revenue Code sets forth criminal penalties, which permit courts to impose substantial fines. *Id.* § 7206 (providing that those who commit tax fraud in a variety of ways "shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $100,000 ($500,000 in the case of a corporation), or imprisoned not more than 3 years, or both, together with the costs of prosecution"). While the entire list of penalties in the Internal Revenue Code is far too long to exhaust

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such person shall pay a penalty in addition to the tax (if any)."). The penalty is the greater of $25,000 or $10 for each gallon of fuel involved. *Id.* § 6715A(b)(1).

[135] *See* 26 U.S.C. § 6720A (imposing "penalty of $10,000" for each violation, "in addition to the tax on such [fuel]").

here, it is apparent that the placement of the individual mandate in the Internal Revenue Code is far from sufficient to convert the individual mandate into a "tax" and has limited value, if any at all, in determining whether the individual mandate is a tax or a penalty.

After careful review of the statute, we conclude that the individual mandate is a civil regulatory penalty and not a tax. As a regulatory penalty, the individual mandate must therefore find justification in a different enumerated power. See *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 393, 60 S. Ct. 907, 912 (1940) ("Congress may impose penalties in aid of the exercise of any of its enumerated powers."); *Virginia v. Sebelius*, 728 F. Supp. 2d at 788; *Florida v. HHS*, 716 F. Supp. 2d at 1143–44.

The individual mandate as written cannot be supported by the tax power.

VII. SEVERABILITY

We now turn to whether the individual mandate, found in 26 U.S.C. § 5000A, can be severed from the remainder of the 975-page Act.

A. Governing Principles

In analyzing this question, we start with the settled premise that severability is fundamentally rooted in a respect for separation of powers and notions of judicial restraint. *See Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329–30, 126 S. Ct. 961, 967–68 (2006). Courts must "strive to salvage" acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact." *Id.* at 329, 126 S. Ct. at 967–68.

"[T]he presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653, 104 S. Ct. 3262, 3269 (1984).

In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute. *See*, *e.g.*, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. __, __, 130 S. Ct. 3138, 3161–62 (2010) (holding tenure provision severable from Sarbanes-Oxley Act); *New York v. United States*, 505 U.S. at 186–187, 112 S. Ct. at 2434 (holding take-title provision severable from Low-Level Radioactive Waste Policy Amendments Act of 1985); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–97, 107 S. Ct. 1476, 1479–86 (1987) (holding legislative veto provision severable from Airline Deregulation Act of 1978); *Chadha*, 462 U.S. at 931–35, 103 S. Ct. at 2774–76 (holding legislative veto provision severable from Immigration and Nationality Act); *Buckley v. Valeo*, 424 U.S. 1, 108–09, 96 S. Ct. 612, 677 (1976) (holding campaign expenditure limits severable from public financing provisions in Federal Election Campaign Act of 1971).[136]

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[136] The paucity of case law supporting the plaintiffs' severability position is underscored by the lack of citation to any modern case where the Supreme Court found a legislative act inseverable. Indeed, the most recent such case cited by the plaintiffs was decided over 75 years ago, before modern severability law had even been established. *See* Private Plaintiffs' Br. at 59–62 (citing *R.R. Ret. Bd. v. Alton R. Co.*, 295 U.S. 330, 55 S. Ct. 758 (1935); *Williams v. Standard Oil Co.*, 278 U.S. 235, 49 S. Ct. 115 (1929); *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 15 S. Ct. 912 (1895), *superseded by* U.S. CONST. amend. XVI).

Indeed, in the Commerce Clause context, the Supreme Court struck down an important provision of a statute and left the remainder of the statute intact. In *Morrison*, the Court invalidated only one provision—the civil remedies provision for victims of gender-based violence. *Morrison*, 529 U.S. at 605, 627, 120 S. Ct. at 1747, 1759. The Supreme Court did not invalidate the entire VAWA—or the omnibus Violent Crime Control and Law Enforcement Act of 1994, of which it was part—even though the text of the two bills did not contain a severability clause.

As these cases amply demonstrate, the Supreme Court has declined to invalidate more of a statute than is absolutely necessary. Rather, "when confronting a constitutional flaw in a statute, we try to limit the solution to the problem." *Ayotte*, 546 U.S. at 328, 126 S. Ct. at 967. Because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people," courts should "act cautiously" and "refrain from invalidating more of the statute than is necessary." *Regan*, 468 U.S. at 652, 104 S. Ct. at 3269.

The Supreme Court's test for severability is "well-established": "Unless it is *evident* that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is *fully operative as a law*." *Alaska Airlines*, 480 U.S. at 684, 107 S. Ct. at 1480 (quotation marks omitted) (emphasis added). As the Supreme Court remarked in *Chadha*, divining legislative intent in the absence of a severability or non-severability clause can be an "elusive" enterprise. 462 U.S. at 932, 103 S. Ct. at 2774.

B. Wholesale Invalidation

Applying these principles, we conclude that the district court erred in its decision to invalidate the entire Act. Excising the individual mandate from the Act does not prevent the remaining provisions from being "fully operative as a law." As our exhaustive review of the Act's myriad provisions in Appendix A demonstrates, the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance. While such wholly unrelated provisions are too numerous to bear repeating, representative examples include provisions establishing reasonable break time for nursing mothers, 29 U.S.C. § 207(r); epidemiology-laboratory capacity grants, 42 U.S.C. § 300hh-31; an HHS study on urban Medicare-dependent hospitals, *id.* § 1395ww note; restoration of funding for abstinence education, *id.* § 710; and an excise tax on indoor tanning salons, 26 U.S.C. § 5000B.

In invalidating the entire Act, the district court placed undue emphasis on the Act's lack of a severability clause. *See Florida ex rel. Bondi v. HHS*, No. 3:10-CV-91-RV/EMT, __ F. Supp. 2d __, 2011 WL 285683, at *35–36 (N.D. Fla. Jan. 31, 2011). Supreme Court precedent confirms that the "ultimate determination of severability will rarely turn on the presence or absence of such a clause." *United States v. Jackson*, 390 U.S. 570, 585 n.27, 88 S. Ct. 1209, 1218 n.27 (1968). Rather, "Congress' silence is just that—silence—and does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686, 107 S. Ct. at 1481.

Nevertheless, the district court emphasized that an early version of Congress's health reform bill did

contain a severability clause. Congress's failure to include such a clause in the final bill, the district court reasoned, "can be viewed as strong evidence that Congress recognized the Act could not operate *as intended* without the individual mandate." *Florida v. HHS*, 2011 WL 285683, at *36. The district court pushes this inference too far.

First, both the Senate and House legislative drafting manuals state that, in light of Supreme Court precedent in favor of severability, severability clauses are unnecessary unless they specifically state that all or some portions of a statute should *not* be severed. *See* Office of Legislative Counsel, U.S. Senate, *Legislative Drafting Manual*, § 131 (Feb. 1997) (providing that "a severability clause is unnecessary" but distinguishing a "nonseverability clause," which "provides that if a specific portion of an Act is declared invalid, the whole Act or some portion of the Act shall be invalid"); Office of Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style*, § 328 (Nov. 1995) (stating that "a severability clause is unnecessary unless it provides in detail which related provisions are to fall, and which are not to fall, if a specified key provision is held invalid").

Second, the clause present in one early version of the Act was a general severability clause, not a non-severability clause. *See* H.R. Rep. No 111-299, pt. 3, at 17 § 155 (2009), *reprinted in* 2010 U.S.C.C.A.N. 474, 537 ("If any provision of this Act . . . is held to be unconstitutional, the remainder of the provisions of this Act . . . shall not be affected."). Thus, according to Congress's own drafting manuals, the severability

clause was unnecessary, and its removal should not be read as any indicator of legislative intent *against* severability. Rather, the removal of the severability clause, in short, has no probative impact on the severability question before us.

In light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection to the individual mandate, the plaintiffs have not met the heavy burden needed to rebut the presumption of severability. We therefore conclude that the district court erred in its wholesale invalidation of the Act.

C. Severability of Individual Mandate from Two Insurance Reforms

The severability inquiry is not so summarily answered, however, with respect to two of the private insurance industry reforms.[137] The two reforms are: guaranteed issue, 42 U.S.C. § 300gg-1 (effective Jan. 1, 2014); and the prohibition on preexisting condition exclusions, *id.* § 300gg-3.

Our pause over the severability of these two reforms is due to the fact that the congressional findings speak in broad, general terms except in one place that states, as noted earlier, that the individual mandate "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). The findings in that paragraph add that if there were no mandate, "many

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[137] For ease of discussion, we refer to those two provisions collectively as the "two reforms."

individuals would wait to purchase health insurance until they needed care."[138] *Id.*

As discussed earlier, a significant number of the uninsured with preexisting conditions voluntarily tried to buy insurance but were denied coverage or had those conditions excluded, resulting in uncompensated health care consumption and cost-shifting. Congress also found that insurers' $90 billion in underwriting costs in identifying unhealthy entrants represented 26% to 30% of premium costs. *Id.* § 18091(a)(2)(J). The two reforms reduce the number of the uninsured and underwriting costs by guaranteeing issue and prohibiting preexisting condition exclusions. To benefit consumers, Congress has improved health insurance products and required insurers to cover consumers who need their products the most.

It is not uncommon that government regulations beneficial to consumers impose additional costs on the industry regulated. These two reforms obviously

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[138] Section 18091(a)(2)(I) provides, in its entirety:

> Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act) [to be codified in 42 U.S.C. §§ 300gg-3, 300gg-4], if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement 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.

42 U.S.C. § 18091(a)(2)(I).

have significant negative effects on the business costs of insurers because they require insurers to accept unhealthy entrants, raising insurers' costs. The individual mandate, in part, seeks to mitigate the reforms' costs on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers' costs in covering the unhealthy. Further, if there were no mandate, the argument goes, the healthy people can wait until they are sick to obtain insurance, knowing they could not then be turned away.[139]

In this regard, our severability concern is not over whether the two reforms can "fully operate as a law." They can. Rather, our severability concern is only whether "it is evident" that Congress "would not have enacted" the two insurance reforms *without* the individual mandate. *Alaska Airlines*, 480 U.S. at 684, 107 S. Ct. at 1480.

At the outset, we note that Congress could easily have included in the Act a non-severability clause stating that the individual mandate should not be severed from the two reforms. Under the legislative drafting manuals, the one instance in which a severability clause is important is where "it provides in detail which related provisions are to fall, and

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[139] When a medical need arises, individuals cannot literally purchase insurance on the way to the hospital. Rather, the Act permits insurers to restrict enrollment to a specific open or special enrollment period. 42 U.S.C. § 300gg-1(b) (effective Jan. 1, 2014). Individuals therefore must wait for an enrollment period. And once an individual applies for insurance, the Act allows up to a 90-day waiting period for group coverage eligibility. *Id. §* 300gg-7 (effective Jan. 1, 2014). We can find no limit in the Act on the waiting period insurers can have in the individual market.

which are not to fall, if a specified key provision is held invalid." Office of Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style*, § 328; *accord* Office of Legislative Counsel, U.S. Senate, *Legislative Drafting Manual*, § 131. Congress did not include any such non-severability clause in the Act, however.

It is also telling that none of the insurance reforms, including even guaranteed issue and coverage of preexisting conditions, contain any cross-reference to the individual mandate or make their implementation dependent on the mandate's continued existence. *See United States v. Booker*, 543 U.S. 220, 260, 125 S. Ct. 738, 765 (2005) (stating that 18 U.S.C. § 3742(e) "contains critical cross-references to the (now-excised) § 3553(b)(1) and consequently must be severed and excised for similar reasons"); *Alaska Airlines*, 480 U.S. at 688–89, 107 S. Ct. at 1482 ("Congress did not link specifically the operation of the first-hire provisions to the issuance of regulations."). Indeed, § 300gg-3's prohibition on preexisting condition exclusions was implemented in 2010 with respect to enrollees under 19, despite the individual mandate not taking effect until 2014. This is a far cry from cases where the Supreme Court has ruled provisions inseverable because it would require courts to engage in quasi-legislative functions in order to preserve the provisions. *See*, *e.g.*, *Randall v. Sorrell*, 548 U.S. 230, 262, 126 S. Ct. 2479, 2500 (2006) (declining to sever Vermont's campaign finance contribution limits because doing so "would require [the Court] to write words into the statute"); *see also Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162 (cautioning courts against "blue-pencil[ing]").

"[T]he remedial question we must ask" is "which alternative adheres more closely to Congress' original objective" in passing the Act: (1) the Act without the individual mandate but otherwise intact; or (2) the Act without the individual mandate and also without these two insurance reforms. *See Booker*, 543 U.S. at 263, 125 S. Ct. at 766–67.

As discussed earlier, a basic objective of the Act is to make health insurance coverage accessible and thereby to reduce the number of uninsured persons. *See*, *e.g.*, 42 U.S.C. § 18091(a)(2) (stating the Act will "increase the number and share of Americans who are insured" and "significantly reduc[e] the number of the uninsured"). Undoubtedly, the two reforms seek to achieve those objectives. All other things being equal, then, a version of the Act that contains these two reforms would hew more closely to Congress's likely intent than one that lacks them.

But without the individual mandate, not all things are equal. We must therefore look to the consequences of the individual mandate's absence on the two reforms. *See Booker*, 543 U.S. at 260, 125 S. Ct. at 765 (considering whether excision of one part of statute would "pose a critical problem"); *Regan*, 468 U.S. at 653, 104 S. Ct. at 3269 (asking whether "the policies Congress sought to advance by enacting § 504 can be effectuated even though the purpose requirement is unenforceable"). In doing so, several factors loom large.

First, the Act retains many other provisions that help to accomplish some of the same objectives as the individual mandate. *See Booker*, 543 U.S. at 264, 125 S. Ct. at 767 ("The system remaining after excision, while lacking the mandatory features that

Congress enacted, retains other features that help to further these objectives."); *New York v. United States*, 505 U.S. at 186, 112 S. Ct. at 2434 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated.").

For example, Congress included other provisions in the Act, apart from and independent of the individual mandate, that also serve to reduce the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage. These include: (1) the extensive health insurance reforms; (2) the new Exchanges; (3) federal premium tax credits, 26 U.S.C. § 36B; (4) federal cost-sharing subsidies, 42 U.S.C. § 18071; (5) the requirement that Exchanges establish an Internet website to provide consumers with information on insurers' plans, *id.* § 18031(d)(4)(D); (6) the requirement that employers offer insurance or pay a penalty, 26 U.S.C. § 4980H; and (7) the requirement that certain large employers automatically enroll new and current employees in an employer-sponsored plan unless the employee opts out, 29 U.S.C. § 218A, just to name a few.

Second, the individual mandate has a comparatively limited field of operation vis-à-vis the number of the uninsured. In *Alaska Airlines*, the Supreme Court found that the unconstitutional legislative veto provision of the Airline Deregulation Act (permitting Congress to veto the Labor

Secretary's implementing regulations) was severable because, among other things, the statute left "little of substance to be subject to a veto." 480 U.S. at 687, 107 S. Ct. at 1481. The Supreme Court noted the "ancillary nature" of the Labor Secretary's obligations and the "limited substantive discretion" afforded the Secretary.[140] *Id.* at 688, 107 S. Ct. at 1482. Thus, the limited field of operation of an unconstitutional statutory provision furnishes evidence that Congress likely would have enacted the statute without it. *Cf. Booker*, 543 U.S. at 249, 125 S. Ct. at 759 (considering whether "the scheme that Congress created" would be "so transform[ed] . . . that Congress likely would not have intended the Act as so modified to stand").

Here, as explained above, the operation of the individual mandate is limited by its three exemptions, its five exceptions to the penalty, and its stripping the IRS of tax liens, interests, or penalties and leaving virtually no enforcement mechanism. Even with the mandate, a healthy individual can pay a penalty and wait until becoming sick to purchase insurance.

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[140] The Supreme Court stated:

> With this subsidiary role allotted to the Secretary, the veto provision could affect only the relatively insignificant actions he might take in connection with the duty-to-hire program. There is thus little reason to believe that Congress contemplated the possibility of vetoing any of these actions and one can infer that Congress would have been satisfied with the duty-to-hire provisions even without preserving the opportunity to veto the DOL's regulations.

Alaska Airlines, 480 U.S. at 688, 107 S. Ct. at 1482 (footnote omitted).

Further, the individual mandate's operation and effectiveness are limited by the fact that, although the individual mandate requires individuals to obtain insurance coverage, the mandate itself does not require them to obtain the "essential health benefits package" or, indeed, any particular level of benefits at all. Although the chosen term "minimum essential coverage" appears to suggest otherwise, when the lofty veneer of the term is stripped away, one finds that the actual "coverage" the individual mandate deems "essential" is nothing more than coverage "essential" to satisfying the individual mandate.

The multiple features of the individual mandate all serve to weaken the mandate's practical influence on the two insurance product reforms.[141] They also weaken our ability to say that Congress considered the individual mandate's existence to be a *sine qua non* for passage of these two reforms. There is tension, at least, in the proposition that a mandate engineered to be so porous and toothless is such a linchpin of the Act's insurance product reforms that they were clearly not intended to exist in its absence.

We are not unmindful of Congress's findings about the individual mandate. But in the end, they do not tip the scale away from the presumption of severability. As observed above, the findings in § 18091(a)(2) track the language of the Supreme Court's Commerce Clause decisions. But the severability inquiry is separate, and very different,

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[141] Studies by the CBO bear this out. Even with the individual mandate, the CBO estimates that in 2016, there will still be more than 21 million non-elderly persons who remain uninsured, the majority of whom will not be subject to the penalty. *See* CBO, *Payments*, *supra* note 131, at 1.

from the constitutional analysis. The congressional language respecting Congress's constitutional authority does not govern, and is not particularly relevant to, the different question of severability (which focuses on whether Congress would have enacted the Act's *other insurance market reforms* without the individual mandate).

An example makes the point. Section 18091(a)(2)(H) of the same congressional findings provides:

> Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

42 U.S.C. § 18091(a)(2)(H). By its text, § 18091(a)(2)(H) states that the individual mandate is essential to "this larger regulation of economic activity"—that is, "regulating health insurance," which it does through ERISA and the Public Health Service Act. If applied to severability, this would mean that Congress intended the individual mandate to be "essential" to, and thus inseverable from, ERISA (enacted in 1974) and the entire Public Health Service Act (or at least all parts of those

statutes that regulate health insurance). This is an absurd result for which no party argues.[142]

These congressional findings do not address the one question that is relevant to our severability analysis: whether Congress would not have enacted the two reforms *but for* the individual mandate. Just because the invalidation of the individual mandate may render these provisions *less desirable*, it does not ineluctably follow that Congress would find the two reforms *so* undesirable without the mandate as to prefer not enacting them at all. The fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable. This is particularly true here because the reforms of health insurance help consumers who need it the most.

In light of all these factors, we are not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.[143] In so concluding, we are mindful of our

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[142] A second illustration of the danger in relying too much on these statements in isolation is that the same congressional findings also state—not once, but six times—that the individual mandate operates "*together with the other provisions of this Act*" to reduce the number of the uninsured, lower health insurance premiums, improve financial security for families, minimize adverse selection, and reduce administrative costs. *See* 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J) (emphasis added). Congress itself states that *all* the provisions of the Act operate together to achieve its goals. On this reasoning, the entire Act would be invalidated along with the individual mandate. As discussed above, this conclusion is invalid.

[143] While we discuss the two reforms specifically, our conclusion—that the individual mandate is severable—is the

duty to "refrain from invalidating more of the statute than is necessary."[144] *Regan*, 468 U.S. at 652, 104 S. Ct. at 3269; *see also Booker*, 543 U.S. at 258–59, 125 S. Ct. at 764 ("[W]e must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." (quotation marks and citations omitted)). And where it is not evident Congress would not have enacted a constitutional provision without one that is unconstitutional, we must allow any further—and perhaps even necessary—alterations of the Act to be rendered by Congress as part of that branch's legislative and political prerogative. *See Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162 ("[S]uch editorial freedom—far more extensive than our holding today—belongs to the Legislature, not the Judiciary. Congress of course remains free to pursue any of these options going forward."). We therefore sever the individual mandate from the remaining sections of the Act.

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same as to the other insurance product reforms, such as community rating and discrimination based on health status.

[144] We acknowledge that the government, in arguing for the individual mandate's constitutionality, stated summarily that the individual mandate cannot be severed from the Act's guaranteed issue and community rating provisions because the individual mandate "is integral to those sections that . . . provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions." Government's Reply Br. at 58. But as explained above, whether a statutory provision is "integral" or "essential" to other provisions for Commerce Clause analytical purposes is a question distinct from severability. And in any event, the touchstone of severability analysis is legislative intent, not arguments made during litigation.

VIII. CONCLUSION

We first conclude that the Act's Medicaid expansion is constitutional. Existing Supreme Court precedent does not establish that Congress's inducements are unconstitutionally coercive, especially when the federal government will bear nearly all the costs of the program's amplified enrollments.

Next, the individual mandate was enacted as a regulatory penalty, not a revenue-raising tax, and cannot be sustained as an exercise of Congress's power under the Taxing and Spending Clause. The mandate is denominated as a penalty in the Act itself, and the legislative history and relevant case law confirm this reading of its function.

Further, the individual mandate exceeds Congress's enumerated commerce power and is unconstitutional. This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to purchase an expensive health insurance product they have elected not to buy, and to make them re-purchase that insurance product every month for their entire lives. We have not found any generally applicable, judicially enforceable limiting principle that would permit us to uphold the mandate without obliterating the boundaries inherent in the system of enumerated congressional powers. "Uniqueness" is not a constitutional principle in any antecedent Supreme Court decision. The individual mandate also finds no refuge in the aggregation doctrine, for decisions to *abstain* from the purchase of a product or service, whatever their

cumulative effect, lack a sufficient nexus to commerce.[145]

The individual mandate, however, can be severed from the remainder of the Act's myriad reforms. The presumption of severability is rooted in notions of judicial restraint and respect for the separation of powers in our constitutional system. The Act's other provisions remain legally operative after the mandate's excision, and the high burden needed under Supreme Court precedent to rebut the presumption of severability has not been met.

Accordingly, we affirm in part and reverse in part the judgment of the district court.

AFFIRMED in part and REVERSED in part.

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[145] Our respected dissenting colleague says that the majority: (1) "has ignored the broad power of Congress"; (2) "has ignored the Supreme Court's expansive reading of the Commerce Clause"; (3) "presume[s] to sit as a superlegislature"; (4) "misapprehends the role of a reviewing court"; and (5) ignores that "as nonelected judicial officers, we are not afforded the opportunity to rewrite statutes we don't like." *See* Dissenting Op. at 208–209, 243. We do not respond to these contentions, especially given (1) our extensive and exceedingly careful review of the Act, Supreme Court precedent, and the parties' arguments, and (2) our holding that the Act, despite significant challenges to this massive and sweeping federal regulation and spending, falls within the ambit and prerogative of Congress's broad commerce power, except for one section, § 5000A. We do, however, refuse to abdicate our constitutional duty when Congress has acted beyond its enumerated Commerce Clause power in mandating that Americans, from cradle to grave, purchase an insurance product from a private company.

MARCUS, Circuit Judge, concurring in part and dissenting in part[1]:

Today this Court strikes down as unconstitutional a central piece of a comprehensive economic regulatory scheme enacted by Congress. The majority concludes that Congress does not have the commerce power to require uninsured Americans to obtain health insurance or otherwise pay a financial penalty. The majority does so even though the individual mandate was designed and intended to regulate quintessentially economic conduct in order to ameliorate two large, national problems: first, the substantial cost shifting that occurs when uninsured individuals consume health care services—as virtually all of them will, and many do each year—for which they cannot pay; and, second, the unavailability of health insurance for those who need it most—those with pre-existing conditions and lengthy medical histories.

In the process of striking down the mandate, the majority has ignored many years of Commerce Clause doctrine developed by the Supreme Court. It has ignored the broad power of Congress, in the words of Chief Justice Marshall, "to prescribe the rule by which commerce is to be governed." *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 196 (1824). It has ignored the undeniable fact that Congress' commerce power has grown exponentially over the past two centuries, and is now generally accepted as having afforded Congress the authority to create rules regulating large areas of our national economy. It

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[1] I concur only in Parts I (standing), III (Medicaid expansion), and VI (taxing power) of the majority opinion.

has ignored the Supreme Court's expansive reading of the Commerce Clause that has provided the very foundation on which Congress already extensively regulates both health insurance and health care services. And it has ignored the long-accepted instruction that we review the constitutionality of an exercise of commerce power not through the lens of formal, categorical distinctions, but rather through a pragmatic one, recognizing, as Justice Holmes put it over one hundred years ago, that "commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business." *Swift & Co. v. United States*, 196 U.S. 375, 398 (1905).

The approach taken by the majority has also disregarded the powerful admonitions that acts of Congress are to be examined with a heavy presumption of constitutionality, that the task at hand must be approached with caution, restraint, and great humility, and that we may not lightly conclude that an act of Congress exceeds its enumerated powers. The circumspection this task requires is underscored by recognizing, in the words of Justice Kennedy, the long and difficult "history of the judicial struggle to interpret the Commerce Clause during the transition from the economic system the Founders knew to the single, national market still emergent in our own era." *United States v. Lopez*, 514 U.S. 549, 568 (1995) (Kennedy, J., concurring).

The plaintiffs and, indeed, the majority have conceded, as they must, that Congress has the commerce power to impose precisely the *same* mandate compelling the *same* class of uninsured

individuals to obtain the *same* kind of insurance, or otherwise pay a penalty, as a necessary condition to receiving health care services, at the time the uninsured seek these services. Nevertheless, the plaintiffs argue that Congress cannot do now what it plainly can do later. In other words, Congress must wait until each component transaction underlying the cost-shifting problem occurs, causing huge increases in costs both for those who have health care insurance and for health care providers, before it may constitutionally act. I can find nothing in logic or law that so circumscribes Congress' commerce power and yields so anomalous a result.

Although it is surely true that there is no Supreme Court decision squarely on point dictating the result that the individual mandate is within the commerce power of Congress, the rationale embodied in the Court's Commerce Clause decisions over more than 75 years makes clear that this legislation falls within Congress' interstate commerce power. These decisions instruct us to ask whether the target of the regulation is economic in nature and whether Congress had a rational basis to conclude that the regulated conduct has a substantial effect on interstate commerce. It cannot be denied that Congress has promulgated a rule by which to comprehensively regulate the timing and means of payment for the virtually inevitable consumption of health care services. Nor can it be denied that the consumption of health care services by the uninsured has a very substantial impact on interstate commerce—the shifting of substantial costs from those who do not pay to those who do and to the providers who offer care. I therefore respectfully

dissent from the majority's opinion insofar as it strikes down the individual mandate.

I.

A.

A considerable portion of the American population—estimated at 50 million—lacks any form of health care insurance.[2] The individual mandate was designed to ameliorate twin problems related to the uninsured as a class: (1) huge cost shifting from the uninsured, who often don't pay for their health care services, to those with health insurance and to health care providers; and (2) the inability of many uninsured individuals to obtain much-needed health insurance coverage because they are effectively blacklisted on account of their pre-existing conditions or medical histories. Congress sought to address these problems by requiring non-exempted individuals to pay a penalty, or "shared responsibility

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[2] In 2009, the total number of uninsured was estimated at 50.7 million, or about 16.7% of the total population. U.S. Census Bureau, U.S. Dep't of Commerce, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23 tbl.8 (2010), available at http://www.census.gov/prod/2010pubs/p60-238.pdf. What's more, the population of uninsured is not confined to those with low incomes. The Census Bureau found that the estimated income brackets for the uninsured are as follows:

> (1) less than $25,000: 15.5 million uninsured, about 26.6% of the total population in this income bracket;
>
> (2) $25,000 to $49,999: 15.3 million, about 21.4%;
>
> (3) $50,000 to $74,999: 9.4 million, about 16.0%;
>
> (4) $75,000 or more: 10.6 million, about 9.1%.

Id.

payment," on their tax returns for any month, beginning in 2014, in which they fail to maintain "minimum essential coverage." 26 U.S.C. § 5000A(a)-(b). And while remaining uninsured is not an option under the Act (at least to avoid paying a penalty), individuals are offered a variety of choices when it comes to satisfying the individual mandate's "minimum essential coverage" requirement. Many insurance plans will satisfy the individual mandate. These plans fall into five general categories, some of which are further divided into subcategories: (1) government-sponsored programs; (2) eligible employer-sponsored plans; (3) plans purchased on the individual market; (4) grandfathered health plans; or (5) any "other coverage" recognized by the Secretary of Health and Human Services ("HHS") in coordination with the Secretary of the Treasury. *Id.* § 5000A(f)(1).

As for the first problem Congress sought to address, it is undeniable that, despite lacking health insurance, the uninsured are still substantial participants in the market for health care services. And when the uninsured do seek medical care, they often fail to pay all or even most of their costs. On average—and these figures are not disputed—the uninsured pay only 37% of their health care costs out of pocket, while third parties pay another 26% on their behalf.[3] The remaining costs are

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[3] These figures come from a study cited by both the plaintiffs and the government: Families USA, Hidden Health Tax: Americans Pay a Premium 2 (2009) [hereinafter Hidden Health Tax], *available* at http://familiesusa2.org/assets/pdfs/hidden-healthtax.pdf. And again, the problem of uncompensated care is not confined to those of limited means. Even in households at or above the median income, people without health insurance pay,

uncompensated—they are borne by health care providers and are passed on in the form of increased premiums to individuals who already participate in the insurance market.

Congress' findings reflect its determination that this problem—the uncompensated consumption of health care services by the uninsured—has *national* economic consequences that require a *national* solution through comprehensive federal regulation. *See* 42 U.S.C. § 18091. As part of the empirical foundation for the individual mandate, Congress quantified the costs associated with the free-riding and cost-shifting problems that result from the provision of uncompensated health care to the uninsured:

> The cost of providing uncompensated care to the uninsured was *$43,000,000,000 [$43 billion]* in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average *over $1,000 a year*. By significantly reducing the number of the uninsured, the [individual mandate], together with the other provisions of this Act, will lower health insurance premiums.

Id. § 18091(a)(2)(F) (emphases added).

The Act thus seeks to regulate the payment for health care consumption through the mechanism of

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on average, less than half the cost of the medical care they consume. *See* 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, 229-31 (2005).

health insurance. As Congress found, the individual mandate "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.* § 18091(a)(2)(A) (emphasis added). In other words, the individual mandate is the means Congress adopted to regulate the *timing* and *method* of individuals' payment for the consumption of health care services.

As for the second problem of millions of uninsured individuals' being unable to obtain health insurance, Congress sought to dramatically reform the health insurance market by regulating the insurers themselves. The Act bars insurers from using many of the tools they had previously employed to protect themselves against the large costs imposed by high-risk individuals. Thus, insurers may no longer deny coverage or charge higher premiums because of an individual's pre-existing conditions or medical history. *Id.* §§ 300gg(a)(1), 300gg-3(a), 300gg-4(a); Act § 2702(a) (to be codified at 42 U.S.C. § 300gg-1(a)). Under the "community rating" provision, insurers may only vary premiums based on (i) whether the plan covers an individual or a family, (ii) rating area, (iii) age, and (iv) tobacco use. 42 U.S.C. § 300gg(a)(1). And under the "guaranteed issue" provisions, insurers must accept every employer or individual who applies for coverage through the individual or group markets. Act § 2702(a) (to be codified at 42 U.S.C. § 300gg-1(a)). Notably, insurers may no longer offer plans that limit or exclude benefits for individuals' pre-existing conditions, 42 U.S.C. § 300gg-3(a), nor may they refuse to cover individuals on the basis of (i) health

status, (ii) medical condition (including both physical and mental illnesses), (iii) claims experience, (iv) receipt of health care, (v) medical history, (vi) genetic information, (vii) evidence of insurability (including conditions arising out of acts of domestic violence), (viii) disability, or (ix) any other health status factor recognized by the Secretary of HHS, *id.* § 300gg-4(a).

Congress determined that the individual mandate was *essential* to the effective implementation of the Act's insurer regulations—that is, "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). Congress further found that waiting until the uninsured actually consume health care services before regulating them would effectively be a day late and a dollar short. *See id.* ("[I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care."); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 634-35 (W.D. Va. 2010) ("As Congress stated in its findings, the individual coverage provision is 'essential' to th[e] larger regulatory scheme because without it, individuals would postpone [acquiring] health insurance until they need substantial care, at which point the Act would obligate insurers to cover them at the same cost as everyone else. This would increase the cost of health insurance and decrease the number of insured individuals—precisely the harms that Congress sought to address . . . ."); Gov't Br. at 19 (citing testimony before Congress that a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital" (internal quotation marks omitted)).

Congress also made findings supporting the proposition that the markets for health insurance and health care services are deeply and inextricably bound together and indicated clearly that it sought to regulate across them both. Congress understood that health insurance and health care consumption are linked as a factual matter. Health insurance is the means by which most of our national health care costs are paid for; in 2009, private and government insurance financed approximately 75% of health care spending. Gov't Br. at 9 (citing non-disputed data from the Centers for Medicare and Medicaid Services ("CMS")). Moreover, Congress expressly connected the increased participation in the health insurance market that it expected to result from the individual mandate with "increasing the supply of, and demand for, health care services." 42 U.S.C. § 18091(a)(2)(C). On a more basic level, Congress also understood that "[h]ealth insurance is not bought for its own sake; it is bought to pay for medical expenses." Gov't Br. at 39 (citing M. Moshe Porat et al., *Market Insurance Versus Self Insurance: The Tax-Differential Treatment and Its Social Cost*, 58 J. Risk & Ins. 657, 668 (1991); Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. Pol. Econ. 251, 253 (1973) [hereinafter Welfare Loss] ("Health insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchases of health services.")); *see also* Brief for Econ. Scholars as Amici Curiae Supporting the Government ("Gov't Econ. Br.") at 12 ("Medical care is the set of services that make one healthier, or prevent deterioration in health. Health insurance is a mechanism for spreading the costs of that medical care across people or over time, from a period when the cost would be

overwhelming to periods when costs are more manageable.").

B.

1.

Congress' commerce power to regulate is, as Chief Justice Marshall taught us almost two hundred years ago, the power "to prescribe the rule by which commerce is to be governed. This power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons*, 22 U.S. at 196.

It is precisely this power to prescribe rules governing commerce that Congress lawfully exercised in enacting the individual mandate.

It is clear that Congress' rule-making power extends to both the health insurance and health care markets, areas of commerce that Congress has long regulated and regulated heavily. First, the parties all agree (as they must) that Congress' commerce power lawfully extends to the regulation of insurance in general, as the Supreme Court concluded more than 60 years ago in United States v. *South-Eastern Underwriters* Ass'n, 322 U.S. 533, 552-53 (1944). Indeed, Congress expressly relied on this proposition in enacting the individual mandate. *See* 42 U.S.C. § 18091(a)(3) (citing *South-Eastern Underwriters* as a basis for Congress' authority to regulate insurance under the Commerce Clause).[4]

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[4] In response to *South-Eastern Underwriters*, Congress enacted the McCarran-Ferguson Act, which provides that state laws regulating insurance will not be "invalidate[d], impair[ed], or supersede[d]" by federal law, unless the federal law "specifically

Second, in light of Congress' undeniable power under the Commerce Clause to regulate the business of insurance generally, it follows—and again there is no dispute—that Congress may also regulate health insurance in particular, which is, after all, a subset of the insurance market. *See* Charles Fried, Written Testimony Before the Senate Judiciary Committee Hearing on "The Constitutionality of the Affordable Care Act" 1 (Feb. 2, 2011), *available* at http://judiciary.senate.gov/pdf/11-02-02%20Fried%20Testimony.pdf. In fact, Congress has extensively exercised its commerce power to regulate the health insurance market for many years, long before the Act was passed. For example, Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. No. 93-406, 88 Stat. 829 (1974), which is a massive piece of legislation regulating the operation of employee benefit plans, including retirement plans, pension plans, and employer-

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relates to the business of insurance." 15 U.S.C. § 1012(b). But this enactment in no way affects or diminishes the Court's clear holding in *South-Eastern Underwriters* that Congress may, concurrently with the states, regulate the business of insurance under the Commerce Clause. What's more, Congress has hardly abdicated its role in regulating the insurance business. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 311, 314 (1999) (holding that federal RICO statute—which is itself grounded in the Commerce Clause – may be applied to insurers because it is not precluded by the McCarran-Ferguson Act); *Id.* at 308 ("We reject any suggestion that Congress intended to cede the field of insurance regulation to the States . . . ."). Rather, the McCarran-Ferguson Act sought "to protect state regulation primarily against *inadvertent* federal intrusion—say, through enactment of a federal statute that describes an affected activity in broad, general terms, of which the insurance business happens to constitute one part." *Barnett Bank of Marion Cnty., N.A. v. Nelson*, 517 U.S. 25, 39 (1996).

provided *health insurance* plans. Congress expressly pegged the broad scope of ERISA's coverage to its Commerce Clause power. 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect interstate commerce . . . ."); *see also id.* § 1003(a). Among other things, the regulatory provisions in Title I of ERISA, 29 U.S.C. § 1001 *et seq.*, set forth "uniform minimum standards to ensure that employee benefit plans are established and maintained in a fair and financially sound manner." U.S. Dep't of Labor, Health Benefits, Retirement Standards, and Workers' Compensation: Employee Benefit Plans, http://www.dol.gov/compliance/guide/erisa.htm (last visited Aug. 10, 2011). Title I of ERISA governs "most private sector employee benefit plans," with the most significant exceptions being "plans established or maintained by government entities or churches." *Id.*; *see also Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991) (concluding that ERISA regulates even "plans covering only a single employee").

Congressional efforts to regulate health insurance did not end with ERISA. Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986), which contains a wide variety of provisions relating to health care and health insurance. As for health insurance, the most significant reforms were amendments to ERISA, which added "continuation coverage" provisions that allow employees to continue receiving employer-sponsored health insurance for a period following the end of their employment in order to prevent gaps in health insurance coverage. 29 U.S.C. §§ 1161, 1162. And in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),

Pub. L. No. 104-191, 110 Stat. 1936 (1996), Congress amended the Public Health Service Act to add insurance portability provisions that prohibit group health plans—including ERISA plans—from discriminating against individual participants and beneficiaries based on health status, that require insurers to offer coverage to small businesses, and that limit pre-existing condition exclusions. *See* 29 U.S.C. §§ 1181-1183.

Under its commerce power, Congress has also repeatedly regulated the content of private health insurers' policies. *See*, *e.g.*, Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 702, 110 Stat. 2874, 2944 (1996) (regulating limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603, 110 Stat. 2874, 2935 (1996) (requiring maternity coverage to provide at least a 48-hour hospital stay); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (1998) (requiring certain plans to offer benefits related to mastectomies); Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008) (providing for parity between mental health/substance abuse disorder benefits and medical/surgical benefits).

Third, it is equally clear that Congress' power under the Commerce Clause likewise extends to the regulation of the provision and consumption of health care services. Indeed, for many years, Congress has substantially regulated both health care providers and the commodities that those providers may use. As far back as 1946, Congress enacted the Hospital

Survey and Construction Act (also known as the "Hill-Burton Act"), Pub. L. No. 79-725, 60 Stat. 1040 (1946), which appropriated funds for the construction of new hospitals in the post-World War II economy. The Hill-Burton Act required hospitals receiving federal construction or renovation funds to provide care to "all persons residing in the territorial area" and to provide a "reasonable volume" of free care to indigent patients. *See* 42 U.S.C. § 291c(e).

The requirement that hospitals provide free care was strengthened and broadened, when, as part of COBRA, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"). COBRA, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (1986). EMTALA requires all hospitals that receive Medicare funds to screen and stabilize, if possible, any patient who comes in with an "emergency medical condition." 42 U.S.C. § 1395dd(a)-(b); *see also Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 250-51 (1999) (per curiam). EMTALA also restricts the ability of hospitals to transfer a patient until he is stable or a medical determination is made that transfer is necessary. 42 U.S.C. § 1395dd(c). EMTALA's provisions are backed by both civil fines and a private cause of action for those harmed by a hospital's failure to comply. *Id. §* 1395dd(d).

Congress has also regulated health care providers (and, as mentioned, health care insurers) through HIPAA. The definition of "health care provider" under HIPAA is extraordinarily broad, covering any "person or organization who furnishes, bills, or is paid for health care in the normal course of business." 45 C.F.R. § 160.103. And in 2009, Congress expanded HIPAA's coverage even further to

include "business associates" of health care providers and health insurers. *See* Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, §§ 13401, 13404, 123 Stat. 115, 260, 264 (2009); 45 C.F.R. § 160.103. In addition to the insurance portability provisions, HIPAA includes a number of privacy provisions that "govern[ ] the use and disclosure of protected health information" by health care providers and health insurers, *Sneed v. Pan Am. Hosp.*, 370 F. App'x 47, 50 (11th Cir. 2010) (per curiam) (unpublished), as well as protect the privacy of employees' health information against inquiries by their employers. HIPAA even regulates what information health care providers may communicate to one another. *See generally* 45 C.F.R. §§ 164.102-164.534; 42 U.S.C. § 1320d-2. HIPAA also requires health care providers to follow several administrative requirements, including the development of physical and technical privacy safeguards and employee training. *See* 45 C.F.R. §§ 164.308, 164.310, 164.312.

Fourth, Congress has extensively regulated under its commerce power the commodities used in the health care services market, most notably drugs and medical devices. For example, in the Food, Drug, and Cosmetics Act, Congress delegated to the Food and Drug Administration the authority to screen and approve drugs and medical devices for use in commerce, and to regulate their continued use once approved. *See*, *e.g.*, 21 U.S.C. §§ 351, 352, 355(a), 360c, 360e, 360j(e).

Fifth, the majority and all the parties also agree that Congress' commerce power extends to the regulation of the *price* to be paid for the consumption

of health care services. Medicare is the most pervasive example. Since 1983, the Medicare program has set the fees it pays to hospitals through a prospective payment system that assigns a fixed amount to each service provided rather than reimbursing hospitals for their actual costs. *See United States v. Whiteside*, 285 F.3d 1345, 1346 (11th Cir. 2002). In 1989, Congress also set a federally determined fee schedule for Medicare payments to physicians. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169 (1989). In this way, Congress directly sets the prices for health care services paid for under Medicare.[5]

Beyond Congress' already substantial regulation of the price of health care services through Medicare and Medicaid, under controlling precedent Congress may lawfully regulate prices for all manner of health care consumption, however wise or unwise that regulation may be. In fact, the Supreme Court has said that Congress may regulate or even fix prices in

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[5] While Medicaid prices are not as directly regulated at the federal level, Congress has legislated in a number of ways that affect the prices to be paid to health care providers and others under the Medicaid program. Most notable is the Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act of 1990. The program provides that, if drug companies want their products to be covered by Medicaid, they must provide detailed price information to, and enter into a national rebate agreement with, the Secretary of HHS. 42 U.S.C. § 1396r-8. Congress has thus regulated prescription drug prices under Medicaid by requiring drug companies to provide discounts to states—in the form of rebates—for their Medicaid drug purchases. *See generally Iowa Dep't of Human Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 576 F.3d 885, 886-87 (8th Cir. 2009).

interstate markets, either directly or by engaging in the "stimulation of commerce" through regulation. *Wickard v. Filburn*, 317 U.S. 111, 128 (1942) ("It is well established . . . that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices."); *accord Gonzales v. Raich*, 545 U.S. 1, 18-19 (2005); *see also* Sunshine Anthracite Coal Co. v. Adkins, 310 U.S. 381, 394 (1940) (holding that Congress could not only regulate price, but could also attach "other conditions to the flow of a commodity in interstate [commerce]"); *id.* ("To regulate the price for . . . transactions is to regulate commerce itself, and not alone its antecedent conditions or its ultimate consequences." (quoting *Carter v. Carter Coal Co.*, 298 U.S. 238, 326 (1936) (Cardozo, J., dissenting in part and concurring in the judgment in part))).

Sixth, and perhaps most significantly, Congress' commerce power includes the power to prescribe rules cutting across the two linked markets of health insurance and health care services. Both the congressional intent to link the two and the empirical relation between the purchase of health insurance and the consumption of health care services are clear. Accordingly, in determining whether Congress has lawfully exercised its commerce power, courts must examine "the entire transaction, of which [the] contract [for insurance] is but a part, in order to determine whether there may be a chain of events which becomes interstate commerce." *South-Eastern Underwriters*, 322 U.S. at 547. I am hard pressed to see how the relevant "chain of events" here does not include the substantial consumption of health care services by the uninsured.

2.

The plaintiffs assert, nevertheless, that in enacting the individual mandate Congress was limited to regulating a single industry at a single point in time—in other words, it could only look at the health insurance market standing alone. In the plaintiffs' view, Congress could not mandate the purchase of insurance as a means of ameliorating a national problem arising in the related but distinct market for health care services. The majority appears to have adopted this view, concluding that the relevant conduct targeted by Congress is not the uncompensated consumption of health care services by the uninsured, but rather only the decision to forego health insurance. Maj. Op. at 126, 136. This approach is wooden, formalistic, and myopic. The plaintiffs and the majority would view the uninsured in a freeze-framed still, captured, like a photograph, in a single moment in time. They contend that Congress cannot constitutionally regulate the uninsured as a class at that single moment, because at that moment any particular uninsured individual may be healthy, may be sitting in his living room, or may be doing nothing at all. The only way the plaintiffs and the majority can round even the first base of their argument against the mandate is by excluding from Congress' purview, for no principled reason that I can discern, the cost-shifting problems that arise in the health care services market.

This blinkered approach cannot readily be squared with the well-settled principle that, in reviewing whether Congress has acted within its enumerated powers, courts must look at the nature of the problem Congress sought to address, based on

economic and practical realities. *See Swift & Co.*, 196 U.S. at 398 ("[C]ommerce among the states is not a technical legal conception, but a practical one, drawn from the course of business."); *Wickard*, 317 U.S. at 123-24 ("[R]ecognition of the relevance of the economic effects in the application of the Commerce Clause . . . has made the mechanical application of legal formulas no longer feasible."); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 41-42 (1937) (observing that "interstate commerce itself is a practical conception"); *N. Am. Co. v. SEC*, 327 U.S. 686, 705 (1946) ("Congress is not bound by technical legal conceptions. Commerce itself is an intensely practical matter. To deal with it effectively, Congress must be able to act in terms of economic and financial realities." (citation omitted)); *Lopez*, 514 U.S. at 571, 574 (Kennedy, J., concurring) (favoring a pragmatic approach to Congress' commerce power grounded in "broad principles of economic practicality" and a "practical conception of commercial regulation"); *Raich*, 545 U.S. at 25 n.35. When the individual mandate is viewed through a more pragmatic and less stilted lens, it is clear that Congress has addressed a substantial economic problem: the uninsured get sick or injured, seek health care services they cannot afford, and shift these unpaid costs onto others.

Moreover, despite their contention that Congress is limited to regulating in a single industry, the plaintiffs nevertheless concede that Congress may use its rule-making power to regulate the *market for health insurance* as a vehicle or means to address the cost-shifting problems arising in the *market for health care services*. They have conceded, both in their briefs and at oral argument, that Congress may

constitutionally regulate the consumption of health care services by the uninsured at the *time* they actually seek medical care. The plaintiffs acknowledge—as does the majority—that Congress may constitutionally require the uninsured to obtain health care insurance on the hospital doorstep, or that Congress may otherwise impose a penalty on those who attempt to consume health care services without insurance. States Br. at 31-32 ("Supreme Court precedent allows Congress to regulate [the practice of consuming health care services without insurance]—for example, by imposing restrictions or penalties on individuals who attempt to consume health care services without insurance."); Maj. Op. at 129-30 ("[W]hen the uninsured actually enter the stream of commerce and consume health care, Congress may regulate their activity at the point of consumption."); *see also Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, at *26 (N.D. Fla. Jan. 31, 2011) ("Congress plainly has the power to regulate [the uninsured] . . . at the time that they initially seek medical care[ ], a fact with which the plaintiffs agree.").[6] Thus, all of the parties agree that, at the

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[6] At oral argument, counsel for the state plaintiffs was explicitly asked whether, at the point of health care consumption, Congress "could compel an individual who doesn't have health insurance to either pay a penalty or obtain insurance at that time," to which counsel responded that "[i]n the health care market, at the time of consumption, yes." And at the district court hearing on the government's motion to dismiss, counsel for the plaintiffs made a similar concession. In response to the district court's question, "Well, the government could impose this penalty at the point of service at the doctor's office or the hospital and say, if you do not have insurance, you are subject to

time of health care consumption, Congress may lawfully cut across a distinct market and impose a financial penalty designed to compel the uninsured to obtain health insurance. And Congress may do so even where the uninsured would otherwise voluntarily choose to finance the consumption of health care services out of pocket, without buying insurance.

If the plaintiffs had argued that Congress cannot constitutionally force anyone to buy health insurance at any time as a means of paying for health care, they at least would have evinced the virtue of consistency. But instead, the plaintiffs' concession undermines their claim that Congress has exceeded its rule-making power by regulating in one industry to address a problem found in another, at least where the two industries are so closely bound together. After all, even at the point of consuming *health care services*, individuals may wish to remain "inactive" in the *health insurance* market. But the plaintiffs and the majority concede that Congress may nevertheless compel individuals at that point to purchase a private insurance product.

Despite this concession, the plaintiffs contend that the regulation of commerce necessarily presupposes a pre-existing voluntary activity to be regulated. The plaintiffs' activity/inactivity dichotomy, however, is nowhere to be found in the text of the Commerce Clause, nor in the jurisprudence surrounding it. The language of the Commerce Clause itself draws no distinction between

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a penalty?," counsel for the plaintiffs responded, "I believe the government would be able to do it, Your Honor." RE 334-35.

activity and inactivity. The seven operative words speak broadly about Congress' power "[t]o regulate Commerce . . . among the several States." U.S. Const. art. I, § 8, cl. 3. The power to regulate is the power "to prescribe the rule by which commerce is to be governed." *Gibbons*, 22 U.S. at 196. And while the power of Congress is limited to specific objects, it is "plenary as to those objects." *Id.* at 197. Creating an artificial doctrinal distinction between activity and inactivity is thus novel and unprecedented, resembling the categorical limits on Congress' commerce power the Supreme Court swept away long ago.

The plaintiffs claim, nevertheless, that the individual mandate exceeds Congress' commerce power because it improperly conscripts uninsured individuals—who are presently *inactive* in the health *insurance* market—to unwillingly enter the stream of commerce to purchase health insurance they would not otherwise choose to buy. The plaintiffs and the majority would have Congress wait at the water's edge until the uninsured literally enter the emergency room. In other words, they say, Congress may not legislate prophylactically, but instead must wait until the cost-shifting problem has boiled over, causing huge increases in costs for those who have health care insurance (through increased premiums), and for those who provide health care services.

At bottom, the plaintiffs' argument seems to boil down only to a temporal question: can Congress, under the Commerce Clause, regulate how and when health care services are paid for by requiring individuals—virtually all of whom will consume health care services and most of whom have done so

already—to pay *now* for those services through the mechanism of health insurance? As I see it, the answer to whether Congress can make this temporal jump under its Commerce Clause power is yes.

There is no doctrinal basis for requiring Congress to wait until the cost-shifting problem materializes for each uninsured person before it may regulate the uninsured as a class. The majority's imposition of a strict temporal requirement that congressional regulation only apply to individuals who first engage in specific market transactions in the health care services market is at war with the idea that Congress may adopt "reasonable preventive measures" to avoid *future* disruptions of interstate commerce. *Consol. Edison Co. v. NLRB*, 305 U.S. 197, 222 (1938) ("[I]t cannot be maintained that the exertion of federal power must await the disruption of [interstate or foreign] commerce."); *see also Katzenbach v. McClung*, 379 U.S. 294, 301 (1964) (quoting same, and noting that "Congress was not required to await the total dislocation of commerce"); *Stevens v. United States*, 440 F.2d 144, 152 (6th Cir. 1971) ("It is not necessary for Congress to await the total dislocation of commerce before it may provide reasonable preventive measures for the protection of commerce." (citing *Katzenbach*, 379 U.S. at 301)), *limited on other grounds by United States v. Bass*, 404 U.S. 336 (1971); *NLRB v. Sunshine Mining Co.*, 110 F.2d 780, 784 (9th Cir. 1940). In *Consolidated Edison*, the Supreme Court explained that, through the National Labor Relations Act—which regulates labor practices—"Congress did not attempt to deal with particular instances" in which interstate commerce was disrupted, concluding that Congress did not need to wait until labor practices actually disrupted

interstate commerce before it could regulate.[7] 305 U.S. at 222. In other words, Congress may lawfully regulate present conduct to prevent future disruptions of interstate commerce from occurring.

What's more, and even more basic, here the disruption of interstate commerce is *already* occurring. The majority inexplicably claims that the individual mandate regulates "the mere *possibility* of *future* activity," Maj. Op. at 129, but as we speak, the uninsured are consuming health care services in large numbers and shifting costs onto others. By ignoring the close relationship between the health insurance and health care services markets, the plaintiffs and the majority seek to avoid the hard fact that the uninsured as a class are actively consuming substantial quantities of health care services now—not just next week, next month, or next year. The uninsured make more than 20 million visits to emergency rooms each year; 68% of the uninsured had routine checkups in the past five years; and 50% had one in the past two years.[8] *See* U.S. Dep't of

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[7] The majority opinion misapprehends this point. *See* Maj. Op. at 129 n.100. *Consolidated Edison* is cited along with *Katzenbach* to make this simple point: Congress need not wait until an economic problem has erupted and the national economy is disrupted before it may act prophylactically, under its commerce power, to address an obvious and apparent economic problem. That *Consolidated Edison* specifically involved the regulation of labor practices or that *Katzenbach* (along with *Heart of Atlanta*) specifically involved the regulation of innkeepers and restaurateurs is beside the point. This principle of Commerce Clause jurisprudence is general, and it remains binding law.

[8] The plaintiffs do not contest the validity of these data. Indeed, at oral argument, counsel for the state plaintiffs conceded that

HHS, New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits (July 15, 2009), available at http://www.hhs.gov/news/press/2009pres/07/20090715b.html; June E. O'Neill & Dave M. O'Neill, Emp't Policies Inst., Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health 20-21 & tbl.9 (2009), *available* at http://epionline.org/studies/oneill_06-2009.pdf; *see also* Hidden Health Tax, *supra*, at 2 (observing that the uninsured consumed $116 billion worth of health care services in 2008); Gov't Econ. Br. at 10 ("57 percent of the 40 million people uninsured in all of 2007 used medical services *that year*." (emphasis added)); NFIB Br. at 5 (citing same 57% statistic). In addition, there were more than two million hospitalizations—not just emergency room visits, but actual admissions to a hospital—of the uninsured in 2008 alone. U.S. Dep't of HHS, ASPE Research Brief, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills 5 (2011), *available* at http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.pdf.

In light of these undisputed figures, there can be little question that substantial numbers of uninsured Americans are currently active participants in the health care services market, and that many of these uninsured currently consume health care services for which they cannot or do not pay. This is, in every real and meaningful sense, classic economic *activity*, which, as Congress' findings tell us, has a profound effect on commerce. *See Thomas More Law Ctr. v.*

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these visits to the emergency room constitute economic activity that Congress may lawfully regulate.

Obama,—F.3d—, 2011 WL 2556039, at *24 (6th Cir. June 29, 2011) (Sutton, J., concurring) ("No matter how you slice the relevant market—as obtaining health care, as paying for health care, as insuring for health care—all of these activities affect interstate commerce, in a substantial way.").[9] Once the artificial barrier drawn between the health insurance and health care services markets breaks down, the plaintiffs' inactivity argument collapses. And there can be no doubt that Congress rationally linked the two markets. Its very findings accompanying the mandate detail at length the impact that going uninsured has on the broader availability of health insurance *and* on the costs associated with the consumption of health care services. *See* 42 U.S.C. § 18091(a)(2). I observe again that "[h]ealth insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchase of health care services." Welfare Loss, *supra*, at 253. And virtually all of us will have the misfortune of having to consume health care services at some unknown point for some unknown malady and at some uncertain price. Each of us remains susceptible to sudden and unpredictable injury. No one can opt out of illness, disability, and death. These, we all must accept, are facts of life.

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[9] Contrary to the majority's assertion, *see* Maj. Op. at 147 n.119, the conduct being regulated by Congress is the *consumption* of health care services by the uninsured. And it is the very act of consuming health care services by those who do not pay for them that has the natural and probable effect of shifting costs to those who do—what occurs when I consume a good, and leave you with the bill. In every real sense, the *conduct* being regulated is analytically and conceptually distinct from its *effects* on interstate commerce.

Thus, even if I were to accept the plaintiffs' distinction between activity and inactivity, the facts undermine the distinction here. The inevitable consumption of health care services by the uninsured is sufficient activity to subject them to congressional regulation.

3.

The plaintiffs and the majority also object to the mandate on different grounds—that it is "overinclusive" insofar as it applies to: "those who do not enter the health care market at all" ("non-consumers"), and those who consume health care services but pay for their services in full and thus do not shift costs ("non-cost-shifters"). Maj. Op. at 127.

The majority understates the point when it acknowledges that "overinclusiveness may not be fatal for constitutional purposes." *Id.* Indeed, the Supreme Court has made it abundantly clear that Congress is not required to "legislate with scientific exactitude." *Raich*, 545 U.S. at 17. Rather, "[w]hen Congress decides that the *total incidence* of a practice poses a threat to a national market, it may regulate the *entire class*." *Id.* (emphases added) (internal quotation marks omitted). As Justice Holmes put it in *Westfall v. United States*, 274 U.S. 256 (1927), "when it is necessary in order to prevent an evil to make the law embrace more than the precise thing to be prevented [Congress] may do so." *Id. at* 259. There is simply no requirement under the Commerce Clause that Congress choose the least restrictive means at its disposal to accomplish its legitimate objectives. Nor is there a requirement that Congress target only those uninsured individuals who will consume health care services at a particular point in

time or just those who will be unable to pay for the health care services they consume. Congress concluded that the "total incidence" of health care consumption by the uninsured threatened the *national* health insurance and health care services markets. It was free to regulate the "entire class" of the uninsured.[10]

Moreover, even if I were to accept the notion that Congress, in regulating commerce, was obliged to somehow draw the class more narrowly, the subclass of "non-consumers"—those individuals who will never enter the health care services market at all—is surely minuscule. The plaintiffs emphasize that it is

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[10] The Court in *Raich* specifically approved of Congress' legislating across a broad class when "enforcement difficulties" would attend drawing the class more narrowly. *Raich*, 545 U.S. at 22. The Court said, "[g]iven the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA." *Id.* (citation and footnote omitted). When it may be difficult to distinguish between categories of conduct, especially when the categories are fluid, Congress may enlarge the regulated class. Here, too, Congress may broadly regulate uninsured individuals because it may be difficult to distinguish between cost-shifters and non-cost-shifters. And the categories are fluid—a non-consumer or non-cost-shifter today may become a cost-shifter tomorrow, especially if a catastrophic injury befalls him. Moreover, the majority concedes that Congress may regulate *all* of the uninsured—cost-shifters and non-cost-shifters alike—at the point of consumption. *See* Maj. Op. at 129-30. Thus, by the majority's own lights, Congress' inclusion of non-cost-shifters within the mandate's reach does not create a constitutional infirmity.

"not strictly true" that everyone will participate in the health care services market. States Br. at 30. But the only elaboration the plaintiffs offer on this point is that some individuals will not participate because of "religious scruples" or the vaguely-put "individual circumstances." *Id.* As for the first, it does not get the plaintiffs very far, because religious groups that opt out of the health care services or health insurance markets may also seek exemption from the individual mandate. 26 U.S.C. § 5000A(d)(2). And as for "individual circumstances," presumably what the plaintiffs mean is that a few individuals either will fortuitously avoid ill health altogether, or—more likely—will fail to consume health care services due to an immediately fatal accident or the like. I am unable to draw a relevant constitutional distinction between the *virtual* inevitability of health care consumption and the absolute, 100% inevitability of health care consumption. There is less of a chance that an individual will go through his entire life without ever consuming health care services than there is that he will win the Irish Sweepstakes at the very moment he is struck by lightning. Nor are there more than a minuscule number of Americans who could afford to take on the financial risk of a personal medical catastrophe out of their own pockets. Yet, on the basis of these slight mathematical possibilities would the majority bring down the individual mandate and all that may fall with it.

Congress has wide regulatory latitude to address "the extent of financial risk-taking in the health care services market," Gov't Reply Br. at 15, which in its view is "a threat to a national market," *Raich*, 545 U.S. at 17. The fact that an exceedingly small set of

individuals may go their whole lives without consuming health care services or can afford to go it alone poses no obstacle to Congress' ability under the Commerce Clause to regulate the uninsured as a class.

Similarly, a group of economists who filed an amicus brief in support of the plaintiffs object to the individual mandate by disputing the substantiality of the cost-shifting impact the mandate seeks to address. First, they claim that the individual mandate targets the young and healthy and that the annual costs of uncompensated care for *those* individuals is much less than $43 billion. *See* Brief for Economists as Amici Curiae Supporting the Plaintiffs ("Plaintiffs Econ. Br.") at 3, 10, 13. The point is unpersuasive, because it conflates the scope of the individual mandate with its relative benefits for different population groups. The individual mandate applies to all non-exempted individuals, 26 U.S.C. § 5000A(a), and while the young and healthy may benefit less than other groups from having health insurance, "[i]t is of the essence of regulation that it lays a restraining hand on the selfinterest of the regulated and that advantages from the regulation commonly fall to others," *Wickard*, 317 U.S. at 129. Balancing different groups' competing economic interests is not a constitutional concern for the courts to calibrate, but rather is "wisely left under our system to resolution by the Congress under its more flexible and responsible legislative process." *Id.* Moreover, the argument that the mandate targets the young and healthy and that, therefore, this Court should only look at the economic impact on interstate commerce of *those* individuals is not even consistent with the plaintiffs' own suggestion that the

individual mandate regulates "*everyone* at *every* moment of their lives, from cradle to grave." States Br. at 29.

The economists also suggest that even if we look at the $43 billion figure as a whole, that amount is less than 1.8% of overall annual health care spending (which Congress found was $2.5 trillion, or 17.6% of the national economy, in 2009, 42 U.S.C. § 18091(a)(2)(B)), and, therefore, the "alleged cost-shifting problem" is relatively modest and fails to justify the individual mandate. Plaintiffs Econ. Br. at 9-10. The argument is unconvincing. It would be novel indeed to examine whether a problem "substantially affects" interstate commerce by comparing the economic impact of the problem to the total size of the regulated market. The argument would also lead to the perverse conclusion that Congress has *less* regulatory power the larger the national market at issue. But in any event, there can be no doubt that $43 billion is a substantial amount by any accounting. Even the economists (as well as the district court) recognize that the amount is "not insignificant." Plaintiffs Econ. Br. at 10; *accord Florida*, 2011 WL 285683, at *26 (noting that $43 billion "is clearly a large amount of money"). In this connection, I am reminded of the comment often attributed to the late Illinois Senator Everett McKinley Dirksen: "A billion here, a billion there, and pretty soon you're talking about real money."

Relying heavily on the economists' brief, the majority goes even further and subjects Congress' findings to an analysis that looks startlingly like strict scrutiny review. The majority engages in a breakdown of who among the uninsured are

responsible for the $43 billion, presumably in order to show that the mandate will not be the most efficacious means of ameliorating the cost-shifting problem. *See* Maj. Op. at 139-41. For instance, the majority claims that low-income individuals and illegal aliens (or other nonresidents) together are responsible for around half of the total cost shifting, yet are exempted from either the mandate or its penalty. *Id.* at 139-40. But even on the majority's own terms, a substantial number of cost-shifters are *not* exempted from the mandate or its penalty, and there was nothing irrational about Congress' decision to subject to the mandate those individuals who could reasonably afford health insurance in the first place.

More fundamentally, however, as I see it, the majority's searching inquiry throughout its opinion into whether the individual mandate fully solves the problems Congress aimed to solve, or whether there may have been more efficacious ways to do so, probes far beyond the proper scope of a court's Commerce Clause review. The majority suggests any number of changes to the legislation that would, it claims, improve it. Thus, for example, the majority offers that Congress should have legislated with a finer scalpel by inserting some element in the statute calling for a "case-by-case inquiry" of each regulated individual's conduct. *Id.* at 128 (internal quotation marks omitted). And the majority would have the IRS enforce the mandate more aggressively. *See* i*d.* at 166; i*d.* at 202 (describing the mandate as "porous and toothless").

Quite simply, the majority would presume to sit as a superlegislature, offering ways in which Congress could have legislated more efficaciously or

more narrowly. This approach ignores the wide regulatory latitude afforded to Congress, under its Commerce Clause power, to address what *in its view* are substantial problems, and it misapprehends the role of a reviewing court. As nonelected judicial officers, we are not afforded the opportunity to rewrite statutes we don't like, or to craft a legislative response more sharply than the legislative branch of government has chosen. What we are obliged to do is to determine whether the congressional enactment falls within the boundaries of Art. 1, § 8, cl. 3. In examining the constitutionality of legislation grounded in Congress' commerce power, "[w]e need not determine whether [the regulated] activities, taken in the aggregate, substantially affect interstate commerce *in fact*." *Raich*, 545 U.S. at 22 (emphasis added). Rather, all we need to do—indeed, all we are *permitted* to do—is determine "whether a 'rational basis' exists for so concluding." *Id.* The courts are not called upon to judge the wisdom or efficacy of the challenged statutory scheme. *See*, *e.g.*, *id.* at 9 ("The question before us, however, is not whether it is wise to enforce the statute in these circumstances."); *Wickard*, 317 U.S. at 129 ("And with the wisdom, workability, or fairness[ ] of the plan of regulation we have nothing to do."). As Justice Cardozo put it, "[w]hether wisdom or unwisdom resides in the scheme of [the statute at issue], it is not for us to say. The answer to such inquiries must come from Congress, not the courts." *Helvering v. Davis*, 301 U.S. 619, 644 (1937); *see also Thomas More Law Ctr.*, 2011 WL 2556039, at *33 (Sutton, J., concurring) ("Time assuredly will bring to light the policy strengths and weaknesses of using the individual mandate as part of this national legislation, allowing

the peoples' political representatives, *rather than their judges*, to have the primary say over its utility." (emphasis added)).

The majority says, nevertheless, that we are compelled to approach the individual mandate with "caution" and with "greater cause for doubt," Maj. Op. at 152, because insurance and health care are "areas of traditional state concern," *Id. at* 150. While it is true that insurance and health care are, generally speaking, areas of traditional state regulation, this observation in no way undermines Congress' commerce power to regulate concurrently in these areas. The sheer size of the programs Congress has created underscores the extensiveness of its regulation of the health insurance and health care industries. "In 2010, 47.5 million people were covered by Medicare . . . ." 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 4 (2011), *available at* http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf. Medicaid is similarly massive. As of December 2008, approximately 44.8 million people were covered by Medicaid. The Kaiser Commission on Medicaid and the Uninsured, Medicaid Enrollment in 50 States 1 (2010), *available* at http://www.kff.org/medicaid/upload/7606-05.pdf. And as the government points out, Medicare and Medicaid accounted for roughly $750 billion of federal spending in 2009 alone. Gov't Br. at 10. It would surely come as a great shock to Congress, or, for that matter, to the 47.5 million people covered by Medicare, the 44.8 million people covered by Medicaid, and the overwhelming number of employers, health insurers, and health care providers regulated by ERISA,

COBRA, and HIPAA, to learn that, because the health care industry also "falls within the sphere of traditional state regulation," Maj. Op. at 153, Congress was somehow skating on thin constitutional ice when it enacted these laws.

4.

In the course of its opinion, the majority also attaches great significance to the unprecedented nature of the legislation before us. It is surely true that, as the district court concluded, the individual mandate is a novel exercise of Congress' Commerce Clause power. *Florida*, 2011 WL 285683, at *20-21. But the mere fact of its novelty does not yield its unconstitutionality. *See Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1252 (11th Cir. 2008) (upholding, under the Commerce and Necessary and Proper Clauses, the constitutionality of the Graves Amendment, 49 U.S.C. § 30106, even though it was a "novel" statute employing the "relatively novel" theory that the rental car market should be protected "by deregulating it"). Every new proposal is in some way unprecedented before it is tried. And to draw the line against any new congressional enactment simply because of its novelty ignores the lessons found in the Supreme Court's Commerce Clause cases. For example, in *Wickard* the Court squarely recognized that the case presented an unprecedented expansion of the Commerce Clause power before then embracing that expansion. 317 U.S. at 120 ("Even today, when this power has been held to have great latitude, there is no decision of this Court that such activities ["local" activities such as production, manufacturing, and mining] may be regulated where no part of the

product is intended for interstate commerce or intermingled with the subjects thereof."). The truth is that any ruling this Court issues on the individual mandate's constitutionality is necessarily a departure from existing case law because the legislation and the issues presented are new. That the Supreme Court has never before upheld a regulation of this kind can hardly be decisive; it has never rejected one either.

Indeed, when measured against the kinds of sweeping changes we have seen in the past, the individual mandate is far from a cataclysmic expansion of Congress' commerce power. Even the briefest examination of the growth of Congress' commerce power over the past 75 years makes the point. Facing the practical realities of an emergent, highly integrated national economy, the Supreme Court abandoned the categorical and formalistic distinctions that it had erected initially, in favor of a pragmatic view of commerce drawn from the course of business. The Court had previously held that broad categories of economic life, such as agriculture, insurance, labor, manufacturing, mining, and production were *antecedent* to commerce itself, which was once viewed as being limited to the *movement* of the fruits of those antecedent activities in and among the states. But a more pragmatic view began to take hold by the mid-1930s. The Court's earlier restrictive view of commerce did not survive the New Deal-era cases, where the Supreme Court swiftly brought all of these categories within the lawful ambit of Congress' commerce power. *See*, *e.g.*, *Jones & Laughlin Steel*, 301 U.S. at 40 ("It is thus apparent that the fact that the employees here concerned were engaged in production is not determinative. The question remains as to the effect upon interstate commerce of

the labor practice involved."); *United States v. Darby*, 312 U.S. 100, 115-17 (1941) ("[W]e conclude that the prohibition of the shipment interstate of goods produced under the forbidden substandard labor conditions is within the constitutional authority of Congress."); *Wickard*, 317 U.S. at 124-25 ("Whether the subject of the regulation in question was 'production,' 'consumption,' or 'marketing' [of wheat] is . . . not material for purposes of deciding the question of federal power before us. . . . [E]ven if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce . . . ."); *South-Eastern Underwriters*, 322 U.S. at 553 ("No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.").

The Court did not stop there. It expanded the scope of Congress' commerce power from the regulation of the "intercourse" of goods moving across borders to the regulation of wholly *intrastate* conduct that substantially affected interstate commerce. *See Darby*, 312 U.S. at 119-20 & n.3. Indeed, *Wickard* involved a jump arguably far greater than the one we face today. In order to regulate price, Congress could penalize conduct—Filburn's growing wheat above a fixed quota for his own personal consumption—absent any indicia that Filburn would *ever* enter into the interstate wheat market. Justice Jackson, writing for the Court, recognized this as a novel exercise of the commerce power. *Wickard*, 317 U.S. at 120. The Court held that Congress could nonetheless regulate

the price of wheat by restricting its production, even on a small farm where it was grown purely for personal consumption. And, according to the Court, if the regulation had the natural and probable effect of "*forcing* some farmers into the market to buy what they could provide for themselves" absent the regulation, so be it. *Id.* at 129 (emphasis added).

In *Wickard*, the Court expanded Congress' commerce power further still, concluding that the impact or effect on interstate commerce is not measured case by case, or person by person, but rather in an *aggregated* way. *Id.* at 127-28. That Filburn's "own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, *taken together with that of many others similarly situated*, is far from trivial." *Id.* (emphasis added); *see also Darby*, 312 U.S. at 123 ("[Congress] recognized that in present day industry, competition by a small part may affect the whole and that the total effect of the competition of many small producers may be great."); *NLRB v. Fainblatt*, 306 U.S. 601, 606 (1939) ("The power of Congress to regulate interstate commerce is plenary and extends to all such commerce be it great or small."). Building upon earlier inklings of an aggregation principle found in *Darby* and *Fainblatt*, the Court firmly established that Congress may regulate classes of local activities that, only in the aggregate, have a substantial effect on interstate commerce.[11]

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[11] The majority attempts to skirt the breadth of the aggregation principle by claiming that an "individual's mere decision not to purchase insurance" is not subject to aggregation. Maj. Op. at 125. But again, the majority has shot at the wrong target.

In a pair of notable civil rights cases, *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964), and *Katzenbach*, 379 U.S. 294, the Supreme Court continued to read the Commerce Clause in an expansive way. The Court upheld nondiscrimination legislation, grounded in the Commerce Clause, that required hoteliers and restaurateurs to enter into economic transactions with racial minorities (indeed, with individuals of any race, color, religion, or national origin) on the same terms as any other patrons (or exit their respective businesses altogether). The Court underscored that "the power of Congress to promote interstate commerce also includes the power to regulate the local incidents thereof, including local activities in both the States of origin and destination, which might have a substantial and harmful effect upon that commerce." *Heart of Atlanta*, 379 U.S. at 258. The Court concluded that, having entered the stream of commerce, these sellers could be forced by Congress to engage in economic transactions into which they would not otherwise enter.

The plaintiffs are quick to point out, however, that the Commerce Clause has not simply expanded unabated. In rejecting the constitutionality of the individual mandate, the plaintiffs and the majority rely heavily upon *Lopez*, 514 U.S. 549, and *United States v. Morrison*, 529 U.S. 598 (2000), the only two Supreme Court cases in the past 75 years to hold that

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Congress is regulating the uninsured's uncompensated consumption of health care services. And under *Wickard* and *Raich*, we are instructed to measure the effect on interstate commerce not case-by-case or person-by-person, but rather in the aggregate and taken as a whole.

an act of Congress exceeded its commerce power. Neither *Lopez*, where the Court struck down a statute criminalizing the possession of a firearm within 1000 feet of a school, nor *Morrison*, where the Court struck down a statute creating a federal civil remedy for victims of gender-motivated felonious acts of violence, answers the question we face today.

Indeed, in *Raich*, 545 U.S. 1, decided five years after *Morrison*, the Supreme Court reaffirmed the vitality of *Wickard*, and specifically applied its holding in a challenge to the constitutionality of the Controlled Substances Act ("CSA"). The Court emphatically distinguished *Lopez* and *Morrison*, observing that the statutes at issue in those cases were singular prohibitions regulating wholly noneconomic criminal behavior. The CSA, on the other hand, was characterized as "a lengthy and detailed statute creating a comprehensive framework for regulating the production, distribution, and possession of five classes of 'controlled substances.'" *Raich*, 545 U.S. at 24. The Court found that, "[u]nlike those at issue in *Lopez* and *Morrison*, the activities regulated by the CSA are quintessentially economic." *Id.* at 25.

Thus, much as in *Raich*, while *Lopez* and *Morrison* remind us that there are discernible limits on Congress' commerce power, the limits drawn in those two cases are of limited help in this one. As a panel of this Circuit recently stated, "*Raich* makes clear that when a statute regulates economic or commercial activity, *Lopez* and *Morrison* are inapposite." *Garcia*, 540 F.3d at 1252. Indeed, when "we are not . . . dealing with a single-subject statute whose single subject is itself non-economic (*e.g.*,

possession of a gun in a school zone or gender-motivated violence)," *Morrison* and *Lopez* have little applicability and instead "*Raich* guides our analysis." *United States v. Maxwell* ("*Maxwell II*"), 446 F.3d 1210, 1216 n.6 (11th Cir. 2006); *see also United States v. Paige*, 604 F.3d 1268, 1273 (11th Cir. 2010) (per curiam). *Lopez* and *Morrison* each involved an effort to regulate *noneconomic* activity (criminal conduct); in neither instance did Congress seek to broadly regulate an *entire* industry; and, unlike in this case, the criminal conduct regulated in those cases was only linked to interstate commerce in a highly attenuated fashion that required piling inference upon inference. Whatever problems there may be with the constitutionality of the individual mandate, they cannot be found in *Lopez* or *Morrison*. *See* Part II.A, *infra*.

The historical growth of Congress' commerce power powerfully suggests that, contrary to the arguments advanced by the plaintiffs, upholding the individual mandate would be far from a cosmic expansion of the boundaries of the Commerce Clause. These past expansions have not been random, accidental, or in any way contrary to first principles or an original understanding of the Constitution. As the Supreme Court has observed, "[t]he Federal Government undertakes activities today that would have been unimaginable to the Framers." *United States v. Comstock*,—U.S.—, 130 S. Ct. 1949, 1965 (2010) (quoting *New York v. United States*, 505 U.S. 144, 157 (1992)). Indeed, the Framers purposely drafted "a Constitution capable of such resilience through time." *Id.*; *see also McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 415 (1819) (describing the Constitution as a document "intended to endure for

ages to come, and consequently, to be adapted to the various *crises* of human affairs").

The long and short of it is that Congress has promulgated a rule (the individual mandate) by which to comprehensively regulate the timing and means of payment for the virtually inevitable consumption of health care services, and to thereby regulate commerce. The individual mandate was enacted as part of a broad scheme to regulate health insurance and health care services, industries already heavily regulated by Congress. Congress made express legislative findings detailing the *economic* problems it saw, and how the mandate would ameliorate those problems. And the substantial impact on interstate commerce cannot be denied. Article 1, § 8, cl. 3 requires no more than this.

C.

The individual mandate is also a valid means under the Necessary and Proper Clause to further the regulatory end of the Act's insurance reforms. "It has been long recognized that Congress has the power to pass laws or regulations necessary and proper to carrying out [its] commerce clause power." *United States v. Ambert*, 561 F.3d 1202, 1211 (11th Cir. 2009). Under the Necessary and Proper Clause, Congress is empowered "[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing [Art. 1, § 8] Powers." U.S. Const. Art. 1, § 8, cl. 18. Both the Supreme Court and this Circuit have said that "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the

statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956 (emphasis added); *United States v. Belfast*, 611 F.3d 783, 804 (11th Cir. 2010).

The constitutionality of the "end"—that is, the Act's insurer regulations—is both clear and unchallenged, as even the district court recognized. *Florida*, 2011 WL 285683, at *32 ("[T]he end of regulating the health care insurance industry (including preventing insurers from excluding or charging higher rates to people with pre-existing conditions) is clearly legitimate and within the scope of the constitution." (internal quotation marks omitted)). Once it has identified a legitimate and constitutional end, Congress has an expansive choice of means. As Chief Justice Marshall enduringly articulated "[i]n language that has come to define the scope of the Necessary and Proper Clause," *Comstock*, 130 S. Ct. at 1956:

> Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.

McCulloch, 17 U.S. at 421. In addition, Chief Justice Marshall broadly defined the term "necessary." It does not mean "absolutely necessary," but rather only "convenient, or useful" or "conducive" to the "beneficial exercise" of one or more of Congress' enumerated powers. *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 413, 414, 418).

It is clear under this expansive definition of "necessary," the validity of which was recently reaffirmed by the Supreme Court in *Comstock*, that requiring the purchase of health insurance is "convenient," "useful," or "conducive" to effectively implementing the Act's insurer regulations. As the states that tried to effectuate guaranteed issue and community rating reforms without some form of individual mandate attest, trying to do the former without the latter simply does not work. *See*, *e.g.*, Brief for Am. Ass'n of People with Disabilities et al. as Amici Curiae Supporting the Government at 5-6 ("Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington enacted legislation that required insurers to guarantee issue to all consumers in the individual market, but did not have a minimum coverage provision. . . . All seven states suffered from sky-rocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers." (footnote omitted)); Brief for Governor of Wash. as Amicus Curiae Supporting the Government at 2 ("Washington knows firsthand the necessity of universal coverage because of the problems it experienced when it eliminated barriers to insurance coverage, like preexisting condition restrictions, without also imposing a minimum coverage requirement."); Brief for Law Professors as Amici Curiae Supporting the Government at 17 ("[A]fter Kentucky enacted reform, all but two insurers (one State-run) abandoned the State.").[12] In this light, the

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[12] During a hearing before the House Ways and Means Committee, an economist stated that "imposition of *community-rated premiums* and *guaranteed* issue on a market of competing

individual mandate is "necessary" to the end of regulating insurers' underwriting practices without running insurers out of business entirely—a point the district court recognized. *Florida*, 2011 WL 285683, at *33 ("The defendants have asserted again and again that the individual mandate is absolutely 'necessary' and 'essential' for the Act to operate as it was intended by Congress. I accept that it is.").

The plaintiffs also claim that the individual mandate exceeds Congress' power because it is not "proper"—that is, because it is inconsistent with "the letter and the spirit of the constitution." *McCulloch*, 17 U.S. at 421. I have little doubt that the individual mandate is also "proper." It violates no other provision of the Constitution.[13] *Cf. Comstock*, 130 S. Ct. 13 at 1957 ("[T]he present statute's validity under provisions of the Constitution other than the Necessary and Proper Clause is an issue that is not before us. . . . [Therefore], the relevant inquiry is simply whether the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power . . . ." (internal quotation marks

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private health insurers will inexorably drive that market into extinction, unless these two features are coupled with . . . a *mandate on individual[s] to be insured*." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (2009) (statement of Dr. Uwe Reinhardt, Professor, Princeton University). In other words, without a mandate, these two insurer reforms would result in adverse selection, increased premiums, decreased enrollment, and fleeing insurers—in short, the insurance market would "implode." *See Id.* at 13 n.4.

[13] I address the plaintiffs' suggestions that the individual mandate violates the Fifth or Tenth Amendments in Part II.B, *infra.*

omitted)). And the mandate is undoubtedly "rationally related" to the end of effectuating the Act's guaranteed issue and community rating reforms. *Id.* at 1956; *Belfast*, 611 F.3d at 804. The mandate arguably renders the insurer regulations practically and economically feasible. Congress found that without the mandate, "many individuals would wait to purchase health insurance until they needed care," 42 U.S.C. § 18091(a)(2)(I)—that is, until they were sick, which would impose enormous costs on insurers and drive them out of the market. And having observed the failed experience of those states that tried to enact insurer reforms without an individual mandate, Congress rationally concluded that one way to prevent this problem was to require that non-exempted individuals enter the insurance risk pool. The Necessary and Proper Clause requires nothing more.

II.

More fundamentally, the plaintiffs have offered two arguments that, they say, undermine the government's position that Congress' commerce power can justify prescribing a rule that compels an individual to buy health insurance. First, they argue that if Congress has the constitutional authority to enact the individual mandate, then there is virtually no limit on its authority, and Art. 1, § 8, cl. 3 of the Constitution (whether standing alone or in concert with the Necessary and Proper Clause) would be transformed into a grant of general police power. Second, they offer, although largely implicitly, that the individual mandate really infringes upon notions of individual liberty and popular sovereignty found

either in the Fifth or Tenth Amendments to the Constitution. I take up each argument in turn.

A.

1.

Perhaps at the heart of the plaintiffs' objection to the mandate—adopted by the majority opinion in conclusion, if not in reasoning[14]—is the notion that allowing the individual mandate to stand will convert Congress' commerce power into a plenary federal police power, admitting of no limits and knowing of no bounds. The parade of horribles said to follow

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[14] The majority comes perilously close to abandoning the central foundation—the dichotomy between activity and inactivity—on which the plaintiffs and the district court rely for their position that upholding the individual mandate would convert the Commerce Clause into an unlimited general police power. *See* Maj. Op. at 109 ("[W]e are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case."). As I understand the position taken by the plaintiffs and the district court, it is this: if the Commerce Clause affords Congress the power to conscript the unwilling uninsured to enter the stream of commerce and buy insurance, then Congress could also conscript any American to buy any private product at a time and under circumstances not of his own choosing. In other words, the plaintiffs say, the individual mandate extends the Commerce Clause beyond its outer limits precisely because it allows the government to conscript the *inactive* and unwilling. Without drawing the distinction between activity and inactivity, I am at a loss to understand the argument that sustaining the individual mandate would transmute the limited power contained in Art. 1, § 8, cl. 3 of the Constitution into an unlimited general police power. For reasons that remain inexplicable to me, the majority opinion seems to suggest that the individual mandate is a "bridge too far"—in the words of the district court—not because it conscripts the inactive, but rather for some inchoate reason stated at the highest order of abstraction.

ineluctably from upholding the individual mandate includes the federal government's ability to compel us to purchase and consume broccoli, buy General Motors vehicles, and exercise three times a week. However, acknowledging the constitutionality of the individual mandate portends no such impending doom.

At the outset, there is always a danger in evaluating the constitutionality of legislation actually before us solely on the basis of conjecture about what the future may hold. The plaintiffs' heavy reliance on "floodgate fears" and a "parade of dreadfuls calls to mind wise counsel: 'Judges and lawyers live on the slippery slope of analogies; they are not supposed to ski it to the bottom.'" *Buckley v. Am. Constitutional Law Found., Inc.*, 525 U.S. 182, 194 n.16 (1999) (quoting Robert Bork, The Tempting of America: The Political Seduction of the Law 169 (1990)). Federal courts may only be called on to resolve ripe controversies, and it is difficult and hazardous for courts to prejudge the next case or the one after that in a vacuum, devoid of a factually developed record sharpened in the crucible of the adversarial process. *See Baker v. Carr*, 369 U.S. 186, 204 (1962) ("[C]oncrete adverseness . . . sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions[.]"). As courts of limited jurisdiction, we ought not lose sight of the legislation before us, viewed in the context of the discrete issues and facts presented. I have little doubt that the federal courts will be fully capable of addressing future problems raised in future cases in the fullness of time.

But a more basic answer is this: upholding the individual mandate leaves fully intact all of the existing limitations drawn around Congress' Commerce Clause power. To begin with, Congress is limited by the constitutional text and Supreme Court doctrine largely to prescribing rules regulating *economic* behavior that has a *substantial* effect on interstate commerce. These powerful limits afford no problem in this case, because Congress has undeniably prescribed a rule (the individual mandate) to regulate economic behavior (consumption of health care services by the uninsured) that has a powerful impact on how, when, and by whom payment is made for health care services. Indeed, the conduct regulated by the Act is even more "quintessentially economic" in nature than the cultivation, possession, and personal use of controlled substances, *see Raich*, 545 U.S. at 25, or the cultivation of wheat for personal consumption, *see Wickard*, 317 U.S. at 119.

In *Lopez* and *Morrison*, the Supreme Court began to flesh out some of the outer limits surrounding Art. I, § 8, cl. 3. Chief Justice Rehnquist, writing for the Court in both instances, posited a series of "significant considerations," none of which pose any problem in this case. *See Morrison*, 529 U.S. at 609-12. First, he observed that the regulated conduct at issue in *Lopez* and *Morrison* was plainly of a noneconomic nature—again, the possession of a handgun within 1000 feet of a school in *Lopez*, and gender-motivated felonious acts of violence in *Morrison*. *See id. at* 610 ("[A] fair reading of *Lopez* shows that the noneconomic, criminal nature of the conduct at issue was central to our decision in that case."). Here, in sharp contrast, Congress has

prescribed a rule governing purely economic behavior. As I've noted already, the Act addresses an economic problem of enormous dimension—$43 billion of annual cost shifting from the uninsured to insured individuals and health care providers, 42 U.S.C. § 18091(a)(2)(F)—by prescribing an economic rule governing the timing and method of payment for health care services. In short, the first problem identified in *Lopez* and *Morrison*—that the statutes reached purely intrastate, noneconomic behavior—is not found in this case, and thus the mandate does not, at least for this reason, penetrate beyond the outer limits of Congress' Commerce Clause power.

A second powerful consideration identified by the Court in both *Lopez* and *Morrison* was that the *nexus* between the criminal conduct regulated by the legislation and its impact—even if taken in the aggregate—on interstate commerce was remote and wholly attenuated, and on its own terms provided no limiting principle surrounding the exercise of Congress' commerce power. In both *Lopez* and *Morrison*, the government relied on a lengthy inferential chain of causal reasoning in order to show that the criminal conduct regulated had a substantial effect on interstate commerce. In *Lopez*—where Congress had made no factual findings regarding the effects upon interstate commerce of gun possession in a school zone—the government had to argue, among other things, that the possession of firearms near schools had the natural effect of disrupting the educational process, and that this disruption, over time, would in turn lower the economic productivity of our citizens, causing an adverse effect on the national economy. *See Lopez*, 514 U.S. at 563-64. It's no surprise, then, that the Court found the

critical link to interstate commerce wanting, and concluded that if this chain of reasoning were an acceptable means of bridging the gap between the regulated conduct and commerce, precious little would fall outside the ambit of Congress' commerce power. *Id.* at 564. By the same token, in *Morrison*, the Court found wanting Congress' chain of reasoning—that felonious acts of violence against women would, inter alia, cause lost hours in the workplace and drive up hospital costs and insurance premiums, which in turn would have an adverse effect on the national economy. *See Morrison*, 529 U.S. at 615. The problem remained the same as in *Lopez*, even though in *Morrison*, Congress had sought to draw the causal inferences itself through express factual findings. Again, the causal reasoning that was required to link the regulated criminal conduct to interstate commerce was lengthy and attenuated. And again, the very method of reasoning offered by Congress afforded no limitations on its commerce power. *Id.* at 615-16.

In this case, no such complex and attenuated causal story is necessary to locate the regulated conduct's nexus with interstate commerce. Here, the substantial effect on commerce occurs directly and immediately when the uninsured consume health care services in large numbers, do not pay for them in full or maybe even at all, and thereby shift powerful economic costs onto insured individuals and health care providers (as Congress found they do). The nexus between the regulated conduct and interstate commerce could not be more direct. I am at a loss to find even a single "inferential leap[ ]," Maj. Op. at 146, required to link them. Moreover, Congress unambiguously and in considerable detail drew the

connection between the regulated conduct and its substantial effect on interstate commerce through extensive findings of fact. *See* 42 U.S.C. § 18091. Contrary to the majority's claim, here there is no need "to pile inference upon inference," *Lopez*, 514 U.S. at 567, to draw the critical nexus, and, therefore, we face no unlimited exercise of congressional power for that reason.

Moreover, in sharp contrast to *Lopez* and *Morrison*, we are confronted today with a comprehensive economic statute, not a one-off, criminal prohibition. *See Raich*, 545 U.S. at 23-24 (drawing a sharp distinction between "brief, single-subject statute[s]" divorced from a larger regulatory scheme and "lengthy and detailed statute[s] creating a comprehensive framework for regulating" an entire market). The individual mandate is "an essential part of a larger regulation of economic activity," without which "the regulatory scheme would be undercut," *Lopez*, 514 U.S. at 561, and the Supreme Court has endorsed the constitutionality of such comprehensive, economic regulatory schemes, *Raich*, 545 U.S. at 24-25; *see also Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981) ("A complex regulatory program such as established by the [Surface Mining] Act can survive a Commerce Clause challenge without a showing that every single facet of the program is independently and directly related to a valid congressional goal. It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfies this test."); *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) ("Though the conduct in *Lopez* was not economic, the Court nevertheless recognized that it could be

regulated as 'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" (quoting *Lopez*, 514 U.S. at 561)). And, according to Eleventh Circuit precedent, "where Congress comprehensively regulates economic activity, it may constitutionally regulate intrastate activity, whether economic or not, so long as the inability to do so would undermine Congress's ability to implement effectively the overlying economic regulatory scheme." *Maxwell II*, 446 F.3d at 1215 (footnote omitted).

The majority, in an effort to distance itself from this precedent, suggests that, because *Raich* involved an as-applied challenge, the inquiry into whether challenged legislation is an "essential part of a larger regulation of economic activity" is only appropriate in as-applied challenges, as opposed to facial ones. Maj. Op. at 158-60. In other words, the majority seems to be saying that, because "the Supreme Court has to date never sustained a statute on the basis of the 'larger regulatory scheme' doctrine in a facial challenge," *id.* at 159, it is irrelevant to the question of the individual mandate's constitutionality that the mandate is an essential part of a larger economic regulatory scheme. There is no doctrinal basis for this view. In *Lopez* itself, the Court applied this principle in the context of a *facial* challenge. In *Raich*, the Court plainly recognized that, unlike the challenge it faced, the challenges to the constitutionality of the Gun-Free School Zones Act in *Lopez*, and, for that matter, to Title III of the Violence Against Women Act in *Morrison*, were facial challenges. Justice Stevens, writing for the majority in *Raich*, said: "Here, respondents ask us to excise

individual applications of a concededly valid statutory scheme. In contrast, in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its *entirety*," the very definition of a facial challenge. *Raich*, 545 U.S. at 23 (emphasis added). Indeed, Justice Thomas, dissenting, likewise expressly recognized that "[i]n *Lopez* and *Morrison*, the parties asserted facial challenges." *Id.* at 71 (Thomas, J., dissenting). And of course in *Lopez*, the Court, for the first time, *applied* this very doctrine, explaining that *even though* the Gun-Free School Zones Act targeted purely local, noneconomic behavior, the Court could have upheld it nonetheless if it had been an "essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Lopez*, 514 U.S. at 561. Moreover, a panel of this Court has recently explained in binding precedent that "what distinguished *Raich* from *Morrison* and *Lopez* . . . was the comprehensiveness of the economic component of the regulation," *Maxwell II*, 446 F.3d at 1214—not whether the challenge was facial or as-applied.

Furthermore, the majority's view that the individual mandate is not an essential part of the Act's concededly economic regulatory scheme, *see* Maj. Op. at 162-66, cannot be squared with the economic realities of the health insurance business or the legislative realities of the Act. Nor can this view be squared with the contrary judgment reached by Congress on this very point. Thus, for example, the majority appears to simply cast aside Congress' finding that the individual mandate "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." 42 U.S.C. § 18091(a)(2)(I). In *Maxwell II*, we explained that "courts have only a limited role in second-guessing" Congress' judgments about whether leaving a class of conduct outside of federal control would "undercut[ ] Congress's unquestioned authority to regulate the broader interstate market." 446 F.3d at 1215 (internal quotation marks omitted). Faced with evidence that the insurance industry would collapse if the Act's guaranteed issue and community rating provisions were implemented without the individual mandate, Congress had more than "a rational basis for concluding," *Raich*, 545 U.S. at 19, that the individual mandate was essential to the success of the Act's concededly valid and quintessentially economic insurer reforms.[15] In short, the real and

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[15] Although the majority seems to take comfort in only striking down the individual mandate, *see* Maj. Op. at 207 n.145, all of the parties have agreed that the individual mandate is so essential to the principal insurer reforms that, at least for severability purposes, the guaranteed issue and community rating provisions necessarily rise and fall with the individual mandate, Gov't Reply Br. at 58 ("As plaintiffs note, the federal government acknowledged below [and continues to acknowledge] that the guaranteed-issue and community-rating provisions due to take effect in 2014 . . . cannot be severed from the minimum coverage requirement. The requirement is integral to those sections that go into effect along with it in 2014 and provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions . . . ."); States Br. at 63 (stating that the individual mandate cannot be severed from "the core, interrelated health insurance reforms"); NFIB Br. at 60-61 (stating that the mandate and the principal insurer provisions "truly are the heart of the Act," and highlighting the government's concession

substantial limits on the commerce power set forth by the Supreme Court in *Lopez* and *Morrison* would be left wholly intact if we were to uphold the individual mandate.

Because the impact on interstate commerce of the conduct that Congress sought to regulate through the individual mandate is so clear and immediate, this case is readily distinguishable from many of the plaintiffs' suggested hypothetical horribles, which suffer from the inference-piling reasoning condemned in *Lopez* and *Morrison*. Thus, for example, in arguing that Congress could force us to purchase broccoli, the plaintiffs necessarily reason as follows: everyone is a participant in the food market; if people buy more broccoli, they will eat more broccoli; eating more broccoli will, in the long run, improve people's health; this, in turn, will improve overall worker productivity, thus affecting our national economy. Such reasoning violates the cautionary note that "under the Government's 'national productivity' reasoning, Congress could regulate any activity that it found was related to the economic productivity of individual citizens . . . . Thus, if we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *Lopez*, 514 U.S. at 564. By contrast, the economic problem that Congress sought to address through the individual mandate does not depend on any remote or long-term effects on economic productivity stemming from individuals' health care choices; indeed, the mandate does not compel individuals to seek health care at all, much

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that the mandate and the insurer reforms "must stand or fall together" (internal quotation marks omitted)).

less any particular form of it. Instead, Congress rationally found that the uninsured's inevitable, substantial, and often uncompensated consumption of health care services—of any form—*in and of itself* substantially affects the national economy.

2.

Moreover, this case does not open the floodgates to an unbounded Commerce Clause power because the particular factual circumstances are truly unique, and not susceptible to replication elsewhere. This factual uniqueness would render any holding in this case limited. I add the unremarkable observation that the holding of every case is bounded by the peculiar fact pattern arising therein. *See Licciardello v. Lovelady*, 544 F.3d 1280, 1288 n.8 (11th Cir. 2008) ("Our holding, as always, is limited to the facts before us."); *see also United States v. Hunter*, 172 F.3d 1307, 1310 (11th Cir. 1999) (Carnes, J., concurring) ("The holdings of a prior decision can reach only as far as the facts and circumstances presented to the Court in the case which produced that decision.").

The health care services market is characterized by five relevant factors, which, when taken in concert, uniquely converge to create a truly *sui generis* problem: (1) the unavoidable need that virtually all of us have to consume medical care; (2) the unpredictability of that need; (3) the high costs associated with the consumption of health care services; (4) the inability of providers to refuse to provide care in emergency situations; and, largely as a result of the previous four factors, (5) the very significant cost shifting that underlies the way medical care is paid for in this country. Gov't Econ. Br. at 1.

These are not just five fortuitous descriptors of the health care market, elevated to artificial constitutional significance. Over the last 75 years the Supreme Court has emphatically and repeatedly counseled a pragmatic approach to Commerce Clause analysis, grounded in a "practical" conception of commercial regulation, "drawn from the course of business." *Swift & Co.*, 196 U.S. at 398; *accord Raich*, 545 U.S. at 25 n.35; *Lopez*, 514 U.S. at 571, 574 (Kennedy, J., concurring); *Wickard*, 317 U.S. at 123-24; *Jones & Laughlin Steel*, 301 U.S. at 41-42. Legislation enacted pursuant to Congress' Commerce Clause power cannot be evaluated in a vacuum, but only in light of the peculiar problems Congress sought to address, what Congress chose to regulate, how Congress chose to regulate, and the connection between the regulated conduct and the problem Congress sought to resolve. Courts must always engage in the "hard work" of "identify[ing] objective markers for confining the analysis in Commerce Clause cases." *Raich*, 545 U.S. at 47 (O'Connor, J., dissenting). Far from being "*ad hoc*" and "illusory," Maj. Op. at 168, these factual criteria are relevant descriptors, drawn from the course of business, of the economic realities Congress confronted. They are, therefore, precisely what the Court has instructed us to consider in the Commerce Clause analysis. And given these unique characteristics of the health care market and the peculiar way these characteristics converge, the individual mandate was part of a practical solution to the cost-shifting problem Congress sought to address.

The first and most basic of these factors is that no individual can opt out of the health care services market, and thus virtually everyone will consume

health care services. Individual participation in the health care services market is properly, therefore, a question of *when* and *how* individuals will consume and pay for such services, not *whether* they will consume them. The plaintiffs are correct that there are other markets that, if defined broadly enough, no one may opt out of, such as the markets for food, transportation, and shelter. But the hypothetical mandates—that Congress can force individuals to buy broccoli, GM cars, or homes—do not follow. Neither those markets nor their hypothetical mandates resemble the market and mandate here.

In the first place, unlike the needs for food, transportation, and shelter—which are always present and have largely predictable costs—illness and injury are wholly unpredictable. Individuals who never intend to consume health care, unlike those who never intend to purchase GM cars or broccoli or a home, will nonetheless do so because of accidents, illnesses, and all the vagaries to which one's health is subject. Indeed, the economists concluded that even the most sophisticated methods of predicting medical spending can explain only 25-35% of the variation in the costs incurred by different individuals; "the vast bulk of [medical] spending needs cannot be forecast in advance." Gov't Econ. Br. at 10-11.

In addition, while the costs associated with obtaining food, transportation, and shelter are susceptible to budgeting, this is not the case for health care, which can be so expensive that most everyone must have some access to funds beyond their own resources in order to afford them. *Id.* at 11-12 (explaining that unpredicted medical costs can eclipse the financial assets of "all but the very well-

to-do"); *see also* Gov't Reply Br. at 15 ("The 'frequency, timing and magnitude' of a given individual's demand for health care are unknowable." (quoting Jennifer Prah Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007))). Moreover, there are lower cost alternatives to purchasing a house or a car, such as renting an apartment, leasing an automobile, or relying on public transportation. There are no realistic alternatives or less expensive substitutes for treating cancer, a heart attack, or a stroke, or for performing a needed organ transplant or hip replacement. Even routine medical procedures, such as MRIs, CT scans, colonoscopies, mammograms, and childbirth, cost more than many Americans can afford. Gov't Econ. Br. at 11. This is not to say that individuals may not budget and plan as best they can for their health care costs, as many surely do, but the combination of uncertain timing, unpredictable malady, and potentially astronomical cost can nonetheless leave individuals wholly unable to pay for the health care services they consume. Indeed, Congress found that "62 percent of all personal bankruptcies are caused in part by medical expenses." 42 U.S.C. § 18091(a)(2)(G).

Largely because of these first three factors—that health care costs are inevitable, unpredictable, and often staggeringly high—the health care services market, unlike other markets, is paid for predominantly through the mechanism of insurance.[16] Gov't Br. at 9 (citing CMS data that

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[16] The unpredictability and wide variation in health care costs demonstrate why the majority's comparison of average health care costs to the average insurance premium misses the point.

payments by private and government insurers comprise 75% of national health care spending). Insurance is thus already intimately linked to the health care services market. People do not similarly insure against the risk that they will need food or shelter, because these needs are apparent and predictable, and people can reliably budget for them. Although the purchase of a car or a home may often be too expensive for many individuals to afford out of pocket, it would be fanciful indeed to suggest that individuals would insure against the sudden and unpredictable purchase of a home or automobile. The plaintiffs admit that "[r]egulations are 'plainly adapted' if they invoke 'the ordinary means of execution.'" NFIB Br. at 42 (quoting *McCulloch*, 17 U.S. at 409, 421). Insurance is the "ordinary means" of paying for health care services. Thus, a mandate to purchase insurance is more appropriately suited to address the problems of non-payment and cost shifting in the health care services market than it would be to address problems in other markets that do not similarly rely on insurance as the primary method of payment.

The fourth important factor distinguishing the health care market from all other markets—and peculiarly contributing to the cost shifting that Congress sought to address through the mandate—is

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Maj. Op. at 140. Individuals pay $4500 in insurance premiums not to avoid the $2000 *average* annual medical bill, but to avoid the *extreme* medical bill. Indeed, the whole point of insurance is to make spending more regular and predictable. Comparing the "*average*" medical bill with the "average" insurance premium is hollow—insurance is purchased for the very reason that one cannot count on receiving the "average" medical bill every year.

the fact that individuals may consume health care services without regard to their ability to pay and often without ever paying for them. Unlike any other sellers in any other marketplace, nearly all hospitals are required by law to provide emergency services to anyone, regardless of ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd. If an individual shows up at the emergency room doorstep with a broken neck from an automobile accident or bleeding from a gunshot wound, or if an individual suffers a heart attack or a stroke, hospitals will not turn him away. Even aside from the federal obligation imposed by EMTALA, by my count, at least ten of the plaintiff states have statutes on the books requiring hospitals with emergency rooms to provide emergency treatment to those in need of it, regardless of ability to pay.[17] Still other plaintiff states have state court judicial rulings imposing similar requirements.[18] And even absent

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[17] *See* Fla. Stat. Ann. § 395.1041(1); Idaho Code Ann. § 39-1391b; La. Rev. Stat. Ann. § 40:2113.4(A); Nev. Rev. Stat. Ann. § 439B.410(1); 35 Pa. Stat. Ann. § 449.8(a); S.C. Code Ann. § 44-7-260(E); Tex. Health & Safety Code Ann. § 311.022(a); Utah Code Ann. § 26-8a-501(1); Wash. Rev. Code § 70.170.060(2); Wis. Stat. Ann. § 256.30(2); see also Gov't Br. at 35 (citing testimony before Congress in 1986 that at least 22 states had enacted statutes or issued regulations requiring provision of emergency medical services regardless of ability to pay, and observing that state court rulings impose a common law duty on doctors and hospitals to provide emergency care).

[18] *See, e.g., Thompson v. Sun City Cmty. Hosp., Inc.*, 688 P.2d 605, 610 (Ariz. 1984) ("[A]s a matter of public policy, licensed hospitals in this state are required to accept and render emergency care to all patients who present themselves in need of such care. . . . This standard of care has, in effect, been set by statute and regulation embodying a public policy which requires private hospitals to provide emergency care that is

any *legal* duty, many hospitals provide free or deeply discounted care as part of their charitable mission, even when the patient's need does not rise to the level of an emergency. *See Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990) (observing in the application of EMTALA that "American hospitals have a long tradition of giving emergency medical aid to anyone in need of it who appeared on the emergency room doorstep"). One expert from the Heritage Foundation persuasively illustrated this distinction between health care and other markets when recommending in 1989 that the government impose a mandate "to obtain adequate [health] insurance":

> 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 his 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.

'medically indicated' without consideration of the economic circumstances of the patient in need of such care."); *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) ("[L]iability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency.").

Stuart M. Butler, Heritage Found., The Heritage Lectures 218: Assuring Affordable Health Care for All Americans 6 (1989);[19] *see also* Gov't Br. at 37.

This obligation of health care providers to provide free medical care creates market imperfections that fall under a variety of labels: "an externality (a situation where one person's actions or inactions affect[ ] others), a free-rider problem (where people buy [or consume] a good and leave the costs to others), or a Samaritan's dilemma (where people choose not to be prepared for emergencies, knowing that others will care for them if needed)." Gov't Econ. Br. at 14-15. Individuals who decline to purchase health insurance are not held to the full economic consequence of that choice, as society does not refuse medical care to a patient in need, even when its cost far exceeds the individual's ability to pay. The ability of health care market participants to demand services without paying for them bolsters Congress' rational conclusion that the individual mandate—which helps to assure payment for services in

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[19] 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.

advance—is peculiarly suited to addressing a unique economic problem in the health care market.[20]

Finally, the four factors described above converge to cause a fifth unique factor of the health care market: the substantial cost shifting from the uninsured to current participants in the health insurance market and to health care providers. This cost shifting does not occur in other markets, even those in which we all participate, such as transportation, food, or housing. When an individual purchases a home or a car, the purchaser pays all of the cost (whether upfront or over time through a loan or mortgage). My neighbor will not help cover my costs of purchasing a home by paying a higher price for his own house. And I will not pay more for my car, simply because my neighbor cannot afford to buy

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[20] Contrary to the plaintiffs' suggestion, it is not problematic that Congress' own legislation—EMTALA—may have contributed to the very market conditions that it sought to address in the Act. Significantly, EMTALA predated the individual mandate by over two decades, and was enacted for reasons wholly unrelated to the mandate. Moreover, EMTALA did not create a new federal obligation out of whole cloth and then impose it on health care providers; rather, it supplemented numerous state laws and overarching social judgments that the sick and injured should be cared for regardless of ability to pay. Nor should we be concerned that Congress might similarly enact legislation requiring companies to give away cars, food, or housing, and then accompany that legislation with a mandate prescribing the pre-purchase of a mechanism for financing those items. Not only is it wholly unrealistic that Congress would require companies to give away free cars or housing (even if it could do so) simply so that it could then impose an insurance requirement on those items, but cars and houses are also products not already predominantly financed through insurance. An insurance mandate thus would not be a well-suited means to regulate payment in those markets.

one for himself. The costs in those markets are borne by the individual purchaser alone. Again, in sharp contrast, the uninsured shift substantial costs to the insured and to health care providers, because the uninsured in the aggregate consume health care services in large numbers and yet bear only a small fraction of the costs for the services they consume. The parties agree that the uninsured fail to pay for 63% of the health care services they receive, and some 37% (amounting to $43 billion) of all health care costs incurred by the uninsured are uncompensated entirely. States Br. at 30-31; Gov't Reply Br. at 8-9, 11. Congress found that this uncompensated care increases the average insured family's annual insurance premiums by $1000. 42 U.S.C. § 18091(a)(2)(F). This cost-shifting phenomenon simply does not occur in other industries.[21] Even under the majority's characterization of the regulated conduct as a "decision not to purchase health insurance," Maj. Op. at 164, deciding to self-insure in the health care market, unlike all other "financial decisions of Americans," *id.* at 115, is a decision to pay for your

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[21] Perhaps the closest analog to the individual mandate is a requirement that individuals buy other types of insurance. The district court rejected the government's contention that the failure to buy health insurance is a "financing decision" by reasoning that "this is essentially true of any and all forms of insurance." *Florida*, 2011 WL 285683, at *28; *see also* Maj. Op. at 133. But of the examples suggested by the district court—supplemental income, credit, mortgage guaranty, business interruption, or disability insurance—none insures against risks or costs that are inevitable, or that will otherwise be subsidized by those with insurance, unlike the relationship between health insurance and health care services.

care if you can afford it *or* to shift costs onto society if you can't.

In sum, the particular problems riddling the health care industry that Congress sought to address, together with the unique factors that characterize the health care market and its peculiar interconnectedness with the health insurance market, all led Congress to enact the individual mandate as an appropriate means of ameliorating two large national problems. Although these economic factors "are not precise formulations, and in the nature of things they cannot be[,] . . . [I] think they point the way to a correct decision of this case." *Lopez*, 514 U.S. at 567; *see also id. at* 579 (Kennedy, J., concurring) ("[A]s the branch whose distinctive duty it is to declare 'what the law is,' we are often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines." (citation omitted) (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803))). Upholding the mandate under the particular circumstances of this case would do little to pave the way for future congressional mandates that address wholly distinct problems that may arise in powerfully different contexts. While the individual mandate is indeed novel, I cannot accept the charge that it is a "bridge too far." The individual mandate, viewed in light of the larger economic regulatory scheme of the Act as a whole and the truly unique and interrelated nature of both markets, is a legitimate exercise of Congress' power under Art. I, § 8, cl. 3 of the Constitution and is not prone to the slippery slope of hypothetical horrors leading to an unlimited federal Commerce Clause power.

B.

Finally, implicit in the plaintiffs' Commerce Clause challenge, and providing the subtext to much of the majority's opinion, is the deeply rooted fear that the federal government is infringing upon the individual's right to be left alone—a fear that is intertwined with a visceral aversion to the government's making us do something we do not want to do (in this case, buy a product we do not wish to purchase). The plaintiffs say that Congress cannot compel unwilling individuals to engage in a private commercial transaction or otherwise pay a penalty. The difficulty, however, is in finding firm constitutional footing for the objection. The plaintiffs suggest that the claim derives, if anywhere, from either of two constitutional provisions: the Fifth Amendment's Due Process Clause or the Tenth Amendment. If derived from the Fifth Amendment, the objection, fairly stated, is that the mandate violates individual liberty, as protected by the substantive component of the Due Process Clause. In the alternative, if derived from the Tenth Amendment, the objection is that the individual mandate infringes on the powers, or rights, retained by "the people."

At the trial court, the plaintiffs squarely raised a Fifth Amendment substantive due process challenge to the individual mandate, which the district court flatly rejected. *Florida ex rel. McCollum v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1161-62 (N.D. Fla. 2010). And while the plaintiffs also challenged the individual mandate on Tenth Amendment grounds, the district court addressed this challenge only implicitly in ruling that the

mandate exceeded Congress' commerce power. *Florida*, 2011 WL 285683, at *33.

On appeal, the plaintiffs have expressly disclaimed any substantive due process challenge to the individual mandate, although they appear still to advance a Tenth Amendment challenge. Nevertheless, it is clear that individual liberty concerns lurk just beneath the surface, inflecting the plaintiffs' argument throughout, although largely dressed up in Commerce Clause and Necessary and Proper Clause terms. For example, the state plaintiffs go so far as to say that the individual mandate is "one of the Act's principal threats to individual liberty," States Br. at 16, and that upholding it would "sound the death knell for our constitutional structure and individual liberties," *id.* at 19. Similarly, the private plaintiffs claim that the individual mandate "exemplifies the threat to individual liberty when Congress exceeds its enumerated powers and attempts to wield a plenary police power." NFIB Br. at 7. Sounding almost entirely in economic substantive due process, the private plaintiffs also assert that "[a]mong the most longstanding and fundamental rights of Americans is their freedom from being forced to give their property to, or contract with, other private parties." *Id.* at 47. Thus, to the extent the plaintiffs' individual liberty-based challenge to the individual mandate derives from the Fifth and Tenth Amendments, I address each constitutional source in turn.

The Fifth Amendment provides that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law." U.S. Const. amend. V. Although the Due Process Clause has both a

procedural and a substantive component, only its substantive aspect is implicated here. "The substantive component [of the Due Process Clause] protects fundamental rights that are so implicit in the concept of ordered liberty that neither liberty nor justice would exist if they were sacrificed." *Doe v. Moore*, 410 F.3d 1337, 1342 (11th Cir. 2005) (internal quotation marks omitted). This narrow band of fundamental rights is largely protected from governmental action, regardless of the procedures employed. *Id. at* 1343. And any law, whether federal *or* state, that infringes upon these rights will undergo strict scrutiny review, which means that the law must be "narrowly tailored to serve a compelling state interest." *Id.* (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)). Today, substantive due process protects only a small class of fundamental rights, including "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, and to abortion," *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (citations omitted)—a list the Supreme Court has been "very reluctant to expand," *Moore*, 410 F.3d at 1343.

In a bygone period known as "the *Lochner* era,"[22] however, substantive due process was more broadly interpreted as also encompassing and protecting the right, liberty, or freedom of contract. *See*, *e.g.*, *Adkins v. Children's Hosp. of D.C.*, 261 U.S. 525, 545

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[22] The name refers, of course, to *Lochner v. New York*, 198 U.S. 45 (1905), where the Supreme Court struck down a New York law setting maximum hours for bakery employees on the ground that it violated the right of contract, as protected by the Fourteenth Amendment's Due Process Clause.

(1923); *Adair v. United States*, 208 U.S. 161, 174-75 (1908). Through this interpretation of the Due Process Clause, the Supreme Court struck down many federal and state laws that sought to regulate business and industrial conditions. *See*, *e.g.*, Adkins, 261 U.S. 525 (striking down a federal law fixing minimum wages for women and children in the District of Columbia); *Jay Burns Baking Co. v. Bryan*, 264 U.S. 504 (1924) (striking down a Nebraska law regulating the weight of loaves of bread for sale).

However, the Supreme Court has long since abandoned the sweeping protection of economic rights through substantive due process. *See*, *e.g.*, *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1963) ("The doctrine that prevailed in *Lochner* . . . and like cases—that due process authorizes courts to hold laws unconstitutional when they believe the legislature has acted unwisely—has long since been discarded."); *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 488 (1955) ("The day is gone when this Court uses the Due Process Clause of the Fourteenth Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought."); *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 391 (1937). Today, economic regulations are presumed constitutional, *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976), and are subject only to rational basis review, *Vesta Fire Ins. Corp. v. Florida*, 141 F.3d 1427, 1430 n.5 (11th Cir. 1998).

In substantive due process cases, binding precedent requires that we "carefully formulat[e]" the

alleged fundamental right, *Glucksberg*, 521 U.S. at 722, which must be "defined in reference to the scope of the [statute at issue]," *Williams v. Att'y Gen. of Ala.*, 378 F.3d 1232, 1241 (11th Cir. 2004). In light of the individual mandate's scope, the carefully formulated right would be the right of non-exempted individuals to refuse to maintain a minimum level of health insurance. And this right—whether cast as the freedom to contract, the right to remain uninsured, or, in the words of one commentator, the "right to force a society to pay for your medical care by taking a free ride on the system"[23] —cannot be characterized as a "fundamental" one receiving heightened protection under the Due Process Clause. The present state of our jurisprudence does not recognize any such right as a "fundamental" one, "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 [it] were sacrificed." *Williams*, 378 F.3d at 1239 (quoting Glucksberg, 521 U.S. at 720-21).

Since the individual liberty interest asserted by the plaintiffs is not a fundamental right, we are obliged to apply rational basis review, which only asks whether the mandate is rationally related to a legitimate government interest. *TRM, Inc. v. United States*, 52 F.3d 941, 945 (11th Cir. 1995). Under rational basis review, "legislation must be sustained if there is any conceivable basis for the legislature to

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[23] *See* Is the Obama Health Care Reform Constitutional? Fried, Tribe and Barnett Debate the Affordable Care Act, Harvard Law School (Mar. 28, 2011), http://www.law.harvard.edu/news/spotlight/constitutional-law/is-obama-health-care-reform-constitutional.html.

believe that the means they have selected will tend to accomplish the desired end." *Id. at* 945-46 (internal quotation marks omitted); *see also Williams v. Morgan*, 478 F.3d 1316, 1320 (11th Cir. 2007) ("A statute is constitutional under rational basis scrutiny so long as 'there is any *reasonably conceivable state of facts* that could provide a rational basis for the [statute].'" (alteration in original) (quoting *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993))).

Here, Congress rationally found that the individual mandate would address the powerful economic problems associated with cost shifting from the uninsured to the insured and to health care providers, and with the inability of millions of uninsured individuals to obtain health insurance. Thus, to the extent the plaintiffs' individual liberty concerns are rooted in the Fifth Amendment's Due Process Clause, they must fail.

The plaintiffs' more provocative argument is found in the Tenth Amendment, which provides that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X. The plaintiffs do not explicitly flesh out *how* the mandate violates the Tenth Amendment. The state plaintiffs cite the Tenth Amendment generally, claiming that "[i]f this Court were to uphold [the individual mandate and the Act's Medicaid expansion], there would remain little if any power 'reserved to the States . . . or to the people.'" States Br. at 3 (alteration in original) (quoting U.S. Const. amend. X).[24] And the private

[24] Indeed, when asked at oral argument if the Tenth Amendment had been abandoned on appeal, counsel for the

plaintiffs suggest that the portion of the amendment reserving undelegated power to the *people* provides the basis for their individual liberty claim. *See* NFIB Br. at 46 (reciting "the Tenth Amendment's admonition that the non-enumerated powers 'are reserved to the States respectively, *or to the people*.'" (quoting U.S. Const. amend. X) (emphasis in original)); *see also* Brief for Cato Institute as Amicus Curiae Supporting the Plaintiffs at 24 ("[T]he text of the Tenth Amendment protects not just state sovereignty, but also popular sovereignty.").

The Supreme Court, however, has said precious little about the tail end of the Tenth Amendment that reserves power to the people. Indeed, no case, either from the Supreme Court or from any lower federal court, has ever invoked this portion of the amendment to strike down an act of Congress. Instead, the Supreme Court's Tenth Amendment cases have grappled almost exclusively with the balance of power between the federal government and the *states*.[25]

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states reiterated that "the Tenth Amendment is still very much in this case," and that "this is both an individual rights case and a Commerce Clause enumerated rights case."

[25] In *Bond v. United States*,—U.S.—, 131 S. Ct. 2355 (2011), the Supreme Court recently held that an individual has prudential standing to "assert injury from governmental action taken in excess of the authority that federalism defines." *Id.* at 2363-64. In other words, Carol Anne Bond had standing to raise federalism-based arguments in challenging the constitutionality of the criminal statute under which she was indicted, 18 U.S.C. § 229 (which prohibits the knowing development, acquisition, possession, or use of chemical weapons). *Id.* at 2360. It remains true, however, that the Court has never used the "people" prong of the Tenth Amendment to invalidate an act of Congress.

In these cases, the Supreme Court has interpreted the Tenth Amendment's reservation of power to the states to mean that the federal government may not "commandeer[ ] the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program." *New York*, 505 U.S. at 176 (quoting *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981)); *see also Printz v. United States*, 521 U.S. 898, 935 (1997) ("The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program."). The Court has thus held that federal laws compelling state governments to enact legislation providing for the disposal of radioactive waste, *New York*, 505 U.S. at 149, and compelling state agents to conduct background checks on prospective handgun purchasers, *Printz*, 521 U.S. at 902, violate the Tenth Amendment. In so holding, the Supreme Court has explained that the limits the Tenth Amendment imposes on Congress' power come not from the amendment's text, but rather from the principle of federalism, or dual sovereignty, that the Tenth Amendment embodies. *See New York*, 505 U.S. at 156-57.

But because of the utter lack of Supreme Court (or any other court) precedent, the amendment's "people" prong provides little, if any, support here. It may be that in time the law will come to breathe practical life into the Tenth Amendment's reservation of power to the people, but that day has not yet arrived.

Setting aside the lack of *any* precedent on point, a Tenth Amendment challenge to the individual mandate fails for an additional, and critical, reason: when a federal law is properly within Congress' delegated power to enact, the Tenth Amendment poses no limit on the exercise of that power. *See*, *e.g.*, *New York*, 505 U.S. at 156 ("If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States . . . ."); *Midrash Sephardi, Inc. v. Town of Surfside*, 366 F.3d 1214, 1242 (11th Cir. 2004) ("Because [the Religious Land Use and Institutionalized Persons Act] is a proper exercise of Congress's power under § 5 of the Fourteenth Amendment, there is no violation of the Tenth Amendment."); *United States v. Williams*, 121 F.3d 615, 620 (11th Cir. 1997) ("[T]he [Child Support Recovery Act] is a valid exercise of Congress's power under the Commerce Clause, and Congress's 'valid exercise of authority delegated to it under the Constitution does not violate the Tenth Amendment.'" (quoting *Cheffer v. Reno*, 55 F.3d 1517, 1519 (11th Cir. 1995))); *N. Ala. Express, Inc. v. ICC*, 971 F.2d 661, 666 (11th Cir. 1992) ("Because the Tenth Amendment reserves only those powers not already delegated to the federal government, the Tenth Amendment has been violated only if [the federal law at issue] goes beyond the limits of Congress' power under the Commerce Clause."). Since the individual mandate falls within Congress' commerce power, its enactment is a proper exercise of a power "delegated to the United States by the Constitution." U.S. Const. amend. X. The Tenth Amendment, therefore, has no independent role to play. In short, the plaintiffs' individual liberty claims

find little support in the Constitution—whether pegged to the Fifth Amendment's Due Process Clause or to the Tenth Amendment's reservation of power to the people.

At bottom, Congress rationally concluded that the uninsured's consumption of health care services, in the aggregate, shifts enormous costs onto others and thus substantially affects interstate commerce. The individual mandate directly and unambiguously addresses this cost-shifting problem by regulating the timing and means of payment for the consumption of these services. Congress also fairly determined that the mandate is an essential part of the Act's comprehensive regulation of the health insurance market. I would, therefore, uphold the mandate as constitutional, and I respectfully dissent on this critical point.

APPENDIX A: OVERALL STRUCTURE OF ACT'S NINE TITLES

The Act's nine Titles are:

I. Quality, Affordable Health Care for All Americans

II. Role of Public Programs

III. Improving the Quality and Efficiency of Health Care

IV. Prevention of Chronic Disease and Improving Public Health

V. Health Care Workforce

VI. Transparency and Program Integrity

VII. Improving Access to Innovative Medical Therapies

VIII. Community Living Assistance Services and Supports

IX. Revenue Provisions[1]

We outline here the structure and many of the key provisions in these nine Titles.

Title I reforms the business and underwriting practices of insurance companies and overhauls their health insurance products. Title I requires that private insurers change their practices and products and offer new and better health insurance policies for consumers. Title I's hefty insurance reforms include: (1) elimination of preexisting conditions exclusions for children immediately, Act §§ 1201, 1255 (as re-

[1] There is also a tenth Title dedicated to amendments to these nine Titles. Although the amendments are actually located in Title X, we list the substance of the amendments under the Title being amended.

numbered by §§ 10103(f)), 10103(e));[2] (2) elimination of preexisting conditions for adults in 2014, §§ 1201, 1255 (as re-numbered by § 10103(f)); (3) elimination of annual and lifetime limits on benefits, §§ 1001, 10101(a); (4) required coverage for preventive services, § 1001; (5) immediate extension of dependent coverage up to age 26, § 1001; (6) imposition of a cap on insurers' administrative costs in relation to their claims-payments (the medical loss ratio), §§ 1001, 10101(f); (7) prohibition on excessive waiting periods to obtain coverage, §§ 1251, 10103(b); (8) guaranteed issue of coverage and guaranteed renewability in 2014, §§ 1201, 1255 (as re-numbered by § 10103(f)(1)); (9) prohibition on rescission except on limited grounds, § 1001; (10) prohibition of coverage denial based on health status, medical condition, claims experience, genetic information, or other health-related factors, § 1201; (11) "community-rated" premiums, § 1201; (12) prohibition of discrimination based on salary, §§ 1001, 10101(d); (13) development and utilization of uniform explanation of coverage documents and standardized definitions, § 1001; (14) coverage appeals process, §§ 1001, 10101(g); and (15) insurance offerings for persons who retire before age 65, § 1102.

In addition to requiring insurers to offer new, improved health insurance products, Title I creates new state-run marketplaces for consumers to buy those new products, accompanied by federal tax credits and subsidies. Title I establishes state-

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[2] In this Appendix, we provide citations to the sections of the Act. Our opinion's in-depth discussion of the contents of specific provisions, however, cites to the sections of the U.S. Code where each provision is now, or will be, codified.

administered Health Benefit Exchanges where both individuals and small groups can, and are encouraged to, purchase health insurance plans through non-profits and private insurers. §§ 1301–1421, 10104–10105. The Exchanges allow individuals, families, and small businesses to pool resources together and obtain premium prices competitive with those of large employer group plans. § 1311. The Exchange provisions include: (1) state flexibility to establish basic health programs for low-income individuals not eligible for Medicaid, § 1331; (2) transitional reinsurance program for sellers of insurance in the individual and small group markets in each state, § 1341; (3) establishment of a temporary risk corridor program for plans in individual and small group markets, § 1342; (4) refundable premium-assistance tax credit and reduced cost-sharing for individuals enrolled in qualified health plans, §§ 1401–02; (5) tax credits for small businesses' employee health insurance expenses, § 1421; and (6) streamlining of enrollment procedures through the Exchanges, Medicaid, CHIP, and health subsidy programs, § 1413.

Title I next addresses employers. Title I imposes penalties on certain employers if they do not offer any, or an adequate, health insurance plan to their employees. § 1513. Title I contains provisions regarding "automatic enrollment" for employees of large corporations, reporting requirements, informing employees of coverage options, and offering of Exchange-participating health plans through "cafeteria" plans. §§ 1511–1515. Miscellaneous Title I provisions include transparency in government, equity for certain eligible survivors, health information technology enrollment standards and

protocols, and prohibition against discrimination on refusal to furnish services or goods used to facilitate assisted suicide. §§ 1552, 1553, 1556, 1561.

Title I contains the individual mandate, which requires individual taxpayers either to purchase health insurance or pay a monetary penalty with their federal tax return. § 1501. Title I includes three exemptions from the mandate and five exceptions to the penalty, which together exclude many uninsured persons from the individual mandate. § 1501.

Title II shifts the Act's focus to publicly-funded programs such as Medicaid, CHIP, and initiatives under the Indian Health Care Improvement Act. As to Medicaid, Title II's provisions: (1) expand Medicaid eligibility to 133% of the federal poverty level, § 2001; (2) provide Medicaid coverage for former foster children, § 2004; (3) rescind the Medicaid Improvement Fund, § 2007; (4) permit hospitals to make presumptive eligibility determinations for all Medicaid-eligible populations, § 2202; (5) extend Medicaid coverage to freestanding birth center services and concurrent care to children, §§ 2301–02; (6) require premium assistance to Medicaid recipients for employer-sponsored coverage, § 2003; (7) provide a state eligibility option for Medicaid family planning services, § 2303; (8) create a Community First Choice Option for Medicaid, § 2401; (9) remove barriers to providing home- and community-based services through Medicaid, § 2402; (10) reauthorize Medicaid programs aimed at moving beneficiaries out of institutions and into their own homes or other community settings, § 2403; and (11) protect Medicaid recipients of home- and community-

based services against spousal impoverishment, § 2404.

As to CHIP, Title II provides enhanced federal support and funding. § 2101. The Act: (1) reauthorizes CHIP through September 2015, § 10203; and (2) from October 2015 through September 2019, increases state matching rates for CHIP by 23 percentage points, up to a 100% cap, § 2101. Title II requires states to maintain CHIP eligibility through September 2019. § 2101.

Title II also amends and extends the Indian Health Care Improvement Act ("IHCIA"). § 10221. The Act's IHCIA amendments, *inter alia*: (1) make the IHCIA's provisions permanent; (2) expand programs to address diseases, such as diabetes, that are prevalent among the Indian population; (3) provide funding and technical assistance for tribal epidemiology centers; (4) establish behavioral health initiatives, especially as to Indian youth suicide prevention; and (5) authorize long-term care and home- and community-based care for the Indian health system. § 10221; *see* S.1790, 111th Cong. (2009).

Title II's provisions also create, or expand, other new publicly-funded programs that: (1) establish a pregnancy assistance fund for pregnant and parenting teens and women, § 10212; (2) fund expansion of State Aging and Disability Resource Centers,§ 2405; (3) fund maternal, infant, and early childhood home visiting programs in order to reduce infant and maternal mortality, § 2951; (4) provide for support, education, and research for postpartum depression, § 2952; (5) support personal responsibility education, § 2953; (6) restore funding

for abstinence education, § 2954; and (7) require inclusion of information about the importance of foster-care children designating a health care power of attorney for them as part of their transition planning for aging out of either foster care or other programs, § 2955.

Title III primarily addresses Medicare. Title III establishes new Medicare programs, including: (1) a value-based purchasing program for hospitals that links Medicare payments to quality performance on common, high-cost conditions, § 3001; (2) a Center for Medicare & Medicaid Innovation to research and develop innovative payment and delivery arrangements, § 3021; (3) an Independent Payment Advisory Board to present to Congress proposals to reduce Medicare costs and improve quality, §§ 3403, 10320(b); and (4) a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care, §§ 3502, 10321. Title III revises the Medicare Part D prescription drug program and reduces the so-called "donut hole" coverage gap in that program.[3] § 3301. Title III extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas. § 3102.

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[3] The Medicare Part D "donut hole" is the gap in prescription drug coverage, where beneficiaries' prescription drug expenses exceed the initial coverage limit but do not yet reach the catastrophic coverage threshold, meaning beneficiaries must pay 100% of those prescription drug costs. *See* 42 U.S.C. § 1395w-102(b)(3)(A), (b)(4) (2009). In 2006, the donut hole extended to yearly prescription drug expenses between $2,250 and $3,600, with values for later years adjusted by an annual percentage increase. *See id.*

Other sundry Medicare provisions in Title III include: (1) quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs, § 3004; (2) permitting physician assistants to order post-hospital extended care services, § 3108; (3) exemption of certain pharmacies from accreditation requirements, § 3109; (4) payment for bone density tests, § 3111; (5) extensions of outpatient hold-harmless provisions, the Rural Community Hospital demonstration project, and the Medicare-dependent hospital program, §§ 3121, 3123–24; (6) payment adjustments for home health care, § 3131; (7) hospice reform, § 3132; (8) revision of payment for power-driven wheelchairs, § 3136; (9) payment for biosimilar biological products, § 3139; (10) an HHS study on urban Medicare-dependent hospitals, § 3142; (11) Medicare Part C benefit protection and simplification amendments, § 3202; and (12) an increase in premium amount for high-income Medicare Part D beneficiaries, § 3308. Title III also includes new federal grants for (1) improving women's health, § 3509; (2) health care delivery system research, § 3501; and (3) medication management services in treatment of chronic diseases, § 3503.

Title IV concentrates on prevention. Title IV creates the National Prevention, Health Promotion, and Public Health Council, and authorizes $15 billion for a new Prevention and Public Health Fund to support initiatives from smoking cessation to fighting obesity. §§ 4001, 4002. Title IV authorizes new publicly-funded programs for (1) an oral healthcare prevention education campaign, § 4102; (2) Medicare coverage for annual wellness visits, § 4103; and (3) the operation and development of schoolbased health

clinics, § 4101. Title IV also: (1) waives Medicare coinsurance requirements and deductibles for most preventive services, § 4104; and (2) provides states with an enhanced funds-match if the state Medicaid program covers certain clinical preventive services and adult immunizations, § 4106. Title IV further provides for: (1) Medicaid coverage of comprehensive tobacco cessation services for pregnant women, § 4107; (2) community transformation grants, § 4201; (3) nutrition labeling of standard menu items at chain restaurants, § 4205; (4) reasonable break time for nursing mothers and a place, other than a bathroom, which may be used, § 4207; (5) research on optimization of public health services delivery, § 4301; (6) CDC and employer-based wellness programs, § 4303; (7) advancing research and treatment for pain care management, § 4305; (8) epidemiology-laboratory capacity grants, § 4304; and (9) funding for childhood obesity demonstration projects, § 4306.

Title V seeks to increase the supply of health care workers through education loans, training grants, and other spending. Title V: (1) modifies the federal student loan program, § 5201; (2) increases the nursing student loan program, § 5202; and (3) establishes a loan repayment program for pediatric subspecialists, juvenile mental health providers, and public health workers who practice in underserved areas, § 5203. Title V also provides for: (1) state health care workforce development grants, § 5102; (2) a national health care workforce commission, § 5101; (3) nurse-managed health clinics, § 5208; (4) workforce diversity grants, § 5404; (5) training in general, pediatric, and public health dentistry, § 5303; (6) mental and behavioral health

education and training grants, § 5306; (7) advanced nursing education grants, § 5309; (8) grants to promote the community health workforce, § 5313; (9) spending for Federally Qualified Health Centers, § 5601; and (10) reauthorization of the Wakefield Emergency Medical Services for Children program, § 5603. Title V addresses: (1) the distribution of additional residency positions, § 5503; and (2) rules for counting resident time for didactic and scholarly activities and in non-provider settings, §§ 5504–05.

Title VI creates new transparency and anti-fraud requirements for physician-owned hospitals participating in Medicare and for nursing facilities under Medicare or Medicaid. Title VI authorizes the HHS Secretary to (1) reduce civil monetary penalties for facilities that self-report and correct deficiencies, § 6111; and (2) establish a nationwide background-check program for employees of certain long-term support and service facilities, § 6201. Title VI also provides: (1) screening of providers and suppliers participating in Medicare, Medicaid, and CHIP, § 6401; and (2) new penalties for false statements on applications or contracts to participate in a federal health care program, § 6408.

Title VI also includes the Elder Justice Act, designed to prevent and eliminate elder abuse, neglect, and exploitation. § 6703. Other Title VI provisions include: (1) dementia and abuse prevention training, § 6121; (2) patient-centered outcomes research funded by a $2 fee on accident or health insurance policies, § 6301; (3) federal coordinating counsel for comparative effectiveness research, § 6302; (4) enhanced Medicare and Medicaid program integrity provisions, § 6402;

(5) elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, § 6403; (6) reduction of maximum period for submission of Medicare claims to not more than 12 months, § 6404; (7) requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse, § 6406; (8) requirement of face-to-face encounter before physicians may certify eligibility for home health services or durable medical equipment under Medicare, § 6407; (9) prohibition on Medicaid payments to institutions or entities outside the United States, § 6505; (10) enablement of the Department of Labor to issue administrative summary cease-and-desist orders and summary seizure orders against plans in financially hazardous condition, § 6605; and (11) mandatory state use of the national correct coding initiative, § 6507.

Title VII extends and expands the drug discounts through the 340B program.[4] § 7101. Title VII establishes a process for FDA licensing of biological products shown to be biosimilar or interchangeable with a licensed biological product. § 7002.

Title VIII establishes a national voluntary long-term care insurance program for purchasing

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[4] Section 340B of the Public Health Service Act, 42 U.S.C. § 256b, establishes a program whereby HHS enters into contracts with manufacturers of certain outpatient drugs under which the manufacturers provide those drugs at discounted prices to "covered entities"— generally, certain enumerated types of federally funded health care facilities serving low-income patients. *Id.*; *see generally Univ. Med. Ctr. of S. Nev. v. Shalala*, 173 F.3d 438, 439 (D.C. Cir. 1999).

community living assistance services and support by persons with functional limitations. § 8002.

Title IX includes: (1) an excise tax on high-premium employer-sponsored health plans, § 9001; (2) an increase in taxes on distributions from individuals' health savings accounts, § 9004; (3) increases in the employee portion of the FICA hospital insurance tax for employees with wages over certain threshold amounts, § 9015; (4) an additional tax of 3.8% on investment income above certain thresholds to fund Medicare, §§ 9001, 10901; HCERA § 1402; (5) a $2,500 limitation on individuals' health flexible spending accounts under cafeteria plans, § 9005; (6) imposition of an annual fee on manufacturers and importers of branded prescription drugs, § 9008; (7) elimination of the tax deduction for expenses allocable to the Medicare Part D subsidy, § 9012; (8) a decrease in the itemized tax deduction for medical expenses, § 9013; and (9) an excise tax on indoor tanning services, § 10907. Title IX also provides for: (1) inclusion of the cost of employer-sponsored health coverage on W-2 forms, § 9002; (2) expansion of information-reporting requirements, § 9006; (3) additional requirements for hospitals to receive "charitable" designation and tax status, § 9007; (4) a study and report on the effect of the Act's new fees on drug manufacturers and insurers on veterans' health care, § 9011; (5) prohibition on health insurers' deducting employee compensation over $500,000, § 9014; (6) tax credit for companies with fewer than 250 employees that are engaged in research on qualifying therapeutic discoveries, § 9023; and (7) establishment of simple cafeteria plans for small businesses, § 9022. Title IX assesses an annual fee on health insurance companies, which

is apportioned among insurers based on a ratio designed to reflect each insurer's share of the net premiums written in the United States health care market. §§ 9010, 10905; HCERA § 1406.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.;

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

_____/

CASE NO.: 3:10-cv-91-RV/EMT

ORDER GRANTING SUMMARY JUDGMENT

On March 23, 2010, President Obama signed health care reform legislation: "The Patient Protection and Affordable Care 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) (the "Act").

This case, challenging the Constitutionality of the Act, was filed minutes after the President signed. It has been brought by the Attorneys General and/or Governors of twenty-six states (the "state

plaintiffs")[1]; two private citizens (the "individual plaintiffs"); and the National Federation of Independent Business ("NFIB") (collectively, the "plaintiffs"). The defendants are the United States Department of Health and Human Services, the Department of Treasury, the Department of Labor, and their secretaries (collectively, the "defendants"). I emphasized once before, but it bears repeating again: this case is not about whether the Act is wise or unwise legislation, or whether it will solve or exacerbate the myriad problems in our health care system. In fact, it is not really about our health care system at all. It is principally about our federalist system, and it raises very important issues regarding the Constitutional role of the federal government.

James Madison, the chief architect of our federalist system, once famously observed:

> If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself.

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[1] The states are Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

The Federalist No. 51, at 348 (N.Y. Heritage Press ed., 1945) ("*The Federalist*").[2] In establishing our government, the Founders endeavored to resolve Madison's identified "great difficulty" by creating a system of dual sovereignty under which "[t]he powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite." *The Federalist* No. 45, at 311 (Madison); *see also* U.S. Const. art. I, § 1 (setting forth the specific legislative powers "herein granted" to Congress). When the Bill of Rights was later added to the Constitution in 1791, the Tenth Amendment reaffirmed that relationship: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

The Framers believed that limiting federal power, and allowing the "residual" power to remain in the hands of the states (and of the people), would help "ensure protection of our fundamental liberties" and "reduce the risk of tyranny and abuse." *See Gregory v. Ashcroft*, 501 U.S. 452, 458, 111 S. Ct. 2395, 115 L. Ed. 2d 410 (1991) (citation omitted). Very early, the great Chief Justice John Marshall

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[2] *The Federalist* consists of 85 articles or essays written by James Madison, Alexander Hamilton, and John Jay, advocating for ratification of the Constitution. "The opinion of the Federalist has always been considered as of great authority. It is a complete commentary on our constitution; and is appealed to by all parties in the questions to which that instrument has given birth. Its intrinsic merit entitles it to this high rank." *Cohens v. Virginia*, 19 U.S. (6 Wheat) 264, 418, 5 L. Ed. 257 (1821) (Marshall, C.J.). It will be cited to, and relied on, several times throughout the course of this opinion.

noted "that those limits may not be mistaken, or forgotten, the constitution is written." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 176, 2 L. Ed. 60 (1803). Over two centuries later, this delicate balancing act continues. Rather than being the mere historic relic of a bygone era, the principle behind a central government with limited power has "never been more relevant than in this day, when accretion, if not actual accession, of power to the federal government seems not only unavoidable, but even expedient." *Brzonkala v. Virginia Polytechnic Institute*, 169 F.3d 820, 826 (4th Cir. 1999) (*en banc*), *aff'd sub nom*, *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000).[3]

To say that the federal government has limited and enumerated power does not get one far, however, for that statement is a long-recognized and well-settled truism. *McCulloch v. Maryland*, 17 U.S. (4 Wheat) 316, 405, 4 L. Ed. 579 (1819) ("This government is acknowledged by all, to be one of

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[3] In *United States v. Lopez*, 514 U.S. 549, 115 S. Ct. 1624, 131 L. Ed. 2d 626 (1995), a watershed decision that will be discussed *infra*, the Supreme Court began its analysis by referring to these limits on federal power as "first principles." In a manner of speaking, they may be said to be "last principles" as well, for the *Lopez* Court deemed them to be so important that it also ended its opinion with a full discussion of them. *See id.* at 567-68. Shortly thereafter, in *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000), which will also be discussed *infra*, the Supreme Court referred to the division of authority and limits on federal power as the "central principle of our constitutional system." *See id.* at 616 n.7. Clearly, if the modern Supreme Court regards the limits of federal power as first, central, and last principles, those principles are profoundly important — even in this day and age — and they must be treated accordingly in deciding this case.

enumerated powers. The principle, that it can exercise only the powers granted to it, . . . is now universally admitted.") (Marshall, C.J.). The ongoing challenge is deciding whether a particular federal law falls within or outside those powers. It is frequently a difficult task and the subject of heated debate and strong disagreement. As Chief Justice Marshall aptly predicted nearly 200 years ago, while everyone may agree that the federal government is one of enumerated powers, "the question respecting the extent of the powers actually granted, is perpetually arising, and will probably continue to arise, so long as our system shall exist." *Id.* This case presents such a question.

BACKGROUND

The background of this case — including a discussion of the original claims, the defenses, and an overview of the relevant law — is set out in my order dated October 14, 2010, which addressed the defendants' motion to dismiss, and it is incorporated herein. I will only discuss the background necessary to resolving the case as it has been winnowed down to the two causes of action that remain.

In Count I, all of the plaintiffs challenge the "individual mandate" set forth in Section 1501 of the Act, which, beginning in 2014 will require that everyone (with certain limited exceptions) purchase federally-approved health insurance, or pay a monetary penalty.[4] The individual mandate allegedly

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[4] I previously rejected the defendants' argument that this penalty was really a tax, and that any challenge thereto was barred by the Anti-Injunction Act. My earlier ruling on the defendants' tax argument is incorporated into this order and, significantly, has the effect of focusing the issue of the

violates the Commerce Clause, which is the provision of the Constitution Congress relied on in passing it. In Count IV, the state plaintiffs challenge the Act to the extent that it alters and amends the Medicaid program by expanding that program, *inter alia*, to: (i) include individuals under the age of 65 with incomes up to 133% of the federal poverty level, and (ii) render the states responsible for the actual provision of health services thereunder. This expansion of Medicaid allegedly violates the Spending Clause and principles of federalism protected under the Ninth and Tenth Amendments. The plaintiffs seek a declaratory judgment that the Act is unconstitutional and an injunction against its enforcement.

These two claims are now pending on cross motions for summary judgment (docs. 80, 82), which is a pre-trial vehicle through which a party shall prevail if the evidence in the record "shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56. While the parties dispute numerous facts (primarily in the context of the Medicaid count, noted *infra*), they appear to agree

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individual mandate on whether it is authorized by the Commerce Clause. To date, every court to consider this issue (even those that have ruled in favor of the federal government) have also rejected the tax and/or Anti-Injunction arguments. *See Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 2011 WL 223010, at *9-*12 (M.D. Pa. Jan. 24, 2011); *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 786-88 (E.D. Va. 2010); *Liberty Univ., Inc. v. Geithner*, — F. Supp. 2d —, 2010 WL 4860299, at *9-*11 (W.D. Va. Nov. 30, 2010); *U.S. Citizens Assoc. v. Sebelius*, — F. Supp. 2d —, 2010 WL 4947043, at *5 (N.D. Ohio Nov. 22, 2010); *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 890-91 (E.D. Mich. 2010).

that disposition of this case by summary judgment is appropriate — as the dispute ultimately comes down to, and involves, pure issues of law. Both sides have filed strong and well researched memoranda in support of their motions for summary judgment ("Mem."), responses in opposition ("Opp."), and replies ("Reply") in further support. I held a lengthy hearing and oral argument on the motions December 16, 2010 ("Tr."). In addition to this extensive briefing by the parties, numerous organizations and individuals were granted leave to, and did, file *amicus curiae* briefs (sixteen total) in support of the arguments and claims at issue.

I have carefully reviewed and considered all the foregoing materials, and now set forth my rulings on the motions and cross-motions for summary judgment. I will take up the plaintiffs' two claims in reverse order.

DISCUSSION

I. Medicaid Expansion (Count Four)

For this claim, the state plaintiffs object to the fundamental and "massive" changes in the nature and scope of the Medicaid program that the Act will bring about. They contend that the Act violates the Spending Clause [U.S. Const. art. I, § 8, cl. 1] as it significantly expands and alters the Medicaid program to such an extent they cannot afford the newly-imposed costs and burdens. They insist that they have no choice but to remain in Medicaid as amended by the Act, which will eventually require them to "run their budgets off a cliff." This is alleged to violate the Constitutional spending principles set

forth in *South Dakota v. Dole*, 483 U.S. 203, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987), and in other cases.[5]

Under *Dole*, there are four restrictions on Congress' Constitutional spending power: (1) the spending must be for the general welfare; (2) the conditions must be stated clearly and unambiguously; (3) the conditions must bear a relationship to the purpose of the program; and 4) the conditions imposed may not require states "to engage in activities that would themselves be unconstitutional." *Supra*, 483 U.S. at 207-10. In addition, a spending condition cannot be "coercive." This conceptional requirement is also from *Dole*, where the Supreme Court speculated (in dicta at the end of that opinion) that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *See id.* at 211 (citation omitted). If that line is crossed, the Spending Clause is violated.

Preliminarily, I note that in their complaint the state plaintiffs appear to have relied solely on a "coercion and commandeering" theory. Nowhere in that pleading do they allege or intimate that the Act also violates the four "general restrictions" in *Dole*, nor did they make the argument in opposition to the defendants' previous motion to dismiss. Thus, as I stated in my earlier order after describing *Dole's* four general restrictions: "The plaintiffs do not appear to dispute that the Act meets these restrictions. Rather,

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[5] The state plaintiffs alleged in their complaint that the Medicaid provisions also violated the Ninth and Tenth Amendments, but those claims have not been advanced or briefed in their summary judgment motion (except in a single passing sentence, *see* Pl. Mem. at 25).

their claim is based principally on [the coercion theory]." Apparently expanding that argument, the state plaintiffs now argue (very briefly, in less than one full page) that the Act's Medicaid provisions violate the four general restrictions. *See* Pl. Mem. at 44-45. This belated argument is unpersuasive. The Act plainly meets the first three of *Dole's* spending restrictions, and it meets the fourth as long as there is no other required activity that would be independently unconstitutional. Thus, the only real issue with respect to Count IV, as framed in the pleadings, is whether the Medicaid provisions are impermissibly coercive and effectively commandeer the states.

The gist of this claim is that because Medicaid is the single largest federal grant-in-aid program to the states, and because the states and the needy persons receiving that aid have come to depend upon it, the state plaintiffs are faced with an untenable Hobson's Choice. They must either (1) accept the Act's transformed Medicaid program with its new costs and obligations, which they cannot afford, or (2) exit the program altogether and lose the federal matching funds that are necessary and essential to provide health care coverage to their neediest citizens (along with other Medicaid-linked federal funds). Either way, they contend that their state Medicaid systems will eventually collapse, leaving millions of their neediest residents without health care. The state plaintiffs assert that they effectively have no choice other than to participate in the program.

In their voluminous materials filed in support of their motion for summary judgment, the state plaintiffs have identified some serious financial and

practical problems that they are facing under the Act, especially its costs. They present a bleak fiscal picture. At the same time, much of those facts have been disputed by the defendants in their equally voluminous filings; and also by some of the states appearing in the case as *amici curiae*, who have asserted that the Act will in the long run save money for the states. It is simply impossible to resolve this factual dispute now as both sides' financial data are based on economic assumptions, estimates, and projections many years out. In short, there are numerous genuine disputed issues of material fact with respect to this claim that cannot be resolved on summary judgment.[6] However, even looking beyond

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[6] Perhaps anticipating this, the state plaintiffs maintained in response to the defendants' filings that "the entire question of whether the States' costs might to some extent be offset by collateral savings is legally irrelevant." *See* Pl. Opp. at 29. Thus, "even if the States were projected to achieve collateral savings, those savings would in no way lessen the coercion and commandeering of which Plaintiff States complain, because they would still be required to do Congress's bidding." *Id.* at 41-42. However, it would appear from the operative complaint that the coercion claim has always been rooted in the underlying contention that the Act forces the states to expend resources that they cannot afford: "Plaintiff States cannot afford the unfunded costs of participating under the Act, but effectively have no choice other than to participate." Second Amended Complaint at ¶ 84; *see also id.* at ¶ 86 (referring to the "fiscal impact" of the Medicaid expansion and explaining that it will compel states "to assume costs they cannot afford"); *id.* at ¶ 41 (Act will "expand eligibility for enrollment beyond the State's ability to fund its participation"); *id.* at ¶ 56 (referring to the projected billions of dollars in additional costs "stemming from the Medicaid-related portions of the Act" which will "grow in succeeding years"); *id.* at ¶ 66 (referencing the "harmful effects of the Act on [the state] fiscs").

these presently impossible-to-resolve disputed issues of fact, there is simply no support for the state plaintiffs' coercion argument in existing case law.

In considering this issue at the motion to dismiss stage, I noted that state participation in the Medicaid program under the Act is — as it always has been — voluntary. This is a fundamental binary element: it either is voluntary, or it is not. While the state plaintiffs insist that their participation is involuntary, and that they cannot exit the program, the claim is contrary to the judicial findings in numerous other Medicaid cases [*see*, *e.g.*, *Wilder v. Virginia Hosp. Assoc.*, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990) (observing that "Medicaid is a cooperative federal-state program [and] participation in the program is voluntary"); *Florida Assoc. of Rehab. Facilities v. Florida Dep't of Health & Rehab. Servs*, 225 F.3d 1208, 1211 (11th Cir. 2000) ("No state is obligated to participate in the Medicaid program."); *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (Medicaid is a program from which the state "always retains [the] option" to withdraw)], and belied by numerous published news reports that several states (including certain of the plaintiffs in this case) are presently considering doing exactly that. Furthermore, two plaintiff states have acknowledged in declarations filed in support of summary judgment that they can withdraw from the program. *See* Declaration of Michael J. Willden (Director of Department of Health and Human Services, Nevada) ("Nevada can still consider opting out of Medicaid a viable option."); Declaration of Deborah K. Bowman (Secretary of Department of Social Services, South Dakota) (conceding that although it would be detrimental to its Medicaid

recipients, South Dakota could "cease participation in the Medicaid Program"). When the freedom to "opt out" of the program is viewed in light of the fact that Congress has expressly reserved the right to alter or amend the Medicaid program [*see* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.")], and has done so many times over the years, I observed in my earlier order that the plaintiffs' argument was not strong. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980) (stating that "participation in the Medicaid program is entirely optional, [but] once a State elects to participate, it must comply with the requirements").

Indeed, a survey of the legal landscape revealed that there was "very little support for the plaintiffs' coercion theory argument" as every single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim. *See*, *e.g.*, *Doe v. Nebraska*, 345 F.3d 593, 599-600 (8th Cir. 2003); *Kansas v. United States*, 214 F.3d 1196, 1201-02 (10th Cir. 2000); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981); *State of New Hampshire Dep't of Employment Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980); *but see West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 288-90 (4th Cir. 2002) (referring to a prior decision of that court, *Commonwealth of Virginia Dep't of Education v. Riley*, 106 F.3d 559 (4th Cir. 1997), where six of the thirteen judges on an en banc panel stated in dicta that a coercion claim may be viable in that court, but going on to note that due to "strong doubts" about the viability of the

coercion theory "most courts faced with the question have effectively abandoned any real effort to apply the coercion theory" after finding, in essence, that it "raises political questions that cannot be resolved by the courts").

In the absence of an Eleventh Circuit case on point, the state plaintiffs' claim was "plausible" at the motion to dismiss stage. Thus, the plaintiffs were allowed to proceed and provide evidentiary support and further legal support for a judicially manageable standard or coherent theory for determining when, in the words of the Supreme Court, a federal spending condition "pass[es] the point at which 'pressure turns into compulsion.'" *See Dole*, *supra*, 483 U.S. at 211. The evidentiary support is substantially in dispute, as already noted, and further legal support has not been forthcoming. It is now apparent that existing case law is inadequate to support the state plaintiffs' coercion claim. As the Ninth Circuit has explained in its analysis of an earlier coercion claim made by the State of Nevada:

> We can hardly fault appellant [for not providing the court with any principled definition of the word "coercion"] because our own inquiry has left us with only a series of unanswered questions. Does the relevant inquiry turn on how high a percentage of the total programmatic funds is lost when federal aid is cut-off? Or does it turn, as Nevada claims in this case, on what percentage of the federal share is withheld? Or on what percentage of the state's total income would be required to replace those funds? Or on the extent to which alternative private, state, or

> federal sources of . . . funding are available? There are other interesting and more fundamental questions. For example, should the fact that Nevada, unlike most states, fails to impose a state income tax on its residents play a part in our analysis? Or, to put the question more basically, can a sovereign state which is always free to increase its tax revenues ever be coerced by the withholding of federal funds — or is the state merely presented with hard political choices?

Nevada v. Skinner, 884 F.2d 445, 448 (9th Cir. 1989). It is not simply a matter of these being generally difficult or complex questions for courts to resolve because, as I have said, "courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court." Rather, as Justice Cardozo cautioned in what appears to have been the first case to hint at the possibility of a coercion theory claim, "to hold that motive or temptation is equivalent to coercion is to plunge the law in *endless* difficulties." *See Steward Machine Co. v. Davis*, 301 U.S. 548, 589-90, 57 S. Ct. 883, 81 L. Ed. 1279 (1937) (emphasis added); *see also*, *e.g.*, *Skinner*, *supra*, 884 F.2d at 448 ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments.").

In short, while the plaintiffs' coercion theory claim was plausible enough to survive dismissal, upon full consideration of the relevant law and the Constitutional principles involved, and in light of the

numerous disputed facts alluded to above, I must conclude that this claim cannot succeed and that the defendants are entitled to judgment as a matter of law. In so ruling, I join all courts to have considered this issue and reached the same result, even in factual situations that involved (as here) the potential withdrawal of a state's entire Medicaid grant. *See*, *e.g.*, *Schweiker*, *supra*, 655 F.2d at 414 ("The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice."); *California*, *supra*, 104 F.3d at 1086 (rejecting coercion theory argument based on the claim that while the state joined Medicaid voluntarily, it had grown to depend on federal funds and "now has no choice but to remain in the program in order to prevent a collapse of its medical system").

I appreciate the difficult situation in which the states find themselves. It is a matter of historical fact that at the time the Constitution was drafted and ratified, the Founders did not expect that the federal government would be able to provide sizeable funding to the states and, consequently, be able to exert power over the states to the extent that it currently does. To the contrary, it was expected that the federal government would have limited sources of tax and tariff revenue, and might have to be supported by the states. This reversal of roles makes any state-federal partnership somewhat precarious given the federal government's enormous economic advantage. Some have suggested that, in the interest of federalism, the Supreme Court should revisit and reconsider its Spending Clause cases. *See* Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195-96 (2001) (maintaining the "greatest threat to state autonomy is, and has long been,

Congress's spending power" and "the states will be at the mercy of Congress so long as there are no meaningful limits on its spending power"). However, unless and until that happens, the states have little recourse to remaining the very junior partner in this partnership.

Accordingly, summary judgment must be granted in favor of the defendants on Count IV.

II. Individual Mandate (Count One)

For this claim, the plaintiffs contend that the individual mandate exceeds Congress' power under the Commerce Clause. To date, three district courts have ruled on this issue on the merits. Two have held that the individual mandate is a proper exercise of the commerce power [*Liberty Univ., Inc. v. Geithner*, — F. Supp. 2d —, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010); *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010)], while the other court held that it violates the Commerce Clause. *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

At issue here, as in the other cases decided so far, is the assertion that the Commerce Clause can only reach individuals and entities engaged in an "activity"; and because the plaintiffs maintain that an individual's failure to purchase health insurance is, almost by definition, "inactivity," the individual mandate goes beyond the Commere Clause and is unconstitutional. The defendants contend that activity is not required before Congress can exercise its Commerce Clause power, but that, even if it is required, not having insurance constitutes activity. The defendants also claim that the individual

mandate is sustainable for the "second reason" that it falls within the Necessary and Proper Clause.[7]

A. Standing to Challenge the Individual Mandate

Before addressing the individual mandate, I must first take up the issue of the plaintiffs' standing to pursue this claim. I previously held on the motion to dismiss that the individual plaintiffs and NFIB had standing, but the defendants have re-raised the issue on summary judgment.[8]

One of the individual plaintiffs, Mary Brown, has filed a declaration in which she avers, among other things: (i) that she is a small business owner and member of NFIB; (ii) that she does not currently have health insurance and has not had health insurance for the past four years; (iii) that she regularly uses

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[7] The Necessary and Proper Clause is not really a separate inquiry, but rather is part and parcel of the Commerce Clause analysis as it augments that enumerated power by authorizing Congress "To make all Laws which shall be necessary and proper" to regulate interstate commerce. *See*, *e.g.*, *Gonzales v. Raich*, 545 U.S. 1, 22, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005); *see also id.* at 34-35, 39 (Scalia, J., concurring in judgment); *accord Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249 (11th Cir. 2008) (the Commerce Clause power is "the combination of the Commerce Clause per se and the Necessary and Proper Clause"). Nevertheless, I will consider the two arguments separately for ease of analysis, and because that is how the defendants have framed and presented their arguments. *See* Def. Mem. at 23 (contending that the individual mandate is an essential part of the regulatory health care reform effort, and is thus "also a valid exercise of Congress's authority if the provision is analyzed under the Necessary and Proper Clause").

[8] It was not necessary to address standing for the Medicaid challenge as the defendants did not dispute that the states could pursue that claim.

her personal funds to meet her business expenses; (iv) that she is not eligible for Medicaid or Medicare and will not be eligible in 2014; (v) that she is subject to the individual mandate and objects to being required to comply as she does not believe the cost of health insurance is a wise or acceptable use of her resources; (vi) that both she and her business will be harmed if she is required to buy health insurance that she neither wants nor needs because it will force her to divert financial resources from her other priorities, including running her business, and doing so will "threaten my ability to maintain my own, independent business"; (vii) that she would be forced to reorder her personal and business affairs because, "[w]ell in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance"; and lastly, (viii) that she "must also now investigate the impact" that compliance with the individual mandate will have on her priorities and whether she can maintain her business, or whether, instead, she will have to lay off employees, close her business, and seek employment that provides qualifying health insurance as a benefit.

The other individual plaintiff, Kaj Ahlburg, has filed a declaration in which he avers, *inter alia*: (i) that he is retired and holds no present employment; (ii) that he has not had health care insurance for the past six years; (iii) that he has no desire or intention to buy health insurance as he is currently, and expects to remain, able to pay for his and his family's own health care needs; (iv) that he is not eligible for Medicaid or Medicare and will not be eligible in 2014; (v) that he is subject to the individual mandate and he objects to being forced to comply with it as it does

not represent "a sensible or acceptable use of my financial resources" and will force him "to divert funds from other priorities which I know to be more important for myself and my family"; and (vi) that he "must now investigate" how and whether to rearrange his finances "to ensure the availability of sufficient funds" to pay for the required insurance premiums.

These declarations are adequate to support standing for the reasons set forth and discussed at length in my prior opinion, which need not be repeated here in any great detail. To establish standing to challenge a statute, a plaintiff needs to show "a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement" [*Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298, 99 S. Ct. 2301, 60 L. Ed. 2d 895 (1979)]; that is "pegged to a sufficiently fixed period of time" [*ACLU of Florida, Inc. v. Miami-Dade County School Bd.*, 557 F.3d 1177, 1194 (11th Cir. 2009)]; and which is not "merely hypothetical or conjectural" [*Florida State Conference of the NAACP v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008)]. The individual plaintiffs, Ms. Brown in particular, have established that because of the financial expense they will definitively incur under the Act in 2014, they are needing to take investigatory steps and make financial arrangements now to ensure compliance then. That is enough to show standing, as the clear majority of district courts to consider legal challenges to the individual mandate have held. *See Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 2011 WL 223010, at *4-*7 (M.D. Pa. Jan. 24, 2011); *Liberty Univ., Inc.*, *supra*, 2010 WL 4860299, at *5-*7; *U.S. Citizens Assoc.*, *supra*, 2010 WL

4947043, at *3; *Thomas More Law Center*, *supra*, 720 F. Supp. 2d 882, 887-89; *but see Baldwin v. Sebelius*, 2010 WL 3418436, at *3 (S.D. Cal. Aug. 27, 2010) (holding that plaintiff in that case lacked standing to challenge individual mandate on the grounds that by 2014 he may have secured insurance on his own). As the District Court for the Eastern District of Michigan properly noted in *Thomas More Law Center* (a case on which the defendants heavily rely because it ultimately upheld the individual mandate): "[T]he government is requiring plaintiffs to undertake an expenditure, for which the government must anticipate that significant financial planning will be required. That financial planning must take place well in advance of the actual purchase of insurance in 2014 . . . There is nothing improbable about the contention that the Individual Mandate is causing plaintiffs to feel economic pressure today." *Thomas More Law Center*, *supra*, 720 F. Supp. 2d at 889.[9]

Because the individual plaintiffs have demonstrated standing, including NFIB member Mary Brown, that means (as also discussed in my earlier order) that NFIB has associational standing as well. This leaves the question of the state plaintiffs' standing to contest the individual mandate — an issue which was not necessary to reach on the motion to dismiss, but which the plaintiffs request that I address now.

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[9] I note that *Thomas More Law Center* is on appeal to the Sixth Circuit, and in their recently-filed appellate brief the Department of Justice has expressly declined to challenge the district court's conclusion that the plaintiffs had standing.

The state plaintiffs have raised several different grounds for standing. One of those grounds is that some of the states have passed legislation seeking to protect their citizens from forced compliance with the individual mandate. For example, on March 17, 2010, before the Act passed into law, plaintiff Idaho enacted the Idaho Health Freedom Act, which provides in pertinent part:

> (1) The power to require or regulate a person's choice in the mode of securing health care services, or to impose a penalty related thereto, is not found in the Constitution of the United States of America, and is therefore a power reserved to the people pursuant to the Ninth Amendment, and to the several states pursuant to the Tenth Amendment. The state of Idaho hereby exercises its sovereign power to declare the public policy of the state of Idaho regarding the right of all persons residing in the state of Idaho in choosing the mode of securing health care services free from the imposition of penalties, or the threat thereof, by the federal government of the United States of America relating thereto.
>
> (2) It is hereby declared that . . . every person within the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty by the federal government of the United States of America.

I.C. § 39-9003 (2010).

Similarly, on March 22, 2010, also before the Act became law, Utah passed legislation declaring that

the then-pending federal government proposals for health care reform "infringe on state powers" and "infringe on the rights of citizens of this state to provide for their own health care" by "requiring a person to enroll in a third party payment system" and "imposing fines on a person who chooses to pay directly for health care rather than use a third party payer." *See generally* U.C.A. 1953 § 63M-1-2505.5.

Judge Henry Hudson considered similar legislation in one of the two Virginia cases. After engaging in a lengthy analysis and full discussion of the applicable law [*see generally Virginia v. Sebelius*, 702 F. Supp. 2d 598, 602-07 (E.D. Va. 2010)], he concluded that despite the statute's declaratory nature, the Commonwealth had adequate standing to bring the suit insofar as "[t]he mere existence of the lawfully-enacted statue is sufficient to trigger the duty of the Attorney General of Virginia to defend the law and the associated sovereign power to enact it." *See id.* at 605-06. I agree with Judge Hudson's thoughtful analysis of the issue and adopt it here. The States of Idaho and Utah, through plaintiff Attorneys General Lawrence G. Wasden and Mark L. Shurtleff, have standing to prosecute this case based on statutes duly passed by their legislatures, and signed into law by their Governors.[10]

In sum, the two individual plaintiffs (Brown and Ahlburg), the association (NFIB), and at least two of the states (Idaho and Utah) have standing to challenge the individual mandate. This eliminates

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[10] I note that several other plaintiff states passed similar laws after the Act became law and during the pendency of this litigation. Other states have similar laws still pending in their state legislatures.

the need to discuss the standing issue with respect to the other state plaintiffs, or the other asserted bases for standing. *See Watt v. Energy Action Educ. Found.*, 454 U.S. 151, 160, 102 S. Ct. 205, 70 L. Ed. 2d 309 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Village of Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252, 264 n.9, 97 S. Ct. 555, 50 L. Ed. 2d 450 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain this suit."); *see also Mountain States Legal Foundation v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) (if standing is shown for at least one plaintiff with respect to each claim, "we need not consider the standing of the other plaintiffs to raise that claim").

Having reaffirmed that the plaintiffs have adequate standing to challenge the individual mandate, I will consider whether that provision is an appropriate exercise of power under the Commerce Clause, and, if not, whether it is sustainable under the Necessary and Proper Clause. The Constitutionality of the individual mandate is the crux of this entire case.

B. Analysis

(1) The Commerce Clause

The current state of Commerce Clause law has been summarized and defined by the Supreme Court on several occasions:

> [W]e have identified three broad categories of activity that Congress may regulate under its commerce power. First, Congress may regulate the use of the channels of interstate

> commerce. Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities. Finally, Congress' commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce, i.e., those activities that substantially affect interstate commerce.

United States v. Lopez, 514 U.S. 549, 558-59, 115 S. Ct. 1624, 131 L. Ed. 2d 626 (1995) (citations omitted); *accord United States v. Morrison*, 529 U.S. 598, 608-09, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000); *see also Hodel v. Virginia Surface Min. & Reclamation Assoc., Inc.*, 452 U.S. 264, 276-77, 101 S. Ct. 2352, 69 L. Ed. 2d 1 (1981); *Perez v. United States*, 402 U.S. 146, 150, 91 S. Ct. 1357, 28 L. Ed. 2d 686 (1971). It is thus well settled that Congress has the authority under the Commerce Clause to regulate three — and only three — "categories of activity." *Lopez*, *supra*, 514 U.S. at 558; *see also*, *e.g.*, *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249-51 (11th Cir. 2008) (discussing in detail the "three categories of activities" that Congress can regulate); *United States v. Maxwell*, 446 F.3d 1210, 1212 (11th Cir. 2006) (noting that, "to date," Congress can regulate only "three categories of activities"). The third category is the one at issue in this case.

As will be seen, the "substantially affects" category is the most frequently disputed and "most hotly contested facet of the commerce power." *Garcia*, *supra*, 540 F.3d at 1250. This is because, while under

the first two categories Congress may regulate and protect actual interstate commerce,

> the third allows Congress to regulate intrastate noncommercial activity, based on its effects. Consideration of effects necessarily involves matters of degree [and] thus poses not two hazards, like Scylla and Charybdis, but three. If we entertain too expansive an understanding of effects, the Constitution's enumeration of powers becomes meaningless and federal power becomes effectively limitless. If we entertain too narrow an understanding, Congress is stripped of its enumerated power, reinforced by the Necessary and Proper Clause, to protect and control commerce among the several states. If we employ too nebulous a standard, we exacerbate the risk that judges will substitute their own subjective or political calculus for that of the elected representatives of the people, or will appear to be doing so.

United States v. Patton, 451 F.3d 615, 622-23 (10th Cir. 2006). Before attempting to navigate among these three "hazards," a full review of the historical roots of the commerce power, and a discussion of how we got to where we are today, may be instructive.

(a) The Commerce Clause in its Historical Context

Chief Justice Marshall wrote in 1824, in the first ever Commerce Clause case to reach the Supreme Court:

> As men, whose intentions require no concealment, generally employ the words which most directly and aptly express the

> ideas they intend to convey, the enlightened patriots who framed our constitution, and the people who adopted it, must be understood to have employed words in their natural sense, and to have intended what they have said.

Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 188, 6 L. Ed. 23 (1824). Justice Marshall continued his opinion by noting that if, "from the imperfection of human language," there are doubts as to the extent of any power authorized under the Constitution, the underlying object or purpose for which that power was granted "should have great influence in the construction." *Id.* at 188-89. In other words, in determining the full extent of any granted power, it may be helpful to not only focus on *what* the Constitution says (i.e., the actual language used), but also *why* it says what it says (i.e., the problem or issue it was designed to address). Both will be discussed in turn.

The Commerce Clause is a mere sixteen words long, and it provides that Congress shall have the power:

> To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.

U.S. Const. art I, § 8, cl. 3. For purposes of this case, only seven words are relevant: "To regulate Commerce . . . among the several States." There is considerable historical evidence that in the early years of the Union, the word "commerce" was understood to encompass trade, and the intercourse, traffic, or exchange of goods; in short, "the activities of buying and selling that come after production and before the goods come to rest." Robert H. Bork &

Daniel E. Troy, *Locating the Boundaries: The Scope of Congress's Power to Regulate Commerce*, 25 Harv. J. L. & Pub. Pol'y 849, 861-62 (2002) ("Bork & Troy") (citing, *inter alia*, dictionaries from that time which defined commerce as "exchange of one thing for another"). In a frequently cited law review article, one Constitutional scholar has painstakingly tallied each appearance of the word "commerce" in Madison's notes on the Constitutional Convention and in *The Federalist*, and discovered that in none of the ninety-seven appearances of that term is it ever used to refer unambiguously to activity beyond trade or exchange. *See* Randy E. Barnett, *The Original Meaning of the Commerce Clause*, 68 U. Chi. L. Rev. 101, 114-16 (2001) ("Barnett"); *see also id.* at 116 (further examining each and every use of the word that appeared in the state ratification convention reports and finding "the term was uniformly used to refer to trade or exchange"). Even a Constitutional scholar who has argued for an expansive interpretation of the Commerce Clause (and, in fact, has been cited to, and relied on, by the defendants in this case) has acknowledged that when the Constitution was drafted and ratified, commerce "was the practical equivalent of the word 'trade.'" *See* Robert L. Stern, *That Commerce Which Concerns More States than One*, 47 Harv. L. Rev. 1335, 1346 (1934) ("Stern").

The Supreme Court's first description of commerce (and still the most widely accepted) is from *Gibbons v. Ogden*, *supra*, which involved a New York law that sought to limit the navigable waters within the jurisdiction of that state. In holding that "commerce" comprehended navigation, and thus it fell within the reach of the Commerce Clause, Chief

Justice Marshall explained that "Commerce, undoubtedly, is traffic, but it is something more: it is intercourse. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and is regulated by prescribing rules for carrying on that intercourse." 22 U.S. at 72. This definition is consistent with accepted dictionary definitions of the Founders' time. *See* 1 Samuel Johnson, *A Dictionary of the English Language* (4th ed. 1773) (commerce defined as "Intercourse; exchange of one thing for another; interchange of any thing; trade; traffick"). And it remained a good definition of the Supreme Court's Commerce Clause interpretation throughout the Nineteenth Century. *See*, *e.g.*, *Kidd v. Pearson*, 128 U.S. 1, 20-21, 9 S. Ct. 6, 32 L. Ed. 346 (1888) ("The legal definition of the term [commerce] . . . consists in intercourse and traffic, including in these terms navigation and the transportation and transit of persons and property, as well as the purchase, sale, and exchange of commodities"). As Alexander Hamilton intimated in *The Federalist*, however, it did not at that time encompass manufacturing or agriculture. *See The Federalist* No. 34, at 212-13 (noting that the "encouragement of agriculture and manufactures" was to remain an object of state expenditure). This interpretation of commerce as being primarily concerned with the commercial intercourse associated with the trade or exchange of goods and commodities is consistent with the original purpose of the Commerce Clause (discussed immediately below), which is entitled to "great influence in [its]

construction." *See Gibbons*, *supra*, 22 U.S. at 188-89.[11]

There is no doubt historically that the primary purpose behind the Commerce Clause was to give Congress power to regulate commerce so that it could eliminate the trade restrictions and barriers by and between the states that had existed under the Articles of Confederation. Such obstructions to commerce were destructive to the Union and believed to be precursors to war. The Supreme Court has explained this rationale:

> When victory relieved the Colonies from the pressure for solidarity that war had exerted,

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[11] As an historical aside, I note that pursuant to this original understanding and interpretation of "commerce," insurance contracts did not qualify because "[i]ssuing a policy of insurance is not a transaction of commerce." *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183, 19 L. Ed. 357 (1868) (further explaining that insurance contracts "are not articles of commerce in any proper meaning of the word" as they are not objects "of trade and barter," nor are they "commodities to be shipped or forwarded from one State to another, and then put up for sale"). That changed in 1944, when the Supreme Court held that Congress could regulate the insurance business under the Commerce Clause. *United States v. South-Eastern Underwriters Assoc.*, 322 U.S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440 (1944). "Concerned that [this] decision might undermine state efforts to regulate insurance, Congress in 1945 enacted the McCarran-Ferguson Act. Section 1 of the Act provides that 'continued regulation and taxation by the several States of the business of insurance is in the public interest,' and that 'silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.'" *Humana Inc. v. Forsyth*, 525 U.S. 299, 306, 119 S. Ct. 710, 142 L. Ed.2d 753 (1999) (quoting 15 U.S.C. § 1011). Thus, ever since passage of the McCarran-Ferguson Act, the insurance business has continued to be regulated almost exclusively by the states.

a drift toward anarchy and commercial warfare between states began . . . [E]ach state would legislate according to its estimate of its own interests, the importance of its own products, and the local advantages or disadvantages of its position in a political or commercial view. This came to threaten at once the peace and safety of the Union. The sole purpose for which Virginia initiated the movement which ultimately produced the Constitution was to take into consideration the trade of the United States; to examine the relative situations and trade of the said states; to consider how far a uniform system in their commercial regulation may be necessary to their common interest and their permanent harmony and for that purpose the General Assembly of Virginia in January of 1786 named commissioners and proposed their meeting with those from other states.

The desire of the Forefathers to federalize regulation of foreign and interstate commerce stands in sharp contrast to their jealous preservation of power over their internal affairs. No other federal power was so universally assumed to be necessary, no other state power was so readily relin[q]uished. There was no desire to authorize federal interference with social conditions or legal institutions of the states. Even the Bill of Rights amendments were framed only as a limitation upon the powers of Congress. The states were quite content with their several and diverse controls over most matters but, as Madison has indicated, "want of a general

> power over Commerce led to an exercise of this power separately, by the States, which not only proved abortive, but engendered rival, conflicting and angry regulations."

H.P. Hood & Sons, Inc. v. Du Mond, 336 U.S. 525, 533-34, 69 S. Ct. 657, 93 L. Ed. 865 (1949) (citations and quotations omitted). The foregoing is a frequently repeated history lesson from the Supreme Court. In his concurring opinion in the landmark 1824 case of *Gibbons v. Ogden*, *supra*, for example, Justice Johnson provided a similar historical summary:

> For a century the States [as British colonies] had submitted, with murmurs, to the commercial restrictions imposed by the parent State; and now, finding themselves in the unlimited possession of those powers over their own commerce, which they had so long been deprived of, and so earnestly coveted, that selfish principle which, well controlled, is so salutary, and which, unrestricted, is so unjust and tyrannical, guided by inexperience and jealousy, began to show itself in iniquitous laws and impolitic measures, from which grew up a conflict of commercial regulations, destructive to the harmony of the States, and fatal to their commercial interests abroad.
>
> This was the immediate cause, that led to the forming of a convention.

Gibbons, *supra*, 22 U.S. at 224. In the Supreme Court's 1888 decision in *Kidd v. Pearson*, Justice Lamar noted that "it is a matter of public history that the object of vesting in congress the power to regulate

commerce . . . among the several states was to insure uniformity for regulation against conflicting and discriminatory state legislation." *See Kidd*, *supra*, 128 U.S. at 21. More recently, Justice Stevens has advised that when "construing the scope of the power granted to Congress by the Commerce Clause . . . [i]t is important to remember that this clause was the Framers' response to the central problem that gave rise to the Constitution itself," that is, the Founders had "'set out only to find a way to reduce trade restrictions.'" *See EEOC v. Wyoming*, 460 U.S. 226, 244-45, 103 S. Ct. 1054, 75 L. Ed. 2d 18 (1983) (Stevens, J., concurring). The foregoing history is so "widely shared," [*see id.* at 245 n.1], that Constitutional scholars with opposing views on the Commerce Clause readily agree on this point. *Compare* Stern, *supra*, at 1344 ("There can be no question, of course, that in 1787 [when] the framers and ratifiers of the Constitution . . . considered the need for regulating 'commerce with foreign nations and among the several states,' they were thinking only in terms of . . . the removal of barriers obstructing the physical movements of goods across state lines."), *with* Bork & Troy, *supra*, at 858, 865 ("One thing is certain: the Founders turned to a federal commerce power to carve stability out of this commercial anarchy" and "keep the States from treating one another as hostile foreign powers"; in short, "the Clause was drafted to grant Congress the power to craft a coherent national trade policy, to restore and maintain viable trade among the states, and to prevent interstate war."). Hamilton and Madison both shared this concern that conflicting and discriminatory state trade legislation "would naturally lead to outrages, and these to reprisals and

wars." *The Federalist* No. 7, at 37 (Hamilton); *see also The Federalist* No. 42, at 282 (Madison) (referencing the "unceasing animosities" and "serious interruptions of the public tranquility" that would inevitably flow from the lack of national commerce power).

To acknowledge the foregoing historical facts is not necessarily to say that the power under the Commerce Clause was intended to (and must) remain limited to the trade or exchange of goods, and be confined to the task of eliminating trade barriers erected by and between the states.[12] The drafters of the Constitution were aware that they were preparing an instrument for the ages, not one suited only for the exigencies of that particular time. *See*, *e.g.*, *McCulloch*, *supra*, 17 U.S. at 415 (the Constitution was "intended to endure for ages to come" and "to be adapted to the various crises of human affairs") (Marshall, C.J.); *Weems v. United States*, 217 U.S. 349, 373, 30 S. Ct. 544, 54 L. Ed. 793 (1910) (explaining that constitutions "are not ephemeral enactments, designed to meet passing occasions," but rather are "designed to approach immortality as nearly as human institutions can

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[12] Although there is some evidence that is exactly what Madison, at least, had intended. In one of his letters, he wrote that the Commerce Clause "'grew out of the abuse of the power by the importing States in taxing the non-importing, and was intended as a negative and preventive provision against injustice among the States themselves, rather than as a power to be used for the positive purposes of the General Government.'" *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 193 n.9, 114 S. Ct. 2205, 129 L. Ed. 2d 157 (1994) (quoting 3 M. Farrand, Records of the Federal Convention of 1787, p. 478 (1911)).

approach it . . . [and], therefore, our contemplation cannot be only of what has been, but of what may be"); *accord New York v. United States*, 505 U.S. 144, 157, 112 S. Ct. 2408, 120 L. Ed. 2d 120 (1992) (the Constitution was "phrased in language broad enough to allow for the expansion" of federal power and allow "enormous changes in the nature of government"). As Hamilton explained:

> Constitutions of civil government are not to be framed upon a calculation of existing exigencies, but upon a combination of these with the probable exigencies of ages, according to the natural and tried course of human affairs. Nothing, therefore, can be more fallacious than to infer the extent of any power, proper to be lodged in the national government, from an estimate of its immediate necessities. There ought to be a *capacity* to provide for future contingencies as they may happen; and as these are illimitable in their nature, it is impossible safely to limit that capacity.

The Federalist No. 34, at 210-11 (emphasis in original).

Thus, the exercise and interpretation of the commerce power has evolved and undergone a significant change "as the needs of a dynamic and constantly expanding national economy have changed." *See EEOC*, *supra*, 460 U.S. at 246 (Stevens, J., concurring). But, I will begin at the beginning.

(b) Evolution of Commerce Clause Jurisprudence

Some have maintained that the Commerce Clause power began as, and was intended to remain, a narrow and limited one. *See*, *e.g.*, Raoul Berger, *Federalism: The Founders Design* (1987) (arguing that the founders sought to create a limited federal government whose power, including the commerce power, was narrow in scope); Barnett, *supra*, at 146 (concluding that "the most persuasive evidence of original meaning . . . strongly supports [the] narrow interpretation of Congress's power [under the Commerce Clause]"). Despite evidence to support this position, it is difficult to prove decisively because for the first century of our history the Clause was seldom invoked by Congress (if at all), and then only negatively to prevent the interference with commerce by individual states. This necessarily means that there is a lack of early congressional and judicial pronouncements on the subject. This, in turn, makes it harder to conclusively determine how far the commerce power was originally intended to reach. It was not until 1824 (more than three decades after ratification) that the Supreme Court was first called upon in *Gibbons v. Ogden* to consider the commerce power. By that time, it would appear that the Clause was given a rather expansive treatment by Chief Justice Marshall, who wrote:

> [The commerce power] is the power to regulate; that is, to prescribe the rule by which commerce is to be governed. This power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution . . . If, as has always been understood, the sovereignty of Congress,

> though limited to specified objects, is plenary as to those objects, the power over commerce with foreign nations, and among the several States, is vested in Congress as absolutely as it would be in a single government, having in its constitution the same restrictions on the exercise of the power as are found in the constitution of the United States. The wisdom and the discretion of Congress, their identity with the people, and the influence which their constituents possess at elections, are, in this, as in many other instances . . . the sole restraints on which they have relied, to secure them from its abuse.

Gibbons, *supra*, 22 U.S. at 75. Notwithstanding this seemingly broad interpretation of Congress' power to negate New York's assertion of authority over its navigable waters, it was not until 1887, one hundred years after ratification, that Congress first exercised its power to affirmatively and positively regulate commerce among the states. And when it did, the Supreme Court at that time rejected the broad conception of commerce and the power of Congress to regulate the economy was sharply restricted. *See*, *e.g.*, *Kidd v. Pearson*, *supra* (1888). Thus, for most of the first century and a half of Constitutional government (with the possible exception of *Gibbons v. Ogden* in 1824), the Clause was narrowly construed and given "miserly construction." *See EEOC*, *supra*, 460 U.S. at 246 (Stevens, J., concurring) (citing *Kidd*, *supra*, 128 U.S. at 20-21 (manufacturing not subject to the commerce power of Congress); *United States v. E.C. Knight Co.*, 156 U.S. 1, 12-16, 15 S. Ct. 249, 39 L. Ed. 325 (1895) (manufacturing monopoly not subject to commerce power); *Adair v. United States*,

208 U.S. 161, 178-179, 28 S. Ct. 277, 52 L. Ed. 436 (1908) (connection between interstate commerce and membership in a labor union insufficient to authorize Congress to make it a crime for an interstate carrier to fire employee for his union membership); *Hammer v. Dagenhart*, 247 U.S. 251, 276, 38 S. Ct. 529, 62 L. Ed. 1101 (1918) (Congress without power to prohibit the interstate transportation of goods produced with child labor); *Carter v. Carter Coal Co.*, 298 U.S. 238, 298, 308-10, 56 S. Ct. 855, 80 L. Ed. 1160 (1936) (holding that commerce power does not extend to the regulation of wages, hours, and working conditions of coal miners; defining commerce — consistent with the original understanding of the term — as "the equivalent of the phrase 'intercourse for the purposes of trade'")).

For example, in *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 55 S. Ct. 837, 79 L. Ed. 1570 (1935), a case well known to first year law students, the Court invalidated regulations fixing employee hours and wages in an intrastate business because the activity being regulated only related to interstate commerce "indirectly." The Supreme Court characterized the distinction between "direct" and "indirect" effects on interstate commerce as "a fundamental one, essential to the maintenance of our constitutional system," for without it "there would be virtually no limit to the federal power and for all practical purposes we should have a completely centralized government." *Id.* at 548.

But, everything changed in 1937, beginning with the first of three significant New Deal cases. In *N.L.R.B. v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 S. Ct. 615, 81 L. Ed. 893 (1937), the Supreme

Court, after recognizing the well known principle "that acts which directly burden or obstruct interstate or foreign commerce, or its free flow, are within the reach of the congressional power" [*see id.* at 31], held for the first time that Congress could also regulate purely intrastate activities that could be said to have a "substantial effect" on interstate commerce. "Although activities may be intrastate in character when separately considered, if they have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions, Congress cannot be denied the power to exercise that control." *Id.* at 37. The question was now "the *effect* upon interstate commerce of the [intrastate activity] involved." *Id.* at 40 (emphasis added).

Four years later, in *United States v. Darby*, 312 U.S. 100, 61 S. Ct. 451, 85 L. Ed. 609 (1941), the Supreme Court overruled *Hammer v. Dagenhart*, *supra*. In upholding the wage and hour requirements in the Fair Labor Standards Act, and its suppression of substandard labor conditions, the Court reaffirmed that with respect to intrastate "transactions" and "activities" having a substantial effect on interstate commerce, Congress may regulate them without doing violence to the Constitution. *See id.* at 118-23.

And then came *Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82, 87 L. Ed. 122 (1942), which, until recently, was widely considered the most far-reaching expansion of Commerce Clause regulatory authority over intrastate activity. At issue in *Wickard* were amendments to the Agricultural Adjustment Act of 1938 that set acreage allotments for wheat farmers in

an effort to control supply and avoid surpluses that could result in abnormally low wheat prices. The plaintiff in that case, Roscoe Filburn, owned a small farm on which he raised and harvested wheat, among other things. When he exceeded his allotment by 12 acres (which yielded 239 bushels of wheat), he was penalized under the statute. Although the intended disposition of the crop involved in the case was not "expressly stated," [*id.* at 114], the Supreme Court assumed and analyzed the issue as though the excess wheat was "not intended in any part for commerce but wholly for consumption on the farm." *See id.* at 118. Even though production of such wheat "may not be regarded as commerce" in the strictest sense of the word, [*see id.* at 125], consumption on the farm satisfied needs that would (theoretically, at least) be otherwise filled by another purchase or commercial transaction. *See id.* at 128 (explaining that homegrown wheat "supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market [and] in this sense competes with wheat in commerce"). In holding that Congress had power under the Commerce Clause to regulate production intended for personal consumption, the Supreme Court stated:

> [E]ven if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce and this irrespective of whether such effect is what might at some earlier time have been defined as "direct" or "indirect."
>
> * * *

> That appellee's own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial.

Id. at 125, 127-28. The latter statement is commonly known and described as the "aggregation principle." It allows Congress under the Commerce Clause to reach a "class of activities" that have a substantial impact on interstate commerce when those activities are aggregated with all similar and related activities — even though the activities within the class may be themselves trivial and insignificant. *See*, *e.g.*, *Maryland v. Wirtz*, 392 U.S. 183, 192-93, 196 n.27, 88 S. Ct. 2017, 20 L. Ed. 2d 1020 (1968) (any claim that reviewing courts have the power to excise, as trivial, individual activity within a broader class of activities "has been put entirely to rest" as the "de minimis character of individual instances arising under [the] statute is of no consequence"). To illustrate this principle, as applied in *Wickard*, even though Filburn's 239 bushels were presumably for his own consumption and seed, and did not significantly impact interstate commerce, if every farmer in the country did the same thing, the aggregate impact on commerce would be cumulatively substantial.

Together, *Jones & Laughlin Steel*, *Darby*, and *Wickard* either "ushered in" a new era of Commerce Clause jurisprudence "that greatly expanded the previously defined authority of Congress under that Clause" [*Lopez*, *supra*, 514 U.S. at 556], or they merely "restored" the "broader view of the Commerce

Clause announced by Chief Justice Marshall." *Perez*, *supra*, 402 U.S. at 151. Regardless of whether the cases represented a new era or simply a restoration of the old, it seemed that from that point forward congressional action under the Commerce Clause was to be given virtually insurmountable deference. *See* Kenneth Klukowski, *Citizen Gun Rights: Incorporating the Second Amendment Through the Privileges or Immunities Clause*, 39 N.M. L. Rev. 195, 232-33 (2009) (noting that in these New Deal cases "the Court read the Commerce Clause so broadly that it is a bold statement to say that the provision even nominally constrained federal action"). And, indeed, from the New Deal period through the next five decades, not a single federal legislative enactment was struck down as exceeding Congress' power under the Commerce Clause power — until *Lopez* in 1995.

In *United States v. Lopez* the Supreme Court considered the Constitutionality of the Gun Free School Zones Act of 1990, which criminalized the possession of a firearm in a school zone. In holding that the statute exceeded Congress' authority under the Commerce Clause, the Supreme Court began by recognizing the "first principles" behind the limitations on federal power as set forth in the Constitution. *See supra*, 514 U.S. at 552. Then, after detailing the history and transformation of Commerce Clause jurisprudence — from *Gibbons*, to *A.L.A. Schechter Poultry*, and up through *Wickard* — the Court observed that even in cases which had interpreted the Commerce Clause more expansively, every decision to date had recognized that the power granted by the Clause is necessarily "subject to outer limits" which, if not recognized and respected, could

lead to federal action that would "effectually obliterate the distinction between what is national and what is local and create a completely centralized government." *See generally id.* at 553-57. Consistent with those limits, the *Lopez* Court stated "we have identified three broad categories of *activity* that Congress may regulate under its commerce power." *See id.* at 558 (emphasis added). The "substantially affects" category was the one at issue there, and in holding that the statute did not pass muster thereunder, the Supreme Court focused on four considerations: (i) the activity being regulated (guns near schools) was not economic in nature; (ii) the statute did not contain jurisdictionally limiting language; (iii) Congress did not make any formal findings concerning the effect of the regulated activity on commerce; and (iv) the connection between that activity and its effect on commerce was attenuated. *See generally id.* at 559-67.

As for the fourth consideration, the Court impliedly conceded the claims by the government and the dissent that: (1) gun-related violence is a serious national problem with substantial costs that are spread throughout the population; (2) such violence has adverse effects on classroom learning (which can result in decreased productivity) and discourages traveling into areas felt to be unsafe; all of which, in turn, (3) represents a substantial threat to interstate commerce. The *Lopez* majority made a point to "pause to consider the implications" of such arguments, however. *See id.* at 563-65. It found that if such theories were sufficient to justify regulation under the Commerce clause (even though their underlying logic and truth were not questioned), "it is difficult to perceive any limitation on federal power"

and "we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *See id.* at 564. To accept such arguments and uphold the statute, the majority concluded, would require the Court:

> . . . to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States. Admittedly, some of our prior cases have taken long steps down that road, giving great deference to congressional action. The broad language in these opinions has suggested the possibility of additional expansion, but we decline here to proceed any further. To do so would require us to conclude that the Constitution's enumeration of powers does not presuppose something not enumerated, and that there never will be a distinction between what is truly national and what is truly local. This we are unwilling to do.

Id. at 567-68; *see also id.* at 578, 580 (explaining that it is the Court's duty to "recognize meaningful limits on the commerce power" and intervene if Congress "has tipped the scales too far" as federal balance "is too essential a part of our constitutional structure and plays too vital a role in securing freedom") (Kennedy, J., concurring) .

The next significant Commerce Clause case to be decided by the Supreme Court was the 2000 case of *United States v. Morrison*, *supra*, 529 U.S. at 598, which involved a challenge to the Violence Against Women Act of 1994. The government argued in that

case — similar to what it did in *Lopez* — that Congress could regulate gender-motivated violence based on a syllogistic theory that victims of such violence are deterred from traveling and engaging in interstate business or employment; they are thus less productive (and incur increased medical and other costs); all of which, in turn, substantially affects interstate commerce. *See id.* at 615. The Court began its analysis by recognizing the foundational principle that the power of the federal government is "defined and limited" and therefore: "Every law enacted by Congress must be based on one or more of its powers enumerated in the Constitution." *See id.* at 607. It emphasized that while the legal analysis of the Commerce Clause "has changed as our Nation has developed," which has resulted in Congress having "considerably greater latitude in regulating conduct and transactions under the Commerce Clause than our previous case law permitted," authority under the Clause "is not without effective bounds." *See id.* at 607-08. The Court then looked to the four "significant considerations" that were identified in *Lopez* and found that, "[w]ith these principles underlying our Commerce Clause jurisprudence as reference points, the proper resolution of the present cases is clear." *See id.* at 610-13. First, the statute at issue in *Morrison* did not regulate economic activity:

> Gender-motivated crimes of violence are not, in any sense of the phrase, economic activity. While we need not adopt a categorical rule against aggregating the effects of any noneconomic activity in order to decide these cases, thus far in our Nation's history our cases have upheld Commerce Clause

> regulation of intrastate activity only where that activity is economic in nature.

Id. at 613. Further, the statute did not contain jurisdictionally limiting language; and while it was supported, in contrast to *Lopez*, with numerous congressional findings regarding the personal, familial, and economic impact of gender-motivated violence, those findings were insufficient to sustain the legislation as they relied on the same "method of reasoning that we have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Id.* at 615. In other words, it would require the Court "to pile inference upon inference," and, in the process, run the risk of "completely obliterat[ing] the Constitution's distinction between national and local authority." *See id.*

In light of the circumscriptial rulings in *Lopez* and *Morrison*, many were surprised by the Supreme Court's subsequent decision in *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005), which was not only seen as a return to the more expansive Commerce Clause jurisprudence [*see*, *e.g.*, Matthew Farley, *Challenging Supremacy: Virginia's Response to the Patient Protection and Affordable Care Act*, 45 U. Rich. L. Rev. 37, 65 (2010)], but was, in fact, viewed by some as even going beyond and "displacing" *Wickard* as the most far-reaching of all Commerce Clause cases. *See* Douglas W. Kmiec, *Gonzales v. Raich: Wickard v. Filburn Displaced*, 2005 Cato Sup. Ct. Rev. 71 (2005).

At issue in *Raich* was whether Congress had authority under the Commerce and Necessary and Proper Clauses to prohibit, via the Controlled

Substances Act, "the local cultivation and use of marijuana in compliance with California law." *See Raich*, *supra*, 545 U.S. at 5. The marijuana at issue, which was being used by two seriously ill women for medicinal purposes pursuant to state law, had been neither bought nor sold and never crossed state lines. It was, and is, illegal in most states, and does not have a legal free market in interstate commerce, the normal attribute of any economic analysis. Nevertheless, the Supreme Court began its analysis by stating: "Our case law firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Id.* at 17. The Court found *Wickard* to be "striking" in similarity and "of particular relevance" to the analysis as that case "establishes that Congress can regulate purely intrastate activity that is not itself 'commercial,' in that it is not produced for sale, if it concludes that failure to regulate that class of activity would undercut regulation of the interstate market in that commodity." *Id.* at 17-18. The Court held that Congress had a "rational basis" for finding that leaving home-consumed marijuana outside of federal control would affect the price and market conditions for that commodity because, as was noted in *Wickard*, the "production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *See id.* at 19. Surprisingly, "[t]hat the market in *Raich* happened to be an illegal one did not affect the Court's analysis in the least." *Maxwell*, *supra*, 446 F.3d at 1214.

The Eleventh Circuit has indicated that the distinguishing feature between *Raich* and *Wickard*

on the one hand, and *Morrison* and *Lopez* on the other, "was the comprehensiveness of the economic component of the regulation." *Maxwell*, *supra*, 446 F.3d at 1214. The statute in *Lopez*, for example, was a brief, single-subject criminal statute that did not regulate any economic activity. By contrast, the statute in *Raich* was a broader legislative scheme "at the opposite end of the regulatory spectrum." *Supra*, 545 U.S. at 24. It was "a lengthy and detailed statute creating a comprehensive framework for regulating the production, distribution, and possession of [controlled substances]," which were "activities" the Supreme Court determined to be "quintessentially economic" in nature. *See id.* at 24-25. The Court reached this conclusion by "quite broadly defin[ing] 'economics' as 'the production, distribution, and consumption of commodities.'" *See Maxwell*, *supra*, 446 F.3d at 1215 n.4 (quoting *Raich*, *supra*, 545 U.S. at 25-26, in turn quoting Webster's Third New International Dictionary 720 (1966)).[13]

(c) Application of the Foregoing to the Facts of this Case

Unsurprisingly, the plaintiffs rely heavily on *Lopez* and *Morrison* in their arguments, while the defendants, of course, look principally to *Wickard* and *Raich*. These cases (along with the others discussed above) all have something to add to the discussion. However, while they frame the analysis, and are

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[13] In objecting to the majority's use of this "broadest possible" definition, Justice Thomas argued in dissent that "economics" is not defined as broadly in other dictionaries, and "the majority does not explain why it selects a remarkably expansive 40-year-old definition." *Raich*, *supra*, 545 U.S. at 69 and n.7 (Thomas, J., dissenting).

important from a historical perspective, they do not by themselves resolve this case. That is because, as Congress' attorneys in the Congressional Research Service ("CRS") and Congressional Budget Office ("CBO") advised long before the Act was passed into law, the notion of Congress having the power under the Commerce Clause to directly impose an individual mandate to purchase health care insurance is "novel" and "unprecedented." *See* Jennifer Staman & Cynthia Brougher, Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 3, 6 ("whether Congress can use its Commerce Clause authority to require a person to buy a good or a service" raises a "novel issue" and "most challenging question") ("CRS Analysis"); Congressional Budget Office Memorandum, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, August 1994 ("A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action.") ("CBO Analysis"). Never before has Congress required that everyone buy a product from a private company (essentially for life) just for being alive and residing in the United States.[14]

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[14] The individual mandate differs from the regulations in *Wickard* and *Raich*, for example, in that the individuals being regulated in those cases were engaged in an activity (regardless of whether it could readily be deemed interstate commerce in itself) and each had the choice to discontinue that activity and avoid penalty. *See*, *e.g.*, *Wickard v. Filburn*, 317 U.S. 111, 130, 63 S. Ct. 82, 87 L. Ed. 122 (1942) (noting Congress "gave the farmer a choice" of several options under the statute). Here, people have no choice but to buy insurance or be penalized. And their freedom is actually more restricted as they do not even

As I explained in my earlier order, the fact that legislation is unprecedented does not by itself render it unconstitutional. To the contrary, all federal legislation carries with it a "presumption of constitutionality." *Morrison*, *supra*, 529 U.S. at 607. However, the presumption is arguably weakened, and an "absence of power" might reasonably be inferred where — as here — "earlier Congresses avoided use of this highly attractive power." *Printz v. United States*, 521 U.S. 898, 905, 908, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997); *id.* at 907-08 ("the utter lack of statutes imposing obligations [like the one at issue in that case] (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power") (emphasis in original); *id.* at 918 ("almost two centuries of apparent congressional avoidance of the practice [at issue] tends to negate the existence of the congressional power asserted here").[15] The mere fact that the defendants have tried to analogize the individual mandate to things like jury service, participation in the census, eminent domain proceedings, forced exchange of gold bullion for paper currency under the *Gold Clause Cases*, and required service in a "posse" under the Judiciary Act of 1789

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have a choice as to the minimum level or type of insurance to buy because Congress established the floor. A single twenty-year old man or woman who only needs and wants major medical or catastrophic coverage, for example, is precluded from buying such a policy under the Act.

[15] Indeed, as the plaintiffs have persuasively noted, not even in the context of insurance under the National Flood Insurance Program did Congress mandate that all homeowners buy flood insurance directly from a private company. *See* Pl. Opp. at 26-27.

(all of which are obviously distinguishable) only underscores and highlights its unprecedented nature.

However, unprecedented or not, I will assume that the individual mandate *can* be Constitutional under the Commerce Clause and will analyze it accordingly. This analysis requires the resolution of two essential questions.

(i) Is Activity Required Under the Commerce Clause?

The threshold question that must be addressed is whether activity is required before Congress can exercise its power under the Commerce Clause. As previously discussed, Commerce Clause jurisprudence has "'taken some turns,'" [*see Lopez*, *supra*, 514 U.S. at 579 (Kennedy, J., concurring)], and contracted and expanded (and contracted and expanded again) during our nation's development. But, in every one of the cases — in both the contractive and expansive — there has always been clear and inarguable *activity*, from exerting control over and using navigable waters (*Gibbons*) to growing or consuming marijuana (*Raich*).[16] In all the cases discussed above, the Supreme Court was called upon to decide different issues (*e.g.*, whether commerce encompassed navigation; whether it included

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[16] The defendants cite to *Raich* for the proposition that Congress may reach "even wholly intrastate, non-commercial matters when it concludes that the failure to do so would undercut a larger program regulating interstate commerce." *See* Def. Mem. at 13. By paraphrasing *Raich* here rather than quoting from the decision the defendants have attempted to obscure the importance of "activity," for the cited portion, and Justice Scalia's concurrence (on which the defendants also rely), do not talk at all of "matters" — either commercial or not. They only mention (and often) "activities."

manufacture and agriculture or was limited to trade or exchange of goods; whether the activity at issue was interstate or intrastate and had a direct or indirect effect on commerce; whether that effect was substantial; whether the activity was economic or non-economic; and whether it was part of a single-subject statute or a necessary and essential component of a broader comprehensive scheme), but it has never been called upon to consider if "activity" is required. On this point at least, the district courts that have reached opposite conclusions on the individual mandate agree. *Compare Thomas More Law Center*, *supra*, 720 F. Supp. 2d at 893 (noting that the Supreme Court "has never needed to address the activity/inactivity distinction advanced by plaintiffs because in every Commerce Clause case presented thus far, there has been some sort of activity"; then proceeding to uphold the individual mandate), *with Virginia*, *supra*, 728 F. Supp. 2d at 781 (noting that "every application of Commerce Clause power found to be constitutionally sound by the Supreme Court involved some form of action, transaction, or deed placed in motion by an individual or legal entity"; then proceeding to strike down the individual mandate).

The defendants contend, however, that despite the inarguable presence of activity in every Supreme Court case to date, activity is not required under the Commerce Clause. *See* Def. Mem. at 31 (maintaining that "there is no 'activity' clause in the constitution"). In fact, they go so far as to suggest that to impose such a requirement would be bold and radical. According to the defendants, because the Supreme Court has never identified a distinction between activity and inactivity as a limitation on Congress'

commerce power, to hold otherwise would "break new legal ground" and be "novel" and "unprecedented." *See* Def. Opp. at 1, 2, 16. First, it is interesting that the defendants — apparently believing the best defense is a good offense — would use the words "novel" and "unprecedented" since, as previously noted, those are the *exact* same words that the CRS and CBO used to describe the individual mandate before it became law. Furthermore, there is a simple and rather obvious reason why the Supreme Court has never distinguished between activity and inactivity before: it has not been called upon to consider the issue because, until now, Congress had never attempted to exercise its Commerce Clause power in such a way before. *See* CBO Analysis (advising Congress during the previous health care reform efforts in 1994 that "[t]he government has never required people to buy any good or service as a condition of lawful residence in the United States."). In every Supreme Court case decided thus far, Congress was not seeking to regulate under its commerce power something that could even arguably be said to be "passive inactivity."[17]

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[17] I note that in *Gibbons v. Ogden*, where Chief Justice Marshall "described the Federal Commerce power with a breadth never yet exceeded" [*Wickard*, *supra*, 317 U.S. at 111], commerce was defined as "intercourse." Even that word would seem to carry with it an implicit presumption of at least *some* sort of preexisting dealing between people or entities. *See* 1 Samuel Johnson, *A Dictionary of the English Language* (4th ed. 1773) (defining "intercourse" as "Commerce; exchange" and "Communication"). Furthermore, as one of the *amici* notes in their brief, the word "regulate" in the Commerce Clause itself would also appear to presuppose action upon some object or activity that is already extant (*see* doc. 121 at 4 n.1, citing Samuel Johnson's dictionary defining "regulate" as "to adjust by

It would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause. If it has the power to compel an otherwise passive individual into a commercial transaction with a third party merely by asserting — as was done in the Act — that compelling the actual transaction is *itself* "commercial and economic in nature, and substantially affects interstate commerce" [*see* Act § 1501(a)(1)], it is not hyperbolizing to suggest that Congress could do almost anything it wanted. It is difficult to imagine that a nation which began, at least in part, as the result of opposition to a British mandate giving the East India Company a monopoly and imposing a nominal tax on all tea sold in America would have set out to create a government with the power to force people to buy tea in the first place. If Congress can penalize a passive individual for failing to engage in commerce, the enumeration of powers in the Constitution would have been in vain for it would be "difficult to perceive any limitation on federal power" [*Lopez*, *supra*, 514 U.S. at 564], and we would have a Constitution in name only. Surely this is not what the Founding Fathers could have intended. *See id.* at 592 (quoting Hamilton at the New York Convention that there would be just cause to reject the Constitution if it would allow the federal government to "penetrate the recesses of domestic life, and control, in all respects, the private conduct of individuals") (Thomas, J., concurring). In *Lopez*, the Supreme Court struck down the Gun Free School Zones Act of 1990 after stating that, if the statute

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rule or method" or "to direct"). Thus, a regulator "comes to an existing phenomenon and orders it." *Id.*

were to be upheld, "we are *hard pressed* to posit any *activity* by an individual that Congress is without power to regulate." *See id.* at 564. (emphasis added). If some type of already-existing activity or undertaking were not considered to be a prerequisite to the exercise of commerce power, we would go beyond the concern articulated in *Lopez* for it would be virtually *impossible* to posit *anything* that Congress would be without power to regulate.

As previously noted, the Supreme Court has summarized and defined the current state of the law under the Commerce Clause, and it has uniformly and consistently declared that it applies to "three broad categories of *activity*." *Lopez*, *supra*, 514 U.S. at 558 (emphasis added); *accord Morrison*, *supra*, 529 U.S. at 608. It has further described the third category as "the power to regulate those *activities* having a substantial relation to interstate commerce." *Lopez*, *supra*, 514 U.S. at 558-59 (emphasis added); *accord Morrison*, *supra*, 529 U.S. at 609; *see also Raich*, *supra*, 545 U.S. at 17; *Perez*, 402 U.S. at 150; *Wickard*, *supra*, 317 U.S. at 124; *Darby*, *supra*, 312 U.S. at 119-20; *Jones & Laughlin Steel*, *supra*, 301 U.S. at 37. Without doubt, existing case law thus extends only to those "activities" that have a substantial relationship to, or substantially affect, interstate commerce. I am required to interpret this law as the Supreme Court presently defines it. Only the Supreme Court can redefine it or expand it further — a point implicitly made by one of the defendants' own cited authorities. *See* Stern, *supra*, at 1363 (stating that the Supreme Court had at one point in time only talked about "movement" of goods across state lines under the Commerce Clause because it was necessary to decide those earlier cases

and there had "been no need for a broader definition" of commerce; going on to opine that "it would seem timely that the *Supreme Court*" expand the definition, as "the time has now arrived for the *[Supreme] Court* to cut loose from the 'old' approach and to select the 'new' one") (emphasis added).

Having found that "activity" is an indispensable part the Commerce Clause analysis (at least as currently understood, defined, and applied in Supreme Court case law), the Constitutionality of the individual mandate will turn on whether the failure to buy health insurance is "activity."

(ii) Is the Failure to Purchase Health Insurance "Activity"?

Preliminarily, based solely on a plain reading of the Act itself (and a common sense interpretation of the word "activity" and its absence), I must agree with the plaintiffs' contention that the individual mandate regulates inactivity. Section 1501 states in relevant part: "If an applicable individual fails to [buy health insurance], there is hereby imposed a penalty." By its very own terms, therefore, the statute applies to a person who does not buy the government-approved insurance; that is, a person who "fails" to act pursuant to the congressional dictate. In fact, prior to final passage of the Act, CRS attorneys advised Congress that it was "unclear" if the individual mandate had "solid constitutional foundation" specifically because:

> One could argue that while regulation of the health insurance industry or the health care system could be considered economic activity, regulating a choice to purchase health insurance is not. It may also be questioned

> whether a requirement to purchase health insurance is really a regulation of an economic activity or enterprise, if individuals who would be required to purchase health insurance are not, but for this regulation, a part of the health insurance market. In general, Congress has used its authority under the Commerce Clause to regulate individuals, employers, and others who voluntarily take part in some type of economic activity. While in *Wickard* and *Raich*, the individuals were participating in their own home activities (i.e., producing wheat for home consumption and cultivating marijuana for personal use), they were acting of their own volition, and this activity was determined to be economic in nature and affected interstate commerce. *However, [the individual mandate] could be imposed on some individuals who engage in virtually no economic activity whatsoever*. This is a novel issue: whether . . . this type of required participation can be considered economic activity.

CRS Analysis, *supra*, at 3, 6 (emphasis added).

The defendants insist that the uninsured are active. In fact, they even go so far as to make the claim — which the plaintiffs call "absurd" — that going without health insurance constitutes "economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*." *See* Def. Mem. at 29. They offer two (somewhat overlapping) arguments why the appearance of inactivity here is just an "illusion."

(iii) The Purported "Uniqueness" of the Health Care Market

The defendants contend that there are three unique elements of the health care market which, when viewed cumulatively and in combination, belie the claim that the uninsured are inactive.[18] First, as living and breathing human beings who are always susceptible to sudden and unpredictable illness and injury, no one can "opt out" of the health care market. Second, if and when health services are sought, hospitals are required by law to provide care, regardless of inability to pay. And third, if the costs incurred cannot be paid (which they frequently cannot, given the high cost of medical care), they are passed along (cost-shifted) to third parties, which has economic implications for everyone. Congress found that the uninsured received approximately $43 billion in "uncompensated care" in 2008 alone. These three things, according to the defendants and various health care industry experts and scholars on whom they rely, are "replicated in no other market" and

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[18] During oral argument, the plaintiffs opposed defining the relevant market broadly as one for health *care*, insisting that the only relevant market for purposes of analyzing the individual mandate is the more specific health *insurance* market. I agree that the plaintiffs' position is the more precise and accurate. Every market can be broadly defined in a way that encompasses the specific characteristics one seeks to reach or include. Nonetheless, I will consider and examine the defendants' claim that the individual mandate is justifiable because the much broader "health care market" is purportedly unique.

defeat the argument that uninsured individuals are inactive.[19]

First, it is not at all clear whether or why the three allegedly unique factors of the health care market are Constitutionally significant. What if only one of the three factors identified by the defendants is present? After all, there are lots of markets — especially if defined broadly enough — that people cannot "opt out" of. For example, everyone must participate in the food market. Instead of attempting to control wheat supply by regulating the acreage and amount of wheat a farmer could grow as in *Wickard*, under this logic, Congress could more directly raise too-low wheat prices merely by increasing demand through mandating that every adult purchase and consume wheat bread daily, rationalized on the grounds that because everyone must participate in the market for food, non-consumers of wheat bread adversely affect prices in the wheat market. Or, as was discussed during oral argument, Congress could require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system. Similarly, because virtually no one can be

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[19] For example, in their briefs and during oral argument, the defendants cited to and relied on the *amicus* brief filed by an impressive list of nearly forty economic scholars, who have urged that these "three observations . . . do not exist in other contexts" and establish that the uninsured are not inactive and passive bystanders, but rather they "participate in the market for medical services and necessarily affect the market for health insurance" (doc. 125 at 6-13).

divorced from the transportation market, Congress could require that everyone above a certain income threshold buy a General Motors automobile — now partially government-owned — because those who do not buy GM cars (or those who buy foreign cars) are adversely impacting commerce and a taxpayer-subsidized business.

I pause here to emphasize that the foregoing is not an irrelevant and fanciful "parade of horribles." Rather, these are some of the serious concerns implicated by the individual mandate that are being discussed and debated by legal scholars. For example, in the course of *defending* the Constitutionality of the individual mandate, and responding to the same concerns identified above, often-cited law professor and dean of the University of California Irvine School of Law Erwin Chemerinsky has opined that although "what people choose to eat well *might* be regarded as a personal liberty" (and thus unregulable), "Congress *could* use its commerce power to require people to buy cars." *See* ReasonTV, *Wheat, Weed, and Obamacare: How the Commerce Clause Made Congress All-Powerful*, August 25, 2010, available at: http://reason.tv/video/show/wheat-weed-and-obamacare-how-t. When I mentioned this to the defendants' attorney at oral argument, he allowed for the possibility that "maybe Dean Chemerinsky is right." *See* Tr. at 69. Therefore, the potential for this assertion of power has received at least some theoretical consideration and has not been ruled out as Constitutionally implausible.[20]

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[20] There is perhaps a general assumption that it is "ridiculous" to believe that Congress *would* do such a thing, even though it *could*. However, before *Wickard* was decided, it is likely that

Or what if two of the purported "unique" factors — inevitable participation coupled with cost-shifting — are present? For example, virtually no one can opt out of the housing market (broadly defined) and a majority of people will at some point buy a home. The vast majority of those homes will be financed with a mortgage, a large number of which (particularly in difficult economic times, as we have seen most recently) will go into default, thereby cost-shifting billions of dollars to third parties and the federal government. Should Congress thus have power under the Commerce Clause to preemptively regulate and require individuals above a certain income level to purchase a home financed with a mortgage (and secured with mortgage guaranty insurance) in order to add stability to the housing and financial markets (and to guard against the possibility of future cost-shifting because of a defaulted mortgage), on the theory that most everyone is currently, or inevitably one day will be, active in the housing market?

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most people (including legal scholars and judges) would have thought it equally "ridiculous" to believe that Congress would one day seek (and be permitted) to regulate (as interstate commerce) the amount of wheat that a farmer grew on a small private farm for his personal consumption. In any event, even if such an assumption is well-founded, "the limitation of congressional authority is not solely a matter of legislative grace." *See Morrison*, *supra*, 529 U.S. at 616; *see also id.* at 616 n.7 (stating that legislative power is not limited only by "the Legislature's self-restraint"); *cf. United States v. Stevens*, — U.S. —, 130 S. Ct. 1577, 1591, 176 L. Ed. 2d 435 (2010) ("[T]he [Constitution] protects against the Government; it does not leave us at the mercy of noblesse oblige. We would not uphold an unconstitutional statute merely because the Government promised to use it responsibly.").

In alluding to these same general concerns, another court has observed that requiring advance purchase of health insurance based on a future contingency that will substantially affect commerce could also "apply to transportation, housing, or nutritional decisions. This broad definition of the economic activity subject to congressional regulation lacks logical limitation and is unsupported by Commerce Clause jurisprudence." *See Virginia*, *supra*, 728 F. Supp. 2d at 781. That the defendants' argument is "unsupported by Commerce Clause jurisprudence" can perhaps best be seen by looking to *Lopez*. Although that case is distinct from this one in some notable ways (e.g., it involved a brief, single-subject criminal statute that did not contain detailed legislative findings), in the context of the defendants' "health care is unique" argument, it is quite similar.

In *Lopez*, the majority was concerned that using the Commerce Clause to regulate things such as possession of guns in school zones would "obliterate" the distinction between what is national and what is local and effectively create a centralized government that could potentially permit Congress to begin regulating "any and all aspects" of our lives, including marriage, divorce, child custody, and education. The dissent insisted that this concern was unfounded because the statute at issue was "aimed at curbing a *particularly acute* threat" of violence in schools that had "*singularly* disruptive potential." *Supra*, 514 U.S. at 624 (Breyer, J., dissenting). Relying on "empirical evidence . . . documented by scholars," the dissent highlighted the link between education and the national economy and "the *special way* in which guns and education are incompatible." *See id.* The impact on commerce, it was urged,

derived from the unchallenged fact that "violent crime in school zones has brought about a decline in the quality of education" which, in turn, has "an adverse impact on interstate commerce." *See id.* at 623 (citation and quotation marks omitted). This was "the *rare* case, then, that a statute strikes at conduct that (when considered in the abstract) seems so removed from commerce, but which (practically speaking) has so significant an impact upon commerce." *Id.* (all emphasis added).

Two things become apparent after reading these arguments attempting to justify extending Commerce Clause power to the legislation in that case, and the majority opinion (which is the controlling precedent) rejecting those same arguments. First, the contention that Commerce Clause power should be upheld merely because the government and its experts or scholars claim that it is being exercised to address a "particularly acute" problem that is "singular[ ]," "special," and "rare" — that is to say "unique" — will not by itself win the day. Uniqueness is not an adequate limiting principle as every market problem is, at some level and in some respects, unique. If Congress asserts power that exceeds its enumerated powers, then it is unconstitutional, regardless of the purported uniqueness of the context in which it is being asserted.

Second, and perhaps more significantly, under *Lopez* the causal link between what is being regulated and its effect on interstate commerce cannot be attenuated and require a court "to pile inference upon inference," which is, in my view, exactly what would be required to uphold the individual mandate. For example, in contrast to

individuals who grow and consume marijuana or wheat (even in extremely small amounts), the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce (not "slight," "trivial," or "indirect," but *no impact whatsoever*) — at least not any more so than the status of being without any particular good or service. If impact on interstate commerce were to be expressed and calculated mathematically, the status of being uninsured would necessarily be represented by zero. Of course, any other figure multiplied by zero is also zero. Consequently, the impact must be zero, and of no effect on interstate commerce. The uninsured can only be said to have a substantial effect on interstate commerce in the manner as described by the defendants: (i) if they get sick or injured; (ii) if they are still uninsured at that specific point in time; (iii) if they seek medical care for that sickness or injury; (iv) if they are unable to pay for the medical care received; and (v) if they are unable or unwilling to make payment arrangements directly with the health care provider, or with assistance of family, friends, and charitable groups, and the costs are thereafter shifted to others. In my view, this is the sort of piling "inference upon inference" rejected in *Lopez*, *supra*, 514 U.S. at 567, and subsequently described in *Morrison* as "unworkable if we are to maintain the Constitution's enumeration of powers." *Supra*, 529 U.S. at 615.[21]

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[21] I suppose it is also possible to contend that being uninsured impacts the economy because (regardless of whether the uninsured receive care that is cost-shifted to others) people without insurance tend to be less healthy and thus less

I do not mean to suggest that these inferences are illogical or unreasonable to draw. As did the majority in *Lopez* and *Morrison*, I do not dispute or question their underlying existence. Indeed, while $43 billion in uncompensated care from 2008 was only 2% of national health care expenditures for that year, it is clearly a large amount of money; and it demonstrates that a number of the uninsured are taking the five sequential steps. And when they do, Congress plainly has the power to regulate them at that time (or even at the time that they initially seek medical care), a fact with which the plaintiffs agree. But, to cast the net wide enough to reach everyone *in the present*, with the expectation that they will (or could) take those steps *in the future*, goes beyond the existing "outer limits" of the Commerce Clause and would, I believe, require inferential leaps of the sort rejected in *Lopez*. To the extent the defendants have suggested it is "empty formalism" [Def. Mem. at 16] to hold that the uninsured can be regulated at the time they seek or fail to pay for medical care (but not before) the Supreme Court has explained:

> Much of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear "formalistic" in a given case to partisans of the measure at issue,

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productive. This seems to be the basis of one of Congress' findings. *See* Act § 1501(a)(2)(E) (finding that the national economy "loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured"). However, such a claim would be similar to the argument that was rejected in *Morrison*, i.e., that victims of gender-motivated violence also tend to be less productive.

> because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day . . . . [A] judiciary that licensed extra-constitutional government with each issue of comparable gravity would, in the long run, be far worse [than the crisis itself].

New York, *supra*, 505 U.S. at 187.

In short, the defendants' argument that people without health insurance are actively engaged in interstate commerce based on the purported "unique" features of the much broader health care market is neither factually convincing nor legally supportable.[22]

(iv) The "Economic Decision" to Forego Health Insurance

The defendants next contend that the uninsured have made the calculated decision to engage in market timing and try to finance their future medical needs out-of-pocket rather than through insurance, and that this "economic decision" is tantamount to activity. The plaintiffs respond by suggesting that it

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[22] The defendants also suggest that the uninsured are "active" in the health insurance market — and therefore can be regulated and forced to buy insurance — because a large percentage of them have had insurance within the past year. The defendants have provided no authority for the suggestion that once someone is in the health insurance market at a particular point in time, they are forever in that market, always subject to regulation, and not ever permitted to leave.

is "a remarkable exaggeration of [the] rational aspects of human nature" to claim that the uninsured (as a rule) make structured and calculated decisions to forego insurance and engage in market timing, as opposed to simply not having it. *See* Tr. at 16 ("All we know is some people do not have insurance and some people do"). The plaintiffs describe the defendants' argument on this point "Orwellian," because they seek "to redefine the inactivity of not having healthcare insurance as an affirmative economic activity of 'deciding' not to buy insurance, or deciding *now* how to pay (or not to pay) for potential *future* economic activity in the form of obtaining medical services." *See* Pl. Opp. at 10 (emphasis in original). This "economic decision" argument has been accepted by two district courts, *Liberty Univ., Inc.*, *supra*, 2010 WL 4860299, at *15; *Thomas More Law Center*, *supra*, 720 F. Supp. 2d at 893-94. For example, in *Liberty University*, the District Court for the Western District of Virginia stated that "by choosing to forego insurance, Plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance," and concluded that these decisions constitute economic activity "[b]ecause of the nature of supply and demand, Plaintiff's choices directly affect the price of insurance in the market, which Congress set out in the Act to control." *See* 2010 WL 4860299, at *15.

The problem with this legal rationale, however, is it would essentially have unlimited application. There is quite literally *no* decision that, in the natural course of events, does not have an economic impact of some sort. The decisions of whether and when (or not) to buy a house, a car, a television, a

dinner, or even a morning cup of coffee also have a financial impact that — when aggregated with similar economic decisions — affect the price of that particular product or service and have a substantial effect on interstate commerce. To be sure, it is not difficult to identify an economic decision that has a cumulatively substantial effect on interstate commerce; rather, the difficult task is to find a decision that does not.[23]

Some of our wisest jurists have pointed out the threat that lies in an over-expansive Commerce Clause construction. The words that Judge Learned Hand wrote in 1935 are even truer today:

> In an industrial society bound together by means of transport and communication as rapid and certain as ours, it is idle to seek for any transaction, however apparently isolated, which may not have an effect elsewhere; such a society is an elastic medium which transmits all tremors throughout its territory; the only question is of their size.

United States v. A.LA. Schechter Poultry Corp., 76 F.2d 617, 624 (2d Cir. 1935), *aff'd in part and rev'd in part*, *supra*, 295 U.S. at 554 (noting in an elastic society like ours everything affects commerce in the sense that "[m]otion at the outer rim is communicated perceptibly, though minutely, to recording instruments at the center;" but to hold that everything may thus be regulated under the Commerce Clause "will be an end to our federal

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[23] As was discussed at the hearing, even personal decisions about whether to marry, whom to marry, or whether to have children could also be characterized as "economic decisions."

system") (Cardozo, J., concurring). As the Supreme Court emphasized in *Morrison*, *supra*: "'In a sense any conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we have not yet said the commerce power may reach so far.'" 529 U.S. at 611 (quoting *Lopez*, *supra*, 514 U.S. at 580 (Kennedy, J., concurring)); *accord Patton*, *supra*, 451 F.3d at 628 (explaining that everything could be said to affect interstate commerce "in the same sense in which a butterfly flapping its wings in China might bring about a change of weather in New York," but if all things affecting interstate commerce were held to be within Congress' regulatory power, "the Constitution's enumeration of powers would have been in vain").

Attempting to deflect this rather common sense rebuttal to their argument, the defendants emphasized during oral argument that it is not just the "economic decision" itself that renders the failure to buy insurance activity; rather, it is that decision coupled with the fact that the uninsured are guaranteed access to medical care in hospital emergency rooms as a "backstop," the use of which can and does shift costs onto third parties. The defendants thus refer to the failure to buy health insurance as a "financing decision." However, this is essentially true of any and all forms of insurance. It could just as easily be said that people without burial, life, supplemental income, credit, mortgage guaranty, business interruption, or disability insurance have made the exact same or similar economic and financing decisions based on their expectation that they will not incur a particular risk at a particular point in time; or that if they do, it is more beneficial for them to self-insure and try to

meet their obligations out-of-pocket, but always with the benefit of "backstops" provided by law, including bankruptcy protection and other government-funded financial assistance and services. *See*, *e.g.*, Katie Zezima, *Indigent Burials Are On the Rise*, New York Times, Oct. 11, 2009, at A23 (reporting the number of burials of those who die with insufficient assets are increasing across the country, up 50% in Oregon, and that funeral expenses are frequently borne by governmental entities; noting that Illinois alone budgets $12 million for these expenses). The "economic decision" to forego virtually any and all types of insurance can (and cumulatively do) similarly result in significant cost-shifting to third parties.[24]

The important distinction is that "economic decisions" are a much broader and far-reaching category than are "activities that substantially affect interstate commerce." While the latter necessarily encompasses the first, the reverse is not true. "Economic" cannot be equated to "commerce." And "decisions" cannot be equated to "activities." Every

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[24] To the extent that people dying without burial insurance is by itself not as severe a problem as people without health insurance — and I readily acknowledge it is not — that is merely a difference in degree, not in kind. The fact that people without health insurance pose a more serious problem than people without burial insurance may give Congress more of a *reason* to act; but it does not give it more Constitutional *authority* to do so. *See United States v. A.LA. Schechter Poultry Corp.*, 76 F.2d 617, 624 (2d Cir. 1935) (noting that "emergency does not create the power [of Congress to act], but it may furnish the occasion for the exercise of the power conferred by the Constitution"), *aff'd in part and rev'd in part*, 295 U.S. 495, 55 S. Ct. 837, 79 L. Ed. 1570 (1935).

person throughout the course of his or her life makes hundreds or even thousands of life decisions that involve the same general sort of thought process that the defendants maintain is "economic activity." There will be no stopping point if that should be deemed the equivalent of activity for Commerce Clause purposes.[25]

The Commerce Clause originally applied to the trade and exchange of goods as it sought to eliminate trade barriers by and between the states. Over the years, the Clause's reach has been expanded from covering actual interstate commerce (and its channels and instrumentalities) to intrastate activities that substantially affect interstate commerce. It has even been applied to activities that involve the mere consumption of a product (even if there is no legal commercial interstate market for

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[25] For example, if the decision to forego insurance qualifies as activity, then presumably the decision to not *use* that insurance once it has been obtained is also activity. The government acknowledged during oral argument in *Virginia v. Sebelius* that although people are required to buy health insurance under the Act, they are not yet required to use it. *See* Transcript of Oral Argument on Defendants' Motion to Dismiss, July 1, 2010, at 26 ("the statute doesn't require anybody to [actually] get medical services"); *see also id.* at 30 ("Congress isn't saying go see a doctor, or you have to go. What Congress is saying is you have to purchase health insurance."). But what happens if the newly-insured (as a class) do not seek preventive medical care? Because Congress found in the Act that the economy loses money each year "because of the poorer health and shorter lifespan of the uninsured" [*see supra* note 19], it would seem only logical under the defendants' rationale that Congress may also regulate the "economic decisions" not to go to the doctor for regular check-ups and screenings to improve health and longevity, which, in turn, is intended and expected to increase economic productivity.

that product). To now hold that Congress may regulate the so-called "economic decision" to *not* purchase a product or service in anticipation of *future* consumption is a "bridge too far." It is without logical limitation and far exceeds the existing legal boundaries established by Supreme Court precedent.

Because I find both the "uniqueness" and "economic decision" arguments unpersuasive, I conclude that the individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress' commerce power, as it is understood, defined, and applied in the existing Supreme Court case law.

(2) The Necessary and Proper Clause

The defendants contend that the individual mandate is "also a valid exercise of Congress's authority if the provision is analyzed under the Necessary and Proper Clause." *See* Def. Mem. at 23. This argument has been appropriately called "the last, best hope of those who defend ultra vires congressional action." *See Printz, supra*, 521 U.S. at 923. Oversimplified, the defendants' argument on this point can be reduced to the following: (i) the Act bans insurers from denying health coverage (guaranteed issue), or charging higher premiums (community rating), to individuals with pre-existing medical conditions (which increases the insurers' costs); (ii) as a result of these bans, individuals will be incentivized to delay obtaining insurance as they are now guaranteed coverage if they get sick or injured (which decreases the insurers' revenues); and (iii) as a result of the foregoing, there will be fewer

healthy people in the insured pool (which will raise the premiums and costs for everyone). Consequently, it is necessary to require that everyone "get in the pool" so as to protect the private health insurance market from inevitable collapse.

At the outset, I note that in *United States v. Comstock*, — U.S. —, 130 S. Ct. 1949, 176 L. Ed. 2d 878 (2010), the Supreme Court's most recent discussion and application of the Necessary and Proper Clause, the Court identified and looked to five "considerations" that informed its decision about whether the legislation at issue was sustainable: (1) the breadth of the Necessary and Proper Clause; (2) the history of federal involvement in the relevant arena, and the modest addition to that arena; (3) the sound reasons for the legislation in light of the government's interest; (4) the statute's accommodation of state interests; and (5) its narrow scope. It is not entirely clear if this constitutes a "five-factor test," as Justice Thomas urged in dissent, *see id.* at 1974, or whether the "considerations" were merely factors that the majority believed relevant to deciding that particular case. To the extent that they constitute a "test," the individual mandate clearly gets a failing score on at least two (and possibly a couple more) of the five elements. A statute mandating that everyone purchase a product from a private company or be penalized (merely by virtue of being alive and a lawful citizen) is not a "modest" addition to federal involvement in the national health care market, nor is it "narrow [in] scope." I will assume, however, that the *Comstock* "considerations" were just that, and that they did not bring about any fundamental change in the Court's long established Necessary and Proper Clause analysis.

The Necessary and Proper Clause provides that Congress shall have the power:

> To make all Laws which shall be *necessary and proper for carrying into Execution the foregoing Powers*, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

U.S. Const. art. I, § 8, cl. 18 (emphasis added). The Supreme Court has repeatedly held, and the emphasized text makes clear, that the Clause is not an independent source of federal power; rather, it is simply "a caveat that the Congress possesses all the means necessary to carry out the specifically granted 'foregoing' powers of [section] 8 'and all other Powers vested by this Constitution.' [It] is 'but merely a declaration, for the removal of all uncertainty, that the means of carrying into execution those (powers) otherwise granted are included in the grant.'" *Kinsella v. United States ex rel. Singleton*, 361 U.S. 234, 247, 80 S. Ct. 297, 4 L. Ed. 2d 268 (1960); *see also Raich*, *supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment) (stating that, while the Clause "empowers Congress to enact laws . . . that are not within its authority to enact in isolation," those laws must be "in effectuation of [Congress'] enumerated powers"); *Kansas v. Colorado*, 206 U.S. 46, 88, 27 S. Ct. 655, 51 L. Ed. 956 (1907) (stating that the Necessary and Proper Clause "is not the delegation of a new and independent power, but simply provision for making effective the powers theretofore mentioned").

Hamilton wrote the following in response to the concern voiced by some that the Necessary and

Proper Clause — and the Supremacy Clause as well — could be used to expand federal power and destroy liberties:

> These two clauses have been the source of much virulent invective and petulant declamation against the proposed Constitution. They have been held up to the people in all the exaggerated colors of misrepresentation as the pernicious engines by which their local governments were to be destroyed and their liberties exterminated; as the hideous monster whose devouring jaws would spare neither sex nor age, nor high nor low, nor sacred nor profane; and yet, strange as it may appear, after all this clamor, to those who may not have happened to contemplate them in the same light, it may be affirmed with perfect confidence, that the constitutional operation of the intended government would be precisely the same, if these clauses were entirely obliterated, as if they were repeated in every article. They are only declaratory of a truth, which would have resulted by necessary and unavoidable implication from the very act of constituting a federal government, and vesting it with certain specific powers.

The Federalist No. 33, at 204-05. To the extent there was anything to fear in the Constitution, Hamilton explained, it must be found in the specific powers that were enumerated and not in the Necessary and Proper Clause, for though the latter "may be chargeable with tautology or redundancy, [it] is at least perfectly harmless." *See id.* at 206. Madison

concurred with this view. *See The Federalist* No. 44, at 302 (explaining that the Clause is entirely redundant for if it had been omitted, "there can be no doubt" that the same power and authority "would have resulted to the government, by unavoidable implication"). If these advocates for ratification had any inkling that, in the early twenty-first century, government proponents of the individual health insurance mandate would attempt to justify such an assertion of power on the basis of this Clause, they probably would have been the strongest opponents of ratification. They would have recognized how such an interpretation and application of the Necessary and Proper Clause would eviscerate the bedrock enumerated powers principle upon which the Constitution rests.

One of the *amicus curiae* briefs illustrates how using the Necessary and Proper Clause in the manner as suggested by the defendants would vitiate the enumerated powers principle (doc. 119). It points out that the defendants' are essentially admitting that the Act will have serious negative consequences, e.g., encouraging people to forego health insurance until medical services are needed, increasing premiums and costs for everyone, and thereby bankrupting the health insurance industry — unless the individual mandate is imposed. Thus, rather than being used to implement or facilitate enforcement of the Act's insurance industry reforms, the individual mandate is actually being used as the means to avoid the adverse consequences of the Act itself. Such an application of the Necessary and Proper Clause would have the perverse effect of enabling Congress to pass ill-conceived, or economically disruptive statutes, secure in the knowledge that the more

dysfunctional the results of the statute are, the more essential or "necessary" the statutory fix would be. Under such a rationale, the more harm the statute does, the more power Congress could assume for itself under the Necessary and Proper Clause. This result would, of course, expand the Necessary and Proper Clause far beyond its original meaning, and allow Congress to exceed the powers specifically enumerated in Article I. Surely this is not what the Founders anticipated, nor how that Clause should operate.

Ultimately, the Necessary and Proper Clause vests Congress with the power and authority to exercise *means* which may not in and of themselves fall within an enumerated power, to accomplish *ends* that must be within an enumerated power. Although Congress' authority to act in furtherance of those ends is unquestionably broad, there are nevertheless "restraints upon the Necessary and Proper Clause authority." *See Raich*, *supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment). Thomas Jefferson warned against an overly expansive application of cause and effect in interpreting the interplay between Congress' enumerated powers and the Necessary and Proper Clause:

> Congress are authorized to defend the nation. Ships are necessary for defense; copper is necessary for ships; mines necessary for copper; a company necessary to work mines; and who can doubt this reasoning who has ever played at "This is the House that Jack Built?"

Letter from Thomas Jefferson to Edward Livingston (Apr. 30, 1800), in 31 *The Papers of Thomas Jefferson*

547 (B. Oberg ed., 2004); *accord Comstock*, *supra*, 130 S. Ct. at 1966 (referencing same analogy and stating that the Necessary and Proper Clause "must be controlled by some limitations lest, as Thomas Jefferson warned, congressional powers become completely unbounded by linking one power to another *ad infinitum*") (Kennedy, J., concurring); *see also id.* at 1970 (explaining that the Clause "does not give Congress carte blanche," and it is the "obligation of this Court" to impose limitations) (Alito, J., concurring). As for where the restraints and limitations might be, it is — as is often the case — appropriate to look to Chief Justice Marshall, who first considered this issue and articulated the still-governing analysis:

> Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.
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> * * *
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> [However,] should congress, in the execution of its powers, adopt measures which are prohibited by the constitution; or should congress, under the pretext of executing its powers, pass laws for the accomplishment of objects not intrusted to the government; it would become the painful duty of this tribunal, should a case requiring such a decision come before it, to say, that such an act was not the law of the land.

McCulloch, *supra*, 17 U.S. at 421, 423.

In light of *United States v. South-Eastern Underwriters*, 322 U.S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440 (1944), the "end" of regulating the health care insurance industry (including preventing insurers from excluding or charging higher rates to people with pre-existing conditions) is clearly "legitimate" and "within the scope of the constitution." But, the means used to serve that end must be "appropriate," "plainly adapted," and not "prohibited" or inconsistent "with the letter and spirit of the constitution." These phrases "are not merely hortatory." *Raich*, *supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment).

The Necessary and Proper Clause cannot be utilized to "pass laws for the accomplishment of objects" that are not within Congress' enumerated powers. As the previous analysis of the defendants' Commerce Clause argument reveals, the individual mandate is neither within the letter nor the spirit of the Constitution. To uphold that provision via application of the Necessary and Proper Clause would authorize Congress to reach and regulate far beyond the currently established "outer limits" of the Commerce Clause and effectively remove all limits on federal power. As the Supreme Court explained in *Printz*:

> When a "Law . . . for carrying into Execution" the Commerce Clause [violates other Constitutional principles], it is not a "Law . . . *proper* for carrying into Execution the Commerce Clause," and is thus, in the words of the Federalist, "merely an act of usurpation" which "deserves to be treated as such."

Printz, *supra*, 521 U.S. at 923-24 (citations and brackets omitted) (emphasis in original); *see also Comstock*, *supra*, 130 S. Ct. at 1967-68 ("It is of fundamental importance to consider whether essential attributes [of federalism embodied in the Constitution] are compromised by the assertion of federal power under the Necessary and Proper Clause; if so, that is a factor suggesting that the power is not one properly within the reach of federal power.") (Kennedy, J., concurring). Here, the "essential attributes" of the Commerce Clause limitations on the federal government's power would definitely be compromised by this assertion of federal power via the Necessary and Proper Clause. If Congress is allowed to define the scope of its power merely by arguing that a provision is "necessary" to avoid the negative consequences that will potentially flow from its *own* statutory enactments, the Necessary and Proper Clause runs the risk of ceasing to be the "perfectly harmless" part of the Constitution that Hamilton assured us it was, and moves that much closer to becoming the "hideous monster [with] devouring jaws" that he assured us it was not.

The defendants have asserted again and again that the individual mandate is absolutely "necessary" and "essential" for the Act to operate as it was intended by Congress. I accept that it is.[26] Nevertheless, the individual mandate falls outside the boundary of Congress' Commerce Clause authority and cannot be reconciled with a limited government of enumerated powers. By definition, it cannot be "proper."

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[26] As will be seen, the defendants' repeated assertions on this point impact the severability analysis.

(3) Constitutionality of the Individual Mandate

The individual mandate is outside Congress' Commerce Clause power, and it cannot be otherwise authorized by an assertion of power under the Necessary and Proper Clause. It is not Constitutional. Accordingly, summary judgment must be granted in favor of the plaintiffs on Count I.

(4) Severability

Having determined that the individual mandate exceeds Congress' power under the Commerce Clause, and cannot be saved by application of the Necessary and Proper Clause, the next question is whether it is severable from the remainder of the Act. In considering this issue, I note that the defendants have acknowledged that the individual mandate and the Act's health insurance reforms, including the guaranteed issue and community rating, will rise or fall together as these reforms "cannot be severed from the [individual mandate]." *See*, *e.g.*, Def. Opp. at 40. As explained in my order on the motion to dismiss: "the defendants concede that [the individual mandate] is absolutely necessary for the Act's insurance market reforms to work as intended. In fact, they refer to it as an 'essential' part of the Act at least fourteen times in their motion to dismiss." Thus, the only question is whether the Act's other, non-health-insurance-related provisions can stand independently or whether they, too, must fall with the individual mandate.[27]

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[27] In considering this issue, I will at times borrow heavily from one of the *amicus* briefs filed in the case for it quite cogently and effectively sets forth the applicable standard and governing analysis of severability (doc. 123).

Severability is a doctrine of judicial restraint, and the Supreme Court has applied and reaffirmed that doctrine just this past year: "'*Generally speaking*, when confronting a constitutional flaw in a statute, [courts] try to limit the solution to the problem,' severing any 'problematic portions while leaving the remainder intact.'" *Free Enterprise Fund v. Public Co. Accounting Oversight Board*, — U.S. —, 130 S. Ct. 3138, 3161, 177 L. Ed. 2d 706 (2010) (citation omitted) (emphasis added). Because the unconstitutionality of one provision of a legislative scheme "does not *necessarily* defeat or affect the validity of its remaining provisions," the "*normal* rule" is that partial invalidation is proper. *Id.* (citations omitted) (emphasis added). Where Congress has "enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not *ordinarily* cause Congress' overall intent to be frustrated." *New York*, *supra*, 505 U.S. at 186 (emphasis added). As the emphasized text shows, the foregoing is not a rigid and inflexible rule, but rather it is the general standard that applies in the typical case. However, this is anything but the typical case.

The question of severability ultimately turns on the nature of the statute at issue. For example, if Congress intended a given statute to be viewed as a bundle of separate legislative enactment or a series of short laws, which for purposes of convenience and efficiency were arranged together in a single legislative scheme, it is presumed that any provision declared unconstitutional can be struck and severed without affecting the remainder of the statute. If, however, the statute is viewed as a carefully-

balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal, and if that goal would be undermined if a central part of the legislation is found to be unconstitutional, then severability is not appropriate. As will be seen, the facts of this case lean heavily toward a finding that the Act is properly viewed as the latter, and not the former.

The standard for determining whether an unconstitutional statutory provision can be severed from the remainder of the statute is well-established, and it consists of a two-part test. First, after finding the challenged provision unconstitutional, the court must determine if the other provisions can function independently and remain "fully operative as a law." *See Free Enterprise Fund*, *supra*, 130 S. Ct. at 3161. In a statute that is approximately 2,700 pages long and has several hundred sections — certain of which have only a remote and tangential connection to health care — it stands to reason that some (perhaps even most) of the remaining provisions can stand alone and function independently of the individual mandate. The defendants have identified several provisions that they believe can function independently: the prohibition on discrimination against providers who will not furnish assisted suicide services; an "Independence at Home" project for chronically ill seniors; a special Medicare enrollment period for disabled veterans; Medicare reimbursement for bone-marrow density tests; and provisions devised to improve women's health, prevent abuse, and ameliorate dementia [Def. Opp. at 40], as well as abstinence education and disease prevention [doc. 74 at 14]. And as was mentioned during oral argument, there is little doubt that the

provision in the Act requiring employers to provide a "reasonable break time" and separate room for nursing mothers to go and express breast milk [Act § 4207] can function without the individual mandate. Importantly, this provision and many others are already in effect and functioning. However, the question is not whether these and the myriad other provisions can function as a technical or practical matter; instead, the "more relevant inquiry" is whether these provisions will comprise a statute that will function "in a *manner* consistent with the intent of Congress." *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987) (emphasis in original). Thus, the first step in the severability analysis requires (at least to some extent) that I try to infer Congress' intent. Although many of the remaining provisions, as just noted, can most likely function independently of the individual mandate, there is nothing to indicate that they can do so in the manner intended by Congress. The analysis at the second step of the severability test makes that conclusion pretty clear.

At this second step, reviewing courts may look to "the statute's text or historical context" to determine if Congress, had it been presented with a statute that did not contain the struck part, would have preferred to have no statute at all. *See Free Enterprise Fund*, *supra*, 130 S. Ct. at 3161-62. "Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *See Alaska Airlines, Inc.*, *supra*, 480 U.S. at 684. But once again, that presupposes that the provisions left over function in a manner consistent with the main

objective and purpose of the statute in the first place. *Cf. New York*, *supra*, 505 U.S. at 187 (unconstitutional provision held to be severable where the remaining statute "still serves Congress' *objective*" and the "*purpose* of the Act is not defeated by the invalidation" of the unconstitutional provision) (emphasis added). While this inquiry "can sometimes be 'elusive'" [*Free Enterprise Fund*, *supra*, 130 S. Ct. at 3161], on the unique facts of this particular case, the record seems to strongly indicate that Congress would not have passed the Act in its present form if it had not included the individual mandate. This is because the individual mandate was indisputably essential to what Congress was ultimately seeking to accomplish. It was, in fact, the keystone or lynchpin of the entire health reform effort. After looking at the "statute's text" (or, rather, its conspicuous lack of text) and the "historical record" [*see Free Enterprise Fund*, *supra*, 130 S. Ct. at 3162], there are two specific facts that are particularly telling in this respect.

First, the Act does not contain a "severability clause," which is commonly included in legislation to provide that if any part or provision is held invalid, then the rest of the statute will not be affected. Although it is true that the absence of such a clause, in and of itself, "does not raise a presumption against severability," [*New York*, *supra*, 505 U.S. at 186], that is not the same thing as saying that its absence is irrelevant to the analysis. In *INS v. Chadha*, 462 U.S. 919, 103 S. Ct. 2764, 77 L. Ed. 2d 317 (1983), for example, the Supreme Court concluded that it did not have to embark on the "elusive inquiry" of whether Congress intended the unconstitutional provision in that case to be severable from the rest of the statute

because Congress included a severability clause with language that was plain and unambiguous. *See id.* at 931-32. And, in *Alaska Airlines, Inc.*, *supra*, 480 U.S. at 686, the Court similarly held that the severability analysis is "eased" when there is a severability clause in the statute, such that only "strong evidence" can overcome it. By necessary implication, the evidence against severability need not be as strong to overcome the general presumption when there is no such clause.

The lack of a severability clause in this case is significant because one had been included in an earlier version of the Act, but it was removed in the bill that subsequently became law. "Where Congress includes [particular] language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the [omitted provision] was not intended." *Russello v. United States*, 464 U.S. 16, 23-24, 104 S. Ct. 296, 78 L. Ed. 2d 17 (1983). In other words, the severability clause was intentionally left out of the Act. The absence of a severability clause is further significant because the individual mandate was controversial all during the progress of the legislation and Congress was undoubtedly well aware that legal challenges were coming. Indeed, as noted earlier, even before the Act became law, several states had passed statutes declaring the individual mandate unconstitutional and purporting to exempt their residents from it; and Congress' own attorneys in the CRS had basically advised that the challenges might well have legal merit as it was "unclear" if the individual mandate had "solid constitutional foundation." *See* CRS Analysis, *supra*, at 3. In light of the foregoing, Congress' failure to include a severability clause in the Act (or, more accurately, its

decision to not include one that had been included earlier) can be viewed as strong evidence that Congress recognized the Act could not operate *as intended* without the individual mandate.

Moreover, the defendants have conceded that the Act's health insurance reforms cannot survive without the individual mandate, which is extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself. The health insurance reform provisions were cited repeatedly during the health care debate, and they were instrumental in passing the Act. In speech after speech President Obama emphasized that the legislative goal was "health *insurance* reform" and stressed how important it was that Congress fundamentally reform how health insurance companies do business, and "protect every American from the worst practices of the insurance industry." *See*, for example, Remarks of President Obama, The State of the Union, delivered Jan. 27, 2009.[28] Meanwhile, the Act's supporters in the Senate and House similarly spoke repeatedly and often of the legislative efforts as being the means to

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[28] *See also*, *e.g.*, The White House, Office of the Press Secretary, Official Transcript of President Obama's News Conference, July 22, 2009, available at: http://www.whitehouse.gov/the-press-office/news-conference-president-july-22-20 09; The White House, Office of the Press Secretary, Official Transcript of President Obama's Remarks at Health Care Reform Town Hall, July 23, 2009, available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Health-C are-Reform-Town-Hall/.

comprehensively reform the health insurance industry.[29]

To be sure, the words "protection" and "affordable" in the title of the Act itself are inextricably tied to the health insurance reform provisions (and the individual mandate in particular), as the defendants have emphasized throughout the course of this litigation. *See*, *e.g.*, Def. Mem. at 1 ("Focusing on insurance industry practices that prevented millions of Americans from obtaining *affordable* insurance, the Act bars insurers from denying coverage to those with pre-existing conditions or from charging discriminatory premiums on the basis of medical history. Congress recognized that these reforms of insurance industry practices were required to *protect* consumers . . .") (emphasis added); Reply in Support of Defendants' Motion to Dismiss, filed August 27, 2010 (doc. 74), at 21 (stating that the individual mandate "is necessary for Congress's insurance reforms to work"; that "those provisions *protect* millions of Americans"; and that "Congress plainly regarded their *protection* as a core objective of the Act") (emphasis added). The defendants have further identified and highlighted the essential role that the individual mandate played

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[29] *See*, *e.g.*, David Welna, *Analyzing Democrats' Word Shift on Health Care*, National Public Radio, Nov. 17, 2009 (reporting that during the health care reform debate the Act's proponents referred to the ongoing efforts as "health insurance reform," which, according to the head of a nonpartisan health care organization, "is a much more accurate label" as the "health care makeover has ended up being largely about [reforming] insurance companies"), available at http://www.npr.org/templates/story/story.php?storyId = 120464701.

in the overall regulatory reform of the interstate health care and health insurance markets:

> [T]he [individual mandate] is essential to the Act's comprehensive scheme to ensure that health insurance coverage is available and *affordable*. In addition to regulating industry underwriting practices, the Act promotes availability and *affordability* through (a) "health benefit exchanges" that enable individuals and small businesses to obtain competitive prices for health insurance; (b) financial incentives for employers to offer expanded insurance coverage, (c) tax credits to low-income and middle-income individuals and families, and (d) extension of Medicaid to additional low-income individuals. *The [individual mandate] works in tandem with these and other reforms*. . . .
>
> Congress thus found that failure to regulate the decision to forgo insurance . . . would undermine the "comprehensive regulatory regime" in the Act. . . .
>
> *[The individual mandate] is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets . . . is "essential" to achieving key reforms of the interstate health insurance market . . . [and is] necessary to make the other regulations in the Act effective.*

Memorandum in Support of Defendants' Motion to Dismiss, filed June 17, 2010 (doc. 56-1), at 46-48 (emphasis added).

Congress has also acknowledged in the Act itself that the individual mandate is absolutely "essential"

to the Act's overarching goal of expanding the availability of affordable health insurance coverage and protecting individuals with pre-existing medical conditions:

> [I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care . . . The [individual mandate] 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.

Act § 1501(a)(2)(I) (emphasis added).

In other words, the individual mandate is indisputably necessary to the Act's insurance market reforms, which are, in turn, indisputably necessary to the purpose of the Act. This is obviously a very different situation than in *Alaska Airlines, Inc.*, *supra*, 480 U.S. at 694 n.18 and 696 (unconstitutional provision severed from rest of statute where the provision was "uncontroversial," and the debate on the final bill demonstrated its "relative unimportance"), and is more in line with the situation alluded to in *New York*, *supra*, 505 U.S. at 187 (suggesting by implication that the entire legislation should be struck when "the purpose of the Act is . . . defeated by the invalidation" of one of its provisions).

In weighing the Act's provisions and attempting to discern legislative intent and purpose, I have kept in mind the rationale underlying the severability doctrine, which the Supreme Court has described as follows:

> Three interrelated principles inform our approach to remedies. First, we try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people. . . . Second, mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from rewriting [a] law to conform it to constitutional requirements even as we strive to salvage it . . . Third, the touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.

Ayotte v. Planned Parenthood of Northern New England, 546 U.S. 321, 329-30, 126 S. Ct. 961, 163 L. Ed. 2d 812 (2006) (citations and brackets omitted). The first principle merely reflects the general judicial policy discussed at the beginning of this section; that is, because a ruling of unconstitutionality frustrates the intent of democratically-elected representatives of the people, the "normal rule" — in the "normal" case — will ordinarily require that as little of a statute be struck down as possible. The two other principles, however, require closer analysis.

As for the second principle, the *Ayotte* Court explained:

> Our ability to devise a judicial remedy that does not entail quintessentially legislative work often depends on how clearly we have already articulated the background constitutional rules at issue . . . But making distinctions in a murky constitutional

> context, or where line-drawing is inherently complex, may call for a "'far more serious invasion of the legislative domain'" than we ought to undertake.

Supra, 546 U.S. at 329-30. Thus, cleanly and clearly severing an unconstitutional provision is one thing, but having to re-balance a statutory scheme by engaging in quasi-legislative "line drawing" is a "'far more serious invasion of the legislative domain'" than courts should undertake. *See id.* This analysis merges into the third principle identified in *Ayotte*:

> After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all? All the while, we are wary of legislatures who would rely on our intervention, for it would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and leave it to the courts to step inside to announce to whom the statute may be applied. This would, to some extent, substitute the judicial for the legislative department of the government.

Id. at 330 (citations and brackets omitted).

Severing the individual mandate from the Act along with the other insurance reform provisions — and in the process reconfiguring an exceedingly lengthy and comprehensive legislative scheme — cannot be done consistent with the principles set out above. Going through the 2,700-page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds) of others, would not only take considerable time and extensive

briefing, but it would, in the end, be tantamount to rewriting a statute in an attempt to salvage it, which is foreclosed by *Ayotte*, *supra*. Courts should not even attempt to do that. It would be impossible to ascertain on a section-by-section basis if a particular statutory provision could stand (and was intended by Congress to stand) independently of the individual mandate. The interoperative effects of a partial deletion of legislative provisions are often unforseen and unpredictable. For me to try and "second guess" what Congress would want to keep is almost impossible. To highlight one of many examples, consider the Internal Revenue Service Form 1099 reporting requirement, which requires that businesses, including sole proprietorships, issue 1099 tax forms to individuals or corporations to whom or which they have paid more than $600 for goods or services in any given tax year [Act § 9006]. This provision has no discernable connection to health care and was intended to generate offsetting revenue for the Act, the need of which is greatly diminished in the absence of the "health benefit exchanges," subsidies and tax credits, and Medicaid expansion (all of which, as the defendants have conceded, "work in tandem" with the individual mandate and other insurance reform provisions). How could I possibly determine if Congress intended the 1099 reporting provision to stand independently of the insurance reform provisions? Should the fact that it has been widely criticized by both Congressional supporters and opponents of the Act and the fact that there have been bipartisan efforts to repeal it factor at all into my determination?

In the final analysis, this Act has been analogized to a finely crafted watch, and that seems to fit. It has

approximately 450 separate pieces, but one essential piece (the individual mandate) is defective and must be removed. It cannot function as originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions — which, as noted, were the chief engines that drove the entire legislative effort — for me to try and dissect out the proper from the improper, and the able-to-stand-alone from the unable-to-stand-alone. Such a quasi-legislative undertaking would be particularly inappropriate in light of the fact that any statute that might conceivably be left over after this analysis is complete would plainly not serve Congress' main purpose and primary objective in passing the Act. The statute is, after all, called "The Patient Protection and Affordable Care Act," not "The Abstinence Education and Bone Marrow Density Testing Act." The Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker.

If Congress intends to implement health care reform — and there would appear to be widespread agreement across the political spectrum that reform is needed — it should do a comprehensive examination of the Act and make a legislative determination as to which of its hundreds of provisions and sections will work as intended without the individual mandate, and which will not. It is Congress that should consider and decide these quintessentially legislative questions, and not the courts.

In sum, notwithstanding the fact that many of the provisions in the Act can stand independently

without the individual mandate (as a technical and practical matter), it is reasonably "evident," as I have discussed above, that the individual mandate was an essential and indispensable part of the health reform efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently. I must conclude that the individual mandate and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit. The individual mandate cannot be severed. This conclusion is reached with full appreciation for the "normal rule" that reviewing courts should ordinarily refrain from invalidating more than the unconstitutional part of a statute, but non-severability is required based on the unique facts of this case and the particular aspects of the Act. This is not a situation that is likely to be repeated.

(5) Injunction

The last issue to be resolved is the plaintiffs' request for injunctive relief enjoining implementation of the Act, which can be disposed of very quickly.

Injunctive relief is an "extraordinary" [*Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312, 102 S. Ct. 1798, 72 L. Ed. 2d 91 (1982)], and "drastic" remedy [*Aaron v. S.E.C.*, 446 U.S. 680, 703, 100 S. Ct. 1945, 64 L. Ed. 2d 611 (1980) (Burger, J., concurring)]. It is even more so when the party to be enjoined is the federal government, for there is a long-standing presumption "that officials of the Executive Branch will adhere to the law as declared by the court. As a result, the declaratory judgment is the functional equivalent of an injunction." *See Comm. on Judiciary of U.S. House of Representatives v. Miers*, 542 F.3d 909, 911 (D.C. Cir. 2008); *accord*

Sanchez-Espinoza v. Reagan, 770 F.2d 202, 208 n.8 (D.C. Cir. 1985) ("declaratory judgment is, in a context such as this where federal officers are defendants, the practical equivalent of specific relief such as an injunction . . . since *it must be presumed that federal officers will adhere to the law as declared by the court*") (Scalia, J.) (emphasis added).

There is no reason to conclude that this presumption should not apply here. Thus, the award of declaratory relief is adequate and separate injunctive relief is not necessary.

CONCLUSION

The existing problems in our national health care system are recognized by everyone in this case. There is widespread sentiment for positive improvements that will reduce costs, improve the quality of care, and expand availability in a way that the nation can afford. This is obviously a very difficult task. Regardless of how laudable its attempts may have been to accomplish these goals in passing the Act, Congress must operate within the bounds established by the Constitution. Again, this case is not about whether the Act is wise or unwise legislation. It is about the Constitutional role of the federal government.

For the reasons stated, I must reluctantly conclude that Congress exceeded the bounds of its authority in passing the Act with the individual mandate. That is not to say, of course, that Congress is without power to address the problems and inequities in our health care system. The health care market is more than one sixth of the national economy, and without doubt Congress has the power to reform and regulate this market. That has not

been disputed in this case. The principal dispute has been about how Congress chose to exercise that power here.[30]

Because the individual mandate is unconstitutional and not severable, the entire Act must be declared void. This has been a difficult decision to reach, and I am aware that it will have indeterminable implications. At a time when there is virtually unanimous agreement that health care reform is needed in this country, it is hard to invalidate and strike down a statute titled "The Patient Protection and Affordable Care Act." As Judge Luttig wrote for an *en banc* Fourth Circuit in

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[30] On this point, it should be emphasized that while the individual mandate was clearly "necessary and essential" to the Act as drafted, it is not "necessary and essential" to health care reform in general. It is undisputed that there are various other (Constitutional) ways to accomplish what Congress wanted to do. Indeed, I note that in 2008, then-Senator Obama supported a health care reform proposal that did not include an individual mandate because he was at that time strongly opposed to the idea, stating that "if a mandate was the solution, we can try that to solve homelessness by mandating everybody to buy a house." *See* Interview on CNN's American Morning, Feb. 5, 2008, transcript available at: http://transcripts.cnn.com/TRANSCRIPTS/0802/05/ltm.02.html. In fact, he pointed to the similar individual mandate in Massachusetts — which was imposed under the state's police power, a power the federal government does not have — and opined that the mandate there left some residents "worse off" than they had been before. *See* Christopher Lee, *Simple Question Defines Complex Health Debate*, Washington Post, Feb. 24, 2008, at A10 (quoting Senator Obama as saying: "In some cases, there are people [in Massachusetts] who are paying fines and still can't afford [health insurance], so now they're worse off than they were . . . They don't have health insurance, and they're paying a fine . . .").

striking down the "Violence Against Women Act" (before the case was appealed and the Supreme Court did the same):

> No less for judges than for politicians is the temptation to affirm any statute so decorously titled. We live in a time when the lines between law and politics have been purposefully blurred to serve the ends of the latter. And, when we, as courts, have not participated in this most perniciously machiavellian of enterprises ourselves, we have acquiesced in it by others, allowing opinions of law to be dismissed as but pronouncements of personal agreement or disagreement. The judicial decision making contemplated by the Constitution, however, unlike at least the politics of the moment, emphatically is not a function of labels. If it were, the Supreme Court assuredly would not have struck down the "Gun-Free School Zones Act," the "Religious Freedom Restoration Act," the "Civil Rights Act of 1871," or the "Civil Rights Act of 1875." And if it ever becomes such, we will have ceased to be a society of law, and all the codification of freedom in the world will be to little avail.

Brzonkala, *supra*, 169 F.3d at 889.

In closing, I will simply observe, once again, that my conclusion in this case is based on an application of the Commerce Clause law as it exists pursuant to the Supreme Court's current interpretation and definition. Only the Supreme Court (or a Constitutional amendment) can expand that.

For all the reasons stated above and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the plaintiffs' motion for summary judgment (doc. 80) is hereby GRANTED as to its request for declaratory relief on Count I of the Second Amended Complaint, and DENIED as to its request for injunctive relief; and the defendants' motion for summary judgment (doc. 82) is hereby GRANTED on Count IV of the Second Amended Complaint. The respective cross-motions are each DENIED.

In accordance with Rule 57 of the Federal Rules of Civil Procedure and Title 28, United States Code, Section 2201 (a), a Declaratory Judgment shall be entered separately, declaring "The Patient Protection and Affordable Care Act" unconstitutional.

DONE and ORDERED this 31st day of January, 2011.

/s/ Roger Vinson
ROGER VINSON
Senior United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

STATE OF FLORIDA, by and through Bill McCollum, et al.;

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

_____/

CASE NO.: 3:10-cv-91-RV/EMT

ORDER AND MEMORANDUM OPINION

Now pending is the defendants' motion to dismiss (doc. 55). This motion seeks dismissal of Counts One, Two, Three, and Six of the plaintiffs' amended complaint for lack of subject matter jurisdiction (pursuant to Rule 12(b)(1), Fed. R. Civ. P.), and dismissal of all counts in the amended complaint for failure to state a claim upon which relief can be granted (pursuant to Rule 12(b)(6), Fed. R. Civ. P.). The plaintiffs have filed a response in opposition, and the defendants have filed a reply to that response. A hearing was held in this matter on September 14, 2010.

I. INTRODUCTION

This litigation — one of many filed throughout the country — raises a facial Constitutional challenge to the federal healthcare reform law, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act"). It has been filed by sixteen state Attorneys General and four state Governors (the "state plaintiffs");[1] two private citizens, Mary Brown and Kaj Ahlburg (the "individual plaintiffs"); and the National Federation of Independent Business ("NFIB") (together, the "plaintiffs"). The defendants are the United States Department of Health and Human Services, Department of Treasury, Department of Labor, and their respective secretaries (together, the "defendants").

Before addressing the plaintiffs' allegations, and the arguments in support of the defendants' motion to dismiss, I will take a moment to emphasize preliminarily what this case is, and is not, about.

The Act is a controversial and polarizing law about which reasonable and intelligent people can disagree in good faith. There are some who believe it will expand access to medical treatment, reduce costs, lead to improved care, have a positive effect on the national economy, and reduce the annual federal

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[1] The state plaintiffs represent: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North and South Dakota, Pennsylvania, South Carolina, Texas, Utah, and Washington.

budgetary deficit, while others expect that it will do exactly the opposite. Some say it was the product of an open and honest process between lawmakers sufficiently acquainted with its myriad provisions, while others contend that it was drafted behind closed doors and pushed through Congress by parliamentary tricks, late night weekend votes, and last minute deals among members of Congress who did not read or otherwise know what was in it. There are some who believe the Act is designed to strengthen the private insurance market and build upon free market principles, and others who believe it will greatly expand the size and reach of the federal government and is intended to create a socialized government healthcare system.

While these competing arguments would make for an interesting debate and discussion, it is not my task or duty to wade into the thicket of conflicting opinion on any of these points of disagreement. For purposes of this case, it matters not whether the Act is wise or unwise, or whether it will positively or negatively impact healthcare and the economy. Nor (except to the limited extent noted in Part III.A(7) *infra*) am I concerned with the manner in which it was passed into law. My review of the statute is not to question or second guess the wisdom, motives, or methods of Congress. I am only charged with deciding if the Act is Constitutional. If it is, the legislation must be upheld — even if it is a bad law. *United States v. Butler*, 297 U.S. 1, 79, 56 S. Ct. 312, 80 L. Ed. 477 (1936) ("For the removal of unwise laws from the statute books appeal lies, not to the courts, but to the ballot and to the processes of democratic government") (Stone, J., dissenting). Conversely, if it is unconstitutional, the legislation must be struck

down — even if it is a good law. *Bailey v. Drexel Furniture Co. (Child Labor Tax Case)*, 259 U.S. 20, 37, 42 S. Ct. 449, 66 L. Ed. 817 (1922) (reviewing court must strike down unconstitutional law even though that law is "designed to promote the highest good. The good sought in unconstitutional legislation is an insidious feature, because it leads citizens and legislators of good purpose to promote it, without thought of the serious breach it will make in the ark of our covenant, or the harm which will come from breaking down recognized standards.").

At this stage in the case, however, my job is much simpler and more narrow than that. In ruling on the defendants' motion to dismiss, I must only decide if this court has jurisdiction to consider some of the plaintiffs' claims, and whether each of the counts of the amended complaint states a plausible claim for relief.

II. BACKGROUND

As Congress has recognized: "By most measures, we have the best medical care system in the world." H.R. Rep. No. 111-443, pt. 1. However, at the same time, no one can deny that there are significant and serious problems. Costs are high and millions do not have insurance. Lack of health insurance can preclude the uninsured from accessing preventative care. If and when the uninsured are injured or become ill, they receive treatment, as the defendants acknowledge, because in this country medical care is generally not denied due to lack of insurance coverage or inability to pay. However, the costs that are incurred to treat the uninsured are sometimes left unpaid — to the tune of $43 billion in 2008 (which is less than 2% of all national healthcare

expenditures for that year). The costs of uncompensated care are passed along to market participants in the form of higher costs and raised premiums, which, in turn, can help perpetuate the cycle (or the "premium spiral," as the defendants call it) and add to the number of uninsured. It was against this backdrop that Congress passed the Act.

A. The Legislative Scheme

At nearly 2,700 pages, the Act is very lengthy and includes many provisions, only a few of which are specifically at issue in this litigation. Chief among them is Section 1501, which, beginning in 2014, will require that all citizens (with stated exceptions) obtain federally-approved health insurance, or pay a monetary penalty (the "individual mandate"). This provision is necessary, according to Congress and the defendants, to lower premiums (by spreading risks across a much larger pool) and to meet "a core objective of the Act," which is to expand insurance coverage to the uninsured by precluding the insurance companies from refusing to cover (or charging exorbitant rates to) people with pre-existing medical conditions. Without the individual mandate and penalty in place, the argument goes, people would simply "game the system" by waiting until they get sick or injured and only then purchase health insurance (that insurers must by law now provide), which would result in increased costs for the insurance companies. This is known as "the moral hazard." The increased costs would ultimately be passed along to consumers in the form of raised premiums, thereby creating market pressures that would (arguably) inevitably drive the health insurance industry into extinction. The plaintiffs

allege that regardless of whether the individual mandate is well-meaning and essential to the Act, it is unconstitutional and will have both a "profound and injurious impact" on the states, individuals, and businesses.

The plaintiffs object to several interrelated portions of the Act as well. First, the Act significantly alters and expands the Medicaid program. Created in 1965, Medicaid is a cooperative federal-state program that provides for federal financial assistance (in the form of matching funds) to states that elect to provide medical care to needy persons. The Act will add millions of new enrollees to the states' Medicaid rolls by expanding the program to include all individuals under the age of 65 with incomes up to 133% of the federal poverty line. Second, the Act provides for creation of "health benefit exchanges" designed to allow individuals and small businesses to leverage their buying power to obtain competitive prices. The Act contemplates that these exchanges will be set up and operated by the states, or by the federal government if the states elect not to do so. And lastly, the Act requires that the states (along with other "large employers") provide their employees with a prescribed minimum level of health insurance coverage (the "employer mandate"). The plaintiffs allege that these several provisions violate the Constitution and state sovereignty by coercing and commandeering the states and depriving them of their "historic flexibility" to run their state government, healthcare, and Medicaid programs. The plaintiffs anticipate that these and various other provisions in the Act will cost Florida (and the other states similarly) billions of dollars between now and the year 2019, not including the administrative costs

it will take to implement the Act, and that these costs will only increase in the subsequent years. In short, the plaintiffs contend that the legislation is coercive, intrusive, and could bankrupt the states.[2]

B. This Lawsuit and the Motion to Dismiss

The plaintiffs advance six causes of action in their amended complaint, and they seek declaratory and injunctive relief with respect to each. They contend that the Act violates the Constitution in the following ways: (1) the individual mandate and concomitant penalty exceed Congress's authority under the Commerce Clause and violate the Ninth and Tenth Amendments (Count I); (2) the individual mandate and penalty violate substantive due process under the Fifth Amendment (Count II); (3) "alternatively," if the penalty imposed for failing to comply with the individual mandate is found to be a tax, it is an unconstitutional unapportioned capitation or direct tax in violation of U.S. Const. art. I, § 9, cl. 4, and the Ninth and Tenth Amendments (Count III); (4) the Act coerces and commandeers the states with respect to Medicaid by altering and expanding the program in violation of Article I and the Ninth and Tenth Amendments (Count IV); (5) it coerces and commandeers with respect to the health benefit exchanges in violation of Article I and the Ninth and Tenth Amendments (Count V); and (6) the

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[2] Not all states feel this way, and there is even a division within a few of the plaintiff states. Three Attorneys General and four Governors previously requested leave to participate in this case as *amici curiae*, and they have indicated that they favor the changes the Act will bring as they believe the new legislation will save money and reduce their already overburdened state budgets (docs. 57, 59).

employer mandate interferes with the states' sovereignty as large employers and in the performance of government functions in violation of Article I and the Ninth and Tenth Amendments (Count VI). *See generally* Amended Complaint ("Am. Compl.") (doc. 42).

The defendants seek to have the complaint dismissed on numerous grounds; four of the counts for lack of jurisdiction (under Rule 12(b)(1)), and all six of them for failure to state a claim upon which relief can be granted (under Rule 12(b)(6)). With respect to jurisdiction, the defendants contend that for the challenges to the individual mandate and employer mandate (Counts I, II, and VI), the plaintiffs lack standing; the claims are not ripe; and the claims are barred by the Anti-Injunction Act. (By not raising similar arguments for Counts IV and V, the defendants appear to impliedly concede that those counts allege injuries that are immediately ripe for review). As for the plaintiffs' "alternative" cause of action contending that, if the individual mandate penalty is deemed to be a tax, then it is an impermissible and unconstitutional one (Count III), the defendants maintain that, too, is precluded by the Anti-Injunction Act.

If the foregoing jurisdictional challenges fail, the defendants go on to assert that those causes of action, and all others, fail to state a claim for which relief can be granted.

III. DISCUSSION

A. Is the "Penalty" for Non-Compliance with the Individual Mandate Actually a "Tax" for Constitutional Analysis?

A fundamental issue overlaps the defendants' challenges to several of the plaintiffs' claims, and that is whether the individual mandate penalty is a "tax" within Congress's broad taxing power and thus subject to the Anti-Injunction Act, or instead, a "penalty" that must be authorized, if at all, by Congress's narrower Commerce Clause power. Because of the importance of this issue, I will analyze it first and at some length.

The defendants contend that the individual mandate penalty is a tax that is sustainable under Congress's expansive power to tax for the general welfare. U.S. Const. art I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the . . . general Welfare"). The plaintiffs urge that, if it is a tax, it is an unconstitutional one. The defendants maintain that the plaintiffs have no standing to raise the claim at this point in time because of the Anti-Injunction Act.

The Anti-Injunction Act [26 U.S.C. § 7421(a)] provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person . . . ." The remedy for challenging an improper tax is a post-collection suit for refund. As the Supreme Court has explained:

> The Anti-Injunction Act . . . could scarcely be more explicit — "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court . . ." The Court has interpreted the principal purpose of this language to be the protection of the Government's need to assess and

> collect taxes as expeditiously as possible with a minimum of preenforcement judicial interference, "and to require that the legal right to the disputed sums be determined in a suit for refund." The Court has also identified "a collateral objective of the Act — protection of the collector from litigation pending a suit for refund."

Bob Jones Univ. v. Simon, 416 U.S. 725, 736-37, 94 S. Ct. 2038, 40 L. Ed. 2d 496 (1974) (citations omitted); *accord*, *e.g.*, *United States v. Clintwood Elkhorn Min. Co.*, 553 U.S. 1, 10, 128 S. Ct. 1511, 170 L. Ed. 2d 392 (2008) ("[The Anti-Injunction Act] commands that (absent certain exceptions) 'no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court,'" even if the tax is alleged to be unconstitutional, which means "the taxpayer must succumb to an unconstitutional tax, and seek recourse only after it has been unlawfully exacted"); *Enochs v. Williams Packing & Navigation Co.*, 370 U.S. 1, 7, 82 S. Ct. 1125, 8 L. Ed. 2d 292 (1962) (explaining that the "manifest purpose" of the Anti-Injunction Act "is to permit the United States to assess and collect taxes alleged to be due without judicial intervention, and to require that the legal right to the disputed sums be determined in a suit for refund. In this manner the United States is assured of prompt collection of its lawful revenue."). The Anti-Injunction Act, in short, applies to "truly revenue-raising tax statutes," *see Bob Jones Univ.*, *supra*, 416 U.S. at 743, and seeks "protection of the revenues" pending a suit for refund. *See id.* at 737, 740.

Because the individual mandate does not go into effect until 2014, which means the penalty for non-

compliance could not be assessed until that time, the Anti-Injunction Act, if it applies, could render much of this case premature and inappropriate as any injunctive or declaratory relief in favor of the plaintiffs could hinder collection of tax revenue. *See id.* at 732 n.7, 738-39 (where the outcome of a suit seeking injunctive or declaratory relief will prevent assessment and collection of tax revenue, the case "falls within the literal scope and the purposes of the [Anti-Injunction Act]"). Consequently, whether the individual mandate penalty is a tax is an important question that not only implicates jurisdiction (vis-a-vis the Anti-Injunction Act), and is not only the specific basis of one of the plaintiffs' causes of action, but it also goes to the merits of the individual mandate-related challenges of Counts One and Two (that is, whether the penalty can be justified by, and enforced through, Congress's indisputably broad taxing power), or whether, instead, the penalty must pass Constitutional muster, if at all, under the more limited Commerce Clause authority. As noted, I should, and will, consider this significant issue at the outset.[3]

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[3] The plaintiffs have briefly suggested that the Anti-Injunction does not apply to this case because their challenge "is to the individual mandate itself" and not the "incidental penalty that accompanies the individual mandate." While it is true that the language of the Anti-Injunction Act only prohibits suits "for the purpose of restraining the assessment or collection of any tax," which would not apply to the individual mandate for every citizen to maintain healthcare coverage, the mandate and penalty clearly work in tandem. If the penalty is a legitimate tax, striking the individual mandate down will necessarily impede assessment and collection of tax revenue. The Anti-Injunction Act is not limited to direct and actual tax assessment or collection; the Eleventh Circuit and other courts have held

(1) Revenue-raising vs. regulatory

The plaintiffs contend that the individual mandate penalty is not a "true tax" because, among other things, it will (at most) "generate only 'some revenue,' and then only as an incident to some persons' failure to obey the law." See Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss ("Pl. Mem."), at 19 (doc. 68). In other words, because its primary purpose is regulatory — and will only raise "little" revenue — it is not a tax as the term is generally understood. It is true, as held in certain of the early tax cases to which the plaintiffs cite, *see*, *e.g.*, *Lipke v. Lederer*, 259 U.S. 557, 42 S. Ct. 549, 66 L. Ed. 1061 (1922); *Hill v. Wallace*, 259 U.S. 44, 42 S. Ct. 453, 66 L. Ed. 822 (1922), that the Supreme Court once drew distinctions between regulatory and revenue-raising taxes. However, those holdings had a very short shelf-life. As noted in *Bob Jones Univ.*, *supra*, which cited to *Lipke* and *Hill* for that position, "the Court . . . subsequently abandoned such distinctions." 416 U.S. at 741 n.12; *see also id.* at 743 (further stating that the cases were "of narrow scope" and "produced a prompt correction in course").

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that the statute also reaches activities that may "eventually" impede the collection of revenue (even if indirectly). *See*, *e.g.*, *Gulden v. United States*, 287 Fed. Appx. 813, 815-17 (11th Cir. 2008) (explaining that the Anti-Injunction Act is "interpreted broadly" and "bars not only suits that directly seek to restrain the assessment or collection of taxes, but also suits that seek to restrain . . . activities 'which are intended to or may culminate in the assessment or collection of taxes'") (citation omitted); *Judicial Watch Inc. v. Rossotti*, 317 F.3d 401, 405 (4th Cir. 2003) ("it is clear that the Anti-Injunction Act extends beyond the mere assessment and collection of taxes to embrace other activities," such as those that may eventually "culminate in the assessment or collection of taxes").

Succeeding case law recognized that "[e]very tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed. But a tax is not any the less a tax because it has a regulatory effect." *Sonzinsky v. United States*, 300 U.S. 506, 513, 57 S. Ct. 554, 81 L. Ed. 772 (1937); *see also id.* ("it has long been established that an Act of Congress which on its face purports to be an exercise of the taxing power is not any the less so because the tax . . . tends to restrict or suppress the thing taxed"). Thus, as the law currently exists, "[i]t is beyond serious question that a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed. The principle applies even though the revenue obtained is obviously negligible, or the revenue purpose of the tax may be secondary." *United States v. Sanchez*, 340 U.S. 42, 44, 71 S. Ct. 108, 95 L. Ed. 47 (1950); *accord United States v. Kahriger*, 345 U.S. 22, 27 n.3, 28, 73 S. Ct. 510, 97 L. Ed. 754 (1953) (holding same and sustaining federal gambling tax even though its proponents sought to hinder the activity at issue and "'indulge[d] the hope that the imposition of this type of tax would eliminate that kind of activity'"), overruled on other grounds, *Marchetti v. United States*, 390 U.S. 39, 88 S. Ct. 697, 19 L. Ed. 2d 889 (1968). The elimination of the "regulatory vs. revenue-raising" test does not necessarily mean, however, that the exaction at issue in this case is a "tax."

(2) The Court's role in ascertaining what Congress intended

In deciding this specific question, I will start from the assumption (only for the analysis of whether it is

a tax) that Congress could have used its broad taxing power to impose the exaction and that, if it had clearly (or even arguably) intended to do so, then the exaction would have been sustainable under its taxing authority. *See Kahriger*, *supra*, 345 U.S. at 28, 31 ("As is well known, the constitutional restraints on taxing are few," and courts are generally "without authority to limit the exercise of the taxing power"); *see also United States v. Ptasynski*, 462 U.S. 74, 103 S. Ct. 2239, 76 L. Ed. 2d 427 (1983) (observing that "Congress's power to tax is virtually without limitation").[4] However, that is not what happened here. Although factually dissimilar, on this point I find instructive the early case of *Helwig v. United States*, 188 U.S. 605, 23 S. Ct. 427, 47 L. Ed. 614 (1903). At issue in that case was a federal law that required importers to pay a duty on imported items based on their declared value, plus "a further sum" for any item subsequently found to have been inadequately valued. The sole question the Supreme Court was called upon to decide was whether, for jurisdictional purposes, the so-called "further sum" was "revenue from imports or tonnage" (i.e., a tax), or whether it was in the nature of a penalty. The Court stated:

> Although the statute, under § 7, *supra*, terms the money demanded as 'a further sum,' and does not describe it as a penalty, still the use of those words does not change the nature and character of the enactment. *Congress may enact that such a provision shall not be considered as a penalty or in the nature of*

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[4] *But see* the discussion with respect to Count Three, Part III.C(4) *infra*.

> *one*, *. . . and it is the duty of the court to be governed by such statutory direction*, but the intrinsic nature of the provision remains, and, *in the absence of any declaration by Congress affecting the manner in which the provision shall be treated*, courts must decide the matter in accordance with their views of the nature of the act.

Id. at 612-13 (emphasis added). In concluding that the provision was a penalty, the Court stated that, based on the statutory language and its application to the facts of the case, it was "impossible *. . .* to hold this provision to be other than penal in its nature." *Id.* at 613. To be clear, it is *not* necessarily significant for our purposes that *Helwig* found the "further sum" to be in the nature of a penalty and not a tax; rather, what is significant is what the Supreme Court said along the way to getting there. In reaching its conclusion, the Court made it a point to stress — as it did in the emphasized portion quoted above — that regardless of the "ordinary or general meaning of the words" in the statute, and regardless of the "nature and character of the enactment," the exaction would *not* have been found a penalty if Congress intended otherwise. Thus, "[i]f it clearly appear that it is the will of Congress that the provision shall *not* be regarded as in the nature of a penalty, *the court must be governed by that will*." *Id.* (emphasis added).

As applied to the facts of this case, *Helwig* can be interpreted as concluding that, regardless of whether the exaction could otherwise qualify as a tax (based on the dictionary definition or "ordinary or general meaning of the word"), it cannot be regarded as one if it "clearly appears" that Congress did not intend it to

be. In this case, there are several reasons (perhaps none dispositive alone, but convincing in total) why it is inarguably clear that Congress did not intend for the exaction to be regarded as a tax.[5]

(3) Congress did not call it a tax, despite knowing how to do so

In addition to the Act, there were several healthcare reform bills introduced and debated during the 111th Congress. For example, "America's Affordable Health Choices Act of 2009" (H.R. 3200) was introduced in the House of Representatives on July 14, 2009. Like the Act, it contained an individual mandate and concomitant penalty. However, it called the penalty a tax. Section 401 was unambiguously titled "Tax on Individuals Without Acceptable Health Care Coverage," and went on to refer to the exaction as a "tax" no less than fourteen times in that section alone. *See*, *e.g.*, *id.* (providing that with respect to "any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax"). H.R. 3200 was thereafter superseded by a

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[5] Although it only matters what Congress intended, I note for background purposes that before the Act was passed into law, one of its chief proponents, President Barack Obama, strongly and emphatically denied that the penalty was a tax. When confronted with the dictionary definition of a "tax" during a much-publicized interview widely disseminated by all of the news media, and asked how the penalty did not meet that definition, the President said it was "absolutely not a tax" and, in fact, "[n]obody considers [it] a tax increase." *See*, *e.g.*, *Obama: Requiring Health Insurance is Not a Tax Increase*, CNN, Sept. 29, 2009, available at: http://www.cnn.com/2009/POLITICS/09/20/obama.health.care/index.html.

similar bill, "Affordable Health Care for America Act" (H.R. 3962), which was actually passed in the House of Representatives on November 7, 2009. That second House bill also included an individual mandate and penalty, and it repeatedly referred to the penalty as a "tax." *See*, *e.g.*, Section 501 (providing that for any person who does not comply with the individual mandate "there is hereby imposed a tax," and referring to that "tax" multiple times); Section 307(c)(1)(A) (further referring to the penalty as a "tax[ ] on individuals not obtaining acceptable coverage").

While the above bills were being considered in the House, the Senate was working on its healthcare reform bills as well. On October 13, 2009, the Senate Finance Committee passed a bill, "America's Healthy Future Act" (S. 1796). A precursor to the Act, this bill contained an individual mandate and accompanying penalty. In the section titled "Excise Tax on Individuals Without Essential Health Benefits Coverage," the penalty was called a "tax." *See* Section 1301 ("If an applicable individual fails to [obtain required insurance] there is hereby imposed a tax").

In contrast to the foregoing, the Act — which was the final version of the healthcare legislation later passed by the Senate on December 24, 2009 — did *not* call the failure to comply with the individual mandate a tax; it was instead called a "penalty." The Act reads in pertinent part: "If an applicable individual fails to meet the requirement of subsection (a) . . . there is hereby imposed a penalty." Act § 1501(b)(1). Congress's conspicuous decision to not use the term "tax" in the Act when referring to the exaction (as it had done in at least three earlier

incarnations of the legislation) is significant. "'Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language.'" *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442, 107 S. Ct. 1207, 94 L. Ed. 2d 434 (1987). Thus, "[w]here Congress includes [certain] language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the [omitted text] was not intended." *Russello v. United States*, 464 U.S. 16, 23-24, 104 S. Ct. 296, 78 L. Ed. 2d 17 (1983); *see also United States v. NEC Corp.*, 931 F.2d 1493, 1502 (11th Cir. 1991) (changes in statutory language "generally indicate[ ] an intent to change the meaning of the statute"); *Southern Pac. Transportation Co. v. Usery*, 539 F.2d 386, 390-91 (5th Cir. 1976) (rejecting the interpretation of a statute that was based on language in an earlier House version that the Senate changed prior to passing into law, and attaching "weight to the [Senate's] conscious and deliberate substitution of [the House's] language") (binding under *Bonner v. City of Prichard, Alabama*, 661 F.2d 1206, 1207 (11th Cir. 1981) (*en banc*)).

Congress's failure to call the penalty a "tax" is especially significant in light of the fact that the Act itself imposes a number of taxes in several other sections (*see*, *e.g.*, Excise Tax on Medical Device Manufacturers, § 1405 ("There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax"); Excise Tax on High Cost Employer-Sponsored Health Coverage, § 9001 ("there is hereby imposed a tax"); Additional Hospital Insurance Tax on High-Income

Taxpayers, § 9015 ("there is hereby imposed a tax"); Excise Tax on Indoor Tanning Services, § 10907 ("There is hereby imposed on any indoor tanning service a tax")). This shows beyond question that Congress knew how to impose a tax when it meant to do so. Therefore, the strong inference and presumption must be that Congress did not intend for the "penalty" to be a tax. *See generally Hodge v. Muscatine County*, 196 U.S. 276, 25 S. Ct. 237, 49 L. Ed. 477 (1905) (noting that "[i]t is not easy to draw an exact line of demarcation between a tax and a penalty," but where the statute uses "tax" in one section and "penalty" in another, courts "cannot go far afield" in treating the exaction as it is called; to do otherwise "would be a distortion of the words employed"); *see also Duncan v. Walker*, 533 U.S. 167, 173, 121 S. Ct. 2120, 150 L. Ed. 2d 251 (2001) ("It is well settled that '[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.'") (citations omitted); *Freemanville Water Sys., Inc. v. Poarch Band of Creek Indians*, 563 F.3d 1205, 1209 (11th Cir. 2009) ("[W]here Congress knows how to say something but chooses not to, its silence is controlling"); *DIRECTV, Inc. v. Brown*, 371 F.3d 814, 818 (11th Cir. 2004) ("[W]hen Congress uses different language in similar sections, it intends different meanings.").

The defendants assert in their memorandum, *see* Memorandum in Support of Defendants' Motion to Dismiss ("Def. Mem."), at 33, 50 n.23 (doc. 56-1), as they did during oral argument, that in deciding whether the exaction is a penalty or tax, "it doesn't

matter" what Congress called it because the label "is not conclusive." *See* Transcript of Oral Argument ("Tr."), at 27-29 (doc. 77). As a general rule, it is true that the label used is not controlling or dispositive because Congress, at times, may be unclear and use inartful or ambiguous language. Therefore, as the Supreme Court recognized more than 100 years ago in *Helwig*, *supra*, the use of a particular word "does not change the nature and character of the [exaction]," and it is the ultimate duty of the court to decide the issue based on "the intrinsic nature of the provision" irrespective of what it is called. *See* 188 U.S. at 612-13; *accord Cooley v. Bd. of Wardens*, 53 U.S. (12 How.) 299, 314, 13 L. Ed. 996 (1851) ("it is the thing, and not the name, which is to be considered"). However, as also noted in *Helwig*, this rule must be set aside when it is clear and manifest that Congress intended the exaction to be regarded as one and not the other. For that reason, the defendants are wrong to contend that what Congress called it "doesn't matter." To the extent that the label used is not just a label, but is actually indicative of legislative purpose and intent, it very much does matter. By deliberately changing the characterization of the exaction from a "tax" to a "penalty," but at the same time including many other "taxes" in the Act, it is manifestly clear that Congress intended it to be a penalty and not a tax.[6]

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[6] A hypothetical helps to further illustrate this point. Suppose that after the Act imposed the penalty it went on to expressly state: "This penalty is not a tax." According to the logic of the defendants' argument, if the intrinsic nature of the penalty was a tax, it could still be regarded as one despite what it was called and despite the clear and unmistakable Congressional intent to the contrary. Such an outcome would be absurd. In my view,

Quoting the Third Circuit in *Penn Mut. Indem. Co. v. C.I.R.*, 277 F.2d 16, 20 (3d Cir. 1960), the defendants maintain that "'Congress has the power to impose taxes generally, and if the particular imposition does not run afoul of any constitutional restrictions then the tax is lawful, call it what you will.'" Def. Mem. at 50 n.23. I do not necessarily disagree with this position, at least not when it is quite clear that Congress intends to impose a tax and is acting pursuant to its taxing power. However, as will be discussed in the next section, that is not the situation here. In the *Penn Mutual Indemnity* case, for example, it was clear and undisputed that Congress had exercised its taxing authority to impose the exaction; it was inarguably a "tax," and the only question was whether it was an excise tax, an income tax, or some other type of tax. It was in that particular context that the Third Circuit's analysis included the quoted statement, and further elaborated that: "It is not necessary to uphold the validity of the tax imposed by the United States that the tax itself bear an accurate label." *See* 277 F.2d at 20. That is obviously a very different situation from the one presented here, where the precise *label* of an acknowledged tax is not being disputed, but rather whether it is even a tax *at all*.

(4) Congress did not state that it was acting under its taxing authority, and, in fact, it treated the penalty differently than traditional taxes

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changing the word from tax to penalty, but at the same time including various other true (and accurately characterized) taxes in the Act, is the equivalent of Congress saying "This penalty is not a tax."

Congress did not state in the Act that it was exercising its taxing authority to impose the individual mandate and penalty; instead, it relied exclusively on its power under the Commerce Clause. U.S. Const. art I, § 8, cl. 3 ("[Congress shall have Power] To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes"). The Act recites numerous (and detailed) factual findings to show that the individual mandate regulates commercial activity important to the economy. Specifically, it states that: "The [individual mandate] is commercial and economic in nature, and substantially affects interstate commerce" in that, *inter alia*, "[h]ealth insurance and health care services are a significant part of the national economy" and the mandate "will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services." Act § 1501(a)(1)-(2)(B)(C). It further states that health insurance "is in interstate commerce," and the individual mandate is "essential to creating effective health insurance markets." *Id.* § 1501(a)(2)(F), (H). The Act contains *no* indication that Congress was exercising its taxing authority or that it meant for the penalty to be regarded as a tax. Although the penalty is to be placed in the Internal Revenue Code under the heading "Miscellaneous Excise Taxes," the plain language of the Code itself states that this does not give rise to any inference or presumption that it was intended to be a tax. *See United States v. Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 222-23, 116 S. Ct. 2106, 135 L. Ed. 2d 506 (1996) (citing to 26 U.S.C. § 7806(b), which provides that: "No inference, implication, or presumption of legislative construction shall be

drawn or made by reason of the location or grouping of any particular section or provision or portion of this title"). In fact, while the penalty is placed under the "Excise Taxes" heading of the Code, at the same time Congress specifically exempted and divorced the penalty from all the traditional enforcement and collection methods used by the Internal Revenue Service, such as tax liens, levies, and criminal proceedings. *See* Act § 1501(b). These exemptions from normal tax attributes — coupled with Congress's failure to identify its taxing authority — belie the claim that, simply because it is mentioned in the Internal Revenue Code, the penalty must be a tax.[7]

(5) Lack of statutorily-identified revenue-generating purpose

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[7] In highlighting that Congress did not identify its taxing power as the basis for imposing the "penalty," I am not suggesting that legislative action is invalid if a power source is not identified. To the contrary, I recognize that "Congress's failure to cite [a particular power] does not eliminate the possibility that [said power] can sustain this legislation." *United States v. Moghadam*, 175 F.3d 1269, 1275 n.10 (11th Cir. 1999); *see also Wilson-Jones v. Caviness*, 99 F.3d 203, 208 (6th Cir. 1996) ("A source of power [can] justify an act of Congress even if Congress did not state that it rested the act on the particular source of power.") (citing cases, including *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144, 68 S. Ct. 421, 92 L. Ed. 596 (1948) ("The question of the constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise.")). Thus, to be clear, I am not saying that the penalty is invalid as a tax because Congress did not expressly identify its taxing power. Rather, its failure to do so (particularly when it took time to extensively identify its Commerce Clause power), is merely one of several facts that shows Congress was not exercising its taxing authority and did not intend for the penalty to be regarded as a tax.

Perhaps most significantly, the Act does not mention any revenue-generating purpose that is to be served by the individual mandate penalty, even though such a purpose is required. *See Rosenberger v. Rector and Visitors of Univ. of Virginia*, 515 U.S. 819, 841, 115 S. Ct. 2510, 132 L. Ed. 2d 700 (1995) ("'A tax, in the general understanding of the term, and as used in the Constitution, signifies an exaction for the support of the Government'"). In this circuit, the ultimate test of tax validity "is whether *on its face* the tax operates as a revenue generating measure and the attendant regulations are in aid of a revenue purpose." *United States v. Ross*, 458 F.2d 1144, 1145 (5th Cir. 1972) (emphasis added) (binding under *Bonner*, *supra*, 661 F.2d at 1207).

The revenue-generating provisions in the Act were an important part of the legislation as they were necessary under current Congressional procedure to score its final cost. To be sure, much of the debate within and outside Congress focused on the bill's final price tag and whether it would exceed the threshold of $1 trillion over the course of the first ten years; and while the legislation was being debated, Congress worked closely and often with the Congressional Budget Office ("CBO") to ensure that it did not. Obviously, if the penalty had been intended by Congress to be a true revenue-generating tax (that could be used to keep the Act's final cost down) then it would have been treated as a tax "on its face." During oral argument, defense counsel stated that "[t]he purpose of the [penalty] is . . . to raise revenue to offset expenditures of the federal government that it makes in connection, for example, with the Medicaid expansion." *See* Tr. at 9. However, there is

absolutely no support for that statement in the statute itself.

On its face, the Act lists seventeen "Revenue Offset Provisions" (including the several taxes described *supra*), and, as reconciled, it further includes a section entitled "Provisions Relating to Revenue" (which also references those taxes and other revenue offsetting provisions). However, the individual mandate penalty is not listed anywhere among them. Nowhere in the statute is the penalty provision identified or even mentioned as raising revenue and offsetting the Act's costs. It is especially noteworthy that the Act does not identify revenue to be generated from the penalty (which the defendants now maintain would raise about *$4 billion* each year), but the statute identifies the tanning salon tax as revenue-raising (even though that tax is expected to raise a significantly smaller *$300 million* annually). *See* Joint Committee on Taxation, Estimated Revenue Effects of the Manager's Amendment to the Revenue Provisions Contained in the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009 (JCX-10-10), March 11, 2010, at 2. If Congress had intended and understood the penalty to be a tax that would raise revenue for the government, which could in turn be used to partially finance the Act's budgetary effect and help keep its ten-year cost below the $1 trillion threshold by offsetting its expenditures, it makes little sense that Congress would ignore a "tax" that could be expected to raise almost $20 billion in revenue between the years 2015-2019, yet mention another tax that was expected to raise less than one-tenth of that revenue annually during the same time period.

To the extent there is statutory ambiguity on this issue, both sides ask that I look to the Act's legislative history to determine if Congress intended the penalty to be a tax. Ironically, they rely on the same piece of legislative history in making their respective arguments, to wit, the 157-page "Technical Explanation" of the Act that was prepared by the Staff of the Joint Committee on Taxation on March 21, 2010 (the same day the House voted to approve and accept the Senate bill and two days before the bill was signed into law). The plaintiffs highlight the fact that the report "consistently" refers to the penalty as a penalty and *not* a tax, *see* Pl. Mem. at 19 (as compared, for example, with the tanning salon tax that is consistently referred to as a "tax" in that same report, *see* JCT, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in Combination with the "Patient Protection and Affordable Care Act" (JCX-18-10), March 21, 2010, at 108). The defendants, on the other hand, highlight the fact that the JCT referred to the penalty as an "excise tax" in a single heading in that report. *See* Def. Mem. at 51.

As the Supreme Court has repeatedly held, "the authoritative statement is the statutory text, not the legislative history or any other extrinsic material. Extrinsic materials have a role in statutory interpretation *only* to the extent they shed a reliable light on the enacting Legislature's understanding of otherwise *ambiguous terms*." *Exxon Mobil Corp. v. Allapattah Services, Inc.*, 545 U.S. 546, 568, 125 S. Ct. 2611, 162 L. Ed. 2d 502 (2005) (emphasis added). On the facts of this case, "penalty" is not an ambiguous term, but rather was a carefully and intentionally selected word that has a specific

meaning and carries a particular import (discussed *infra*). Moreover, even if the term was ambiguous, the Supreme Court has pointed out two "serious criticisms" of attempting to rely on legislative history:

> Not all extrinsic materials are reliable sources of insight into legislative understandings . . ., and legislative history in particular is vulnerable to two serious criticisms. First, legislative history is itself often murky, ambiguous, and contradictory. Judicial investigation of legislative history has a tendency to become, to borrow Judge Leventhal's memorable phrase, an exercise in "'looking over a crowd and picking out your friends.'" *See* Wald, Some Observations on the Use of Legislative History in the 1981 Supreme Court Term, 68 Iowa L. Rev. 195, 214 (1983). Second, judicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article I, may give unrepresentative committee members — or, worse yet, unelected staffers and lobbyists — both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text. *Id.*

In this case, both criticisms are directly on the mark. The report is ambiguous and contradictory, as evidenced by the simple fact that both sides claim it supports their position. Should I look to the heading (that calls the exaction an "excise tax"), or should I look to the actual body of the report (that calls it a penalty no less than twenty times with no mention of

it being a tax)? It is, as Judge Leventhal said, like "looking over a crowd and picking out your friends." Further, a strong argument could be (and has been) made that the staffers who drafted the report were merely engaging in last minute "strategic manipulation" to secure results they were unable to achieve through the Act itself. *See*, *e.g.*, *The Insurance Mandate in Peril*, Wall St. J., Apr. 29, 2010, at A19 (opining that the "excise tax" heading in the JCT report should not be used to convert the penalty into a tax because the Supreme Court "will not allow staffers and lawyers to change the statutory cards that Congress already dealt when it adopted the Senate language"). For these reasons, as recognized by the Supreme Court, resort to, or reliance upon, the JCT staff's Technical Explanation would be inappropriate on the facts of this case — even if the term "penalty" was ambiguous (which it is not).

To summarize the foregoing, it "clearly appears" from the statute itself, *see Helwig*, *supra*, 188 U.S. 613, that Congress did not intend to impose a tax when it imposed the penalty. To hold otherwise would require me to look beyond the plain words of the statute. I would have to ignore that Congress:

(i) specifically changed the term in previous incarnations of the statute from "tax" to "penalty;"

(ii) used the term "tax" in describing the several other exactions provided for in the Act;

(iii) specifically relied on and identified its Commerce Clause power and not its taxing power;

(iv) eliminated traditional IRS enforcement methods for the failure to pay the "tax;" and

(v) failed to identify in the legislation any revenue that would be raised from it, notwithstanding that at least seventeen other revenue-generating provisions were specifically so identified.

The defendants have not pointed to any reported case decided by any court of record that has ever found and sustained a tax in a situation such as the one presented here, and my independent research has also revealed none. At bottom, the defendants are asking that I divine hidden and unstated intentions, and despite considerable evidence to the contrary, conclude that Congress really meant to say one thing when it expressly said something else. The Supreme Court confronted the inverse of this situation in *Sonzinsky*, *supra*, and I believe the rationale of that case forecloses the defendants' argument.

The issue in *Sonzinsky* was whether a levy on the sale of firearms was a tax. The exaction was called a tax on its face, and it was undisputed that it had been passed pursuant to Congress's taxing power. Nonetheless, the petitioner sought to invalidate the tax because it was "prohibitive in effect and [disclosed] unmistakably the legislative purpose to regulate rather than to tax." The petitioner argued that it was not "a true tax, but a penalty." In rejecting this argument, the Supreme Court explained:

> Inquiry into the hidden motives which may move Congress to exercise a power constitutionally conferred upon it is beyond the competency of courts. They will not undertake, by collateral inquiry as to the measure of the regulatory effect of a tax, to

> ascribe to Congress an attempt, under the guise of taxation, to exercise another power.

Stated somewhat differently, reviewing courts cannot look beyond a statute and inquire as to whether Congress meant something different than what it said. If an exaction says "tax" on its face and was imposed pursuant to Congress's taxing power, courts "are not free to speculate as to the motives which moved Congress to impose it, or as to the extent to which it may [be a penalty intended] to restrict the activities taxed." *See generally Sonzinsky*, *supra*, 300 U.S. at 511-14; *accord Kahriger*, *supra*, 345 U.S. at 22 (similarly declining invitation to hold that "under the pretense of exercising" a particular power, Congress was, in fact, exercising another power).

The holding of *Sonzinsky* cuts both ways, and applying that holding to the facts here, I have no choice but to find that the penalty is not a tax. Because it is called a penalty on its face (and because Congress knew how to say "tax" when it intended to, and for all the other reasons noted), it would be improper to inquire as to whether Congress really meant to impose a tax. I will not assume that Congress had an unstated design to act pursuant to its taxing authority, nor will I impute a revenue-generating purpose to the penalty when Congress specifically chose not to provide one. It is "beyond the competency" of this court to question and ascertain whether Congress really meant to do and say something other than what it did. As the Supreme Court held by necessary implication, this court cannot "undertake, by collateral inquiry as to the measure of the [revenue-raising] effect of a [penalty],

to ascribe to Congress an attempt, under the guise of [the Commerce Clause], to exercise another power." *See Sonzinsky*, *supra*, 300 U.S. at 514. This conclusion is further justified in this case since President Obama, who signed the bill into law, has "absolutely" rejected the argument that the penalty is a tax. *See supra* note 5.

To conclude, as I do, that Congress imposed a penalty and not a tax is not merely formalistic hair-splitting. There are clear, important, and well-established differences between the two. *See Dep't of Revenue of Montana v. Kurth Ranch*, 511 U.S. 767, 779-80, 114 S. Ct. 1937, 128 L. Ed. 2d 767 (1994) ("Whereas [penalties] are readily characterized as sanctions, taxes are typically different because they are usually motivated by revenue-raising, rather than punitive, purposes."); *Reorganized CF&I Fabricators of Utah, Inc.*, *supra*, 518 U.S. at 224 ("'a tax is a pecuniary burden laid upon individuals or property for the purpose of supporting the Government,'" whereas, "if the concept of penalty means anything, it means punishment for an unlawful act or omission"); *United States v. La Franca*, 282 U.S. 568, 572, 51 S. Ct. 278, 75 L. Ed. 551 (1931) ("A 'tax' is an enforced contribution to provide for the support of government; a 'penalty,' as the word is here used, is an exaction imposed by statute as punishment for an unlawful act.'"). Thus, as the Supreme Court has said, "[t]he two words are not interchangeable one for the other . . .; and if an exaction be clearly a penalty it cannot be converted into a tax by the simple expedient of calling it such." *La Franca*, *supra*, 282 U.S. at 572.

(6) Does the Anti-Injunction Act apply anyway?

The defendants insist that the Anti-Injunction Act should still preclude the individual mandate challenges even if the penalty is not a tax. For this argument, the defendants rely on Title 26, United States Code, Section 6671, which states that the "penalties" provided under subchapter B of chapter 68 of the IRS Code (a classification that includes the individual mandate penalty) "shall be assessed and collected in the same manner as taxes." If the penalty is intended to be assessed and collected in the same manner as a tax, the defendants contend, then the Anti-Injunction Act should apply. I do not agree. First of all, the penalty is obviously not to be collected and treated "in the same manner as taxes" in light of the fact that Congress specifically divorced the penalty from the tax code's traditional collection and enforcement mechanisms. Further, and more significantly, as noted *supra*, the whole point of the Anti-Injunction Act is to protect the government in the collection of its lawful tax revenues, and thus it applies to "truly revenue-raising tax statutes," which Congress plainly did not understand and intend the penalty to be. The Eleventh Circuit has recognized (albeit by implication) that the Anti-Injunction Act does not reach penalties that are, as here, "imposed for substantive violations of laws not directly related to the tax code" and which are not good-faith efforts to enforce the technical requirements of the tax law. *Cf. Mobile Republican Assembly v. United States*, 353 F.3d 1357, 1362 n.5 (11th Cir. 2003). The defendants have cited two out-of-circuit cases in support of their contention that Section 6671(a) requires penalties to be treated the same as taxes for Anti-Injunction Act purposes, *Barr v. United States*, 736 F.2d 1134 (7th Cir. 1984); *Warren v. United*

States, 874 F.2d 280 (5th Cir. 1989). Although those cases did indeed hold that the penalties at issue fell under the Anti-Injunction Act, they do not really support the defendants' position. As the plaintiffs note, the penalties in both those cases were imposed for failing to pay an undisputed *tax*, that is, falsely claiming an exemption in *Barr*, and refusing to sign a tax return in *Warren*. In other words, the penalties were "directly related to the tax code." *Cf. Mobile Republican Assembly*, *supra*, 353 F.3d at 1362 n.5. Allowing IRS penalties such as those to qualify as a tax for Anti-Injunction Act purposes "is simply a means for ensuring that the [underlying] tax is paid." *See Botta v. Scanlon*, 314 F.2d 392, 393 (2d Cir. 1963). That is not the situation here. It would be inappropriate to give tax treatment under the Anti-Injunction Act to a civil penalty that, by its own terms, is not a tax; is not to be enforced as a tax; and does not bear any meaningful relationship to the revenue-generating purpose of the tax code. Merely placing a penalty (which virtually all federal statutes have) in the IRS Code, even though it otherwise bears no meaningful relationship thereto, is not enough to render the Anti-Injunction Act (which only applies to true revenue-raising exactions) applicable to this case.

(7) Accountability

I will say one final thing on the tax issue, which, although I believe it to be important, is not essential to my decision. For purposes of this discussion, I will assume that the defendants are correct and that the penalty is (and was always intended to be) a tax.

In *Virginia v. Sebelius*, 3:10cv188, one of the twenty or so other lawsuits challenging the Act, the

federal government's lead counsel (who is lead defense counsel in this litigation, as well) urged during oral argument in that case that the penalty is proper and sustainable under the taxing power. Although that power is broad and does not easily lend itself to judicial review, counsel stated, "there is a check. It's called Congress. *And taxes are scrutinized*. And the reason we don't have all sorts of crazy taxes is because taxes are among the *most scrutinized* things we have. *And the elected representatives in Congress are held accountable for taxes that they impose.*" *See* Transcript of Oral Argument (Virginia case), at 45 (emphasis added).

This foregoing statement highlights one of the more troubling aspects of the defendants' "newfound"[8] tax argument. As noted at the outset of this order, and as anyone who paid attention to the healthcare reform debate already knew, the Act was very controversial at the time of passage. Irrespective of the merits of the arguments for or against it, the legislation required lawmakers in favor of the bill to cast politically difficult and tough votes. As it turned out, the voting was extremely close. Because by far the most publicized and controversial part of the Act was the individual mandate and penalty, it would no doubt have been even more difficult to pass the penalty as a tax. Not only are taxes always

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[8] *See*, *e.g.*, *Changing Stance, Administration Now Defends Insurance Mandate as a Tax*, N.Y. Times, July 17, 2010, at A14 ("When Congress required most Americans to obtain health insurance or pay a penalty, Democrats denied that they were creating a new tax. But in court, the Obama administration and its allies now defend the requirement as an exercise of the government's 'power to lay and collect taxes.'").

unpopular, but to do so at that time would have arguably violated pledges by politicians (including the President) to not raise taxes, which could have made it that much more difficult to secure the necessary votes for passage. One could reasonably infer that Congress proceeded as it did specifically *because* it did not want the penalty to be "scrutinized" as a $4 billion annual tax increase, and it did not want at that time to be "held accountable for taxes that they imposed." In other words, to the extent that the defendants are correct and the penalty was intended to be a tax, it seems likely that the members of Congress merely called it a penalty and did not describe it as revenue-generating to try and insulate themselves from the potential electoral ramifications of their votes.

Regardless of whether the members of Congress had this specific motivation and intent (which, once again, is not my place to say), it is obvious that Congress did not pass the penalty, in the version of the legislation that is now "the Act," as a tax under its taxing authority, but rather as a penalty pursuant to its Commerce Clause power. Those two exactions, as previously noted, are not interchangeable. And, now that it has passed into law on that basis, government attorneys have come into this court and argued that it was a tax after all. This rather significant shift in position, if permitted, could have the consequence of allowing Congress to avoid the very same accountability that was identified by the government's counsel in the Virginia case as a check on Congress's broad taxing power in the first place. In other words, the members of Congress would have reaped a *political advantage* by calling and treating it as a penalty while the Act was being debated, *see*

Virginia v. Sebelius, 702 F. Supp. 2d 598, 612 (E.D. Va. 2010) (referring to "preenactment representations by the Executive and Legislative branches" that the penalty was *not* "a product of the government's power to tax for the general welfare"), and then reap a *legal advantage* by calling it a tax in court once it passed into law. *See* Def. Mem. at 33-34, 49 (arguing that the Anti-Injunction Act bars any challenge to the penalty which, in any event, falls under Congress's "very extensive" authority to tax for the general welfare). This should not be allowed, and I am not aware of any reported case where it ever has been.

Congress should not be permitted to secure and cast politically difficult votes on controversial legislation by deliberately calling something one thing, after which the defenders of that legislation take an "Alice-in-Wonderland" tack[9] and argue in court that Congress really meant something else entirely, thereby circumventing the safeguard that exists to keep their broad power in check. If Congress intended for the penalty to be a tax, it should go back and make that intent clear (for example, by calling it a tax, relying on Congress's Constitutional taxing power, allowing it to be collected and enforced as a tax, or identifying revenue to be raised) so it can be "scrutinized" as a tax and Congress can accordingly

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[9] Lewis, Carroll, *Through the Looking-Glass*, Chapter 6 (Heritage 1969):

> "When *I* use a word," Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean — neither more or less."
>
> "The question is," said Alice, "whether you *can* make words mean so many different things."

be held accountable. They cannot, however, use a different linguistic with a perhaps secret understanding between themselves that the word, in fact, means something else entirely. As the First Circuit has explained, the integrity of the process must be guaranteed by the judiciary:

> In our republican form of government, legislators make laws by writing statutes — an exercise that requires putting words on paper in a way that conveys a reasonably definite meaning. Once Congress has spoken, it is bound by what it has plainly said, notwithstanding the nods and winks that may have been exchanged. . . . And the judiciary must stand as the ultimate guarantor of the integrity of an enacted statute's text.

State of Rhode Island v. Narragansett Indian Tribe, 19 F.3d 685, 699-70 (1st Cir. 1994).

(8) For Constitutional purposes, it is a penalty, and must be analyzed under Congress's Commerce Clause power

For all the above reasons, I conclude that the individual mandate penalty is not a "tax." It is (as the Act itself says) a penalty. The defendants may not rely on Congress's taxing authority under the General Welfare Clause to try and justify the penalty after-the-fact. If it is to be sustained, it must be sustained as a penalty imposed in aid of an enumerated power, to wit, the Commerce Clause power. *See Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 393, 60 S. Ct. 907, 84 L. Ed. 1263 (1940) ("Congress may impose penalties in aid of the exercise of any of its enumerated powers"). Therefore,

the Anti-Injunction Act does not deprive this court of jurisdiction. *See Lipke*, *supra*, 259 U.S. at 562 ("The collector demanded payment of a penalty, and [thus the Anti-Injunction Act], which prohibits suits to restrain assessment or collection of any tax, is without application."). I will next consider the rest of the defendants' jurisdictional challenges.

B. Rule 12(b)(1) ("Lack of Subject Matter Jurisdiction") Challenges

The defendants raise two additional jurisdictional arguments: first, that the individual plaintiffs and the NFIB do not have standing to pursue Counts One and Two, and the state plaintiffs do not have standing with respect to Count Six; and second, that those same causes of action are not ripe.

(1) Standing

The Constitution limits the subject matter of the federal courts to "cases" and "controversies." U.S. Const. art III, § 2. "[T]he core component of standing is an essential and unchanging part of the case-or-controversy requirement of Article III." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S. Ct. 2130, 119 L. Ed. 2d 351 (1992). The "irreducible constitutional minimum of standing" contains three elements: "(1) an injury in fact, meaning an injury that is concrete and particularized, and actual or imminent, (2) a causal connection between the injury and the causal conduct, and (3) a likelihood that the injury will be redressed by a favorable decision." *Granite State Outdoor Advertising Inc. v. City of Clearwater*, 351 F.3d 1112, 1116 (11th Cir. 2003). The defendants appear to concede that (2) and (3) are present in this litigation, but contend that the

plaintiffs cannot establish an injury-in-fact. Accordingly, only element (1) is at issue here.

For purposes of ruling on the defendants' motion to dismiss, I simply need to examine the plaintiffs' factual allegations:

> At the pleading stage, general factual allegations of injury resulting from defendant's conduct may suffice, for on a motion to dismiss we "presum[e] that general allegations embrace those specific facts that are necessary to support the claim."

Lujan, *supra* , 504 U.S. at 561 (quoting *Lujan v. Nat'l Wildlife Federation*, 497 U.S. 871, 889, 110 S. Ct. 3177, 111 L. Ed. 2d 695 (1990)). Thus, "mere allegations of injury" are sufficient to withstand a motion to dismiss based on lack of standing. *Dep't of Commerce v. U.S. House of Representatives*, 525 U.S. 316, 329, 119 S. Ct. 765, 142 L. Ed. 2d 797 (1999); *accord Miccosukee Tribe of Indians of Florida v. Southern Everglades Restoration Alliance*, 304 F.3d 1076, 1081 (11th Cir. 2002) (noting "at the motion to dismiss stage [the plaintiff] is only required to generally allege a redressable injury caused by the actions of [the defendant] about which it complains").

The individual plaintiffs make numerous allegations in the amended complaint that are relevant to the standing issue. According to those allegations, Mary Brown is a small business owner and current member of the NFIB. She has not had health insurance for the last four years. She devotes her available resources to maintaining her business and paying her employees. She does not currently qualify for Medicaid or Medicare, and she does not expect to qualify for those programs prior to the

individual mandate taking effect. Thus, "Ms. Brown will be subject to the mandate and objects to being forced to comply with it" because, *inter alia*, it will force her (and other NFIB members) "to divert resources from their business endeavors" and "reorder their economic circumstances" to obtain qualifying coverage. Similarly, Kaj Ahlburg has not had health insurance for more than six years; he has no intention or desire to get health insurance; he does not qualify for Medicaid or Medicare and will thus be subject to the individual mandate and penalty; and he is, and expects to remain, financially able to pay for his own healthcare services if and as needed. The individual plaintiffs object to the Act's "unconstitutional overreaching" and claim injury because the individual mandate will force them to spend their money to buy something they do not want or need (or be penalized). *See* Am. Compl. ¶¶ 27-28, 62. The defendants make several arguments why these claims are insufficient to establish an injury-in-fact.

First, quoting *Lujan*, *supra*, the defendants contend that "[a] plaintiff alleging 'only an injury at some indefinite future time' has not shown injury in fact." Def. Mem. at 26. While that statement is certainly true, the injury alleged in this case will not occur at "some indefinite future time." Instead, the date is definitively fixed in the Act and will occur in 2014, when the individual mandate goes into effect and the individual plaintiffs are forced to buy insurance or pay the penalty. *See ACLU of Florida, Inc. v. Miami-Dade County School Bd.*, 557 F.3d 1177, 1194 (11th Cir. 2009) (standing shown in pre-enforcement challenge where the claimed injury was "pegged to a sufficiently fixed period of time").

Because time is the primary factor here, this case presents a durational issue, and not a contingency issue. "A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement. But, 'one does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough.'" *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298, 99 S. Ct. 2301, 60 L. Ed. 2d 895 (1979) (citations and brackets omitted). The defendants contend that the forty-months gap between now and 2014 is "too far off" and not immediate enough to confer standing. However, as the Eleventh Circuit has expressly held:

> [P]laintiffs here have alleged when and in what manner the alleged injuries are likely going to occur. Immediacy requires only that the anticipated injury occur with some fixed period of time in the future, not that it happen in the colloquial sense of soon or precisely within a certain number of days, weeks, or months.

Fla. State Conf. of the NAACP v. Browning, 522 F.3d 1153, 1161 (11th Cir. 2008) (citing *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 115 S. Ct. 2097, 132 L. Ed. 2d 158 (1995)); *accord 520 Michigan Ave. Associates, Ltd. v. Devine*, 433 F.3d 961, 962 (7th Cir. 2006) ("Standing depends on the probability of harm, not its temporal proximity. When injury . . . is likely in the future, the fact that [the complained of harm] may be deferred does not prevent federal litigation now.").

The defendants concede that an injury does not have to occur immediately to qualify as an injury-in-fact, but they argue that forty months "is far longer than typically allowed." Def. Mem. at 27. It is true that forty months is longer than the time period at issue in the particular cases the defendants cite. *See*, *e.g.*, *ACLU*, *supra*, 557 F.3d at 1194 (harm was six weeks away); *Nat'l Parks Conservation Ass'n v. Norton*, 324 F.3d 1229, 1242 (11th Cir. 2003) (harm was between one week to one month away). But, the fact that the harm was closer in those cases does not necessarily mean that forty months is ipso facto "too far off." In *Village of Bensenville v. FAA*, 376 F.3d 1114 (D.C. Cir. 2004), for example, the plaintiffs challenged a passenger fee at Chicago's O'Hare International Airport that was not scheduled to be imposed until *thirteen years* in the future. The District of Columbia Circuit held that, despite the significant time gap, there was an "'impending threat of injury'" to plaintiffs that was "'sufficiently real to constitute injury-in-fact and afford constitutional standing'" because the decision to impose the fee was "final and, absent action by us, come 2017 Chicago will begin collecting [it]." *See id.* at 1119 (citations omitted). That is the same situation at issue here. Imposition of the individual mandate and penalty, like the fee in *Village of Bensenville*, is definitively fixed in time and impending. And absent action by this court, starting in 2014, the federal government will begin enforcing it.

The defendants suggest that the individual plaintiffs may not have to be forced to comply with the individual mandate in 2014. They contend that the individual plaintiffs "cannot reliably predict that insurance will be an economic burden" to them when

the individual mandate is in place because, once the Act "mak[es] health insurance more affordable," they may decide to voluntarily buy insurance on their own. Def. Mem. at 26. This argument appears to presuppose that the individual plaintiffs object to the individual mandate solely on the grounds that it will be an "economic burden" to them, and that they do not currently have insurance because they cannot afford it. That does not appear to be the case. Ms. Brown alleges in the amended complaint that she devotes her resources to running and maintaining her business and paying her employees; she does *not* allege that she has no money left over after doing so or that she is otherwise *unable* to buy insurance if she wanted it. Rather, she has apparently just made the decision that she would prefer to direct and divert her resources elsewhere because obtaining insurance, in her particular situation, is not "a worthwhile cost of doing business." *See* Am. Comp. ¶¶ 27, 62. Further, Mr. Ahlburg has affirmatively stated that he is financially able to pay for all of his own healthcare-related services. Thus, both he and Ms. Brown do not want to be forced to spend their money (whether they have a little or a lot) on something they do not want (or feel that they need), and, in this respect, they object to the individual mandate as "unconstitutional overreaching." *See* Am. Comp. at ¶¶ 27, 28.[10]

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[10] And in any event, the defendants' argument seems to assume that the Act will, in fact, reduce premiums so that insurance is "more affordable." That claim is both self-serving and far from undisputed. Indeed, most objective analyses indicate an insurance premium *increase*, and the CBO itself has predicted that premiums will rise 10-13% under the Act, at least with respect to individuals with certain policies who do not qualify

Continuing this argument, the defendants further contend that there is too much "uncertainty" surrounding the individual plaintiffs' allegations. They allege, for example, that while Ms. Brown may not want to purchase healthcare insurance now (because she would rather devote her resources to her business), and although Mr. Ahlburg does not need insurance now (because he is financially able to pay for his own healthcare out-of-pocket and as needed), the "vagaries" of life could alter their situations by 2014. Def. Mem. at 26. The defendants suggest that because "businesses fail, incomes fall, and disabilities occur," by the time the individual mandate is in effect, the individual plaintiffs "could find that they need insurance, or that it is the most sensible choice." *See id.* That is possible, of course. It is also "possible" that by 2014 either or both the plaintiffs will no longer be alive, or may at that time fall within one of the "exempt" categories. Such "vagaries" of life are always present, in almost every case that involves a pre-enforcement challenge. If the defendants' position were correct, then courts would essentially *never* be able to engage in pre-enforcement review. Indeed, it is easy to conjure up hypothetical events that could occur to moot a case or deprive any plaintiff of standing in the future. In *Pierce v. Society of Sisters*, 268 U.S. 510, 45 S. Ct. 571, 69 L. Ed. 2d 1070 (1925), for example, a private school sought and obtained review of a law that required children to attend public schools, even though that law was not to take effect for more than two years. Under the defendants'

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for government subsidies. *See* Congressional Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009.

position, there was no standing to consider the case because — since "businesses fail" — it was possible that the school may have closed down by the time the law finally went into effect. However, the Supreme Court found that it had standing to consider the challenge, notwithstanding the universe of possibilities that could have occurred between the filing of the suit and the law going into effect years later. The Court concluded that it was appropriate to consider the challenge because the complained of injury "was present and very real, not a mere possibility in the remote future," and because the "[p]revention of impending injury by unlawful action is a well-recognized function of courts of equity." *Id.* at 536.

In short, to challenge the individual mandate, the individual plaintiffs need not show that their anticipated injury is absolutely certain to occur despite the "vagaries" of life; they need merely establish "a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement," *see Babbitt*, *supra*, 442 U.S. at 298, that is reasonably "pegged to a sufficiently fixed period of time," see *ACLU*, *supra*, 557 F.3d at 1194, and which is not "merely hypothetical or conjectural," see *NAACP*, *supra*, 522 F.3d at 1161. Based on the allegations in the amended complaint, I am satisfied that the individual plaintiffs have done so. Accordingly, they have standing to pursue Counts One and Two.

The defendants next contend that the state plaintiffs do not have standing to pursue the employer mandate being challenged in Count Six. They devote less than one paragraph to this

argument, *see* Def. Mem. at 21, and I can be equally brief in addressing it. For this count, the state plaintiffs contend that in their capacities as "large employers," they will have to offer and enroll state employees in federally-approved health plans, which they currently do not do. They claim, for example, that under existing Florida law, thousands of OPS (Other Personnel Services) employees are excluded from that state's healthcare plan, but under the Act the employees will have to be enrolled in an approved health plan, which will cost the state money if they do, and will cost the state money (in the form of penalties) if they do not. I am satisfied that this qualifies as an injury-in-fact, for essentially the same reasons discussed with respect to the individual mandate — to wit, the state plaintiffs have established a realistic (and not hypothetical or conjectural) danger of sustaining a redressable injury at a sufficiently fixed point in time as a result of the Act's operation or enforcement.

The individual plaintiffs thus have standing to pursue Counts One and Two, and the state plaintiffs have standing to pursue Count Six. Because those are the only causes of action for which the defendants have challenged standing, this eliminates any need to discuss whether the NFIB also has standing. *See Watt v. Energy Action Educational Foundation*, 454 U.S. 151, 160, 102 S. Ct. 205, 70 L. Ed. 2d 309 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Village of Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252, 264 n.9, 97 S. Ct. 555, 50 L. Ed. 2d 450 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to

maintain this suit."); *see also Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) ("For each [challenged] claim, if . . . standing can be shown for at least one plaintiff, we need not consider the standing of the other plaintiffs to raise that claim.") (citing *Watt* and *Village of Arlington Heights*, *supra*).

However, for the sake of completeness, I will briefly discuss whether the NFIB has standing as well. Under *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 97 S. Ct. 2434, 53 L. Ed. 2d 383 (1977), an association has representative standing when "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Id.* at 343. All three elements have been satisfied here. First, the NFIB's members (including Ms. Brown, as noted) plainly have standing to challenge the individual mandate, thus meeting *Hunt's* first element. Furthermore, the interests that the NFIB seeks to protect in challenging the individual mandate on behalf of its members — certain of whom operate sole proprietorships and will suffer cost and cash flow consequences if they are compelled to buy qualifying healthcare insurance — are germane to the NFIB's purpose and mission "to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully-imposed governmental requirements." Am. Comp. ¶ 26; *see*, *e.g.*, *New York State Club Ass'n, Inc. v. City of New York*, 487 U.S. 1, 10 n.4, 108 S. Ct. 2225, 101 L. Ed. 2d 1 (1988) (consortium of private

clubs had standing to sue on behalf of its members to enjoin state anti-discrimination law because the interests it sought to protect were "clearly" germane to its broad purpose "'to promote the common business interests of its [member clubs]'") (brackets in original). And lastly, because the NFIB seeks injunctive relief which, if granted, will benefit its individual members, joinder is generally not required. *See*, *e.g.*, *NAACP*, *supra* , 522 F.3d at 1160 (*Hunt's* third element satisfied because, "when the relief sought is injunctive, individual participation of the organization's members is 'not normally necessary'") (citation omitted).

In light of the foregoing, the plaintiffs have standing to pursue their claims.

(2) Ripeness

There is a "conspicuous overlap" between the doctrines of standing and ripeness and the two "often converge[ ]." *See Elend v. Basham*, 471 F.3d 1199, 1205 (11th Cir. 2006). Nevertheless, they warrant separate analyses.

"Ripeness is peculiarly a question of timing. Its basic rationale is to prevent the courts, through premature adjudication, from entangling themselves in abstract disagreements." *Thomas v. Union Carbide Agr. Products Co.*, 473 U.S. 568, 580, 105 S. Ct. 3325, 87 L. Ed. 2d 409 (1985) (citations and alterations omitted). "A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S. 296, 300, 118 S. Ct. 1257, 140 L. Ed. 2d 406 (1998) (citation omitted). The ripeness inquiry turns on "'the fitness of the issues for judicial decision' and 'the hardship to the parties

of withholding court consideration." *Pacific Gas and Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 201, 103 S. Ct. 1713, 75 L. Ed. 2d 752 (1983) (citation omitted). In the context of a facial challenge, as in this case, "a purely legal claim is presumptively ripe for judicial review because it does not require a developed factual record." *Harris v. Mexican Speciality Foods, Inc.*, 564 F.3d 1301, 1308 (11th Cir. 2009).

Because the individual mandate and employer mandate will not take effect until 2014, the defendants contend that those claims are unripe because no injury can occur before that time. However, "[w]here the inevitability of the operation of a statute against [plaintiffs] is patent, it is irrelevant to the existence of a justiciable controversy that there will be a time delay before the disputed provisions come into effect." *Blanchette v. Connecticut Gen. Ins. Corps.*, 419 U.S. 102, 143, 95 S. Ct. 335, 42 L. Ed. 2d 320 (1974). "The Supreme Court has long . . . held that where the enforcement of a statute is certain, a preenforcement challenge will not be rejected on ripeness grounds." *NAACP*, *supra* , 522 F.3d at 1164 (citing *Blanchette*, *supra*, 419 U.S. at 143).

The complained of injury in this case is "certainly impending" as there is no reason whatsoever to doubt that the federal government will enforce the individual mandate and employer mandate against the plaintiffs. Indeed, with respect to the individual mandate in particular, the defendants concede that it is absolutely necessary for the Act's insurance market reforms to work as intended. In fact, they refer to it as an "essential" part of the Act at least

fourteen times in their motion to dismiss. It will clearly have to be enforced. *See Commonwealth of Pennsylvania v. State of West Virginia*, 262 U.S. 553, 592-93, 262 U.S. 553, 43 S. Ct. 658 (1923) (suit filed shortly after the challenged statute passed into law and before it was enforced was not premature where the statute "certainly would operate as the complainant states apprehended it would"). The individual mandate will have to be imposed and enforced against the plaintiffs and others because if it is not, and with proscriptions against insurance companies denying coverage for pre-existing medical conditions, there would the potential for an enormous moral hazard.

The fact that the individual mandate and employer mandate do not go into effect until 2014 does not mean that they will not be felt in the immediate or very near future. To be sure, responsible individuals, businesses, and states will have to start making plans now or very shortly to comply with the Act's various mandates. Individuals who are presently insured will have to confirm that their current plans comply with the Act's requirements and, if not, take appropriate steps to comply; the uninsured will need to research available insurance plans, find one that meets their needs, and begin budgeting accordingly; and employers and states will need to revamp their healthcare programs to ensure full compliance. I note that at least two courts considering challenges to the individual mandate have thus far denied motions to dismiss on standing and ripeness grounds. *See Virginia*, *supra*, 702 F. Supp. 2d at 607-08 (determining that because the individual mandate "radically changes the landscape of health insurance coverage in America,"

it will be felt by individuals, insurance carriers, employers, and states "in the near future"); *Thomas More Law Center v. Obama*, 2010 WL 3952805, at *4 (E.D. Mich. Oct. 7, 2010) ("[T]he government is requiring plaintiffs to undertake an expenditure, for which the government must anticipate that significant financial planning will be required. That financial planning must take place well in advance of the actual purchase of insurance in 2014 . . . There is nothing improbable about the contention that the Individual Mandate is causing plaintiffs to feel economic pressure today.")[11]

The Supreme Court and the Eleventh Circuit, as noted, have not hesitated to consider pre-enforcement challenges to the constitutionality of legislation when the complained of injury is certainly impending and more than a hypothetical possibility. Because the issues in this case are fully framed, and the relevant facts are settled, "[n]othing would be gained by postponing a decision, and the public interest would be well served by a prompt resolution of the constitutionality of [the statute]." *See Thomas*, *supra*,

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[11] The defendants have recently filed a notice of supplemental authority in which they have attempted to distinguish *Thomas More Law Center* by claiming that the standing analysis in that case "hinge[d] on allegations not present here"; specifically, according to the defendants, the plaintiffs alleged in that case that "they were being compelled to 'reorganize their affairs,' and 'forego certain spending today, so they will have the funds to pay for health insurance when the Individual Mandate takes effect in 2014" (doc. 78 at 1-2). The defendants allege that "[t]he individual plaintiffs here make no comparable assertion." *See id.* That does not appear to be so. Ms. Brown has alleged that the individual mandate will force her to "divert resources from [her] business" and "reorder [her] economic circumstances" in order to obtain qualifying coverage. Am. Comp. ¶ 62.

473 U.S. at 582. Therefore, the case is ripe for review.[12]

Because the defendants' jurisdictional challenges fail, I will now turn to their arguments for failure to state a claim upon which relief can be granted under Rule 12(b)(6), Fed. R. Civ. P.

C. Rule 12(b)(6) Challenges for Failure to State a Claim Upon which Relief Can be Granted

A motion to dismiss for failure to state a claim under Rule 12(b)(6) will be granted if the complaint alleges no set of facts that, if proved, would entitle the plaintiff to relief. *Blackston v. Alabama*, 30 F.3d 117, 120 (11th Cir. 1994). On a motion to dismiss, the court must accept all the alleged facts as true and take all the inferences from those facts in the light most favorable to plaintiff. *See Cruz v. Beto*, 405 U.S. 319, 322, 92 S. Ct. 1079, 31 L. Ed. 2d 263 (1972); *Hunnings v. Texaco, Inc.*, 29 F.3d 1480, 1484 (11th Cir. 1994). Although the Federal Rules do not require plaintiffs to set out in detail the facts on which they base their claim — Rule 8(a) only requires a "short and plain statement" showing that the plaintiff is entitled to relief — the complaint's "factual allegations must be enough to raise a right to relief above the speculative level." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555, 127 S. Ct. 1955, 167 L.

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[12] Further strengthening the conclusion that the public interest would be best served by a prompt resolution, I recognize that this court is but the first of probably several steps this case will take. Because that process will likely take another year or two, and because this court "will be in no better position later than we are now" to decide the case, *see Blanchette*, *supra*, 419 U.S. at 145, it would not serve the public interest to postpone the first step of this litigation until at least 2014.

Ed. 2d 929 (2007); *accord Ashcroft v. Iqbal*, — U.S. — , 129 S. Ct. 1937, 1949, 173 L. Ed. 2d 868 (2009) (explaining that "the pleading standard Rule 8 announces does not require 'detailed factual allegations,' but it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation'"). Thus, "to survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Iqbal*, *supra*, 129 S. Ct. at 1949 (quoting *Twombly*, *supra*, 550 U.S. at 570). This does not "impose a probability requirement at the pleading stage." *See Twombly*, 550 U.S. at 556. Rather, the test is whether the complaint "succeeds in 'identifying facts that are suggestive enough to render [the claim] plausible.'" *See Watts v. Florida Int'l University*, 495 F.3d 1289, 1296 (11th Cir. 2007) (quoting *Twombly*, *supra*, 550 U.S. at 556).

The defendants claim that all counts in the amended complaint are deficient under Rule 12(b)(6); in other words, no cause of action is "plausible." Each claim must be both factually and legally plausible. This requires me to examine each of the claims factually and to "take a peek" at the status of the applicable existing Constitutional law. Several of the plaintiffs' claims arise under Constitutional provisions for which the Supreme Court's interpretations have changed over the years. But, of course, the court is bound by the law as it exists now. Each count will be discussed below, in reverse order.

(1) Interference with state sovereignty as employers and performance of governmental functions (Count VI)

For this count, the plaintiffs object to the Act's employer mandate which requires the states, in their capacities as large employers, to offer and automatically enroll state employees in federally-approved insurance plans or else face substantial penalties and assessments. These "extensive new benefits," the plaintiffs contend, will "impose immediate and expensive requirements on the States that will continue to increase," *see* Pl. Mem. at 55-56, and "burden[ ] the States' ability to procure goods and services and to carry out governmental functions," *see* Am. Compl. ¶ 90. The employer mandate allegedly exceeds Article I of the Constitution and also runs afoul of state sovereignty in violation of the Ninth and Tenth Amendments.

Regardless of whether the employer mandate will be costly and burdensome to the states in their capacity as large employers (which at this stage of the case is assumed to be true), it is a "generally applicable" law that reaches both public and private employers alike. Although a law of general applicability, as opposed to one directed only at the states, is not per se Constitutional, it is a factor that the Supreme Court and the courts of appeal have consistently found to be significant. In the landmark case of *Garcia v. San Antonio Metro. Transit Auth.*, the Supreme Court held that a city's transit authority (SAMTA) was bound by the minimum wage and overtime pay provisions in the Fair Labor Standards Act ("FLSA"). During the course of its decision, the Court stated:

> [W]e need go no further than to state that we perceive nothing in the overtime and minimum-wage requirements of the FLSA, as

> applied to SAMTA, that is destructive of state sovereignty or violative of any constitutional provision. SAMTA faces nothing more than the same minimum-wage and overtime obligations that hundreds of thousands of other employers, public as well as private, have to meet.

469 U.S. 528, 554, 105 S. Ct. 1005, 83 L. Ed. 2d 1016 (1985); *see also Reno v. Condon*, 528 U.S. 141, 151, 120 S. Ct. 666, 145 L. Ed. 2d 587 (2000) (generally applicable law upheld that regulated the entire "universe of entities" in the market, both in the public and private realm, and applied "to individuals as well as States"); *see also Oklahoma Dep't of Public Safety v. United States*, 161 F.3d 1266, 1271 (10th Cir. 1998) (noting the "logical distinction" that the Supreme Court has drawn between generally applicable laws that "incidentally apply to states" and those that apply only to states; explaining that "because generally applicable laws are not aimed at uniquely governmental functions," and because such "laws affecting both private and public interests are subject to stricter political monitoring by the private sector," a law is less likely to be found oppressive "where the law is aimed at both private and public entities"). The Seventh Circuit has thus stated:

> Neutrality between governmental and private spheres is a principal ground on which the Supreme Court has held that states may be subjected to regulation when they participate in the economic marketplace — for example, by hiring workers covered by the Fair Labor Standards Act. So long as public market participants are treated the same as private

> ones, they enjoy the protection the latter have been able to secure from the legislature; and as Congress is not about to destroy private industry (think what that would do to the tax base!) it can not hobble the states either.

Travis v. Reno, 163 F.3d 1000, 1002-03 (7th Cir. 1998) (citations omitted). I find these cases to be instructive. Although a law of general applicability may not be per se Constitutional, *see Condon*, *supra*, 528 U.S. at 151 (leaving the question open), the fact that the employer mandate is generally applicable goes a long way toward sustaining it.

Further, in this case, the mere fact that the states will be required to provide the same healthcare benefits to employees as private employers does not, by itself, implicate or interfere with state functions and sovereignty. In *Maryland v. Wirtz*, 392 U.S. 183, 88 S. Ct. 2017, 20 L. Ed. 2d 1020 (1968), the Supreme Court rejected the argument that extending FLSA wage and overtime pay provisions to the states would violate state sovereignty by telling public hospitals and schools how to carry out their sovereign functions:

> The Act establishes only a minimum wage and a maximum limit of hours unless overtime wages are paid, and does not otherwise affect the way in which school and hospital duties are performed. Thus appellants' characterization of the question in this case as whether Congress may, under the guise of the commerce power, tell the States how to perform medical and educational functions is not factually accurate. Congress has "interfered with" these state functions

> only to the extent of providing that when a State employs people in performing such functions it is subject to the same restrictions as a wide range of other employers whose activities affect commerce, including privately operated schools and hospitals.

Id. at 193-94. The state plaintiffs allege that the employer mandate will interfere with their sovereignty and impede state functions insofar as it will be financially burdensome and that, if it is allowed to stand, the state's authority "to define the conditions of its officeholders and employees and to control appropriations [will be] usurped." Pl. Mem. at 57; *see also id.* at 56 n.59 (contending that "Congress may [not] decree the basic terms of the employment relationship with State officers and employees and usurp the States' authority over their budgets and resources").

However, virtually any and all attempts to regulate the wages and conditions of employment in the national labor market (which Congress has long done) will result in similar restrictions and adversely impact the state fisc. The minimum wage and overtime pay provisions in the FLSA, which the Supreme Court upheld against the states in *Wirtz* and *Garcia*, *supra*, certainly had much the same effect, as the dissenters in those cases made it a point to emphasize. *See* Garcia, *supra* , 469 U.S. at 528 ("The financial impact on States and localities of displacing their control over wages, hours, overtime regulations, pensions, and labor relations with their employees could have serious, as well as unanticipated, effects on state and local planning, budgeting, and the levying of taxes.") (Powell, J.,

dissenting); *Wirtz*, *supra*, 392 U.S. at 203 (stating that "[t]here can be no doubt" that if the FLSA is extended to the states it could "disrupt the fiscal policy of the States and threaten their autonomy in the regulation of health and education") (Douglas, J., dissenting). The majority opinions in those two cases control here, unless there is a discernable reason to treat healthcare benefits differently than compensation and conditions of employment.

I see no persuasive reason why healthcare benefits — which are generally viewed as a condition of employment and part of an employee's compensation package[13] — should be treated differently than other aspects of compensation and conditions of employment that the Supreme Court has already held Congress may regulate and mandate against the states (such as wages, hours, overtime pay, etc). This is particularly so in light of the fact that, as the defendants correctly point out, to some extent Congress already regulates health benefits for state employees, for example, with respect to COBRA's temporary continuation of coverage provisions and HIPAA's restrictions on the

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[13] *Cf.*, *e.g.*, *Owen v. McKibben*, 78 Fed. Appx. 50, 51 n.3 (10th Cir. 2003) (compensation package at issue included healthcare insurance); *United States v. City of New York*, — F. Supp. 2d —, 2010 WL 1948562, at *1 (S.D.N.Y. May 13, 2010) (same); *Portugues-Santa v. B. Fernandez Hermanos, Inc.*, 614 F. Supp. 2d 221, 228 (D.P.R. 2009) (same); *Laselva v. Schmidt*, 2009 WL 1312559, *1 (N.D.N.Y. May 7, 2009) (same); *Plitt v. Ameristar Casino, Inc.*, 2009 WL 1297404, at *1 (E.D. Mo. May 6, 2009) (same); *Perrotti v. Wal-Mart Stores, Inc.*, 2006 WL 146232, *1 (D.N.H. Jan. 19, 2006) (same); *Hudson v. International Computer Negotiations, Inc.*, 2005 WL 3087865, at *1 (M.D. Fla. Nov. 16, 2005) (same).

ability of group plans to deny coverage due to pre-existing conditions. *See* Def. Mem. at 22. If the employer mandate in the Act is unconstitutional as applied to the states, for the reasons claimed by the plaintiffs, then the FLSA (and arguably COBRA and HIPAA) are likewise unconstitutional as applied to the states. The plaintiffs tried to distinguish Garcia during oral argument by contending that the case was justified because Congress there was trying to ensure that workers "were, in effect, not going to be abused with regard to hours or inadequate wages." Tr. at 79. Whether the plaintiffs feel that Congress had a more noble and well-meaning *purpose* in passing the FLSA is irrelevant. The *power* that Congress asserted (and the effect it would have on the state fisc) is essentially the same as here.

For the foregoing reasons, I believe *Wirtz* and *Garcia* control. I recognize that *Wirtz* (state employers subject to the FLSA) was overruled by *National League of Cities v. Usery*, 426 U.S. 833, 96 S. Ct. 2465, 49 L. Ed. 2d 245 (1975) (state employers not subject to the FLSA), which was in turn overruled by Garcia (state employers once again subject to the FLSA). Accordingly, in light of this "unsteady path" of Supreme Court jurisprudence, *New York v. United States*, 505 U.S. 144, 160, 112 S. Ct. 2408, 120 L. Ed. 2d 120 (1992), the plaintiffs would most likely have stated a plausible claim if it had been brought between 1975 and 1985. But, of course, I am required to apply the law as it now exists.

Because the Act's employer mandate regulates the states as participants in the national labor market the same as it does private employers, and

because the Supreme Court has held in this context that adversely impacting the state fisc (by requiring a minimum level of employment-based benefits) does not interfere with state sovereignty and impede state functions, the employer mandate does not violate the Constitution as a matter of law — under the current law. Therefore, Count Six does not state a plausible claim upon which relief can be granted and must be dismissed.[14]

(2) Coercion and commandeering as to healthcare insurance (Count V)

The Act provides for the creation of health benefit exchanges to foster and provide "consumer choices and insurance competition." The Act gives the states the option to create and operate the exchanges themselves, or have the federal government do so. The plaintiffs acknowledge that they have a choice, but they claim it is tantamount to no choice because the Act forces them to operate the exchange "under threat of removing or significantly curtailing their long-held regulatory authority" (*see* Am. Compl.

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[14] The plaintiffs argue that the employer mandate runs afoul of the inter-governmental-tax-immunity doctrine, *see* Pl. Mem. at 58-60, but the defendants persuasively respond that the claim has not been pled in the amended complaint and that, in any event, it must fail as a matter of law, *see* Reply in Support of Defendants' Motion to Dismiss ("Reply Mem."), at 8-11 (doc. 74). Indeed, under the current state of the law, it is unclear if the inter-governmental-tax-immunity even retains any viability. *See South Carolina v. Baker*, 485 U.S. 505, 518 n.11, 108 S. Ct. 1355, 99 L. Ed. 2d 592 (1988) (noting the inter-governmental-tax-immunity doctrine has "shifted into the modern era," and declining to decide "the extent, *if any*, to which States are currently immune from direct nondiscriminatory federal taxation") (emphasis added).

¶ 88), which will "displace State authority over a substantial segment of intrastate insurance regulation . . . that the States have always possessed under the police powers provided in the Constitution." *See id.* ¶ 44. This is improper "coercion and commandeering" in violation of the Ninth and Tenth Amendments, according to the plaintiffs.

The plaintiffs' argument for this claim is directly foreclosed by *Hodel v. Virginia Surface Min. & Reclamation Association, Inc.*, 452 U.S. 264, 101 S. Ct. 2352, 69 L. Ed. 2d 1 (1981). That case involved a pre-enforcement challenge to the Surface Mining Control and Reclamation Act, which was a comprehensive statute designed to "'establish a nationwide program to protect society and the environment from the adverse effects of surface coal mining operations.'" *Id.* at 268. Pursuant to the statute, "any State wishing to assume permanent regulatory authority over the surface coal mining operations" was required to submit a "proposed permanent program" demonstrating compliance with federal regulations. *Id.* at 271. If any state chose not to do so, the statute provided that the Secretary of the Interior would "develop and implement" the program for that particular state. Virginia filed suit and alleged that the statute violated the Constitution in that "the threat of federal usurpation of their regulatory roles coerces the States into enforcing the Surface Mining Act." *Id.* at 289. The district court agreed, reasoning that while the statute "allows a State to elect to have its own regulatory program, the 'choice that is purportedly given is no choice at all' because the state program must comply with federally prescribed standards." *Id.* at 285 n.25. However, the Supreme Court flatly rejected the

argument and reversed. In doing so, the Court explained that the statute merely established "a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Id.* at 289. It "prescribes federal minimum standards governing surface coal mining, which a State may either implement itself or else yield to a federally administered regulatory program." *Id.* The Supreme Court further stated that:

> A wealth of precedent attests to congressional authority to displace or pre-empt state laws regulating private activity affecting interstate commerce when these laws conflict with federal law. Although such congressional enactments obviously curtail or prohibit the States' prerogatives to make legislative choices respecting subjects the States may consider important, the Supremacy Clause permits no other result.
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> * * *
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> Thus, Congress could constitutionally have enacted a statute prohibiting any state regulation of surface coal mining. We fail to see why the Surface Mining Act should become constitutionally suspect simply because Congress chose to allow the States a regulatory role.

Id. at 290 (citations omitted). Notably, the Court made it a point to emphasize that its conclusion applied even though — as the plaintiffs maintain in this case — "the federal legislation displaces laws enacted under the States' 'police powers.'" *Id.* at 291.

Commandeering was found in *New York*, *supra*, 505 U.S. at 144, where Congress passed a statute requiring state legislatures to enact a particular kind of law, and that holding was later extended in *Printz v. United States*, 521 U.S. 898, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997), to apply to individual state officials. *Id.* at 935 (holding that "Congress cannot circumvent [the prohibition in *New York*] by conscripting the State's officers directly"). The plaintiffs rely heavily on these two decisions for their argument, but both cases are factually and substantively different from the one here. The plaintiffs have not identified any provision in the Act that requires the states to enact a particular law or regulation, as in *New York*, nor have they identified any provision that requires state officials to enforce federal laws that regulate private individuals, as in *Printz*. "[T]he anti-commandeering rule comes into play *only* when the federal government calls on the states to use their sovereign powers as regulators of their citizens." *Travis*, *supra*, 163 F.3d at 1004¬05 (emphasis added); *see also id.* at 1004 (noting that states may be objects of regulation but "cannot be compelled to become regulators of private conduct"). Indeed, both *New York* and *Printz* cited *Hodel* with approval and distinguished it from the facts presented in those two cases. *See Printz*, *supra*, 521 U.S. at 925-26 (explaining "the Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs," which the legislation at issue in *Hodel* did not do "because it merely made compliance with federal standards a precondition to continued state regulation in an otherwise pre-empted field"); *New York*, *supra* , 505 U.S. at 161, 167 (the statute at

issue in *Hodel* was an example of "cooperative federalism" that did not commandeer the legislative process because the states were not compelled to enforce the statute, expend any state funds, or participate in the program "in any manner whatsoever"; they could have elected not to participate and "the full regulatory burden will be borne by the Federal Government"). Because the health benefit exchanges are voluntary and do not compel states to regulate private conduct of their citizens, Count Five does not state a claim upon which relief can be granted. The Act gives the states the choice to establish the exchanges, and is therefore the type of cooperative federalism that was authorized in *Hodel*, *supra*.[15]

(3) Coercion and commandeering as to Medicaid (Count IV)

For this claim, the state plaintiffs object to the "fundamental changes in the nature and scope of the Medicaid program" that the Act will bring about. *See* Am. Comp. ¶ 86. They have described these changes at length in their complaint, *see* Am. Comp. ¶¶ 39-60, and they need not be repeated here in any great

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[15] The plaintiffs appear to suggest that our case is distinguishable from *Hodel* because, unlike the statute under review in that case, the federal government here has not accepted the "full regulatory burden" of the health benefit exchanges. For this, the plaintiffs rely on six statutory provisions that they maintain "conscript and coerce States into carrying out critical elements of the insurance exchange program." *See* Pl. Mem. at 51-54. As the defendants correctly point out, however, *see* Reply Mem. at 6-7, upon close and careful review, each challenged provision is voluntary and generally applicable only if the state elects to establish the exchange.

detail. It is sufficient to say that the state plaintiffs maintain that the Act drastically expands and alters the Medicaid program to such an extent they cannot afford the newly-imposed costs as it will force them to "run [their] budgets off a cliff." Tr. 72. The Medicaid provisions in the Act allegedly run afoul of Congress's Article I powers; exceed the Commerce Clause; and violate the Ninth and Tenth Amendments.

The defendants do not appear to deny that the Act will significantly alter and expand the Medicaid program as it currently exists (although they do point out that the federal government will be absorbing 100% of the new costs for the first three years[16]). Rather, the defendants rest their argument on this simple and unassailable fact: state participation in Medicaid under the Act is, as it always has been, entirely voluntary. When the freedom to opt out of the program is considered in conjunction with the fact that Congress has expressly reserved the right to alter and amend the program, *see* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress."), and, in fact, it has done so numerous times over the years, *see* Def. Mem. at 10, the defendants contend that the state plaintiffs have failed to state a claim. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980) (noting "[a]lthough participation in the Medicaid program is entirely optional, once a State elects to participate, it must

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[16] One could argue, however, that the "federal government" will not really be absorbing the costs as the government has little money except through taxpayers, who almost exclusively reside within the states.

comply with the requirements" that Congress sees fit to impose).

The state plaintiffs assert that they do not actually have the freedom to opt out. They note that "'Medicaid is the single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to states.'" *See* Pl. Mem. at 50 (quoting Bipartisan Comm'n on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005)). They further note that in Florida, for example, 26% of its budget is presently devoted to Medicaid outlays, and because the federal government contributes an average of 55.45% of Medicaid costs, Florida's outlays would have to be more than doubled (to the point of consuming more than 58% of its state budget) to offer the same level of benefits that its Medicaid enrollees now receive. In short, the plaintiffs contend that the Act imposes a Hobson's Choice. They must either: (1) accept the Act's transformed Medicaid program with all its new obligations and costs that the states cannot afford; or (2) exit the program altogether and lose federal matching funds that are necessary and essential for them to provide healthcare to their neediest citizens (along with other Medicaid-linked federal funds). Either way, they contend that their Medicaid systems will eventually collapse, leaving millions of their neediest residents without any health insurance. Consequently, they claim that they are being forced into accepting the changes to the Medicaid program — even though they cannot afford it and doing so will work an enormous financial hardship — because they "effectively have no choice other than to participate." *See* Am. Comp. ¶ 84. Although this claim has intuitive appeal, the status of existing law makes it a close call as to whether it

states a "plausible" claim upon which relief can be granted.

The underlying question presented is whether the Medicaid provisions satisfy the Spending Clause. There are four "general restrictions" on Congress's spending power: (1) the exercise of spending power must be for the general welfare; (2) the conditions must be stated clearly and unambiguously; (3) the conditions must bear a relationship to the purpose of the program; and (4) the conditions imposed may, of course, not require states "to engage in activities that would themselves be unconstitutional." *See generally South Dakota v. Dole*, 483 U.S. 203, 207-10, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987). The plaintiffs do not appear to dispute that the Act meets these restrictions. Rather, their claim is based principally on a single sentence near the end of *Dole*, where the Supreme Court speculated that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211. For that statement, the Court relied upon an earlier decision, *Steward Machine Co. v. Davis*, 301 U.S. 548, 57 S. Ct. 883, 81 L. Ed. 1279 (1937), which likewise speculated that there may be a point at which Congressional pressure turns into impermissible coercion. However, the *Steward Machine* Court made no attempt to define exactly where that line might be drawn and, in fact, suggested that no such line could be drawn. Justice Cardozo cautioned that any spending measure (in that case, in the form of a tax rebate) "conditioned upon conduct is in some measure a temptation. But to hold that motive or temptation is equivalent to

coercion is to plunge the law in endless difficulties." *Id.* at 589-90.

Accordingly, the coercion theory has been often discussed in case law and scholarship, but never actually applied. While it appears that the Eleventh Circuit has not yet been called upon to consider the issue, the courts of appeal that have considered the theory have been almost uniformly hostile to it. *See*, *e.g.*, *Doe v. Nebraska*, 345 F.3d 593, 599 (8th Cir. 2003) (acknowledging what the Supreme Court said in *Dole*, but going on to note that the "circuits are in accord" with the view that no coercion is present if a state — even when faced with the possible "sacrifice" of a large amount of federal funding — voluntarily exercises its own choice in accepting the conditions attached to receipt of federal funds; noting that a "politically painful" choice does not compulsion make); *Kansas v. United States*, 214 F.3d 1196, 1201-02 (10th Cir. 2000) ("The cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court's discussion of the coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it"; the theory is "unclear, suspect, and has little precedent to support its application."); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) ("The coercion theory has been much discussed but infrequently applied in federal case law, and never in favor of the challenging party. . . . The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments."); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981)

(pre-*Dole*) (coercion argument rejected because courts "are not suited to evaluating whether states are faced here with an offer they cannot refuse or merely a hard choice. Even a rough assessment of the degree of temptation would require extensive and complex factual inquiries on a state-by-state basis. We therefore follow the lead of other courts that have explicitly declined to enter this thicket when similar funding conditions have been at issue."); *State of New Hampshire Dep't of Employment Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980) (pre-*Dole*) ("Petitioners argue, however, that this option of the state to refuse to participate in the program is illusory, since the severe financial consequences that would follow such refusal negate any real choice . . . We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stakes that controls, but the rules of the game.").

Perhaps the case most analogous to this one is *California v. United States*, 104 F.3d 1086 (9th Cir. 1997), where California challenged the Medicaid program, in pertinent part, because it conditioned the receipt of federal matching funds on the provision of emergency medical services to illegal aliens. Because illegal aliens comprised 5% of its population, the state was having to spend $400 million each year on providing health care to the aliens. California objected to having to spend that money and argued, like plaintiffs here, that it was being coerced into doing so because, while its initial decision to participate in Medicaid was voluntary, "it now has no choice but to remain in the program in order to prevent a collapse of its medical system." In rejecting this argument, the Ninth Circuit questioned the

"viability" of the coercion theory, as well as the possibility that any "sovereign state which is always free to increase its tax revenues [could] ever be coerced by the withholding of federal funds." The Court of Appeals concluded — as have all courts to have considered the issue — that the state was merely presented with a "hard political choice." *See generally id.* at 1089-92; *accord Padavan v. United States*, 82 F.3d 23, 28-29 (2d Cir. 1996) (holding same and noting that "Medicaid is a voluntary program in which states are free to choose whether to particulate. If New York chose not to participate, there would be no federal regulation requiring the state to provide medical services to illegal aliens").

The Fourth Circuit appears to be the one circuit where the coercion theory has been considered and "is not viewed with such suspicion." *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 290 (4th Cir. 2002) (referencing a prior decision of that court, *Commonwealth of Virginia Dep't of Education v. Riley*, 106 F.3d 559 (4th Cir. 1997), where six of the thirteen judges on the *en banc* panel stated in dicta that coercion theory may be viable). Notwithstanding that the theory may be available in the Fourth Circuit, *West Virginia* acknowledged that because of "strong doubts about the viability of the coercion theory"; in light of the fact that it is "somewhat amorphous and cannot easily be reduced to a neat set of black-letter rules of application"; and given the "difficulties associated with [its] application," there is "no decision from any court finding a conditional grant to be impermissibly coercive." Therefore, "most courts faced with the question have effectively abandoned any real effort to apply the coercion theory" after finding, in essence,

that it "raises political questions that cannot be resolved by the courts." *See id.* at 288-90. All this to say, if the coercion theory stands at all, it stands on extremely "wobbly legs." *See Skinner*, *supra*, 884 F.2d at 454.

In light of the foregoing, the current status of the law provides very little support for the plaintiffs' coercion theory argument. Indeed, when the "pressure turns into compulsion" theory is traced back, its entire underpinning is shaky. In *Steward Machine Co.*, *supra*, the Supreme Court held that there was no coercion because "[n]othing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with the fitness to the relations between state and nation*." 301 U.S. at 590 (emphasis added). Thus, in addition to being left undefined, the theory appears to stem from a "what if" assumption. Nevertheless, while the law does not provide much support for the plaintiffs' argument, it does not preclude it either (at least not in this circuit).

Further, I cannot ignore that, based on the allegations in the complaint, the plaintiffs are in an extremely difficult situation. They either accept the sweeping changes to Medicaid (which they contend will explode their state budgets), or they withdraw from the system entirely (which they allege could leave millions of their poorest and neediest citizens without any medical coverage). The plaintiffs have argued that this is tantamount to no choice at all, which can perhaps be inferred from the fact that Congress does not really anticipate that the states will (or could) drop out of the Medicaid program. To be sure, since the Act seeks to reduce costs, reduce

uncompensated care, and reduce the number of uninsured, it would make little sense for Congress to expect that objecting states would opt out of Medicaid and leave millions of the country's poorest citizens without medical coverage, and thus make each of those stated problems significantly worse.

In addition, if the state plaintiffs make the decision to opt out of Medicaid, federal funds taken from their citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to the states that have agreed to continue participating in the program.[17]

If the Supreme Court meant what it said in *Dole* and *Steward Machine Co.* (and I must presume that it did), there is a line somewhere between mere pressure and impermissible coercion. The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court. Because the Eleventh Circuit (unlike the other circuits) has apparently not directly addressed and foreclosed this argument, and because,

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[17] *See*, *e.g.*, Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195, 213-14 (2001) ("[S]hould a state decline proffered federal funds because it finds a condition intolerable, it receives no rebate of any tax dollars that its residents have paid into the federal fisc. In these cases, the state (through its residents) contributes a proportional share of federal revenue only to receive less than a proportional share of federal spending. Thus, when the federal government offers the states money, it can be understood as simply offering to return the states' money to them, often with unattractive conditions attached.").

in any event, "the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, *of fact*," *Steward Machine Co.*, *supra*, 301 U.S. at 590 (emphasis added), the plaintiffs have stated a "plausible" claim in this circuit.

(4) Violation of constitutional prohibition of unapportioned capitation or direct tax (Count III)

For this count, the plaintiffs object to the individual mandate penalty. They make an "alternative" claim that, *if* the penalty is a tax (which they do not believe it is, and some Constitutional authorities have concluded it could not be[18]), it is an unconstitutional capitation or direct tax, prohibited by Article I, Section 9, Clause 4 of the Constitution.[19] Although the argument is not only plausible, but appears to have actual merit, as some commentators have noted, *see*, *e.g.*, Steven J. Willis and Nakku

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[18] *See*, *e.g.*, Randy Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional*, N.Y.U. J.L. & Liberty (forthcoming), at 27 (stating that the argument for the penalty being justified under Congress's broad taxing authority is based on a "radical" theory that, if accepted, would authorize Congress "to penalize or mandate any activity by anyone in the country, provided it limited the sanction to a fine enforced by the Internal Revenue Service," which would "effectively grant Congress a general police power").

[19] This is the same Constitutional provision under which the Supreme Court held that the first attempt to impose a federal income tax was unconstitutional to the extent it was not apportioned. *See generally Pollock v. Farmers' Loan & Trust Co.*, 157 U.S. 429, 15 S. Ct. 673, 39 L. Ed. 759 (1895). Subsequently, passage of the Sixteenth Amendment in 1913 authorized the imposition of an income tax without the need for apportionment among the states.

Chung, *Constitutional Decapitation and Healthcare*, Tax Notes (2010), I need not be concerned with the issue. As previously explained, it is quite clear that Congress did not intend the individual mandate penalty to be a tax; it is a penalty. It must be analyzed on the basis of whether it is authorized under Congress's Commerce Clause power, not its taxing power. Therefore, Count Three will be dismissed as moot.

(5) Challenge to individual mandate on due process grounds (Count II)

The plaintiffs next allege that the individual mandate violates their rights to substantive due process under the Fifth Amendment. Again, this claim would have found Constitutional support in the Supreme Court's decisions in the years prior to the New Deal legislation of the mid-1930's, when the Due Process Clause was interpreted to reach economic rights and liberties. *See Lochner v. New York*, 198 45, 25 S. Ct. 539, 49 L. Ed. 937 (1905); *see also Coppage v. Kansas*, 236 1, 35 S. Ct. 240, 59 L. Ed. 441 (1915), *Adkins v. Children's Hospital*, 261 525, 43 S. Ct. 394, 67 L. Ed. 785 (1923); *Jay Burns Baking Co. v. Bryan*, 264 U.S. 504, 44 S. Ct. 412, 68 L. Ed. 813 (1924). However, "[t]he doctrine that prevailed in *Lochner*, *Coppage*, *Adkins*, *Burns*, and like cases — that due process authorizes courts to hold laws unconstitutional when they believe the legislature has acted unwisely — has long since been discarded." *Ferguson v. Skrupa*, 372 726, 730, 83 S. Ct. 1028, 10 L. Ed. 2d 93 (1963); *see also New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 439 U.S. 96, 106-07, 99 S. Ct. 403, 58 L. Ed. 2d 361 (1978) (since the demise of substantive due process in the arena of economic

regulation, legislatures have "broad scope to experiment with economic problems").

Therefore, as the law now exists, if a challenged statute does not implicate the very limited and narrow class of rights that have been labeled "fundamental," courts reviewing legislative action on substantive due process grounds will accord substantial deference to the legislative judgments. In the absence of a fundamental right, the question is not whether the court thinks the legislative action is wise, but whether the legislature could reasonably conclude that the measure at issue is "rationally related" to a legitimate end. As the Eleventh Circuit has explained:

> Substantive due process claims not involving a fundamental right are reviewed under the rational basis test. The rational basis test is not a rigorous standard [and] is generally easily met. A searching inquiry into the validity of legislative judgments concerning economic regulation is not required. . . . The task is to determine if "any set of facts may be reasonably conceived to justify" the legislation. . . . To put it another way, the legislation must be sustained if there is any conceivable basis for the legislature to believe that the means they have selected will tend to accomplish the desired end. Even if the court is convinced that the political branch has made an improvident, ill-advised or unnecessary decision, it must uphold the act if it bears a rational relation to a legitimate governmental purpose.

TRM, Inc. v. United States, 52 F.3d 941, 945-46 (11th Cir. 1995) (citations omitted).

The plaintiffs contend that the individual mandate does, in fact, implicate fundamental rights to the extent that people have "recognized liberty interests in the freedom to eschew entering into a contract, to direct matters concerning dependent children, and to make decisions regarding the acquisition and use of medical services." *See* Pl. Mem. at 43-44; *accord* Tr. at 82 ("The fundamental interest involved here, aside from the liberty of contract, is the right to . . . bodily autonomy and use of medical care . . . the right to run your family life as you see fit with some limited intrusions available"). Fundamental rights are a narrow class of rights involving the rights to marry, have children, direct the education of those children, marital privacy, contraception, bodily integrity, and abortion; and the Supreme Court is "very reluctant to expand" that list. *See Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005). There is, to be sure, a liberty interest in the freedom to be left alone by the government. We all treasure the freedom to make our own life decisions, including what to buy with respect to medical services. Is that a "fundamental right"? The Supreme Court has not indicated that it is — at least not yet. That is the current state of the law, and it is not a district court's place to expand upon that law.

Congress made factual findings in the Act and concluded that the individual mandate was "essential" to the insurance market reforms contained in the statute. This is a "rational basis" justifying the individual mandate — if it does not relate to a fundamental right, which only the

Supreme Court can recognize. In the absence of such a recognized fundamental right, that stated "rational basis" is sufficient to withstand a substantive due process challenge. This count must be dismissed.

(6) Challenge to individual mandate as exceeding Commerce Clause (Count I)

Under the Commerce Clause, Congress may regulate: (1) the channels of interstate commerce; (2) the instrumentalities of interstate commerce; and (3) activities "affecting" interstate commerce. *Perez v. United States*, 402 U.S. 146, 150, 91 S. Ct. 1357, 28 L. Ed. 2d 686 (1971). Only (3) is at issue here.

For this count, the plaintiffs maintain that the individual mandate does not regulate activity affecting interstate commerce; instead, it seeks to impermissibly regulate economic *inactivity*. The decision not to buy insurance, according to the plaintiffs, is the exact opposite of economic activity. Because the individual mandate "compels all Americans to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside within any of the United States," the plaintiffs contend that it will deprive them of "their rights under State law to make personal healthcare decisions without governmental interference." Am. Comp. ¶¶ 70, 75. Thus alleged, the individual mandate exceeds the Commerce Clause, and violates the Ninth and Tenth Amendments.

The defendants, of course, have a different take. They contend that "[t]he appearance of inactivity here is just an illusion" because the people who decide to not buy insurance *are* participating in the relevant economic market. *See* Tr. at 30. Their argument on this point can be broken down to the

following syllogism: (1) because the majority of people will at some point in their lives need and consume healthcare services, and (2) because some of the people are unwilling or unable to pay for those services, (3) Congress may regulate everyone and require that everyone have specific, federally-approved insurance. Framed this way, the defendants insist that the individual mandate does not require people to pay for a service they do not want; rather, it merely tells them how they must pay for a service they will almost certainly consume in the future.

It is, according to the defendants, no different than Congress telling people "you need to pay by cash instead of check or credit card." Tr. at 88; *accord* Def. Mem. at 43 ("[Individuals who choose not to buy insurance] have not opted out of health care; they are not passive bystanders divorced from the health care market. Instead, they have chosen a method of payment for services they will receive, no more 'inactive' than a decision to pay by credit card rather than by check."). Also, because the individual mandate is essential to the insurance market reforms in the Act, the defendants argue that it is sustainable for the "second reason" that it falls within the Necessary and Proper Clause. *See* Def. Mem. at 44-48.

At this stage in the litigation, this is not even a close call. I have read and am familiar with all the pertinent Commerce Clause cases, from *Gibbons v. Ogden*, 22 (9 Wheat.) 1, 6 L. Ed. 23 (1824), to *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005). I am also familiar with the relevant Necessary and Proper Clause cases, from *M'Culloch*

v. Maryland, 17 U.S. (4 Wheat.) 316, 4 Ed. 579 (1819), to *United States v. Comstock*, — U.S. —, 130 S. Ct. 1949, 176 L. Ed. 2d 878 (2010). This case law is instructive, but ultimately inconclusive because the Commerce Clause and Necessary and Proper Clause have never been applied in such a manner before. The power that the individual mandate seeks to harness is simply without prior precedent. The Congressional Research Service (a nonpartisan legal "think tank" that works exclusively for Congress and provides analysis on the constitutionality of pending legislation) advised Congress on July 24, 2009, long before the Act was passed into law, that "it is unclear whether the [Commerce Clause] would provide a solid constitutional foundation for legislation containing a requirement to have health insurance." The analysis goes on to state that the individual mandate presents "the most challenging question . . . as it is a novel issue whether Congress may use this clause to require an individual to purchase a good or service." Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 3. Even *Thomas More Law Center*, *supra* , 2010 WL 3952805, which recently upheld the individual mandate, seems to recognize that the individual mandate is without any precedent. *See id.* at *8 ("The Supreme Court has always required an economic or commercial component in order to uphold an act under the Commerce Clause. The Court has never needed to address the activity/inactivity distinction advanced by plaintiffs because in every Commerce Clause case

presented thus far, there has been some sort of activity").[20]

The defendants "firmly disagree" with the characterization of the individual mandate as "unprecedented" and maintain that it is "just false" to suggest that it breaks any new ground. *See* Tr. 31, 33. During oral argument, as they did in their memorandum, *see* Def. Mem. at 44, they attempted to analogize this case to *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 85 S. Ct. 348, 13 L. Ed. 2d 258 (1964), which held that Congress had the power under the Commerce Clause and the Civil Rights Act to require a local motel to rent rooms to black guests; and *Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82, 87 L. Ed. 122 (1942), which held that Congress could limit the amount of wheat grown for personal consumption on a private farm in an effort to control supply and avoid surpluses or shortages that could result in abnormally low or high wheat prices. The defendants have therefore suggested that because the motel owner in *Heart of Atlanta* was required to rent rooms to a class of people he did not want to serve, Congress was regulating inactivity. And, because the farmer in *Wickard* was limited in the amount of wheat he could grow for his own personal consumption, Congress was forcing him to buy a product (at least to the extent that he wanted or needed more wheat than he was allowed). There

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[20] The district court, however, went on to adopt the government's argument that the Commerce Clause should not only reach economic activity — which had "always" been present in "every Commerce Clause case" decided to date — but it should be applied to "economic decisions" as well, such as the decision not to buy health insurance.

are several obvious ways in which *Heart of Atlanta* and *Wickard* differ markedly from this case, but I will only focus on perhaps the most significant one: the motel owner and the farmer were each involved in an activity (regardless of whether it could readily be deemed interstate commerce) and each had a choice to discontinue that *activity*. The plaintiff in the former was not required to be in the motel business, and the plaintiff in the latter did not have to grow wheat (and if he did decide to grow the wheat, he could have opted to stay within his allotment and use other grains to feed his livestock — which would have been most logical, since wheat is usually more expensive and not an economical animal feed — and perhaps buy flour for him and his family). Their respective obligations under the laws being challenged were tethered to a voluntary undertaking. Those cases, in other words, involved activities in which the plaintiffs had chosen to engage. All Congress was doing was saying that if you *choose* to engage in the activity of operating a motel or growing wheat, you are engaging in interstate commerce and subject to federal authority.

But, in this case we are dealing with something very different. The individual mandate applies across the board. People have no choice and there is no way to avoid it. Those who fall under the individual mandate either comply with it, or they are penalized. It is not based on an activity that they make the choice to undertake. Rather, it is based solely on citizenship and on being alive. As the nonpartisan CBO concluded sixteen years ago (when the individual mandate was considered, but not pursued during the 1994 national healthcare reform efforts): "A mandate requiring all individuals to purchase

health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service *as a condition of lawful residence in the United States*." *See* Congressional Budget Office Memorandum, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, August 1994 (emphasis added).

Of course, to say that something is "novel" and "unprecedented" does not necessarily mean that it is "unconstitutional" and "improper." There may be a first time for anything. But, at this stage of the case, the plaintiffs have most definitely stated a plausible claim with respect to this cause of action.[21]

IV. CONCLUSION

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[21] Starting in the First World War, there have been at least six attempts by the federal government to introduce some kind of universal healthcare insurance coverage. At no point — until now — did it mandate that everyone buy insurance (although it was considered during the healthcare reform efforts in 1994, as noted above). While the novel and unprecedented nature of the individual mandate does not automatically render it unconstitutional, there is perhaps a *presumption* that it is. In *Printz*, *supra*, 521 U.S. at 898, the Supreme Court stated several times that an "absence of power" to do something could be inferred because Congress had never made an attempt to exercise that power before. *See id.* at 905 (stating that if "earlier Congresses avoided use of this highly attractive power, we would have reason to believe that the power was thought not to exist"); *see id.* at 907-08 ("the utter lack of statutes imposing obligations [like the one at issue there] (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power") (emphasis in original); *see id.* at 918 (stating "almost two centuries of apparent congressional avoidance of the practice [at issue] tends to negate the existence of the congressional power asserted here").

> The Supreme Court has said:
>
> > Some truths are so basic that, like the air around us, they are easily overlooked. Much of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear "formalistic" in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

New York, *supra*, 505 U.S. at 187. As noted at the outset of this order, there is a widely recognized need to improve our healthcare system. How to accomplish that is quite controversial. For many people, including many members of Congress, it is one of the most pressing national problems of the day and justifies extraordinary measures to deal with it. However, "a judiciary that licensed extraconstitutional government with each issue of comparable gravity would, in the long run, be far worse." *See id.* at 187-88. In this order, I have not attempted to determine whether the line between Constitutional and extraconstitutional government *has* been crossed. That will be decided on the basis of the parties' expected motions for summary judgment, when I will have the benefit of additional argument

and all evidence in the record that may bear on the outstanding issues. I am only saying that (with respect to two of the particular causes of action discussed above) the plaintiffs have at least stated a plausible claim that the line has been crossed.

Accordingly, the defendants' motion to dismiss (doc. 55) is GRANTED with respect to Counts Two, Five, and Six, and those counts are hereby DISMISSED. The motion is DENIED with respect to Counts One and Four. Count Three is also DISMISSED, as moot. The case will continue as to Counts One and Four pursuant to the scheduling order previously entered.

DONE and ORDERED this 14th day of October, 2010.

/s/ Roger Vinson
ROGER VINSON
Senior United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA PENSACOLA DIVISION

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.;

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

Case No.: 3:10-cv-91-RV/EMT

ORDER

My order of January 31, 2011 ("Order"), granted summary judgment for the plaintiffs (in part); held the "individual mandate" provision of The Patient Protection and Affordable Care Act (the "Act") unconstitutional; and declared the remainder of the Act void because it was not severable. The defendants have now filed a motion to "clarify" this ruling (doc. 156) ("Def. Mot."). During the four-plus weeks since entry of my order, the defendants have seemingly continued to move forward and implement the Act. In their response in opposition to the

defendants' motion, the plaintiffs have asserted that "[i]f the Government was not prepared to comply with the Court's judgment, the proper and respectful course would have been to seek an immediate stay, not an untimely and unorthodox motion to clarify" (doc. 158 at 2) ("Pl. Resp.").

While I believe that my order was as clear and unambiguous as it could be, it is possible that the defendants may have perhaps been confused or misunderstood its import. Accordingly, I will attempt to synopsize the 78-page order and clarify its intended effect. To that extent, the defendants' motion to clarify is GRANTED.

I. Clarification

Let me begin the clarification by emphasizing, once again, what this case is all about. The plaintiffs filed this case to challenge the Constitutionality of the Act. The complaint raised several causes of action, but the crux of the case centered on the Constitutionality of the individual mandate, which, beginning in 2014, will require everyone (with certain stated exceptions) to buy federally-approved health insurance or pay a monetary "penalty." Like every single district court to consider this issue so far — including those that have ruled for the federal government — I rejected the defendants' argument that the penalty should be construed as a tax barred by the Anti-Injunction Act. Instead, I concluded that it was a civil regulatory penalty which could not be based on the federal government's broad taxing power. The issue was thus narrowed to whether the individual mandate fell within, or went beyond, Congress's Constitutional authority "To regulate Commerce . . . among the several States." U.S. Const. art I, § 8, cl. 3.

In granting summary judgment in favor of the plaintiffs on that question, I traced the historical roots of the Commerce Clause and the evolution of its judicial interpretation. I noted that the word "commerce" had a well-understood meaning when the Founding Fathers drafted our Constitution and when "We the People" later adopted it. I analyzed and discussed (in detail) every significant and pertinent Commerce Clause case decided by the Supreme Court, including the primary cases relied on by the defendants: *Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82, 87 L. Ed. 122 (1942); and *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005). I concluded, however, that those (and other) cases neither supported the defendants' position nor directly resolved the Constitutional question at issue. Indeed, as Congress's own attorneys (in the Congressional Research Service) have explained:

> While in *Wickard* and *Raich*, the individuals were participating in their own home activities (i.e., producing wheat for home consumption and cultivating marijuana for personal use), they were acting of their own volition, and this activity was determined to be economic in nature and affected interstate commerce. However, [the individual mandate] could be imposed on some individuals who engage in virtually no economic activity whatsoever. *This is a novel issue*: whether Congress can use its Commerce Clause authority to require a person to buy a good or a service and whether this type of required participation can be considered economic activity.

Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 6 ("CRS Analysis") (emphasis added).[1]

I recognized in my order that "novel" and unprecedented did not, by itself, mean "unconstitutional," so I then proceeded to address the defendants' several arguments in support of the individual mandate. Following the Supreme Court's precedent in *United States v. Lopez*, 514 U.S. 549, 115 S. Ct. 1624, 131 L. Ed. 2d 626 (1995), I "pause[d] to consider the implications of the Government's arguments" by discussing possible hypothetical extensions of the logic underlying them. *See id.* at 564-65. For example, in *Lopez*, the Court also used hypothetical examples to illustrate other areas that "Congress could regulate" and activities that "Congress could mandate" in the future under the federal government's logic, and concluded that, under such reasoning, it would be hard "to posit any activity by an individual that Congress is without power to

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[1] Even the district courts that have upheld the individual mandate seem to agree that "activity" is indeed required before Congress can exercise its authority under the Commerce Clause. They have simply determined that an individual's *decision* not to buy health insurance qualifies as *activity*. For example, in the most recent case, *Mead v. Holder*, — F. Supp. 2d —, 2011 WL 611139 (D.C.C. Feb. 22, 2011), the District Court for the District of Columbia concluded that "[m]aking a choice is an affirmative action, whether one decides to do something or not do something," and, therefore, Congress can regulate "*mental activity*" under the commerce power. *See id.* at *18 (emphasis added). As that court acknowledged, however, there is "little judicial guidance" from the Supreme Court with respect to this issue as "previous Commerce Clause cases have all involved physical activity." *Id.*

regulate." *See id.* I similarly concluded that the government's arguments in this case — including the "economic decisions" argument — could authorize Congress to regulate almost any activity (or inactivity). This could not be reconciled with a federal government of limited and enumerated powers. I thus concluded that the meaning of the term "commerce" as understood by the Founding Fathers would not have encompassed the individual mandate, not because of some vague "original intent," but because it would have violated the fundamental and foundational principles upon which the Constitution was based: a federal government with limited enumerated powers which can only exercise those specific powers granted to it.

Similarly, I determined (consistent with the *Lopez* majority's rejection of the dissent's arguments) that "market uniqueness" is not an adequate limiting principle as the same basic arguments in support of the individual mandate could be applied in other contexts outside the "unique" health care market, and could be used to require that individuals buy (under threat of penalty) virtually any good or service that Congress has a "rational basis" to conclude would help the national economy, from cars to broccoli.[2] I thus held that the individual mandate

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[2] Although some have suggested that the possibility of Congress being able to claim such a power is Constitutionally implausible, subsequent events have only reinforced the legitimacy of this concern. On February 2, 2011, two days after my order was entered, the Senate Judiciary Committee held a hearing to explore the Constitutionality of the individual mandate. The possibility of a "broccoli mandate" was discussed at this hearing. Former Solicitor General and Harvard law professor Charles Fried testified (during the course of *defending* the

exceeded Congress's authority under the Commerce Clause (at least as understood, defined, and applied in existing case law). Such an unprecedented and potentially radical expansion of Congress's commerce power could only be authorized in the first instance

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Constitutionality of the individual mandate) that under this view of the commerce power Congress could, indeed, mandate that everyone buy broccoli. See Transcript of Senate Judiciary Committee Hearing: Constitutionality of the Affordable Care Act (Feb. 2, 2011); *see also* Written Testimony of Charles Fried, Beneficial Professor of Law, Harvard Law School, Before the Senate Judiciary Committee on "The Constitutionality of the Affordable Care Act" (Feb. 2, 2011), at 4. This testimony only highlights my concern because it directly undercuts the defendants' principal argument for why an economic mandate is justified here; to wit, that it is justified in this case (and only this case) because the broad health care market is "unique" and because the failure to buy health insurance constitutes an "economic financing decision" about how to pay for an unavoidable service that hospital emergency rooms (unlike sellers of produce and other commodities) are required under law to provide regardless of ability to pay. As noted, to the extent that one may respond to this hypothetical concern by suggesting that "political accountability" would prevent Congress from ever imposing a "broccoli mandate" (even though it could), the Supreme Court has specifically rejected that as the appropriate test for "the limitation of congressional authority is not solely a matter of legislative grace." *See United States v. Morrison*, 529 U.S. 598, 616, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000); *see also id.* at 616 n.7 (explaining that Congress's authority under the Commerce Clause is not "limited only by public opinion and the Legislature's self-restraint," and thereby rejecting the claim that "political accountability is . . . the only limit on Congress' exercise of the commerce power"); *cf. United States v. Stevens*, — U.S. —, 130 S. Ct. 1577, 1591, 176 L. Ed. 2d 435 (2010) ("[T]he [Constitution] protects against the Government; it does not leave us at the mercy of *noblesse oblige*. We would not uphold an unconstitutional statute merely because the Government promised to use it responsibly.").

by the Supreme Court, or possibly by a Constitutional amendment. It is not for a lower court to expand upon Supreme Court jurisprudence, and in the process authorize the exercise of a "highly attractive power" *that Congress has never before claimed in the history of the country* [*see generally Printz v. United States*, 521 U.S. 898, 905-18, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997)], and which Congress's very own attorneys have warned "could be perceived as virtually unlimited in scope." *See* CRS Analysis, *supra*, at 7. After concluding that the individual mandate could not be supported by existing Commerce Clause precedent — nor under Necessary and Proper Clause case law, including the recent doctrinal analysis articulated in *United States v. Comstock*, — U.S. —, 130 S. Ct. 1949, 176 L. Ed. 2d 878 (2010) — I then considered the question of severability.

In deciding the severability issue, I began by recognizing and acknowledging that, if at all possible, courts will usually only strike down the unconstitutional part of a statute and leave the rest intact. However, I noted that this was not the usual case, and that its unique facts required a finding of non-severability. In particular, I noted that:

(i) At the time the Act was passed, Congress knew for certain that legal challenges to the individual mandate were coming;

(ii) Congress's own Research Service had essentially advised that the legal challenges would have merit (and therefore might result in the individual mandate being struck down) as it could not be said that the individual mandate had "solid constitutional foundation" [CRS Analysis, *supra*, at 3];

And yet, Congress specifically (and presumably intentionally) *deleted* the "severability clause" that had been included in the earlier version of the Act.

I concluded that, in light of the foregoing facts, the conspicuous absence of a severability clause — which is ordinarily included in complex legislation as a matter of routine — could be viewed as strong evidence that Congress recognized that the Act could not operate as intended if the individual mandate was eventually struck down by the courts.

I also found that the defendants' own arguments in defense of the individual mandate on Necessary and Proper grounds necessarily undermined its argument for severability. I noted, for example, that during this case the defendants consistently and repeatedly highlighted the "essential" role that the individual mandate played in the regulatory reform of the interstate health care and health insurance markets, which was the entire point of the Act. As the defendants themselves made clear:

> [The individual mandate] is *essential* to the Act's comprehensive scheme to ensure that health insurance coverage is available and affordable [and it "works in tandem" with the health benefit exchanges, employer incentives, tax credits, and the Medicaid expansion].
>
> * * *
>
> [The absence of an individual mandate] would *undermine the "comprehensive regulatory regime"* in the Act.
>
> * * *
>
> [*The individual mandate] is essential to Congress's overall regulatory reform of the*

> *interstate health care and health insurance markets . . . [it] is "essential" to achieving key reforms of the interstate health insurance market . . . [and it is] necessary to make the other regulations in the Act effective*.

Memorandum in Support of Defendants' Motion to Dismiss (doc. 56-1), at 46-48 (emphasis added). Therefore, according to the defendants' own arguments, the individual mandate and the insurance reform provisions must rise or fall together.[3]

In the course of applying the two-part severability analysis, I noted that the Supreme Court has stressed that the "relevant inquiry in evaluating severability is whether the statute [with the unconstitutional provision removed] will function in a manner consistent with the intent of Congress." *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987). In light of the defendants' own arguments as quoted above and dozens of similar representations that they made throughout this case, I had no choice but to find that the individual mandate was essential to, and thus could not be severed from, the rest of the Act.

I further noted that, because the Act was extremely lengthy and many of its provisions were

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[3] As explained in my order, the mere fact that the individual mandate was "necessary" to the Act as drafted does not mean it was Constitutionally "proper." *See*, *e.g.*, *Printz v. United States*, 521 U.S. 898, 923-24, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997) ("When a 'Law for carrying into Execution' the Commerce Clause violates [other Constitutional principles], it is not a 'Law *proper* for carrying into Execution the Commerce Clause'") (emphasis in original) (ellipses omitted).

dependent (directly or indirectly) on the individual mandate, it was improper for me (a judge) to engage in the quasi-legislative undertaking of deciding which of the Act's several hundred provisions could theoretically survive without the individual mandate (as a technical or practical matter) and which could not — or which provisions Congress could have arguably *wanted* to survive. To demonstrate this problem, I discussed the Act's much-maligned Internal Revenue Service Form 1099 reporting requirement, which was an apparent revenue-generating provision with no connection to health care:

> How could I possibly determine if Congress intended the 1099 reporting provision to stand independently of the insurance reform provisions? Should the fact that it has been widely criticized by both Congressional supporters and opponents of the Act and the fact that there have been bipartisan efforts to repeal it factor at all into my determination?

Order at 73. In fact, on February 2, 2011, two days after entry of my order, the Senate voted (with bipartisan support) to repeal the Form 1099 provision (and the House is expected to follow with a similar vote in upcoming weeks). This is exactly how the process should be, as it highlights that it is Congress — and not courts — that should consider and decide the quintessentially legislative questions of which, if any, of the statute's hundreds of provisions should stay and which should go.

Because of these atypical and unusual circumstances (e.g., the *deletion of a severability clause* in the face of inevitable and well-founded legal

challenges; the defendants' *repeated acknowledgment* in this case that the individual mandate was the keystone or lynchpin of the statute's overall purpose; and the obvious difficulty (if not impropriety) of reconfiguring an *extremely lengthy and comprehensive statute* with so many interconnected provisions), I concluded that these facts were not likely to be present in future litigation, and that the "normal rule" of severability — which would still apply in the vast majority of cases — was not applicable here.

Compare, for example, the unusual facts of this case with a case where the "normal rule" has been applied. In *New York v. United States*, 505 U.S. 144, 157, 112 S. Ct. 2408, 120 L. Ed. 2d 120 (1992), the Supreme Court was called upon to consider the Constitutionality of the Low-Level Radioactive Waste Policy Act, which, in an effort to address a looming shortage of disposal sites of low level radioactive waste, set forth three "incentives" to states that provided for disposal of waste generated within their borders. The Supreme Court held that the first two incentives were Constitutional, but the third — the take title provision — was not. In holding that provision could be severed from the statute, the Court explained:

> Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated. . . . [The one incentive] may fail, and still the great body of the statute

> have operative force, and the force contemplated by the legislature in its enactment . . . .
>
> [T]he take title provision may be severed *without doing violence* to the rest of the Act. The Act is still operative and it *still serves Congress' objective* of encouraging the States to attain local or regional self-sufficiency in the disposal of low level radioactive waste. It still includes two incentives that coax the States along this road. . . . *The purpose of the Act* is not defeated by the invalidation of the take title provision, so we may leave the remainder of the Act in force.

Id. at 186-67 (emphasis added). Plainly, the "normal case" is very different from the one presented here, where the federal government has repeatedly made clear that the primary and overall *purpose* (albeit not necessarily every single provision) of the Act would be directly and irretrievably compromised by the removal of the central feature that Congress described as "essential" in the words of the Act itself. *See* Act § 1501 (a)(2)(l).[4]

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[4] For example, during the summary judgment hearing and oral argument, the defendants' attorney stressed that the individual mandate is absolutely necessary to the health insurance reforms as those reforms "literally can't work without" the individual mandate [*see* Tr. 83]. As noted, this was very significant because the insurance reform provisions were not a small or inconsequential part of the Act. In fact, they were its primary purpose and main objective — as clearly demonstrated, *inter alia*, by the title of the Act itself and the fact that its proponents frequently referred to the legislative efforts as "health insurance reform." It is, quite frankly, difficult to comprehend how severing and removing the "health insurance reform provisions"

After determining that the individual mandate was unconstitutional and that it could not be severed from the remainder of the Act — and thus "the entire Act must be declared void" — I finally considered the plaintiffs' request for injunctive relief. I explained that the "extraordinary" and "drastic" remedy of an injunction is not typically required against the federal government because:

> . . . there is a long-standing presumption "that officials of the Executive Branch will adhere to the law as declared by the court. As a result, the declaratory judgment is the functional equivalent of an injunction." *See Comm. on Judiciary of U.S. House of Representatives v. Miers*, 542 F.3d 909, 911 (D.C. Cir. 2008); *accord Sanchez-Espinoza v. Reagan*, 770 F.2d 202, 208 n.8 (D.C. Cir. 1985) ("declaratory judgment is, in a context such as this where federal officers are defendants, the practical equivalent of specific relief such as an injunction . . . since *it must be presumed that federal officers will adhere to the law as declared by the court*") (Scalia, J.) (emphasis added).
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> There is no reason to conclude that this presumption should not apply here. Thus, the award of declaratory relief is adequate and separate injunctive relief is not necessary.

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from "health insurance reform legislation" could even arguably leave *a statute that would* "function in a manner consistent with the intent of Congress." *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987)

Order at 75. The above language seems to be plain and unambiguous. Even though I expressly declared that the entire Act was "void," and even though I emphasized that "separate injunctive relief is not necessary" only because it must be presumed that "the Executive Branch will adhere to the law as declared by the court," which means that "declaratory judgment is the functional equivalent of an injunction," the defendants have indicated that they "do not interpret the Court's order as requiring them to immediately cease [implementing and enforcing the Act]." *See* Def. Mot. at 4; *see also id.* at 6 ("we do not understand the Court's declaratory judgment of its own force to relieve the parties to this case of any obligations or deny them any rights under the Act"). They have reportedly continued with full implementation of the Act. They claim that they have done so based on certain language in (and legal analyses left out of) my order, which they believe suggests that the ruling "does not in itself automatically and in self-executing manner relieve the parties of their obligations or rights under the [Act] while appellate review is pending." *See id.*

The defendants have suggested, for example, that my order and judgment could not have been intended to have the full force of an injunction because, if I had so intended, I would have been "required to apply the familiar four-factor test" to determine if injunctive relief was appropriate. *See* Def. Mot. at 14. That well-settled four-factor test requires the party seeking an injunction to demonstrate:

> (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that,

> considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.

eBay, Inc. v. MercExchange, LLC, 547 U.S. 388, 391, 126 S. Ct. 1837, 164 L. Ed. 2d 641 (2006). I did not undertake this four-factor analysis for a simple reason: it was not necessary. Even though the defendants had technically disputed that the plaintiffs could satisfy those four factors, the defendants had acknowledged in their summary judgment opposition brief that, if I were to find for the plaintiffs, separate injunctive relief would be superfluous and unnecessary. The defendants expressly assured the court that, in light of the "long-standing presumption that a declaratory judgment provides adequate relief as against an executive officer, as it will not be presumed that that officer will ignore the judgment of the Court," any declaratory judgment in the plaintiffs' favor "would [ ] be adequate to vindicate [the plaintiffs'] claims." Defendants' Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment (doc. 137), at 43. Consequently, there was no need to discuss and apply the four-factor test to determine if injunctive relief was appropriate because the defendants had confirmed that they would "not . . . ignore the judgment of the Court" and that my "declaratory judgment would [ ] be adequate." In other words, the defendants are now claiming that it is somehow confusing that I bypassed the four-factor test and applied the "long-standing presumption" that they themselves had identified and specifically insisted that they would honor.

I am aware that in their opposition brief the defendants attempted to qualify and limit the "long-standing presumption" — and avoid the declaratory judgment's *immediate* injunction-like effect — by intimating that it should apply "after appellate review is exhausted." *See id*. There were several problems with this claim (which is why I rejected it *sub silentio*). First of all, the case the defendants cited in making their qualifying statement [*Miers*, *supra*, 542 F.3d at 911] does not at all support the position that a district court's declaratory judgment will only be presumed to have injunctive effect against federal officials "after appellate review is exhausted." Quite to the contrary, in that case the Court of Appeals for the District of Columbia determined that the presumption attached *immediately* and thus the district court's declaratory judgment had immediate injunction-like effect (which is why the order under review was "immediately appealable" in the first instance). *See id*. at 910-11. Accordingly, while the defendants may have tried to qualify the long-standing presumption and limit it to post-appeal, I was (and still am) unpersuaded that the presumption can (or should) be limited in such fashion. Indeed, I note that the federal government previously advanced the exact same "after appellate review is exhausted" argument (almost word-for-word) in one of the Virginia cases [*see* doc. 96, in 3:10-cv-188, at 34-35], where it appears to have been rejected *sub silentio* as well. *See Virginia v. Sebelius*, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010) (declaring individual mandate unconstitutional, but declining to issue injunction because, in light of the long-standing presumption against enjoining federal officers, "the award of declaratory judgment is sufficient to stay

the hand of the Executive branch *pending* appellate review") (emphasis added).

Furthermore, as the plaintiffs have correctly pointed out [*see* Pl. Resp. at 3-6], to suggest that a declaratory judgment will only be effective and binding on the parties after the appeals process has fully run its course is manifestly incorrect and inconsistent with well established statutory and case law. A declaratory judgment establishes and declares "the rights and other legal relations" between the parties before the court and has "the force and effect of a final judgment." *See* 28 U.S.C. § 2201 (a). "A declaratory judgment cannot be enforced by contempt proceedings, but it has the same effect as an injunction in fixing the parties' legal entitlements . . . . A litigant who tries to evade a federal court's judgment — and a declaratory judgment is a real judgment, not just a bit of friendly advice — will come to regret it." *Badger Catholic, Inc. v. Walsh*, 620 F.3d 775, 782 (7th Cir. 2010). If it were otherwise, a federal court's declaratory judgment would serve "no useful purpose as a final determination of rights." *See Public Service Comm'n of Utah, v. Wycoff Co., Inc.*, 344 U.S. 237, 247, 73 S. Ct. 236, 97 L. Ed. 2d 291 (1952). For the defendants to suggest that they were entitled (or that in the weeks after my order was issued they thought they might be entitled) to basically ignore my declaratory judgment until "after appellate review is exhausted" is unsupported in the law.[5]

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[5] The defendants have claimed that "[i]n other declaratory judgment cases, pending appellate review, 'the Government has been free to continue to apply [a] statute' following entry of a declaratory judgment." *See* Def. Mot. at 4-5 (citing *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 83 S. Ct. 554, 9 L. Ed. 2d 644

So to "clarify" my order and judgment: The individual mandate was declared unconstitutional. Because that "essential" provision was unseverable from the rest of the Act, the entire legislation was void. This declaratory judgment was expected to be treated as the "practical" and "functional equivalent of an injunction" with respect to the parties to the litigation. This expectation was based on the "long-standing presumption" that the defendants themselves identified and agreed to be bound by, which provides that a declaratory judgment against federal officials is a *de facto* injunction. To the extent that the defendants were unable (or believed that they were unable) to comply, it was expected that they would immediately seek a stay of the ruling, and at that point in time present their arguments for why such a stay is necessary, which is the usual and standard procedure. It was not expected that they would effectively ignore the order and declaratory judgment for two and one-half weeks, continue to

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(1963); *Carreno v. Johnson*, 899 F. Supp. 624 (S. D. Fla. 1995)). Quoting from *Mendoza-Martinez*, the defendants further claim that "'a single federal judge'" is not authorized to "'paralyze totally the operation of an entire regulatory scheme, either state or federal, by issuance of a broad injunctive order' prior to appellate review." *See id.* at 5. The two cited cases are plainly inapposite for the reasons identified by the plaintiffs. *See* Pl. Resp. at 4-5. *Mendoza-Martinez*, for example, applied a statute that precluded single-judge district courts from enjoining an Act of Congress; but that statute was repealed by Congress thirty-five years ago, in 1976. The defendants' selective quoting from those cases — to suggest that the federal government may simply ignore a declaratory judgment by a district court until the appeals process has fully run its course — borders on misrepresentation.

implement the Act, and only then file a belated motion to "clarify."[6]

The plaintiffs have contended that the defendants did not actually need any of the above clarification as they were not really confused by, or unsure of, the effect of my order and judgment. They have suggested that if the defendants had truly believed there was any uncertainty or ambiguity, they would have immediately sought clarification rather than continuing to move forward with implementing the Act as if nothing had happened. The plaintiffs have asserted that the defendants' motion to clarify is, "in fact, a transparent attempt, through the guise of seeking clarification, to obtain a stay pending appeal." *See* Pl. Resp. at 2. At certain parts in the pleading, the defendants' motion does seem to be more of a motion to stay than a motion to clarify. Because the defendants have stated that they intend to file a subsequent motion to stay [Def. Mot. at 15] if I were to "clarify" that I had intended my declaratory judgment to have immediate injunction-like effect (which I just did), I will save time in this time-is-of-the-essence case by treating the motion to clarify as one requesting a stay as well.

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[6] The defendants have suggested in reply to the plaintiffs' response that the reason for the delay was due to the fact that my order "required careful analysis," and it was only after this "careful review" that the defendants could determine its "potential impact" with respect to implementation of the Act (*see* doc. 164 at 11). This seems contrary to media reports that the White House declared within *hours* after entry of my order that "implementation will proceed apace" regardless of the ruling. *See*, *e.g.*, N.C. Aizenman and Amy Goldstein, *U.S. Judge in Florida Rejects Health Law*, Washington Post, Feb. 1, 2011, at A01 (quoting a senior White House official).

II. Motion to Stay

In deciding whether to grant a stay pending appeal, courts should generally examine four factors: (1) whether the applicants have made a strong showing that they are likely to prevail; (2) whether the applicants will be irreparably injured if a stay is not granted; (3) whether granting the stay will substantially injure the other parties interested in the proceeding; and (4) "where the public interest lies." *Hilton v. Braunskill*, 481 U.S. 770, 776, 107 S. Ct. 2113, 95 L. Ed. 2d 724 (1987).

For the first factor, I cannot say that the defendants do not have a likelihood of success on appeal. They do. And so do the plaintiffs. Although I strongly believe that expanding the commerce power to permit Congress to regulate and mandate mental decisions not to purchase health insurance (or any other product or service) would emasculate much of the rest of the Constitution and effectively remove all limitations on the power of the federal government, I recognize that others believe otherwise. The individual mandate has raised some novel issues regarding the Constitutional role of the federal government about which reasonable and intelligent people (and reasonable and intelligent jurists) can disagree. To be sure, members of Congress, law professors, and several federal district courts have already reached varying conclusions on whether the individual mandate is Constitutional. It is likely that the Courts of Appeal will also reach divergent results and that, as most court-watchers predict, the Supreme Court may eventually be split on this issue as well. Despite what partisans for or against the individual mandate might suggest, this litigation presents a question with some strong and

compelling arguments on both sides. Ultimately, I ruled the way I did, not only because I believe it was the right overall result, but because I believe that is the appropriate course for a lower court to take when presented with a (literally) unprecedented argument whose success depends on stretching existing Supreme Court precedent well beyond its current high water mark and further away from the "first principles" that underlie our entire federalist system. Under these circumstances, I must conclude that the defendants do have some (sufficient for this test only) likelihood of success on appeal.

I must next consider the injury to the defendants if the stay is not entered, and the injury to the plaintiffs if it is. The Act, as previously noted, is obviously very complicated and expansive. It contains about 450 separate provisions with different time schedules for implementation. Some are currently in effect, while others, including the individual mandate, are not scheduled to go into effect for several years. In their motion, the defendants have identified and described the "significant disruption" and "wide-ranging and indeterminate consequences" that could result if implementation of the entire Act must stop immediately [*see* Def. Mot. at 4, 7-11], and, upon review and consideration of these arguments, I agree that it would indeed be difficult to enjoin and halt the Act's implementation while the case is pending appeal. It would be extremely disruptive and cause significant uncertainty.

Against this, however, I must balance the potential injury to the plaintiffs if a stay is entered. Relying on their previous summary judgment filings, the plaintiffs have argued that the Act is causing

them substantial harm now because the state plaintiffs are being required to expend significant funds and resources in order to comply with the Act's numerous provisions. In this respect, it is apparent that the plaintiffs will be injured by a stay of my ruling.[7] Similarly, businesses, families, and individuals are having to expend time, money, and effort in order to comply with all of the Act's requirements. Further, I do not doubt that — assuming that my ruling is eventually affirmed — the plaintiffs will sustain injury if the Act continues to be implemented. Reversing what is presently in effect (and what will be put into effect in the future) may prove enormously difficult. Indeed, one could argue that was the entire point in front-loading certain of the Act's provisions in the first place. It could also be argued that the Executive Branch seeks to continue the implementation, in part, for the very reason that the implemented provisions will be hard to undo once they are fully in place. However, after balancing the potential harm to the plaintiffs against the potential harm to the defendants, I find that, on balance, these two factors weigh in favor of granting a stay — particularly in light of several unusual facts present in this case.

For example, my declaratory judgment, of course, only applies to the parties to this litigation. The State of Michigan is one of those parties. However, a federal district court in Michigan has already upheld

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[7] Although the severity of that injury is undercut by the fact that at least eight of the plaintiff states (noted further *infra*) have represented that they will continue to implement and fully comply with the Act's requirements — in an abundance of caution while this case is on appeal — irrespective of my ruling.

the Act and the individual mandate. *See Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010). Can (or should) I enjoin and halt implementation of the Act in a state where one of its federal courts has held it to be Constitutional? In addition, many of the plaintiff states have publicly represented that they will immediately halt implementation of the Act in light of my declaratory judgment, while at least eight plaintiff states (as identified by the defendants in their motion and reply) have suggested that, in an abundance of caution, they will *not* stop implementing the Act pending appeal. In addition to these apparent disagreements *among* the plaintiff states, there is even disagreement *within* the plaintiff states as to whether the implementation should continue pending appeal. For example, while the plaintiffs (a group that includes the *Attorney General* of Washington) have requested that I enjoin the defendants from implementing the Act, the *Governor* of Washington has just filed an amicus brief specifically opposing that request (doc. 163). At this point in time, and in light of all this uncertainty, it would be difficult to deny the defendants a stay pending appeal. Nonetheless, in light of the potential for ongoing injury to the plaintiffs, the stay should be in place for as short of time as possible (months, and not years), as discussed immediately below.

Finally, for the last factor, I must consider "where the public interest lies." Although the defendants' pleadings present a reasonably persuasive argument for why the "public interest lies" in having my declaratory judgment and *de facto* injunction stayed pending appeal, almost every argument that the defendants have advanced speaks much more

persuasively to why the case should be immediately appealed and pursued in the most expeditious and accelerated manner allowable. As both sides have repeatedly emphasized throughout this case, the Act seeks to comprehensively reform and regulate more than one-sixth of the national economy. It does so via several hundred statutory provisions and thousands of regulations that put myriad obligations and responsibilities on individuals, employers, and the states. It has generated considerable uncertainty while the Constitutionality of the Act is being litigated in the courts. The sooner this issue is finally decided by the Supreme Court, the better off the entire nation will be. And yet, it has been more than one month from the entry of my order and judgment and still the defendants have not filed their notice of appeal.

It should not be at all difficult or challenging to "fast-track" this case.[8] The briefing with respect to the general issues involved are mostly already done, as the federal government is currently defending several other similar challenges to the Act that are making their way through the appellate courts. Furthermore, the legal issues specific to this case have already been fully and very competently briefed. With a few additional modifications and edits (to comply with the appellate rules), the parties could probably just change the caption of the case, add colored covers, and be done with their briefing.

After careful consideration of the factors noted above, and all the arguments set forth in the defendants' motion to clarify, I find that the motion,

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[8] I note that two of the pending appeals (in the Fourth and Sixth Circuits) are apparently proceeding on an expedited basis.

construed as a motion for stay, should be GRANTED. However, the stay will be conditioned upon the defendants filing their anticipated appeal within seven (7) calendar days of this order and seeking an expedited appellate review, either in the Court of Appeals or with the Supreme Court under Rule 11 of that Court. *See*, *e.g.*, *NML Capital Ltd. v. Republic of Argentina*, 2005 WL 743086, at *5 (S.D.N.Y. Mar. 31, 2005) (district court granted motion to stay its own ruling, "conditioned on as prompt as possible appeal and a motion for an expedited appeal").

III. Conclusion

As I wrote about two weeks after this litigation was filed: "the citizens of this country have an interest in having this case resolved as soon as practically possible" (doc. 18 at 4). That was nearly eleven months ago. In the time since, the battle lines have been drawn, the relevant case law marshaled, and the legal arguments refined. Almost everyone agrees that the Constitutionality of the Act is an issue that will ultimately have to be decided by the Supreme Court of the United States. It is very important to everyone in this country that this case move forward as soon as practically possible.

Therefore, the defendants' motion to clarify (doc. 156) is GRANTED, as set forth above. To the extent that motion is construed as a motion to stay, it is also GRANTED, and the summary declaratory judgment entered in this case is STAYED pending appeal, conditioned upon the defendants filing their notice of appeal within seven (7) calendar days of this order and seeking an expedited appellate review.

DONE and ORDERED this 3rd day of March, 2011.

/s/ Roger Vinson
ROGER VINSON
Senior United States District Judge

APPENDIX E

U.S. Const., art. I, § 8, cl. 1 provides:

Section 8, Clause 1. Powers of Congress; Levy of Taxes for Common Defense and General Welfare; Uniformity of Taxation

The Congress shall have 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; but all Duties, Imposts and Excises shall be uniform throughout the United States;

U.S. Const., art. I, § 8, cl. 3 provides:

Section 8, Clause 3. Regulation of Commerce

To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes;

U.S. Const., art. I, § 8, cl. 18 provides:

Section 8, Clause 18. Enactment of Laws for Execution of Governmental Powers

To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

26 U.S.C. § 5000A provides:

§ 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

(1) In general.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.—

(1) In general.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.—An amount equal to the following percentage of the excess of the

taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.—For purposes of paragraph (1)—

(A) In general.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year,

determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.—For purposes of this section—

(A) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[**(D) Repealed.** Pub.L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) Applicable individual.—For purposes of this section—

(1) In general.—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions.—

(A) Religious conscience exemption.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry.—

(i) In general.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage.—

(A) In general.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such

individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination

under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) Indexing.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.—

(A) In general.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.—For purposes of this section—

(1) In general.—The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan.—Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.—Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.—Coverage under a grandfathered health plan.

(E) Other coverage.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

42 U.S.C. § 300gg provides:

§ 300gg. Fair health insurance premiums

(a)[1] Prohibiting discriminatory premium rates

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

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[1] So in original. No subsec. (b) enacted.

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define

the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18033(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

42 U.S.C. § 300gg-1 provides:

§ 300gg-1. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following

health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 300gg [FN1] of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing

(1) Limitation on requesting or requiring genetic testing

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment

(A) In general

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations

promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 300gg-91 of this title).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing

of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(1)(F), (b)(3), (c) , and (d) and subsection (b)(1) and section 300gg of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 300gg-21(a) of this title.

(f) Genetic information of a fetus or embryo

Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

42 U.S.C. § 300gg-3 provides:

§ 300gg-3. Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance

coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) of this section in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f) of this section.

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C.A. § 1395c et seq. or § 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C.A. § 1396s].

(E) Chapter 55 of Title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of Title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of Title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2) of this section) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before February 13, 2011—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a

TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of Title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3) of this section, a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or

category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group group [FN1] market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the

employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of Title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of Title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization

Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOS as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no

premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

42 U.S.C. § 300gg-4 provides:

§ 300gg-4. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed--

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) **No group-based discrimination on basis of genetic information**

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing

(1) Limitation on requesting or requiring genetic testing

A group health plan, and a health insurance issuer offering health insurance coverage in connection with

a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment

(A) In general

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health

insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or

purchase genetic information for underwriting purposes (as defined in section 300gg-91 of this title).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(6), (b)(3), (c) , and (d) and subsection (b)(1) and section 300gg-3 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 300gg-21(a) of this title.

(f) Genetic information of a fetus or embryo

Any reference in this part to genetic information concerning an individual or family member of an individual shall--

(1) with respect to such an individual or family member of an individual who is a pregnant woman,

include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(j) Programs of health promotion or disease prevention

(1) General provisions

(A) General rule

For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a "wellness program") shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) No conditions based on health status factor

If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) Conditions based on health status factor

If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate

this section if the requirements of paragraph (3) are complied with.

(2) Wellness programs not subject to requirements

If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) Wellness programs subject to requirements

If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50

percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows--

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a

statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(k) Existing programs

Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to March 23, 2010 and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(l) Wellness program demonstration project

(1) In general

Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) Expansion of demonstration project

If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

(3) Requirements

(A) Maintenance of coverage

The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that--

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 18071 of this title.

(B) Other requirements

States that participate in the demonstration project under this subsection--

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall require verification from health

insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts--

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not lead to cost shifting; and

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(m) Report

(1) In general

Not later than 3 years after March 23, 2010, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning--

(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) Data collection

In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

(n) Regulations

Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

42 U.S.C. § 18091 provides:

§ 18091. Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement 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. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In

Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement 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.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.